

KENTUCKY
STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

TN # 90-05
SUPERSEDES
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: Kentucky

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LIST OF ATTACHMENTS

<u>No.</u>	<u>Title of Attachments</u>
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2-A	Organization and Function of State Agency
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*Supplement 2 -	Definitions of Blindness and Disability (<u>Territories only</u>)
*Supplement 3 -	Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements (<u>States only</u>)
*Supplement 1 -	Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
*Supplement 2 -	Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and other Optional Groups
*Supplement 3 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
*Supplement 4 -	Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

*Forms Provided

<u>No.</u>	<u>Title of Attachments</u>
*Supplement 5 -	Section 1902(f) Methodologies for Treatment of Resources that Differ from those of the SSI Program
*Supplement 5a -	Methodologies for Treatment of Resources for Individuals with Incomes Up to a Percentage of the Federal Poverty Level
*Supplement 6 -	Standards for Optional State Supplementary Payments
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*2.6-A	Eligibility Conditions and Requirements (<u>Territories Only</u>)
*Supplement 1 -	Income Eligibility Levels – Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries
*Supplement 2 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
*Supplement 3 -	Resource Levels for Optional Groups with Incomes Up to a Percentage of the Federal Poverty Level and Medically Needy
*Supplement 4 -	Consideration of Medicaid Qualifying Trusts – Undue Hardship
*Supplement 5 -	Liberal Methods of Treating Income Under Section 1902(r)(2) of the Act
*Supplement 6 -	More Liberal Methods of Treating Resources Under Section 1902(r)(2) of the Act

*Forms Provided

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<u>No.</u>	<u>Title of Attachments</u>
*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy
	* Supplement 1 - Case Management Services
	Supplement 2 - Alternative Health Care Plans for Families Covered Under Section 1925 of the Act
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*Forms Provided

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7.2-A	Methods of Administration — Civil Rights (Title VI)

*Forms Provided



Medicaid Administration

State Plan Administration Designation and Authority A1

42 CFR 431.10

Designation and Authority

State Name:

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency:

Type of Agency:

- Title IV-A Agency
- Health
- Human Resources
- Other

Type of Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

The single state agency supervises the administration of the state plan by local political subdivisions.

- Yes No

The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

- Yes No

Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.



Medicaid Administration

The waivers are still in effect.

Yes No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY): 11/07/13

The type of responsibility delegated is (check all that apply):

- Determining eligibility
- Conducting fair hearings
- Other

Name of state agency to which responsibility is delegated:

Division of Administrative Hearings

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

The Division of Administrative Hearings is housed within the Cabinet Secretary's Office and consists of two branches: the Health Services Administrative Hearings Branch and the Families & Children Administrative Hearings Branch. The HS AHB hearing officers conduct hearings in service appeal cases. These cases include both members and providers. The F&C AHB hearing officers conduct hearings primarily in eligibility appeal cases. Any party unsatisfied with the hearing officer determination may appeal to the Appeals Board. This board is appointed by the Secretary and presently consists of three attorneys along with support staff. Decisions of the appeals board are final and not reviewed by DMS.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

The Division of Administrative Hearings provides impartial hearing officers for various Cabinet for Health and Family Services administrative hearings to resolve disputes concerning benefits, services and actions in a variety of programs administered by the Cabinet and governed by state and federal law.

The Division of Administrative Hearings has two branches:

Families and Children Administrative Hearings Branch
Health Services Administrative Hearings Branch

Families and Children Administrative Hearings Branch

Conducts hearings for the Kentucky Transitional Assistance Program (K-TAP) including initial and ongoing eligibility for monthly payments, eligibility as an incapacitated individual, non-participation in the Kentucky Works Program (KWP) and concerning other services provided by the Department for Community Based Services.

Conducts hearings for the Food Stamp Program including initial and ongoing eligibility for program benefits, participation in the employment and training program and recoupment of overpayment of benefits. Conducts hearings for individuals who allegedly have committed an intentional program violation.



Medicaid Administration

Conducts hearings for Medicaid including initial and ongoing eligibility for medical benefits, eligibility as a permanent and totally disabled individual and monthly personal obligation for cost of nursing facility care.

Conducts hearings for the Division of Child Support including obligation amounts, tax intercept, payment arrearages and suspension of drivers licenses.

Conducts hearings for the Division of Protection and Permanency including program issues about services for and treatment of families, children and vulnerable adults.

Health Services Administrative Hearings Branch

Process and schedule hearing requests in a timely manner and in accordance with applicable laws and regulations;

Conduct pre-hearing conferences in a timely manner and in accordance with appropriate laws and regulations;

Conduct hearings in accordance with KRS 13B requirements or in accordance with hearing procedures approved by the Attorney General and the legislature;

Render decisions or reports in a timely manner in accordance with appropriate laws and regulations;

Maintain hearing records in accordance with federal and state statutes;

Issue subpoenas; Administrative Subpoena; CAPTA Administrative Subpoena
Assist the CHFS secretary on appeals and hearings when requested.

-DMS will ensure that DAH complies with all federal and state laws, regulations and policies.

-DMS does retains oversight of the State Plan and will establish a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by DAH.

-DMS will ensure that every applicant and beneficiary is informed, in writing, of the fair hearing process and how to contact DAH and how to obtain information about fair hearings from that agency.

Add

- The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act



Medicaid Administration

The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

- Medicaid agency
- Title IV-A agency
- An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- Medicaid agency
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

Yes No

State Plan Administration

Organization and Administration

A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The organizational structure of the Department for Medicaid Services consists of a commissioner, deputy commissioner, medical director, pharmacy director, dental director and six (6) divisions. Each division director assumes specific responsibility in one of the following divisions: Division of Program Quality and Outcomes, Division of Community Alternatives, Division of Provider and Member Services, Division of Fiscal Management, Division of Policy and Operations and Division of Program Integrity.

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

The Division of Program Quality and Outcomes consists of the Disease and Case Management Branch and the Managed Care Oversight - Quality Branch. Each branch consists of Nurse Consultants, Medicaid Specialists and Program Coordinators.

The Division of Community Alternatives consists of the Mental Health/Intellectual and Developmental Disabilities Branch, Acquired Brain Injury Branch, Home and Community Based Services Branch and Community Transitions Branch. Each branch consists of Nurse Consultants, Medicaid Specialists and Program Coordinators.

The Division of Provider and Member Services consists of the Member Services Branch and the Provider Services Branch. Each branch consists of Medicaid Specialists.

The Division of Fiscal Management consists of the Administrative Services Branch, Financial Management Branch and Rate Setting Branch. This division consists of Healthcare Data Administrators, Actuary, Internal Policy Analysts and Medicaid Specialists.

The Division of Policy and Operations consists of the Eligibility Policy Branch, Benefit Policy Branch and the Managed Care



Medicaid Administration

Oversight - Contract Management Branch. This division consists of Medicaid Specialists, Internal Policy Analysts and Nurse Consultants.

The Division of Program Integrity consists of the Recovery Branch, Third Party Liability Branch and Provider Licensing and Certification Branch. The division consists of Medicaid Specialists.

The Department for Medicaid Services is directly concerned with administration of all aspects of the Program (excluding the eligibility determinations function). 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 healthcare. 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;
6. Developing and implementing a managed care program for the delivery of physical and behavioral health services;
7. Developing and implementing a capitated non-emergency medical transportation delivery system, excluding ambulance stretcher services; and

B. In the course of carrying out the above specifically designated functions 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.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.



Medicaid Administration

The Cabinet for Health and Family Services is the primary agency in state government responsible for the development and operation of health and human service 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 and reports to the Office of the Governor.

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.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

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.

Remove

Type of entity that determines eligibility:

- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

A Memorandum of Understanding has been signed between the Department for Medicaid Services and the Office of the Kentucky Health Benefit Exchange, within the Cabinet for Health and Family Services, to facilitate coordination and administration of programs and systems that support Medicaid/KCHIP. One aspect of the Exchange includes a "no wrong door approach" to allow one enrollment system for multiple programs. This Eligibility and Enrollment (E&E) system will allow individuals to enroll in Medicaid and KCHIP, if determined eligible. This E&E system is owned by the Exchange and replaces the mainframe system the Department for Medicaid Services is currently using for eligibility determinations for Medicaid and KCHIP.

Remove



Medicaid Administration

Type of entity that determines eligibility:

- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

- Yes No

State Plan Administration

Assurances

A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

- The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- All requirements of 42 CFR 431.10 are met.
- There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.
- The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:



Medicaid Administration

- There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

- There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).
- When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

- The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Non-Financial Eligibility
Citizenship and Non-Citizen Eligibility S89

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

Citizenship and Non-Citizen Eligibility

The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42

CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

The state provides Medicaid eligibility to otherwise eligible individuals:

Who are citizens or nationals of the United States; and

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity

Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or

satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

Yes No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

Yes No

The date benefits are furnished is:

The date of application containing the declaration of citizenship or immigration status.

The date the reasonable opportunity notice is sent.

Other date, as described:



Medicaid Eligibility

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

Yes No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

Yes No

Pregnant women

Individuals under age 21:

Individuals under age 21

Individuals under age 20

Individuals under age 19

An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

Granted employment authorization under 8 CFR 274a.12(c);

Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

Granted Deferred Action status;

Granted an administrative stay of removal under 8 CFR 241;

Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who -

Has been granted employment authorization; or

Is under the age of 14 and has had an application pending for at least 180 days;



Medicaid Eligibility

6. Has been granted withholding of removal under the Convention Against Torture;
7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);
8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));
10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

Other

The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;

Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process

S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

- The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

- The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

- An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

- An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

- Yes No

TN No: 13-0007-MM2
Kentucky

Approval Date: 11-06-13
S94 1-2

Effective Date: 01/01/14



Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	Facsimile	Faxing an application	X

- The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

- Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:
- Once every 12 months
 - Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

- Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):
- Once every 12 months
 - Once every 6 months
 - Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

- The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between
- Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

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USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

Paper Application Online Application

TRANSMITTAL NUMBER:

STATE:

13-0007-MM2

Kentucky

Through June 30, 2014, the state is using an interim online alternative single streamlined application. After June 30, 2014, the state will use a revised online alternative single streamlined application, which will address the issues outlined in the CMS letter concerning the state's application. The revised application will be incorporated by reference into the state plan.



Medicaid Eligibility

OMB Control Number 0938-1148
 OMB Expiration date: 10/31/2014

AFDC Income Standards

S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
 AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

	Household size	Standard (\$)	
+	1	147	X
+	2	179	X
+	3	207	X
+	4	259	X
+	5	303	X
+	6	342	X
+	7	381	X

Additional incremental amount

Yes No

Increment amount \$

The dollar amounts increase automatically each year

Yes No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a



Medicaid Eligibility

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

	Household size	Standard (\$)	
+	1	186	X
+	2	225	X
+	3	262	X
+	4	328	X
+	5	383	X
+	6	432	X
+	7	482	X

Additional incremental amount

- Yes No

Increment amount \$

The dollar amounts increase automatically each year

- Yes No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard



Medicaid Eligibility

	Household size	Standard (\$)	
+	1	223	X
+	2	274	X
+	3	324	X
+	4	403	X
+	5	470	X
+	6	532	X
+	7	595	X

Additional incremental amount

Yes No

Increment amount \$

The dollar amounts increase automatically each year

Yes No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard.



Medicaid Eligibility

	Household size	Standard (\$)	
+	1	401	X
+	2	460	X
+	3	526	X
+	4	592	X
+	5	658	X
+	6	724	X
+	7	790	X

Additional incremental amount

Yes No

Increment amount \$

The dollar amounts increase automatically each year

Yes No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

Yes No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:



Medicaid Eligibility

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No

PRA Disclosure Statement



Medicaid Eligibility

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Parents and Other Caretaker Relatives

S25

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

- Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

The state attests that it operates this eligibility group in accordance with the following provisions:

- Individuals qualifying under this eligibility group must meet the following criteria:

- Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

- This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

- Options relating to the definition of caretaker relative (select any that apply):

- The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.

Definition of domestic partner:

- The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.

If a parent is not included in the case, one (1) other caretaker relative may be included to the same extent he would have been eligible in the Aid to Families with Dependent Children program using the AFDC methodology in effect on July 16, 1996.

A caretaker relative shall include:

1. Grandfather;
2. Grandmother;
3. Brother;
4. Sister;



Medicaid Eligibility

Description of other relatives:

5. Uncle;
6. Aunt;
7. Nephew;
8. Niece;
9. First cousin;
10. A relative of the half-blood;
11. A preceding generation denoted by a prefix of:
 - a. Grand;
 - b. Great; or
 - c. Great-great; or
12. A stepfather, stepmother, stepbrother, or stepsister.

The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

Options relating to the definition of dependent child (select the one that applies):

The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

Have household income at or below the standard established by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for this group

Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

Maximum income standard



Medicaid Eligibility

- The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

- The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

- A percentage of the federal poverty level: %
- The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- Other dollar amount
- Income standard chosen:

Indicate the state's income standard used for this eligibility group:

- The minimum income standard
- The maximum income standard
- The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.
- Another income standard in-between the minimum and maximum standards allowed
- There is no resource test for this eligibility group.
- Presumptive Eligibility



Medicaid Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage	S28
Pregnant Women	

42 CFR 435.116
 1902(a)(10)(A)(i)(III) and (IV)
 1902(a)(10)(A)(ii)(I), (IV) and (IX)
 1931(b) and (d)
 1920

Pregnant Women - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

Yes No

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for this group

Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

Enter the amount of the minimum income standard (no higher than 185% FPL): % FPL

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant

women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.



Medicaid Eligibility

- The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- 185% FPL

The amount of the maximum income standard is: % FPL

Income standard chosen

Indicate the state's income standard used for this eligibility group:

- The minimum income standard
- The maximum income standard
- Another income standard in-between the minimum and maximum standards allowed.

There is no resource test for this eligibility group.

Benefits for individuals in this eligibility group consist of the following:

- All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

- Yes No

The presumptive period begins on the date the determination is made.

The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

There may be no more than one period of presumptive eligibility per pregnancy.

A written application must be signed by the applicant or representative.



Medicaid Eligibility

Yes No

The presumptive eligibility determination is based on the following factors:

The woman must be pregnant

Household income must not exceed the applicable income standard at 42 CFR 435.116.

State residency

Citizenship, status as a national, or satisfactory immigration status

The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities

S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966

Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

Is a state or Tribal child support enforcement agency under title IV-D of the Act

Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act

Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

Other entity the agency determines is capable of making presumptive eligibility determinations:



Medicaid Eligibility

The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Infants and Children under Age 19

S30

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

Infants and Children under Age 19 - Infants and children under age 19 with household income at or below standards established by the state based on age group.

The state attests that it operates this eligibility group in accordance with the following provisions:

Children qualifying under this eligibility group must meet the following criteria:

- Are under age 19
- Have household income at or below the standard established by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for infants under age one

Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

Enter the amount of the minimum income standard (no higher than 185% FPL): % FPL

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.



Medicaid Eligibility

- The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
 - The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
 - 185% FPL

Enter the amount of the maximum income standard: % FPL

Income standard chosen

The state's income standard used for infants under age one is:

The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

Income standard for children age one through age five, inclusive

Minimum income standard



Medicaid Eligibility

The minimum income standard used for this age group is 133% FPL.

Maximum income standard

- The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

- The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: % FPL

Income standard chosen

The state's income standard used for children age one through five is:

- The maximum income standard
- If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),
- 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),
- 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.



Medicaid Eligibility

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

Income standard for children age six through age eighteen, inclusive

Minimum income standard

The minimum income standard used for this age group is 133% FPL.

Maximum income standard

- The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

- The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- 133% FPL

Enter the amount of the maximum income standard: % FPL

Income standard chosen



Medicaid Eligibility

The state's income standard used for children age six through eighteen is:

- The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),

- 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children

- age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and

- if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and

- if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

- There is no resource test for this eligibility group.

- Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

- Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Adult Group

S32

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

Yes No

Adult Group - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Have attained age 19 but not age 65.

Are not pregnant.

Are not entitled to or enrolled for Part A or B Medicare benefits.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

Have household income at or below 133% FPL.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is

receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

Under age 19, or

A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No

PRA Disclosure Statement



Medicaid Eligibility

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Former Foster Care Children

S33

42 CFR 435.150
1902(a)(10)(A)(i)(IX)

Former Foster Care Children - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

The state attests that it operates this eligibility group under the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Are under age 26.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

Yes No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals above 133% FPL	S50
1902(a)(10)(A)(ii)(XX) 1902(hh) 42 CFR 435.218	
Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218. <input type="radio"/> Yes <input checked="" type="radio"/> No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage	
Optional Coverage of Parents and Other Caretaker Relatives	S51

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage	S52
Reasonable Classification of Individuals under Age 21	

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance

S53

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage	
Optional Targeted Low Income Children	S54

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals with Tuberculosis	S55
1902(a)(10)(A)(ii)(XII) 1902(z)	
Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services. <input type="radio"/> Yes <input checked="" type="radio"/> No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Independent Foster Care Adolescents	S57
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42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage	
Individuals Eligible for Family Planning Services	S59

1902(a)(10)(A)(ii)(XXI)
42 CFR 435.214

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

Yes No

PRA Disclosure Statement

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Presumptive Eligibility by Hospitals

S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

Yes No

The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A qualified hospital is a hospital that:

Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

Yes No

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

Pregnant Women

Infants and Children under Age 19

Parents and Other Caretaker Relatives

Adult Group, if covered by the state

Individuals above 133% FPL under Age 65, if covered by the state

Individuals Eligible for Family Planning Services, if covered by the state

Former Foster Care Children

Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

Other Family/Adult groups:

Eligibility groups for individuals age 65 and over

Eligibility groups for individuals who are blind

Eligibility groups for individuals with disabilities

Other Medicaid state plan eligibility groups

Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.



Medicaid Eligibility

Yes No

The presumptive period begins on the date the determination is made.

The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

Periods of presumptive eligibility are limited as follows:

No more than one period within a calendar year.

No more than one period within two calendar years.

No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

Yes No

The presumptive eligibility determination is based on the following factors:

The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

State residency

Citizenship, status as a national, or satisfactory immigration status

The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

MAGI-Based Income Methodologies

S10

1902(e)(14)
42 CFR 435.603

- The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size
- Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

- Yes No



Medicaid Eligibility

The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

Age 19

Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility State Residency

S88

42 CFR 435.403

State Residency

- The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
 - Intends to reside in the state, including without a fixed address, or
 - Entered the state with a job commitment or seeking employment, whether or not currently employed.
- Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
 - Residing in the state, with or without a fixed address, or
 - The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
 - Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
 - Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
 - If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- IV-E eligible children living in the state, or



Medicaid Eligibility

Otherwise meet the requirements of 42 CFR 435.403.



Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

Yes No

The state has interstate agreements with the following selected states:

- | | | | |
|--|---|--|--|
| <input checked="" type="checkbox"/> Alabama | <input checked="" type="checkbox"/> Illinois | <input checked="" type="checkbox"/> Montana | <input checked="" type="checkbox"/> Rhode Island |
| <input checked="" type="checkbox"/> Alaska | <input checked="" type="checkbox"/> Indiana | <input checked="" type="checkbox"/> Nebraska | <input checked="" type="checkbox"/> South Carolina |
| <input checked="" type="checkbox"/> Arizona | <input checked="" type="checkbox"/> Iowa | <input checked="" type="checkbox"/> Nevada | <input checked="" type="checkbox"/> South Dakota |
| <input checked="" type="checkbox"/> Arkansas | <input checked="" type="checkbox"/> Kansas | <input checked="" type="checkbox"/> New Hampshire | <input checked="" type="checkbox"/> Tennessee |
| <input checked="" type="checkbox"/> California | <input type="checkbox"/> Kentucky | <input checked="" type="checkbox"/> New Jersey | <input checked="" type="checkbox"/> Texas |
| <input checked="" type="checkbox"/> Colorado | <input checked="" type="checkbox"/> Louisiana | <input checked="" type="checkbox"/> New Mexico | <input checked="" type="checkbox"/> Utah |
| <input checked="" type="checkbox"/> Connecticut | <input checked="" type="checkbox"/> Maine | <input type="checkbox"/> New York | <input checked="" type="checkbox"/> Vermont |
| <input checked="" type="checkbox"/> Delaware | <input checked="" type="checkbox"/> Maryland | <input checked="" type="checkbox"/> North Carolina | <input checked="" type="checkbox"/> Virginia |
| <input checked="" type="checkbox"/> District of Columbia | <input checked="" type="checkbox"/> Massachusetts | <input checked="" type="checkbox"/> North Dakota | <input checked="" type="checkbox"/> Washington |
| <input checked="" type="checkbox"/> Florida | <input checked="" type="checkbox"/> Michigan | <input checked="" type="checkbox"/> Ohio | <input checked="" type="checkbox"/> West Virginia |
| <input checked="" type="checkbox"/> Georgia | <input checked="" type="checkbox"/> Minnesota | <input checked="" type="checkbox"/> Oklahoma | <input checked="" type="checkbox"/> Wisconsin |
| <input checked="" type="checkbox"/> Hawaii | <input checked="" type="checkbox"/> Mississippi | <input checked="" type="checkbox"/> Oregon | <input type="checkbox"/> Wyoming |
| <input checked="" type="checkbox"/> Idaho | <input checked="" type="checkbox"/> Missouri | <input checked="" type="checkbox"/> Pennsylvania | |

The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- Are IV-E eligible
- Are in the state only for the purpose of attending school
- Are out of the state only for the purpose of attending school
- Retain addresses in both states
- Other type of individual

The state has a policy related to individuals in the state only to attend school.

Yes No

Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

Yes No

PRA Disclosure Statement



Medicaid Eligibility

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

(1)

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)

OMB No. 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: Kentucky

Citation

As a condition for receipt of Federal funds under title XIX
of the Social Security Act, the

42 CFR
430.10

Department for Medicaid Services

(Single State Agency)

Submits the following State plan for the medical assistance
program, and hereby agrees to administer the program in
accordance with the provisions of this State plan, the
requirements of titles XI and XIX of the Act, and all
applicable Federal regulations and other official issuances
of the Department.

TN No. 92-1
Supersedes
TN No. 86-1

Approval Date NOV 14 1994

Effective Date 1-1-92
HCFA ID: 7982E

(2)

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Kentucky

Section 1 SINGLESTATE AGENCY ORGANIZATION

Citation

42 CFR 431.10
AT-79-29

1.1 Designation and Authority

- (a) The Department for Medicaid Services is the single State agency designated to Administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to the Medicaid agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

TN No. 86-1
Supersedes
TN No. 78-14

Approval Date 6-23-86

Effective Date 3-1-86

(3)

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation

Sec. 1902(a)
of the Act

1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

Yes. The State agency so designated is

This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

TN No. 78-14
Supersedes
TN No. _____

Approval Date 6-25-79

Effective Date 8-31-78

(4)

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Kentucky

Citation

Intergovernmental
Cooperation Act of 1968.
of 1968

1.1(c) Waivers of the single State agency requirement
which are currently operative have been granted
under authority of the Cooperation Act

- Yes. ATTACHMENT 1.1-B describes
these waivers and the approved alternative
organizational arrangements.
- Not applicable. Waivers are no longer in
effect.
- Not applicable. No waivers have ever been
granted.

TN No. 77-2
Supersedes
TN No. _____

Approval Date 2-28-77

Effective Date 1-1-77

(5)

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Kentucky

Citation

42 CFR 431.10
AT-79-29

- 1.1(d) The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan.
- Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

TN No. 77-2
Supersedes
TN No. _____

Approval Date 2-28-77

Effective Date 1-1-77

(6)

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Kentucky

Citation

42 CFR 431.10
AT-79-29

1.1(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.

TN No. 77-2
Supersedes
TN No. _____

Approval Date 2-28-77

Effective Date 1-1-77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Kentucky

Citation

42 CFR 431.11
AT-79-29

1.2 Organization for Administration

- (a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.
- (b) Within the State agency, the Department for Medicaid Services has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.
- (c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.
- d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.
 - Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.

TN No. 86-1
Supersedes
TN No. 74-8

Approval Date: 6-23-86

Effective Date: 3-1-86

(8)

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation

42 CFR
431.50(b)
AT-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

- The plan is State administered.
- The plan is administered by the political subdivisions of the State and is mandatory on them.

TN No. 74-8
Supersedes
TN No. _____

Approval Date: 9-12-74

Effective Date: 4-1-74

(9)

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation

42 CFR
431.12(b)
AT-78-90

1.4 State Medical Care Advisory Committee
There is an advisory committee to the Medicaid agency director on health and medical care Services established in accordance with and Meeting all the requirements of 42 CFR 431.12.

42 CFR
438.104

The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: Kentucky

Citation 1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.
 - a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory committee on Immunization Practices and without charge for the vaccines.
 - b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.
 - c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.
 - d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.
 - e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.
 - f. The State will assure that no vaccine eligible child is denied vaccines because of an inability to pay an administration fee.
 - g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

(9b)

Revision: HCFA-PM-94-3 (MB)
APRIL 1994

State/Territory: Kentucky

Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.
3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.
4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:
 - State Medicaid Agency
 - State Public Health Agency

TN No. 94-18
Supersedes
TN No. None

Approval Date: 2-1-95

Effective Date 10-1-94

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

OMB No. : 0938-

State: Kentucky

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation

2.1 Application, Determination of Eligibility and
Furnishing Medicaid

42 CFR
435.10 and
Subpart J

(a) The Medicaid agency meets all requirements of 42 CFR435Applications, determining eligibility, and furnishing Medicaid.

TN No. 92-1
Supersedes
TN No. 75-8

Approval Date NOV-14-1994

Effective Date 1-1-92
HCFA ID: 7982E

KENTUCKY MEDICAID STATE PLAN

State Plan Definition of HMO

(11)

Revision: HCFA-PM- (MB)

State Territory: Kentucky

Citation

42 CFR
435.914
1902(a)(34)
of the Act

2.1(b) (1) Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.

1902(e)(8) and
1905(a) of the
Act

(2) For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after The end of the month which the individual is first Determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

1902(a)(47) and

(3) Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

(11a)

Revision: HCFA-PM-91-8 (MB)
October 1991

OMB No.

State/Territory: Kentucky

Citation

1902(a)(55)
of the Act

2.1(d) The Medicaid agency has procedures to take of the Act applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in S1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(V1), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

TN No. 92-1
Supersedes
TN No. 91-28

Approval Date NOV-14-1994

Effective Date 1-1-92
HCFA ID: 7985E

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)

OMB No.: 0938-

State: Kentucky

Citation

42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

- Mandatory categorically needy and other required special groups only.
- Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.
- Mandatory categorically needy, other required special groups, and specified optional groups.
- Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

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

Approval Date NOV-14-1994

Effective Date 1-1-92
HCFA ID: 7982E

Revision: HCFA-PM-87-4
MARCH 1987

(BERC)

OMB No.: 0938—0193

State: Kentucky

Citation

2.3. Residence

435.10 and
435.403, and
1902(b) of the
Act, P.L. 99-272
(Section 9529)
and P.L. 99-509
(Section 9405)

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

TN No. 87-15
Supersedes
TN No. 86-7

Approval Date 1-22-88

Effective Date 10-1-87
HCFA ID: 1006P/0010P

Revision: HCFA-PM-87-4
MARCH 1987

(BERC)

OMB No.: 0938-0193

State: Kentucky

Citation

2.4 Blindness

42 CFR 435.530(b)
42 CFR 435.531
AT-78-90
AT-79-29

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

TN No. 87-15
Supersedes
TN No. 76-2

Approval Date JAN-22-2988

Effective Date 10-1-87
HCFA ID: 1006P/0010P

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)

OMB No.: 0938-

State: Kentucky

Citation

2.5 Disability

42 CFR
435.121,
435.540(b)
435.541

All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.

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

Approval Date NOV-14-1994

Effective Date 1-1-92
HCFA ID: 7982E

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

State: Kentucky

Citation(s)

2.6 Financial Eligibility

42 CFR
435.10 and
Subparts G & H
1902(a)(10) (A) Ci)
(III), (IV), (V)1
(VI), and (VII),
1902(a)(10)(A)(ii)
(IX), 19C2(a)(10)
(A)(ii)(X), 1902
(a)(10)(C),
1902(f), 1902(1)
and (rn),
190S(p) and (s),
1902(r)(2),
and 1920

- (a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

Revision: HCFA-PM-86-20 (BERC)
SEPTEMBER 1986

State/Territory: Kentucky

Citation

431.52 and
1902(b) of the
Act, P.L. 99-272
(Section 9529)

2.7 Medicaid Furnished Out of State

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

TN No. 86-7
Supersedes
TN No. 82-21

Approval Date NOV-12-1987

Effective Date 10-1-86
HCFA ID: 0053C/0061E

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

OMB No.: 0938-

State/Territory: Kentucky

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation
42 CFR, Part 440, Subpart B1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

3.1 Amount Duration, and Scope of Services
(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act is provided as defined in 42 CFR Part 440, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, as defined in 42 CFR 440.165 are provided to the extent that nurse-midwives are authorized to practice under State law or regulation. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Not applicable. Nurse-midwives are not authorized to practice in this State.

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

OMB No.: 0938-

State/Territory: Kentucky

Citation 3.1(a)(1) Amount, Duration, and Scope of Services:
Categorically Needy (Continued)

1902(e)(5) of
the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for medical conditions complicate the pregnancy (other pregnancy-related or postpartum provided to pregnant women.

1902(a) (10),
clause (VII)
of the matter
following (F)
of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

(19b)

Revision: HCFA-PM-92-7 (MB)
OCTOBER 1992

State/Territory: Kentucky

Citation	3.1(a)(1)	<u>Amount, Duration, and Scope of Services:</u> <u>Categorically Needy (Continued)</u>
1902(a)(10)(D)	(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act	(vii)	Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	<input type="checkbox"/> (viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act	(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and 1929	<input type="checkbox"/> (x)	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.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)

OMB No.: 0938-

State/Territory: Kentucky

Citation

3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440,
Subpart B

(a)(2) Medically needy.

- This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv)
of the Act
42 CFR 440.220

- (i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 105(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

- Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of
the Act

- (ii) Prenatal care and delivery services for pregnant women.

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

OMB No.: 0938-

State/Territory: Kentucky

Citation 3i(a)(2) Amount, Duration, and Scope of Services:
Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140,
440.150, 440.160
Subpart B,
442.441,
Subpart C
1902(a) (20)(C)
and (21) of the Act
1902(a)(10)(D)

(vii) Services in an institution for mental diseases for individuals over age 65..

(viii) Services in an intermediate care facility for the mentally retarded.

(ix) Inpatient psychiatric services for individuals under age 21

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

Approval Date NOV -14-1994

HCFA ID: 7982E

Effective Date 1-1-92

(20b)

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: Kentucky

Citation 3.1(a)(2)4 Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of the Act (x) Respiratory care services are provided ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a) (23) and 1929 (xi) 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.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy—related services and services for conditions that may complicate the pregnancy.

State: Kentucky

<u>Citation</u>	3.1	<u>Amount, Duration, and Scope of Services (continued)</u>
1902(a)(10)(E)(i). and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act	(a)(3)	<u>Other Required Special Groups: Qualified Medicare Beneficiaries</u> Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.1 of this plan.
1902(a)(10)(E)(ii) and 1905(s) of the Act	(a)(4)(i)	<u>Other Required Special Groups: Qualified Disabled and Working Individuals</u> Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.1 of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3) (A)(ii) of the Act	(ii)	<u>Other Required Special Groups: Specified Low-Income Medicare Beneficiaries</u> Medicare Part B premiums for specified low-income income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iv)(I) 1905(p)(3)(A)(ii) and 1933 of the Act	(iii)	<u>Other Required Special Groups: Qualifying Individuals – 1</u> Medicare Part B premiums for qualifying individuals described in Section 1902(a)(10)(E)(iv)(I) and subject to Section 1933 of the Act are provided as indicated in item 3.2 of this plan.

State: Kentucky

- (iv) Other Required Special Groups: Qualifying Individuals - 2
- 1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(iv)(II), 1905(p)(3) of the Act
- The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in Section 1902(A)(10)(E)(iv)(II) and subject to Section 1933 of the Act are provided as indicated in item 3.2 of this plan.
- (a)(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits
- 1925 of the Act
- Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.
- (a)(6) Homeless Individuals
- 1905(a)(9) of the Act
- Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
- (a)(7) Presumptively Eligible Pregnant Women
- 1902(a)(47) and 1920 of the Act
- Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
- (a)(8) EPSDT Services
- 42 CFR 441.55, 50 CFR 43654, 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act
- The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

(21b)

State: Kentucky

P.L. 102-585
Section 402

(a)(9) Qualified Alien

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. 104-193, 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).

(a)(10) Limited Coverage for Certain Aliens

1902(a) and 1903(v)
of the Act and
Section
401(b)(1)(A) of P.L.
104-193

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.

Revision: HCFA-PM-91- (BPD)

State: Kentucky

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60 The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements. * *

42 CFR 440.240 and 440 .250 (a)(10) Comparability of Services

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(G), 1925(b)(4), and 1932 of the Act Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the

Immigration and Nationality Act, permit exceptions:

- (i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.
- (ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.
- (iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.
- (iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

** Describe here.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.

Revision: HCFA - Region VI
November 1990

State: Kentucky

<u>Citation</u>	3.1(b)	<u>Home health services are provided in accordance with the requirements of 42 CFR 441.15.</u>
42 CFR Part 440 Subpart B 42 CFR 441.15 AT-78-90 AT-80-34 Section 1905 (a)(4)(A) Of Act (Sec. 4211(f) of P.L. 100-203).	(1)	Home health services are provided to all categorically needy individuals 21 years of age or over.
	(2)	Home health services are provided to all categorically needy Individuals under 21 years of age.
		<input checked="" type="checkbox"/> Yes
		<input type="checkbox"/> Not applicable. The State plan does t provide for nursing facility for such individuals
	(3)	Home health services are provided to the medically needy:
		<input type="checkbox"/> Yes to all
		<input checked="" type="checkbox"/> Yes, to individuals age 21 or over; nursing facility services are provided.
		<input checked="" type="checkbox"/> Yes to individuals under age 21; nursing facility services are provided
		<input type="checkbox"/> No; nursing facility services are not provided.
		<input type="checkbox"/> Not applicable; the medically needy are not included under this plan

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

OMB No.: 0938-

State/Territory: Kentucky

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR 431.53 (c) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation

3.1(d) Methods and Standards to Assure Quality of Services

42 FR 440.260
AT- 78-90

The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

TN No. 92-1
Supersedes
TN No. 76-21

Approval Date 11-14-94

Effective Date 1-1-92

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation

3.1(e) Family Planning Services

42 CFR 441.20
AT-78-90

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

TN No. 76-21
Supersedes
TN No. ____

Approval Date 1-27-77

Effective Date 11-23-76

Revision: HCFA-PM-87-5
APRIL 1987

(BERC)

OMB No.: 0938-0193

State/Territory: Kentucky

Citation _____
42 CFR 441.30
AT- 7 8-90

3.1 (f)

(1) Optometric Services

Optometric services (other than those provided under SS435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

- Yes.
- No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.
- Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)
of the Act
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

- No.
- Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards f or the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938—0193

State/Territory: Kentucky

Citation

3.1 (g) Participation by Indian Health Service Facilities

42 CFR 431.110(b)
AT-78-90

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of
the Act,
P.L. 99-509
(Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals
Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who --

- (1) Are medically dependent on a ventilator for life support at least six hours per day;
- (2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of 30 consecutive days;
 - days (the maximum number of inpatient
 - days allowed under the State plan);
- (3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;
- (4) Have adequate social support services to be cared for at home; and
- (5) Wish to be cared for at home.
 - Yes. The requirements of section 1902(e)(9) of the Act are met.
 - * Not applicable. These services are not included in the plan.

* Pen and ink mark agreed to by Hugh Walker 1-20-88

TN No. 87-15
Supersedes
TN No. 78-4

Approval Date JAN-22-88

Effective Date 10-1-87
HCFA ID: 1008P/011P

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938—0193

State/Territory: Kentucky

Citation 3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

(i) Qualified Medicare Beneficiaries (QMB)

1902(a)(10)(E) and
1905(p) of the Act

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, by the following method:

- Group premium payment arrangement for Part A
- Buy-In agreement for
 - Part A Part B
- Other arrangements described below.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Kentucky

(29a)

Citation

- 1902(a)(10)(E)(ii)
and 1905(s) of the
Act
- (ii) Qualified Disabled and Working Individual (QDWI)
The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.
- 1902(a) (10) (E)(iii)
and
1905(p)(3)(A)(ii) of
the Act
- (iii) Specified Low-Income Medicare beneficiary (SLMB)
The Medicaid agency pays Medicare Part B premiums under the State buy in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.
- 1902(a)(10)(E)(iv)(I)
1905(p)(3)(A)(ii),
and 1933 of the Act
- (iv) Qualifying Individual - 1 (QI-1)
The Medicaid Agency pays Medicare Part B premiums under the State buy in process for individuals described in Section 1902(a) (10) (E)(iv)(I) and subject to Section 1933 of the Act.
- 1902(a) (10) (E) (iv)
(II),
1905(p) (3) (A) (ii),
and 1933 of the Act
- (v) Qualifying Individual -2 (QI-2)
The Medicaid agency pays the portion of the amount of the increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in Section 1902(a)(10)(E)(iv)(II) and subject to Section 1933 of the Act.

TN No. 98-02
Supersedes
TN No. 92-01

Approval Date 6-3-98

Effective Date 1-1-98

(29b)

State: Kentucky

1843(b) and 1905(a)
of the Act and 42
CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

- Individuals within categories listed at 42 CFR 407.42 (b)(6), including categorically needy individuals who are receiving SSI or SSP cash assistance; individuals who are treated for Medicaid eligibility purposes as though they were receiving SSI or SSP; Qualified Medicare Beneficiaries; and individuals under Attachment 2.2-A, item A. 21., who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336.
- All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV or XVI (ABD or SSI); (b) receiving State supplements under title XIV; or (c) within a group listed at 42 CFR 431.625(d)(2).
- Individuals receiving title II or Railroad Retirement benefits.
- Medically needy individuals (FFP is not available for this group).

(2) Other Health Insurance

1902(a)(30) and
1905(a) of the Act

- The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

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

OMB No.: 0938-

State/Territory: Kentucky

Citation (b) Deductibles /Coinsurance

(1) Medicare Part A and B

Section 1902(n)
of the Act

Attachment 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902
(a)(10)(E) and
1905(p) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays deductibles and coinsurance for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

42 CFR 431.625
1902(a)(10)(E) and
of the Act
1905(a)

(ii) Other Medicaid Recipients

The Medicaid agency pays Medicare deductibles and coinsurance (subject to any nominal Medicaid copayment) for services furnished to individuals who are described in section 3.2(a)(1)(iii) above, as follows:

For the entire range of services available under Medicare.

Only for the amount, duration, and scope of services otherwise available under this plan.

(iii) Dual Eligible--OMB plus Other Medicaid Recipients

The Medicaid agency pays deductibles and coinsurance for services furnished to individuals eligible both as QMB. and categorically or medically needy (subject to any nominal Medicaid copayment) for all services available under Medicare.

Revision: HCFA-PM-91-8 (MB)
October 1991

OMB No.:

State/Territory: Kentucky

<u>Citation</u>	<u>Condition or Requirement</u>
1906 of the Act	<p>(c) <u>Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations</u></p> <p>The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.</p> <p>When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).</p>
1902(a) (10) (F) of the Act	<p>(d) <input type="checkbox"/> The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.</p>

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 3

Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

42 CFR 441.101,
42 C1 431.620(c)
and (d)
AT-79-29

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

Yes. The requirements of 42 CFR Part 441, Su1art C, and 42 CFR 431.620(c) and (d) are met.

Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

TN No. 76-21
Supersedes
TN No. ____

Approval Date 1-27-77

Effective Date 11-23-76

Revision: HCFA-Nr-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 3.4 Special Requirements Applicable to Sterilization Procedures

42 CFR 441.252 All requirements of 42 CFR Part 441, Subpart F are met.
AT-78-99

TN # 79-3
Supersedes
TN #: _____

Approval Date: 4/4/79

Effective Date: 2/6/79

(3la)

Revision: HCFA-PM-91-6 (BPD)
AUGUST 1991
State: Kentucky

OMB No.: 0938-

Citation 3.5 Families Receiving Extended Medicaid Benefits

1902(a) (52)
and 1925 of
the Act.

- (a) Services provided to families during the first 6—month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).
- (b) services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--
 - Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).
 - Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:
 - Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
 - Medical or remedial care provided by licensed practitioners.
 - Home health services.

TN No. 92-1
Supersedes
TN No. 90-22

Approval Date NOV 14, 1994

Effective Date: 1-1-92
HCFA ID: 7982E

(31b)

Revision HCFA-PM-91-4
AUGUST 1991

(BPD)

OMB No.: 0938-

State: Kentucky

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

- Private duty nursing services.
- Physical therapy and related services.
- Other diagnostic, screening, preventive, and rehabilitation services.
- Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- Intermediate care facility services for the mentally retarded.
- Inpatient psychiatric services for individuals under age 21.
- Hospice services.
- Respiratory care services.
- Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

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

Approval Date NOV 14, 1994

Effective Date 1-1-92
HCFA ID: 7982E

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

OMB No.: 0938-

State: Kentucky

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

- (c) The agency pays the family’s premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker’s employer as payments for medical assistance--
 - 1st 6 months 2nd 6 months
 - The agency requires caretakers to enroll in employers’ health plans as a condition of eligibility.
 - 1st 6 months 2nd 6 months
- (d) (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:
 - Enrollment in the family option of an employer’s health plan.
 - Enrollment in the family option of a State employee health plan.
 - Enrollment in the State health plan for the uninsured.
 - Enrollment in an eligible health maintenance organization (MO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

(31d)

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

OMB No.: 0938-

State: Kentucky

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

- (i) Pays all premiums and enrollment fees imposed on the family for such plan(s).
- (ii) Pays all deductibles and coinsurance the family for such plan(s).

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: Kentucky

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

Citation

4.1 Methods of Administration

42 CFR 431.15
AT-79-29

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

TN No. 87-15
Supersedes -
TN No. 74-7

Approval Date: JAN 22, 1988

Effective Date 10-1-87

HCPA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 4.2 Hearings for Applicants and Recipients

42 CFR 431.202
AT-79-29
AT-80-34

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

TN # 74-7

Supersedes

TN # _____

Approval Date 9/12/74

Effective Date: 4/1/74

Revision: HCFA-AT-87-9 (BERC)
AUGUST1987

OMB No.: 0938-0193

State/Territory: Kentucky

Citation 4.3 Safeguarding Information on Applicants and Recipients

42 CFR 431.301
AT-79-29

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967

All other requirements of 42 CFR Part 431, Subpart F are met.

Revision: HCFA-AT-97-9 (BERC)
AUGUST 1987

OMB No.: 0938—0193

State/Territory: Kentucky

Citation 4.4 Medicaid Quality Control

42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of
the Act,
P.L. 99-509
(Section 9407)

- (a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.
- (b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h), (j) and (k).
 - Yes
 - No applicable. The State has an approved Medicaid Management Information System (MMIS)

TN No. 89-26
Supersedes
TN No. 87-15

Approval Date: AUG 08, 1989

Effective Date: 7/1/89

HCFA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938—0193

State/Territory: Kentucky

Citation 4.5 Medicaid Agency Fraud Detection and Investigation Program

42 CFR 455.12
AT- 78—90
48 FR 3742
52 FR 48817

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

TN No. 88-24
Supersedes
TN No. 83-7

Approval Date DEC 12, 1988

Effective Date 10-1-88

HCFA ID: 1010P/0012P

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.5.1 Medicaid Recovery Audit Contractor Program

Citation The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State Plan and under any waiver of the State Plan.

Section 1902(a)(42)(B)(i)
Of the Social Security Act

The State is seeking an exception to establishing such program for the following reasons:

Section 1902(a)(42)(B)(ii)(I) of the Act

The State/Medicaid Agency has contract of the types(s) listed in Section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.

Place a check mark to provide assurance of the following:

The State will make payments to the RAC(S) only from amounts recovered.

The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

Section 1902(a)(42)(B)(ii)(II)(aa) of the Act

The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

- | | | |
|--|-------------------------------------|--|
| | <input type="checkbox"/> | The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee. |
| Section 1902 (a)(42)(B)(ii)(II)bb) of the Act | <input checked="" type="checkbox"/> | The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee): |
| Section 1902 (a)(42)(B)(ii)(III) of the Act | <input checked="" type="checkbox"/> | The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s). |
| Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act | <input checked="" type="checkbox"/> | The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State Plan or a waiver of the Plan. |
| Section 1902 (a)(42)(B)(ii)(IV)(bb) of the Act | <input checked="" type="checkbox"/> | The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share. |
| Section 1902 (a)(42)(B)(ii)(IV)(cc) of the Act | <input checked="" type="checkbox"/> | Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State Plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program |

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.5.1 Medicaid Recovery Audit Contractor Program (EXCEPTIONS)

Citation

Exception

42 CFR 455.508(f)

1. Exception from 3 year look back period

The Commonwealth of Kentucky (hereinafter referred to as the Commonwealth) is requesting an exception to the 3 year look back period defined in §455.508 Eligibility requirements for Medicaid RACs (f) that states, "The entity must not review claims that are older than 3 years from the date of the claim, unless it receives approval from the State."

Kentucky seeks approval for a 5 year look back period for its retrospective reviews in order to be consistent with Kentucky policy prior to CMS RAC regulations.

Kentucky Administrative code requires all Medicaid participating providers to maintain documentation for a minimum of five years from "a. the date of final payment for services"

- This requirement not only holds Medicaid providers responsible for the accuracy of paid claims, but also allows the Commonwealth to recover any overpayments identified due to noncompliance with the Commonwealth rules and regulations for a five year period.
- A five year look back period is consistent with the record requirement period by other licensing and regulatory agencies.
- A five year look back maximizes the identified overpayments and lessened the interval period by which a particular provider can be cost effectively audited. The five year look back period will result in audit cost saving and be less burdensome to the providers.

TN No. 11-012
Supersedes
TN No. None

Approval Date: 02-01-12

Effective Date: January 1, 2012

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.5.1 Medicaid Recovery Audit Contractor Program (EXCEPTIONS) (continued)

42 CFR 455.508(b)

2. Exception from 455.508(b) requiring 1.0 FTE Medical Director

The Medicaid RAC Final rule at 42 CFR §455.508(b) provides that “the [RAC] must hire a minimum of 1.0 [full time equivalent] FTE Contractor Medical Director (CMD) who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities, where applicable to review Medicaid claims.”

Kentucky’s RAC vendor, OptumInsight, has been operating since 2010. The RAC vendor is making Medicaid overpayment and underpayment determinations based on coding criteria and State policy, using claims data and medical records where appropriate. At this time, OptumInsight is not making medical necessity determinations or using medical judgment that would require its RAC to hire a CMD. As a result, the RAC utilizes certified coders and program subject matter experts to make its determinations.

This SPA will be in effect for two years after its approval date. At that time,

1. Kentucky must evaluate the performance of its RAC program without a CMD; and
2. Determine whether it will submit a new request for an exception to the requirement that the RAC hire a minimum of 1.0 FTE CMD.

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.5.1 Medicaid Recovery Audit Contractor Program (EXCEPTIONS) (continued)

2. Exception from 455.508(b) requiring 1.0 FTE Medical Director (continued)

- For limited items that may require a Medical Director, the Commonwealth can utilize the Department for Medicaid services Medical Director. Additionally, the Commonwealth may utilize the contractor's Medical Director on an as needed basis but who is not dedicated solely to the Commonwealth. This as needed approach is the most efficient and economical use of time.

TN No. 12-003
Supersedes
TN No.: None

Approved Date: 05-24-12

Effective Date: January 1 2012

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Kentucky

Citation 4.6 Reports

42 CFR 431.16
AT-79-29

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

TN # 78-1
Supersedes
TN # _____

Approval Date: 2/23/78

Effective Date 10/1/77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 4.7 Maintenance of Records

42 CFR 431.17
AT-79-29

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

TN # 78-1
Supersedes
TN # _____

Approval Date: 2/23/78

Effective Date: 10/1/77

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 4.8 Availability of Agency Program Manuals

42 CFR 431.18(b)
AT-79-29

Program manuals and other policy issuances that affect the public, issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

TN # 74-5
Supersedes
TN # _____

Approval Date 9/12/74

Effective Date: 2/18/74

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 4.9 Reporting Provider Payments to Internal Revenue Service

42 CFR 433.37
AT-78-90

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

New: HCFA-PM-99-3
JUNE 1999

State: Kentucky

Citation

4.10 Free Choice of Providers

42 CFR 431.51
AT 78-90
46 FR 48524
48 FR 23212
1902(a)(23)
P.L. 100-93
(section 8(f))
P.L. 100-203
(Section 41 13)

- (a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis.
- (b) Paragraph (a) does not apply to services furnished to an individual
 - (1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or
 - (2) Under a waiver approved under 42 CFR 431 .55, subject to the limitations in paragraph (c), or
 - (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,
 - (4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or
 - (5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).
- (c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 19 15(a), 1915(b)(1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

Section I 902(a)(23))
of the Social
Security Act
P.L. 105-33

Section 1932(a)(I)
Section 1905(t)

Revision HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 4.11 Relations with Standard-Setting and Survey Agencies

42 CFR 431.610
AT-78-90
AT-80-34

- (a) The State agency utilized by the Secretary to determine qualifications of institutions and suliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is the Department for Human Resources.
- (b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): the Department for Human Resources
- (c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

TN # 74-5
Supersedes
TN # _____

Approval Date: 9/12/74

Effective Date: 2/18/74

(43)

Revision: HCFA-M-80-38 (BPP)
May 22, 1980

State Kentucky

Citation 4.11(d)

42 CFR 431.610
AT-78-90
AT-89-34

The Department for Human Resources (agency) which is the State agency responsible for licensing health institutions determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

TN 74-5
Supersedes
TN # _____

Approval Date: 9/12/74

Effective Date: 4/18/74

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 4.12 Consultation to Medical Facilities

42 CFR 431.105(b)
AT-78-90

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

Yes, as listed below:

Not applicable. Similar services are not provided to other types of medical facilities.

TN # 74-1

Supersedes

TN # _____

Approval Date: 9/12/74

Effective Date: 10/1/73

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

OMB No.: 0938-

State/Territory: Kentucky

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

- 42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
- 42 CFR Part 483 (b) For providers of NF services, the requirements of 1919 of the Act 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
- 42 CFR Part 483 (c) For providers of ICFIMR services, the requirements Subpart C of participation in 42 CFR Part 483, Subpart D are also met.
- 1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920 (b)(2) and (c) are met.
 - Yes.
 - Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

October 1991

45(a)

Advance Directives

State/Territory: Kentucky

Citation 4.13

- 1902 (a)(58)
1902(w)
- (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:
- (1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:
 - (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
 - (b) Provide written information to all adult individuals on their policies concerning implementation of such rights;
 - (c) Document in the individual's medical records whether or not the individual has executed an advance directive;
 - (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
 - (e) Ensure compliance with requirements of State Law (whether

TN # 03-10
Supersedes
TN # 91-31

Approval Date NOV 13, 2003

Effective Date: 8/13/03

Revision: HCFA-PM-91-9 (MB)
October 1991State/Territory: KentuckyCitation 4.13

statutory or recognized by the courts) concerning advance directives; and

- (f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.
- (2) Providers will furnish the written information described in paragraph (I)(a) to all adult individuals at the time specified below:
- (a) Hospitals at the time an individual is admitted as an inpatient.
 - (b) Nursing facilities when the individual is admitted as a resident.
 - (c) Providers of home health care or personal care services before the individual comes under the care of the provider;
 - (d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and
 - (e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.
- (3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.
- Not applicable. No State law Or court decision exist regarding advance directives.

Revision: HCFA-PM-91-10 (MB)
DECEMBER 1991

EQRO

State: Kentucky

Citation4.14 Utilization/Quality Control

42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and
1902(d) of the
Act, P.L. 99-509
(Section 9431)

- (a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

- Directly
- By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO-
- (1) Meets the requirements of 434.6(a):
 - (2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
 - (3) Identifies the services and providers subject to PRO review,
 - (4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
 - (5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

EQRO

1932(c)(2)
and 1902(d) of the
ACT, P.L. 99-509
(section 9431)

- A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E of each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation

TN# 03-10
Supersedes
TN # 92-2

Approval Date: NOV 18 2003

Effective Date: 8/13/03

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State/Territory: Kentucky

OMB NO: 0938-0193

Citation 4.14

42 CFR 456.2
50 FR 15312

- (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.
- Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.
 - Utilization review is performed in accordance with 42 CFR Part 456, Subpart K that specifies the conditions of a waiver of the Requirements of Subpart C for:
 - All hospitals (other than mental hospitals).
 - Those specified in the waiver.
 - No waivers have been granted.

TN No. 85-2
Supersedes
TN No. 77-7

Approval Date: 10/23/86

Effective Date: 7-1-85
HCFA ID: 0048P/0002P

STATE: KentuckyCitation 4.1442 CFR 456.2
50 FR 15312

(c) The Medicaid agency meets the requirements 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals. *

- Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews. *
- Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:
 - All mental hospitals.
 - Those specified in the waiver.
 - No waivers have been granted.
- Not applicable. Inpatient services in mental hospitals are not provided under this plan.

* For all mental hospitals and psychiatric residential treatment facilities, the required reviews are performed by a professional review agency.

TN# 92-23
Supersedes
TN# 85-2Approved Date: JAN 07, 1993Effective Date 10/1/1992

STATE: Kentucky

Citation 4.14

42 CFR 456.2
50 FR 15312

- (d) The Medicaid agency meets the requirements of 42 CFR Part 456, subpart E, for the control of utilization of nursing facility services
- Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.
 - Utilization review is performed in accordance with 42 CFR Part 456, Subpart H that specifies the conditions of a waiver of the requirements of Subpart E for:
 - All skilled nursing facilities.
 - Those specified in the waiver.
 - No waivers have been granted.

TN # 92-23
Supersedes
TN # 85-2

Approved JAN 07, 1993

Eff. Date: 10-1-92

STATE: Kentucky

Citation 4.14

42 CFR 456.2
50 FR 15312

- (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:
- Facility-based review.
 - Direct review by personnel of the medical assistance unit of the State agency. *
 - Personnel under contract to the medical assistance unit of the State agency.
 - Utilization and Quality Control Peer Review Organizations.
 - Another method as described in ATTACHMENT 4.14-A
 - Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.
- Not applicable. Intermediate care facility services are not provided under this plan.

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: Kentucky

42 CFR 43 8.356(e)

For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

42CFR438.354

42 CFR 438.356(b) and (d)

The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review- related activities meets the competence and independence requirements.

Not applicable.

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: Kentucky

Citation 4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part 456 Subpart I, and 1902(a) (31) and 1903(g) of the Act

- The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:
- ICFs/MR;
- Inpatient psychiatric facilities for recipients under age 21*;
and
- Mental Hospitals. *

CFR Part 456 Subpart A and 1902(a) (30) of the Act

- All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.
- Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.
- Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.
- Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

* For all mental hospitals and all inpatient psychiatric facilities serving recipients age twenty-one (21) years and younger, the required reviews are performed by a professional review agency.

TN No. 92-23
Supersedes
TN No. 76-3

Approval Date: JAN 07 1993

Effective Date 10-1-92

HCFA ID:

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

42 CFR 431.615(c) AT-78-90 The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with Title V grantees, that meet the requirements of 42 CFR 431.615 and 42 CFR 431.620.

42 CFR 431.620 Attachment 4.16 A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: KentuckyCitation

4.17 Liens and Adjustments or Recoveries

42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of
the Act

(a) Liens

- The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

- The State imposes liens on real property on account of benefits incorrectly paid.
- The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.
- The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford those individuals notice, hearing procedures, and due process requirements.)
- The State imposes liens on both real and personal property of an individual after the individual's death.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

- (1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.
 - Adjustments or recoveries are made for all other medical assistance made on behalf of the individual.
- (2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).
- (3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital, and prescription drug services.
 - In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

Recover for physician services related to the above mandatory services, for individuals age 55 and over. Aside from these limited mandatory services and related physician services, there is no other recovery, including Medicare Cost Sharing as identified in Section 4.17(b)(3) (Continued).

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

- (i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.
- (ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

TN No.: 10-013
Supersedes
TN No.: None

Approval Date: 02-08-11

Effective Date: October 1, 2010

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

- 1917(b)1(C) (4) If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

TN No. 08-009
Supersedes
TN No. 03-014

Approval Date 10/17/08

Effective Date 7/14/2008

Revision: HCFA-PM-95-3 (MB)
May 1995

Revised

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) or the Act and regulations at 42 CFR 433.36(h)- (i).

- (1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.
- (2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to their cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:
 - (a) A sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or
 - (b) A child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the individual provided permitted the individual to reside at home rather than become institutionalized.
- (3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

Revision: HCFA-PM-95-3 (MB)
May 1995

Revised

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

(d) ATTACHMENT 4.17-A

- (1) Specifies the procedures for determining that an institutionalized individual cannot be reasonably expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).
- (2) Specifies the criteria by which a son or daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).
- (3) Defines the following terms:
 - estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
 - individual's home,
 - equity interest in the home,
 - residing in the home for at least 1 or 2 years, on a continual basis,
 - discharge from the medical institution and return home, and
 - lawfully residing.

TN No. 03-014 -
Supersedes
TN No. None

Approval Date: NOV 19 2003

Effective Date 9/01/03

Revision: HCFA-PM-95-3 (MB)
May 1995

Revised

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

- (4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.
- (5) Defines when adjustment or recovery is not cost- effective. Defines cost-effective and includes methodology or thresholds used to determine cost- effectiveness.
- (6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

TN No. 03-014
Supersedes
TN No. None

Approval Date NOV 19 2003

Effective Date 9/01/03

Revision: HCFA-AT-91-4 (BPD)
AUGUST 1991

State/Territory: Kentucky

Citation

4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.5
through 447.58

1916(a) and (b)
of the Act

- (a) Unless a waiver under 42 CFR 43 1.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.
- (b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(l) of the Act) under the plan:
- (1) No enrollment fee, premium, or similar charge is imposed under the plan.
- (2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:
- (i) Services to individuals under age 18, or under--
- Age 19
 - Age 20
 - Age 21
 - Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.
 - Recipients between the ages of 18 and 21 who are in state custody and are in foster care or residential treatment are exempted from copayments.
- (ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991State/Territory: Kentucky

Citation 4.18(b)(2) (Continued)

42 CFR 447.51
through
447.58

- (iii) All services furnished to pregnant women.
- Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
- (iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.
- (v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
- (vi) Family planning services and supplies furnished to individuals of childbearing age.
- (vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

- Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.
- Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act,
P.L. 99-272,
(Section 9505).

- (viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

State: Kentucky

Citation 4.18 Recipient Cost Sharing and Similar Charges (Continued)

42 CFR 447.51

- (b) (3) Unless a waiver under 42 CFR 431.55(g) applies, through 447.58 nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.
- Not applicable. No such charges are imposed.
- (i) For any service, no more than one type of charge is imposed.
- (ii) Charges apply to services furnished to the following age groups:
- 18orolder
 - 19orolder
 - 20 or older
 - 21 or older
- Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

State: Kentucky

Citation

4.18 Recipient Cost Sharing and Similar Charges (Continued)

42 CFR 447.51
through 447.58

- (b) (3)
- (iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:
- (A) Service(s) for which a charge(s) is applied;
 - (B) Nature of the charge imposed on each service;
 - (C) Amount(s) of and basis for determining the charge(s);
 - (D) Method used to collect the charge(s);
 - (E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;
 - (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
 - (G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.
- Not applicable. There is no maximum.

State: KentuckyCitation4.18 Recipient Cost Sharing and Similar Charges (Continued)1916(c) of
the Act(b) (4)

A monthly premium is imposed on pregnant women and infants who are covered under section 1 902(a)(1 0)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining what constitutes unique hardship for waiving payment of premiums by recipients.

1 902(a)(52)
and 1925(b)
of the Act(5)

For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act. ATTACHMENT 4.18-F specifies the method the State uses for determining the premium.

1916(d) of
the Act(6)

A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1 902(a)(1 0)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

State: Kentucky

Citation 4.18 Recipient Cost Sharing and Similar Charges (Continued)

42 CFR 447.51
through 447.58

(c) Individuals are covered as medically needy under the plan.

(1) An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through
through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under

Age 19

Age 20

Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

- Recipients between the ages of 18 and 21 who are in state custody and are in foster care or residential treatment are exempted from copayments.

State: Kentucky

Citation 4.18 Recipient Cost Sharing and Similar Charges (Continued)

42 CFR 447.51
through 447.58

(C) (2)

- (ii) Services to pregnant women related to pregnancy or any other medical condition that may complicate the pregnancy.
- (iii) All services furnished to pregnant women.
 - Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
- (iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.
- (v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
- (vi) Family planning services and supplies furnished to individuals of childbearing age.
- (vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

1916 of the Act,
P.L. 99-272
(Section 9505)

State: Kentucky

Citation

4.18 Recipient Cost Sharing and Similar Charges (Continued)

42 CFR 447.51
through 447.58

- (c) (3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (c)(2) above.
- Not applicable. No such charges are imposed.
 - (i) For any service, no more than one type of charge is imposed.
 - (ii) Charges apply to services furnished to the following age groups:
 - 18 or older
 - 19 or older
 - 20 or older
 - 21 or older
 - Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable:

State: Kentucky

Citation 4.18 Recipient Cost Sharing and Similar Charges (Continued)

42 CFR 447.51
through 447.58

(c) (3)

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

- (A) Service(s) for which charge(s) is applied;
- (B) Nature of the charge imposed on each service;
- (C) Amount(s) of and basis for determining the charge(s);
- (D) Method used to collect the charge(s);
- (E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;
- (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
- (G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.
 - Not applicable. There is no maximum.

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

OMB No.: 0938-

State/Territory: Kentucky

Citation

42 CFR 447.252
1902(a) (13)
and 1923 of
the Act

4.19 Payment for Services

- (a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

- Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.
- Inappropriate level of care days are not covered.

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

Approval Date: NOV 14 1994

Effective Date: 1-1-92

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

OMB No.: 0938-

State/Territory: Kentucky

Citation 4.19

42 CFR 447.201
42 CFR 447.302
52 FR 28648
1902(a) (13) (E)
1903(a)(l) and
(n), 1920, and
1926 of the Act

- (b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:
- (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
 - (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and - intermediate care facilities for the mentally retarded services that are described in other attachments.

TN No. 92-1
Supersedes
TN No. 90-11

Effective Date: NOV 14 1994

Approval Date 1-1-92

Revision: HCFA-AT-80-38 (BPP)
May 22 1980

State Kentucky

Citation 4.19

42 CFR 447.40
AT-78-90

(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

Yes. The State's policy is described in ATTACHMENT 4.19-C.

No.

TN # 77-6

Supersedes

TN # _____

Approval Date 11/23/77

Effective Date 1/1/78

Revision: HCFA - Region VI
November 1990

State/Territory: Kentucky

Citation 4.19

42 CFR 447.252
47 FR 47964
48 FR 56046
• 42 CFR 447.280
47 FR 31518
52 FR 28141
Section 1902(a)
(13)(A) of Act
(Section 4211 (h)
(2)(A) of P.L.
100—203).

- (d) (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for nursing facility services and intermediate care facility services for the mentally retarded.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for nursing facility services and intermediate care facility services for the mentally retarded.

- (2) The Medicaid agency provides payment for routine nursing facility services furnished by a Swing-bed hospital.

- At the average rate per patient day paid to NFs for routine services furnished during the previous calendar year.
- At a rate established by the Stat., which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.
- Not applicable. The agency does not provide payment for NF services to a swing- bed hospital.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 4.19

42 CFR 447.45(c) (e) The Medicaid agency meets all requirements of 42 CFR 447.45 for
P-79-50 timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

TN # 79-13

Supersedes

TN # _____

Approval Date: 1/10/80

Effective Date: 8/23/79

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 09838-0193

State/Territory: Kentucky

<p><u>Citation</u></p> <p>42 CFR 447.15 AT-78-90 AT-90-34 48 FR 5730</p>	<p>4.19 (f)</p>	<p>The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.</p> <p>No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.</p>
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TN No. 87-15
Supersedes
TN No. 83-11

Approval Date JAN 22 1989

Effective Date: 10-1-87

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
MARCH 1987

State/Territory: Kentucky

Citation 4.19

42 CFR 447.201 (g) The Medicaid agency assures appropriate audit of records when
42 CFR 447.202 payment is based on costs of services or in a fee plus cost of
AT-78-90 materials.

TN # 79-9

Supersedes

TN # _____

Approval Date: 9/17/79

Effective Date: 8/6/79

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State: Kentucky

Citation 4.19

42 CFR 447.201 (h) The Medicaid agency meets the requirements of 42 CFR 447.203 for
42 CFR 447.203 documentation and availability of payment rates.
AT-78-90

TN # 79-9

Supersedes

TN #: _____

Approval Date: 9/17/79

Effective Date: 8/6/79

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 4.19

42 CFR 447.201
42 CFR 447.204
AT-78-90

- (i) The Medicaid agency's payments are sufficient to enlist enough providers that services under the plan are available to recipients at least to the extent that those services are available to the general population.

TN # 79-9
Supersedes
TN # _____

Approval Date: 9/17/79

Effective Date: 8/6/79

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

OMB No.: 0938-

State: Kentucky

Citation 4.19

42 CFR
447.201
and 447.205

(j) The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.

1903(v) of the Act

(k) The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

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

Approval Date NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7982E

Revision: HCFA-PM- 92-7 (MB)
October 1992

State/Territory: Kentucky

Citation 4.19

1903(i) (14) (l) The Medicaid agency meets the requirements of Section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

TN No. 93-9
Supersedes
TN No. None

Approval Date: JUN 4 1993

Effective Date: 4-1-93

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1994

State/Territory: Kentucky

Citation 4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928 (c) (2)
(C)(ii) of
the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

- sets a payment rate at the level of the regional maximum established by the DHHS Secretary.
- is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.
- sets a payment rate below the level of the regional maximum established by the DHS Secretary.*
- is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State. *

The State pays the following rate for the administration of a vaccine:

\$3.30 per administration fee (with a limit of 3 administration fees per recipient, per date of service).

*At the request of Anita Moore, 1/20/95, this change was made

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

The state's administration fee was established by using Medicare's administration fee of \$3.28 rounded to the nearest ten (10) cents. The state believes the use of Medicare's fee in combination with Kentucky's KenPAC Program will assure adequate access to immunization.

TN No. 94-18
Supersedes
TN No. None

Approval Date: 2/1/95

Effective Date: 10/1/94

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation 4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

42 GFR 447.25(b)
AT-78-9 0

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

- Yes, for physicians' services
- dentists' services

ATTACHMENT 4.20 - A specifies the conditions under which such payments are made.

- Not applicable. No direct payments are made to recipients.

TN # 78-2
Supersedes
TN # _____

Approval Date: 3/16/78

Effective Date: 9/16/77

Revision: HCFA-AT-81-34 (BPP)

10-81

State Kentucky

Citation 4.21 Prohibition Against Reassignment of Provider Claims

42 CFR 447.10(c)
AT-78-90
46 FR 42699

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

TN # 81-31
Supersedes
TN # 78-10

Approval Date 12-4-81

Effective Date 7-1-81

Revision: HCFA-PM-94--1 (MB)
FEBRUARY 1994 -

State/Territory: Kentucky

Citation 4.22 Third Party Liability

- 42 CFR 433.137 (a) The Medicaid agency meets all requirements of:
- (1) 42 CFR 433.138 and 433.139.
 - (2) 42 CFR 433.145 through 433.148.
 - (3) 42 CFR 433.151 through 433.154.
 - (4) Sections 1902(a) (25) (H) and (I) of the Act.
- 1902(a)(25)(H) and (I) of the Act
- 42 CFR 433.138(f) (b) ATTACHMENT 4.22-A –
- (1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;
 - (2) Describes the methods the agency uses for and (2)(ii) meeting the followup requirements contained in §433.138(g)(1)(i) and (g) (2) (i);
 - (3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and
 - (4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.
- 42 CFR 433.138(g)(1)(ii)
- 42 CFR 433.138(g)(3)(i) and (iii)
- 42 CFR 433.138(g)(4)(i) through (iii)

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: Kentucky

Citation

- (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried Out by the State IV-D agency.
- (d) ATTACHMENT 4.22-B specifies the following:
- 42 CFR 433.139(b)(3)(ii)(C) (1) The method used in determining a providers compliance with the third party billing requirements at §433.139(b)(3)(ii) (C).
- 42 CFR 433.139(f)(2) (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
- 42 CFR 433.139(f)(3) (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
- 42 CFR 447.20 (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: Kentucky

Citation 4.22 continued

42 CFR 433.151(a) (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

Other appropriate State agency(s)-

Other appropriate agency(s) of another State--

Courts and law enforcement officials.

1902(a) (60) of the Act (g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

The Secretary's method as provided in the State Medicaid Manual, Section 3910.

The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

Revision: HCFA-AT-84-2 (HERC)
01-84

State/Territory: Kentucky

Citation 4.23 Use of Contracts

42 CFR 434.4
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

Not applicable. The State has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):

Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2

a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2

a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.

Not applicable.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Kentucky

Citation 4.24 Standards for Payments for Skilled Nursing and Intermediate Care Facility Services.

42 CFR 442.10
and 442.100
AT-78-90
AT-79-18
AT-80-25
AT-80-34
52 FR 32544

With respect to skilled nursing and intermediate care facilities, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.

Not applicable to intermediate care facilities; such services are not provided under this plan.

TN # 89-26
Supersedes
TN # 80-3

Approval Date: AUG 08 1989

Effective Date: 7/1/89

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Kentucky

Citation 4.25 Program for Licensing Administrators of Nursing Homes

42 CFR 431.702
AT-78-90

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

TN # 74-2
Supersedes
TN # _____

Approval Date: 9/12/74

Effective Date: 10/1/73

Revision: HCFA-PM- (MB)

State/Territory: KentuckyCitation 4.26 Drug utilization Review Program

- 1927(g)
42 CFR 456.700
- 1927(g) (1) (A)
- 1927(g) (1) (a)
42 CFR 456.705(b) and
4 56.709(b)
- 1927 (g) (1) (B)
42 CFR 456.703
(d)and(f)
- A. 1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.
2. The DUR program assures that prescriptions for outpatient drugs are:
- Appropriate
 - Medically necessary
 - Are not likely to result in adverse medical results
- B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:
- Potential and actual adverse drug reactions
 - Therapeutic appropriateness
 - Overutilization and underutilization
 - Appropriate use of generic products
 - Therapeutic duplication
 - Drug disease contraindications
 - Drug—drug interactions
 - Incorrect drug dosage or duration of drug treatment
 - Drug-allergy interactions
 - Clinical abuse/misuse
- C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:
- American Hospital Formulary Service Drug Information
 - United States Pharmacopeia-Drug Information
 - American Medical Association Drug Evaluations

TN No.: 93-11
Supersedes
TN No. 93-1

Approval Date JUN 1 1993Effective Date: 4-1-93

Revision: HCFA-PM- (MB)

State/Territory: KentuckyCitation1927(g) (1) (D)
42 CFR 456.703(b)

- D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The state has nevertheless chosen to include nursing home drugs in:

- Prospective DUR
 Retrospective DUR.

1927(g) (2) (A)
42 CFR 456.705(b)

- E. 1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g)(2) (A)(i)
42 CFR 456.705(b),
(1)-(7))

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:
- Therapeutic duplication
 - Drug-disease contraindications
 - Drug-drug interactions
 - Drug-interactions with non-prescription or over-the-counter drugs
 - Incorrect drug dosage or duration of drug treatment
 - Drug allergy interactions
 - Clinical abuse/misuse

1927(g) (2)(A) (ii)
42 CFR 456.705 (c)
and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g) (2) (B)
42 CFR 456.709(a)

- F. 1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:
- Patterns of fraud and abuse
 - Gross overuse
 - Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

Revision: HCFA-PM (MB)

State/Territory: KentuckyCitation

- 927(g) (2) (C)
42 CFR 456.709(b)
- F. 2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:
- Therapeutic appropriateness
 - Overutilization and underutilization
 - Appropriate use of generic products
 - Therapeutic duplication
 - Drug-disease contraindications
 - Drug-drug interactions
 - Incorrect drug dosage/duration of drug treatment
 - Clinical abuse/misuse
- 1927(g) (2) (D)
42 CFR 456.711
3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.
- 1927(g) (3) (A)
42 CFR 456.716(a)
- G. 1. The DUR program has established a State DUR Board either:
- Directly, or
 - Under contract with a private organization
2. The DUR Board membership includes health professionals (one—third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:
- Clinically appropriate prescribing of covered outpatient drugs.
 - Clinically appropriate dispensing and monitoring of covered outpatient drugs.
 - Drug use review, evaluation and intervention.
 - Medical quality assurance
- 927(g)(3) (C)
42 CFR 456.716(d)
3. The activities of the DUR Board include:
- Retrospective DUR,
 - Application of Standards as defined in section 1927(g)(2)(C), and
 - Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

Revision: HCFA-PM- (MB)

OMB No.

State/Territory: KentuckyCitation

- | | | |
|--|-------|--|
| 1927(g) (3) (C)
42 CFR 456.711
(a)-(d) | G. 4 | The interventions include in appropriate instances: <ul style="list-style-type: none"> • Information dissemination • Written, oral, and electronic reminders • Face-to-Face discussions • Intensified monitoring/review of prescribers/dispensers |
| 1927(g) (3) (D)
42 CFR 456.712
(A) and (B) | H. | The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DLJR Board, and that the State will adhere to the plan, steps, procedures as described in the report. |
| 1927(h) (1)
42 CFR 456.722 | I. 1. | The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management System to perform on-line: <ul style="list-style-type: none"> • real time eligibility verification • claims data capture • adjudication of claims • assistance to pharmacists, etc. applying for and receiving payment. |
| 1927(g) (2) (A) (i)
42 CFR 456.705(b) | 2. | Prospective DUR is performed using an electronic point of sale drug claims processing system. |
| 1927(j) (2)
42 CFR 456.703(c) | J. | Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs. |

* U.S. G.P.O.: 1993—342—239:80043

 TN No. 93-11
 Supersedes
 TN No. 93-1
Approval Date JUN 1 1993Effective Date 4-1-93

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Kentucky

Citation 4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

42 CFR 431.115(c)
AT-78-90
AT-79-74

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 FR 431.115.

TN # 79-23
Supersedes
TN # _____

Approval Date: 1/3/80

Effective Date: 10/15/79

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Kentucky

Citation

4.28 Appeals Process

42 CFR 431.152;
AT-79-18
52 FR 22444;
Secs.
1902(a)(28)(D)(i)
and 1919(e) (7) of
the Act; P.L.
100—203 (Sec. 4211(c)).

- (a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.
- (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

TN No. 94-1
Supersedes
TN No. 90-5

Approval Date APR 12 1994

Effective Date 1-1-94

Conflict of Interest

New: HCFA-PM-99-3
JUNE 1999

State: Kentucky

Citation

4.29 Conflict of Interest Provisions

1902(a)(4)(C) of the
Social Security Act
P.L. 105-33

The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

1902(a)(4)(D) of the
Social Security Act
P.L. 105-33
1932(d)(3)
42 CFR 438.58

The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

TN # 03-10
Supersedes
TN #80-4

Approval Date NOV 18 2003

Effective Date: 8/13/03

Revision HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Kentucky

Citation 4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

- (a) All requirements of 42 CFR Part 1002, Subpart B are met.
- The agency, under the authority of State law, imposes broader sanctions.

TN No. 89-26
Supersedes
TN Ho. 87-15

Approval Date: AUG 08 1989

Effective Date: 7/1/89

HCFA ID: I010P/0012P

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

State/Territory: Kentucky

Citation 4.30

(b) The Medicaid agency meets the requirements of-

1902(p) of the Act

(1) Section 1902(p) of the Act by excluding from participation-

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, I 128A, or 1866(b)(2).

42 CFR 438.808

(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that -

(i) Could be excluded under section 11 28(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1 128(b)(8)(B) of the Act.

1932(d)(1)
42 CFR 438.610

(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c)

Revision: HCFA-AT-87-14
OCTOBER 1987

(BERC)

OMB No.: 0938—0193

State/Territory: KentuckyCitation

1902(a)(39) of the Act
P.L. 100-93
(sec. 8(f))

(2) Section 1902(a)(39) of the Act by-

(A) excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of-

1902(a)(41)
of the Act.
P.L. 96-272,
(sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act
P.L. 100-93
(sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

TN No. 89-26

Supersedes

TN No. NoneApproval Date: AUG 08 1989Effective Date: 7/1/89

HCFA ID: I010P/0012P

Revision: HCFA-PM-87-14 (BERC)
October 1987

OMB No.: 0938-0193

State/Territory: Kentucky

Citation

455.103
44 FR 41644
1902(a)(38)
of the Act
P.L. 100-93
(sec. 8(f))

- 4.31 Disclosure of Information by Providers and Fiscal Agents
The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act

435.940
Through 435.960
52 FR 5967
54 FR 8738

- 4.32 Income and Eligibility Verification Systems
(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960

(b) Attachment 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

42 CFR 435.940 through
435.960 (Section 1903(r) of
the Act.

- (c) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify Title XIX applicants and individuals eligible for covered Title XIX services consistent with applicable PARIS agreements.

TN No. KY-10-010
Supersedes
TN No. 90-5

Approval Date: 12-17-2010

Effective Date 10-01-10

Revision: HCFA-PM-87-14 (BRC)
OCTOBR 1987

OMB No.: 0938-0193

State/Territory: Kentucky

Citation

4.33 Medicaid Eligibility Cards for Homeless Individuals

1902 (a) (48)
of the Act,
P.L. 99-570
(Section 11005)
P.L 100-93
(sec. 5(a)(3))

- (a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.
- (b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

TN No. 89-26
Supersedes
TN No. 87-15

Approval Date: AUG 08 1989

Effective Date 7/1/89

HCFA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Kentucky

Citation 4.34 Systematic Alien Verification for Entitlements

1137 of
the Act

P.L. 99-603
(sec. 121)

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

- The State Medicaid agency has elected to participate in the option period of October 1, to September 30, 1988 to verify alien status through the INS designated system (SAVE).
- The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.
- Total waiver
 - Alternative system
 - Partial implementation

TN No. 88-24
Supersedes
TN No. None

Approval Date: DEC 12 1988

Effective Date: 10-1-88

HCFA ID: 1010P/0012P

Revision: HCFA-PH-90-2 (BPD)
 JANUARY 1990

OMB No.: 0938—0193

State/Territory: Kentucky

- | | | |
|---|---|---|
| <u>Citation</u> | 4.35 | <u>Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation</u> |
| 1919(h) (1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a)) | (a) | <p>The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. <u>ATTACHMENT 4.35-A</u> describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.</p> <p><input type="checkbox"/> Not applicable to intermediate care facilities; these services are not furnished under this plan.</p> |
| | <input type="checkbox"/> (b) | <p>The agency uses the following remedy(ies):</p> <p>(1) Denial of payment for new admissions.</p> <p>(2) Civil money penalty.</p> <p>(3) Appointment of temporary management.</p> <p>(4) In emergency cases, closure of the facility and/or transfer of residents.</p> |
| 1919(h)(2) (B)(ii) of the Act | <input checked="" type="checkbox"/> (c) | <p>The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). <u>ATTACHMENT 4.35-B</u> describes these alternative remedies and specifies the basis for their use.</p> |
| 1919(h)(2)(F) of the Act | <input checked="" type="checkbox"/> (d) | <p>The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:</p> <p><input checked="" type="checkbox"/> (1) Public recognition.</p> <p><input type="checkbox"/> (2) Incentive payments.</p> |

TN No. 89-36
 Supersedes
 TN No. None

Approval Date: APR 19 1990

Effective Date: 10-1-89

HCFA ID: I010P/0012P

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: Kentucky

- Citation 4.35 Enforcement of Compliance for Nursing Facilities
- 42 CFR §488.402(f) (a) Notification of Enforcement Remedies
- When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).
- (i) The notice (except for civil money penalties and State monitoring) specifies the:
- (1) nature of noncompliance,
 - (2) which remedy is imposed,
 - (3) effective date of the remedy, and
 - (4) right to appeal the determination leading to the remedy.
- 42 CFR §488.434 (ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.
- 42 CFR §488.402(f)(2) (iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.
- 42 CFR §488.456(c)(d) (iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.
- (b) Factors to be Considered in Selecting Remedies
- 42 CFR §488.488.404(b)(1) (i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).
- The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: Kentucky

Citation

(c) Application of Remedies

- 42 CFR
§488.410
- (i) If there is immediate jeopardy to residents' health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.
- 42 CFR
§488.417(b)
§ 1919(h)(2)(c)
Of the Act
- (ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.
- 42 CFR
§488.414
§1919(h)(2)(D)
Of the Act.
- (iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.
- 42 CFR
§488.408
1919(h)(2)(A)
of the Act
- (iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.
- 42 CFR
§488.412(a)
- (v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR §488.412(a) are not met.

(d) Available Remedies

- 42 CFR
§488.406(b)
§1919(h)(2)(A)
of the Act.
- (i) The State has established the remedies defined in 42 CFR §488.406(b).
- (1) Termination
 - (2) Temporary Management
 - (3) Denial of Payment for New Admissions
 - (4) Civil Money Penalties
 - (5) Transfer of Residents; Transfer of Residents with Closure of Facility
 - (6) State Monitoring

Attachments 4.35-8 through 4.35-G describe the criteria for applying the above remedies.

TN No. 95-13
Supersedes
TN No. None

Approval Date: 1-16-96

Effective Date: 7/1/95

Revision: HCFA-PM-95-4
JUNE 1995

State/Territory: Kentucky

Citation

42 CFR
§488.406(b)
§1919(h) (2) (B) (ii)
of the Act.

(ii) The State uses alternative remedies.
The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

- (1) Temporary Management
- (2) Denial of Payment for New Admissions
- (3) Civil Money Penalties
- (4) Transfer of Residents; Transfer of Residents with Closure of Facility
- (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR
§488.303(b)
1910(h) (2) (F)
of the Act.

(e) State Incentive Programs
 (1) Public Recognition
 (2) Incentive Payments

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

OMB No.: 0938-

State/Territory: Kentucky

Citation 4.36 Required Coordination Between the Medicaid and WIC Programs

1902(a)(11)(C)
and 1902(a)(53)
of the Act

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a) (53) of the Act.

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7982E

Revision: HCFA-PH-91-10 (BPD)
DECEMBER 1991

State/Territory: Kentucky

Citation

4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(2), : 1919(e)c1) and(2), and 1919(f)(2), P.L. 100—203 (Sec. 4211(a)(3)); P.L. 101—239 (Sees. 6901(b)(3) and (4)); P.L. 101—508 (Sec. 4801(a)).

- (a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
- (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150 (b) (1)
- (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b) (2) to have met the nurse aide training and competency evaluation requirements.
- (d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42-CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
- (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
- (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

TN No. 92-2
Supersedes
TN No. None

Approval Date: 2-26-92

Effective Date: 2-1-92

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: Kentucky

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902 (a) (28.) :
1919(e) (1) and (2)
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a).3); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation or program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
- (h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
- (i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
- (j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
- (k) For program reviews other than the initial review, the State visits the entity providing the program.
- (l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

TN No. 92-2
Supersedes
TN No. None

Approval Date: 2-26-92

Effective Date: 2-1-92

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: Kentucky

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs 1902(a)(28),
1919(e)(1) and(2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b) (3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
- n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
- (o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
- (p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
- (q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
- (r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

TN No. 92-2
Supersedes
TN No. None

Approval Date 2-26-92

Effective Date 2-1-92

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: Kentucky

Citation

42 CFR 483.75; 42
CFR. 43 Subpart...D;
Sécs. 1902(a)'(28'),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b) (3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (s) When the State withdraws approval from a nurse aide training and, competency evaluation program or competency evaluation program, the State notifies the program in-writing, indicating the reasons for withdrawal of approval.
- (t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
- (u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
- (v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
- (w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
- (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
- (y) The State has a standard for successful completion of competency evaluation programs.

TN No. 92-2
Supersedes
TN No. None

Approval Date 2-26-92

Effective Date 2-1-92

Revision HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: Kentucky

Citation

42 CFR. 483.75, 42
CFR 483 Subpart D;
Sec 1902 (a)(28)
1919(e) (1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b) (3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent
- (aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
- (bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
- (cc) The State includes home health aides on the registry.
- (dd) The State contracts the operation of the registry to a non State entity.
- (ee) ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
- (ff) ATTACHMENT 4.38—A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

TN No. 92-2
Supersedes
TN No. None

Approval Date: 2-26-92

Effective Date: 2-1-92

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Kentucky

Citation 4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

- Secs. 1902(a) (28) (D) (1) and 1919(e) (7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec. 4801(b)).
- (a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).
 - (b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100—138.
 - (c) The State does not claim as “medical assistance under the State Plan” the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.
 - (d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as “medical assistance under the State plan” the cost of NF services to individuals who are found not to require NF services.
 - * (e) ATTACHMENT 4.39 specifies the state’s definition of specialized services.

* P&I HCFA 7-12-94

TN No. 94-1
Supersedes
TN No. None

Approval Date: APR 12 1994

Effective Date 1-1-94

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Kentucky

Citation 4.39 (Continued)

- (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most if not all, NFs and that a more appropriate placement should be utilized.
- (g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

TN No. 94-1
Supersedes
TN No. None

Approval Date: APR 12 1994

Effective Date: 1-1-94

Revision: HCFA-PM-92-3 (HSQB)
 APRIL 1992

State/Territory: Kentucky

Citation 4.40 Survey & Certification Process

- Sections 1919(g)(1) Thru (2) and 1919(g)(4) Thru (5) of The Act. P.L. 100-200 (Sec. 4212(a))
- (a) The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
- 1919(g)(1) (B) of the Act
- (b) The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.
- 1919(g)(1) (C) of the Act
- (c) The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the States process.
- 1919(g)(1) (c) of the Act
- (d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?
-
- 1919(g)(1) (c) of the Act
- (e) The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
- 1919(g)(1) (c) of the Act
- (f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

TN No. 93-6
 Supersedes
 TN No. None

Approval Date: 8/12/97

Effective Date: 1-1-93

HCFA ID:

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

OMB No:

State/Territory: Kentucky

Citation

- 1919(g)(2)
(A)(i) of
the Act
- (g) The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.
- 1919(g)(2)
(A)(ii) of
the Act
- (h) The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessment and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
- 1919(g)(2)
(A)(iii)(I)
of the Act
- (i) The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
- 1919(g)(2)
(A)(iii)(II)
of the Act
- (j) The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
- 1919(g)(2)
(B) of
Act
- (k) The State conducts extended surveys immediately the or, if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
- 1919(g)(2)
(C) of the
Act
- (l) The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

TN No. :93-06
Supersedes
TN No. None

Approval Date 8/12/97

Effective Date 1-1-93

HCFA ID:

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

OMB No:

State/Territory: Kentucky

Citation

- 1919(g) (2) (D) of the Act (m) The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
- 1919(g) (2) (E)(i) of the Act (n) The State uses a multidisciplinary team of professionals including a registered professional nurse.
- 1919(g) (2) (E)(ii) of the Act (o) The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
- 1919(g) (2) (E)(iii) of the Act (p) The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
- 1919(g) (4) of the Act (q) The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures.
- 1919(g) (5) (A) of the Act (r) The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
- 1919(g)(5) (B) of the Act (s) The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
- 1919(g) (5) (C) of the Act (t) If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
- 1919(g)(5) (D) of the Act (u) The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

TN No. 93-06
Supersedes
TN No. None

Approval Date: 8/12/97

Effective Date 1-1-93

HCFA ID:

Revision: HCFA-PM-92- 2 (HSQB)
MARCH 1992

State/Territory: Kentucky

Citation 4.41 Resident Assessment for Nursing Facilities

- Sections 1919(b) (3) and 1919 (e)(5) of the Act
- (a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in 1919(b)(3)(A) of the Act.
- 1919 (e) (5) (A) of the Act
- (b) The State is using:
- the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal 1241 of the State Operations Manual) [S1919(e)(5)(A)J]; or
- 1919(e) (5) (B) of the Act
- a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [S1919(e)(5)(B)J].

TN No. 93-06
Supersedes
TN No. None

Approval Date: 8/12/97

Effective Date 1-1-93

HCFA ID: _____

Citation

1902(a)(68) of
the Act,
P.L. 109-171
(section 6032)

4.42 Employee Education About False Claims Recoveries

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the \$5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- (C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of , Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.
- (2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.
- (3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
- (4) The requirements of this law should be incorporated into each State's provider enrollment agreements.
- (5) The State will implement this State Plan amendment on January 1, 2007.
- (b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Citation

4.43 Cooperation with Medicaid Integrity Program Efforts.

1902(a)(69) of
the Act,
P.L. 109-171
(section 6034)

The Medicaid agency assures it complies with such requirements determined
by the Secretary to be necessary for carrying out the Medicaid Integrity
Program established under section 1936 of the Act.

TN No: 08-005
Supersedes
TN No: None

Approval Date: 06/11/08

Effective Date 07/01/08

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

SECTION 4 — GENERAL PROGRAM ADMINISTRATION

Citation

4.46 **Provider Screening and Enrollment**

Section 1902(a)(77)
1902(a)(39)
1902(kk);
P.L. 111-148
And P.L. 111-152

The State Medicaid agency gives the following assurances:

PROVIDER SCREENING

42 CFR 455
Subpart E

- Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

ENROLLMENT AND SCREENING OF PROVIDERS

42 CFR 445.410

- Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.
- Assures that the State Medicaid Agency requires all ordering or referring physicians or other professionals to be enrolled under the State Plan or under a waiver of the Plan as a participating provider.

VERIFICATION OF PROVIDER LICENSES

42 CFR 455.412

- Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.

REVALIDATION OF ENROLLMENT

42 CFR 455.414

- Assures that providers will be revalidated regardless of provider type at least every 5 years.

TERMINATION OR DENIAL OF ENROLLMENT

42 CFR 455.416

- Assures that the State Medicaid agency will comply with section 1902 (a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

REACTIVATION OF PROVIDER ENROLLMENT

42 CFR 455.420

- Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

TN No. 12-001
Supersedes
TN No. None

Approval Date: 3/14/2012

Effective Date: 01/01/2012

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

SECTION 4 — GENERAL PROGRAM ADMINISTRATION

<u>Citation</u>	4.46 <u>Provider Screening and Enrollment</u>
	APPEAL RIGHTS
42 CFR 455.422	<input checked="" type="checkbox"/> Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.
	SITE VISITS
42 CFR 455.432	<input checked="" type="checkbox"/> Assures that pre-enrollment and post-enrollment site visits of providers who are in “moderate” or “high” risk categories will occur.
	CRIMINAL BACKGROUND CHECKS
42 CFR 455.434	<input checked="" type="checkbox"/> Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.
	FEDERAL DATABASE CHECKS
42 CFR 455.436	<input checked="" type="checkbox"/> Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.
	NATIONAL PROVIDER IDENTIFIER
42 CFR 455.440	<input checked="" type="checkbox"/> Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.
	SCREENING LEVELS FOR MEDICAID PROVIDERS
42 CFR 455.450	<input checked="" type="checkbox"/> Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

TN No.: 12-001
Supersedes
TN No.: None

Approval Date 3/14/2012

Effective Date; 1/1/ 2012

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

SECTION 4 — GENERAL PROGRAM ADMINISTRATION

Citation

4.46 **Provider Screening and Enrollment**

APPLICATION FEE

42 CFR 455.460

- Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

42 CFR 455.470

- Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

TN No.: 12-001

Supersedes

TN No.: None

Approval Date 3/14/2012

Effective Date: 1/1/2012

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/ Territory: Kentucky

SECTION 4 — GENERAL PROGRAM ADMINISTRATION

Citation

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Section 1902(a)(80) of
P.L. 111-148 (Section
6505)

- The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

TN No.: 11-001
Supersedes
TN No.: None

Approval Date 1-31-11

Effective Date; January 1, 2011

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

SECTION 5 PERSONNEL ADMINISTRATION

Citation 5.1 Standards of Personnel Administration

42 CFR 432.10 (a)
AT-78-90
AT-79-23
AT-80-34

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetable and meets all other requirements of 5 CFR Part 900, Subpart F.

TN # 77-11

Supersedes

TN # _____

Approval Date: 10/25/77

Effective Date: 9/30/77

Revision: HCFA-AT-80-38 (BFP)
May 22, 1980

State: Kentucky

5.2 [Reserved]

TN # _____
Supersedes
TN # _____

Approval Date _____

Effective Date _____

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Kentucky

Citation

42 CFR Part 432,
Subpart B
AT-78-90

5.1 Training Program; Subprofessional and Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of suprofessional staff and volunteers.

TN # 78-3
Supersedes
TN # _____

Approval Date: 4/20/78

Effective Date: 2/27/78

Revision: HCFA-AT-80-38 (BFP)
May 22, 1980

State Kentucky

SECTION 6 – FINANCIAL ADMINISTRATION

Citation

42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

TN # 76-9
Supersedes
TN # _____

Approval Date: 7/8/76

Effective Date: 6/30/76

Revision: HCFA-AT-81 (BPP)

State: Kentucky

Citation

42 CFR 433.34
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

TN # 82-24
Supersedes
TN # 76-9

Approval Date: 10/28/87

Effective Date 10-1-82

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Kentucky

Citation

42 FR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

- (a) State funds are used in both assistance and administration.
- State funds are used to pay all of the non-Federal share of total expenditures under the plan
- There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.
- (b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

TN # 76-9
Supersedes
TN # _____

Approval Date: 7/9/76

Effective Date: 6/30/76

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

OMB No. 0938-

State/Territory: Kentucky

SECTION 7 - GENERAL PROVISIONS

Citation

7.1 Plan Amendments

42 CFR 430.12(c)

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

TN No. 92-1
Supersedes
TN No. 90-5

Approval Date NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7982E

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

OMB No. 0938-

State/Territory: Kentucky

Citation 7.2 Nondiscrimination

45 CFR Parts
80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

TN No. 92-1
Supersedes
TN No. 79-4

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7982E

State: KentuckyCitation 7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid Agency will provide opportunity for the Office of Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

- Not Applicable. The Governor-
 Does not wish to review any plan material.
 Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department for Medicaid Services

(Designated Single State Agency)

Date: July 2, 2012

//s/ _____

Lawrence Kissner, Commissioner
Department for Medicaid Services

TN#: 12-004

Supersedes

TN#: 10-009Approval Date: 7/18/12Effective Date: July 2, 2012