

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

TN # 90-05
SUPERSEDES
TN # UNKNOWN

APPROVED: APR 27, 1990

EFFECTIVE DATE: 4-1-90

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

OMB No 0938

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: Kentucky

	SECTION	PAGE NUMBERS
State Plan Submittal Statement		1
SECTION 1 – SINGLE STATE AGENCY ORGANIZATION		2
1.1	Designation and Authority	2
1.2	Organization for Administration	7
1.3	Statewide Operation	8
1.4	State Medical Care Advisory Committee	9

TN No. 87-15
Supersedes
TN No. Unk.

Approval Date JAN 22, 1988

Effective Date: 10-1-87
HCFA ID: 1002P/0010P

SECTION		PAGE NUMBERS
SECTION 2 – COVERAGE AND ELIGIBILITY		10
2.1	Application, Determination of Eligibility And Furnishing Medicaid	10
2.2	Coverage and Conditions of Eligibility	12
2.3	Residence	13
2.4	Blindness	14
2.5	Disability	15
2.6	Financial Eligibility	16
2.7	Medicaid Furnished Out-of-State	18

	SECTION	PAGE NUMBERS
	SECTION 3 – SERVICES: GENERAL PROVISIONS	19
3.1	Amount, Duration, and Scope of Services	19
3.2	Coordination of Medicaid with Medicare Part B	29
3.3	Medicaid for Individuals Age 65 or Over In Institutions for Mental Diseases	30
3.4	Special Requirements Applicable to Sterilization Procedures	31
3.5	Medicaid for Medicare Cost Sharing for Qualified Medicare Beneficiaries	31a
3.6	Ambulatory Prenatal Care for Pregnant Women During Presumptive Eligibility Period	31b

SECTION	PAGE NUMBERS
SECTION 4 – GENERAL PROGRAM ADMINISTRATION	32
4.1 Methods of Administration	32
4.2 Hearings for Applicants and Recipients	33
4.3 Safeguarding Information on Applicants And Recipients	34
4.4 Medicaid Quality Control	35
4.5 Medicaid Agency Fraud Detection and Investigation Program	36
4.6 Reports	37
4.7 Maintenance of Records	38
4.8 Availability of Agency Program Manuals	39
4.9 Reporting Provider Payments to the Internal Revenue Service	40
4.10 Free Choice of Providers	41
4.11 Relations with Standard-Setting And Survey Agencies	42
4.12 Consultation to Medical Facilities	44
4.13 Required Provider Agreement	45
4.14 Utilization Control	46
4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases	51
4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees	52
4.17 Liens and Recoveries	53
4.18 Cost Sharing and Similar Charges	54
4.19 Payment for Services	57

	SECTION	PAGE NUMBERS
4.20	Direct Payments to Certain Recipients for Physicians' or Dentists' Services	67
4.21	Prohibition Against Reassignment of Provider Claims	68
4.22	Third Party Liability	69
4.23	Uses of Contracts	71
4.24	Standards for Payments for Skilled Nursing and Intermediate Care Facility Services	72
4.25	Program for Licensing Administrators of Nursing Homes	73
4.26	Reserved	74
4.27	Disclosure of Survey Information and Provider or Contractor Evaluation	75
4.28	Appeals Process for Skilled Nursing And Intermediate Care Facilities	76
4.29	Conflict of Interest Provisions	77
4.30	Exclusion of Providers and Suspension of Practitioners Convicted and Other Individuals	78
4.31	Disclosure of Information by Providers And Fiscal Agents	79
4.32	Income and Eligibility Verification System	79
4.33	Medicaid Eligibility Cards For Homeless Individuals	79a
4.34	Systematic Alien Verification for Entitlements	79b
4.35	Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation	79c

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

OMB No 0938-0193

SECTION

PAGE NUMBERS

SECTION 5 – PERSONNEL ADMINISTRATION

80

5.1 Standards of Personnel Administration

80

5.2 RESERVED

81

5.3 Training Programs; Subprofessional and
Volunteer Programs

82

TN No. 87-15
Supersedes
TN No. Unk.

Approval Date JAN 22, 1988

Effective Date: 10-1-87

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

OMB No 0938-0193

SECTION

PAGE NUMBERS

SECTION 6 – FINANCIAL ADMINISTRATION

83

6.1 Fiscal Policies and Accountability

83

6.2 Cost Allocation

84

6.3 State Financial Participation

85

TN No. 87-15
Supersedes
TN No. Unk.

Approval Date JAN 22, 1988

Effective Date: 10-1-87

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

OMB No 0938-

	SECTION	PAGE NUMBERS
	SECTION 7 – GENERAL PROVISIONS	86
7.1	Plan Amendments	86
7.2	Nondiscrimination	87
7.3	Maintenance of AFDC Effort	88
7.4	State Governor's Review	89

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

Approval Date NOV 14, 1994

Effective Date: 1-1-92

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
1.2-B	Organization of Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Description of Staff Making Eligibility Determination
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
*Supplement 1 -	Reasonable Classifications of Individuals under The Age of 21, 20, 19 and 18
*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
*Supplement 7 -	Income Levels for 1902(f) States – Categorically Needy Who Are Covered under Requirements More Restrictive than SSI
*Supplement 8 -	Resource Standards for 1902(f) States – Categorically Needy
*Supplement 8a -	More Liberal Methods of Treating Income Under Section 1902(r)(2) of the Act
*Supplement 8b -	More Liberal Methods of Treating Resources Under Section 1902(r)(2) of the Act
*Supplement 9 -	
*Supplement 10 -	
*Supplement 11 -	Cost Effective Methods for COBRA Group (States and Territories)
*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

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

Approval Date: NOV 14, 1994

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

<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
*3.1-B	Amount, Duration, and Scope of Services Provided Medically Needy Groups
3.1-C	Standards and Methods of Assuring High Quality Care
3.1-D	Methods of Providing Transportation
*3.1-E	Standards for the Coverage of Organ Transplant Procedures
4.11-A	Standards for Institutions
4.14-A	Single Utilization Review Methods for Intermediate Care Facilities
4.14-B	Multiple Utilization Review Methods for Intermediate Care Facilities
4.16-A	Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees
4.17-A	Determining that an Institutionalized Individual Cannot Be Discharged and Returned Home
*4.18-A	Charges Imposed on Categorically Needy
*4.18-B	Medically Needy - Premium
*4.18-C	Charges Imposed on Medically Needy and other Optional Groups
*4.18-D	Premiums Imposed on Low Income Pregnant Women and Infants
*4.18-E	Premiums Imposed on Qualified Disabled and Working Individuals
4.19-A	Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

*Forms Provided

No.	Title of Attachments
4.19-B	Methods and Standards for Establishing Payment Rates - Other Types of Care
	* Supplement 1 - Methods and Standards for Establishing Payment Rates for Title XVIII Deductible/Coinsurance
4.19-C	Payments for Reserved Beds
4.19-D	Methods and Standards for Establishing Payment Rates - Skilled Nursing and Intermediate Care Facility Services
4.19-E	Timely-Claims Payment - Definition of Claim
4.20-A	Conditions for Direct Payment for Physicians' and Dentists' Services
4.22-A	Requirements for Third Party Liability--Identifying Liable Resources
*4.22-B	Requirements for Third Party Liability--Payment of Claims
*4.22-C	Cost-Effective Methods for Employer-Based Group Health Plans
*4.32-A	Income and Eligibility Verification System Procedures: Requests to Other State Agencies
*4.33-A	Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals
4.35-A	Criteria for the Application of Specified Remedies for Nursing Facilities
4.35-B	Alternative Remedies to Specified Remedies for Nursing Facilities
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:

Kentucky

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:

Department for Medicaid Services

Type of Agency:

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

Type of Agency State Medicaid 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:

KRS 194A.030

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

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.



Health Coverage & Help Paying Costs

Application for More Than One Person

THINGS TO KNOW

<p>Use this application to see what insurance choices you qualify for</p>	<ul style="list-style-type: none"> • Free or low-cost coverage from Medicaid or the Kentucky Children's Health Insurance Program (KCHIP) • Payment Assistance that can help you pay for your health coverage • Affordable health insurance plans that offer comprehensive coverage to help you stay well
<p>Who is this application for?</p>	<p>Members of a household (spouses, partners, children, other) who:</p> <ul style="list-style-type: none"> • Live in Kentucky and plan to stay in Kentucky • Are included on your tax return, even if they don't live with you • Live with you, even if taxes are not filed
<p>Apply faster online</p>	<p>Apply faster online at www.kynect.ky.gov.</p>
<p>What you may need to apply</p>	<ul style="list-style-type: none"> • Your social security number (or document number if you are a legal immigrant) • Employer and income information (for example, paystubs, W-2 forms, or wage and tax statements)
<p>Why do we ask for this information?</p>	<p>We ask about your Social Security Number (SSN), your income and other information to see if you qualify for and if you can get any help paying for your health coverage costs.</p> <p>If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.</p> <p>We'll keep all the information you give us private, as required by law.</p>
<p>What happens next?</p>	<ul style="list-style-type: none"> • Mail or fax your completed, signed application to: <p style="text-align: center;">Office of the Kentucky Health Benefit Exchange 12 Mill Creek Park Frankfort, KY 40601</p> <p style="text-align: center;">Fax: 1-502-573-2005</p> • If you do not have all the information we ask for, submit your application anyway. We will contact you for the missing information if we cannot complete the determination based on the information you give us. • If we can make a determination, we will send you detailed information about the steps you will need to follow to select a plan. You will need to go online, call us, or get assistance from an insurance agent or kynector to enroll in a plan.
<p>To get help</p>	<ul style="list-style-type: none"> • Online: www.kynect.ky.gov • By phone: Call Customer Service at 1-855- 4kynect (459-6328) • In person: Find a list of places near where you live by visiting our website or calling us. • Contact an insurance agent or kynector: Visit our website or call 1-855-4kynect (459-6328) for a list of insurance agents and kynectors near you. • Español: Llame a nuestro Servicio al Cliente gratis al 1-855- 4kynect (459-6328) • TTY users call 1-855-326-4654



Health Coverage & Help Paying Costs

Application for More Than One Person

STEP 1 Tell Us about Yourself (the Responsible Party)

Complete this part of the application with information about the Responsible Party (even if the Responsible Party is not applying for coverage). If you are completing this application for someone else, you must use **Appendix B** to enter your contact information.

1. First name, Middle initial, Last name & Suffix (as it appears on your Social Security card)			
2. Social Security Number (SSN)		We need your SSN if you want coverage and have a SSN. Giving us your SSN can be helpful if you don't want health coverage too since it can speed up the application process.	
3. If you want coverage and SSN is not provided, select the reason for not providing it.			
<input type="checkbox"/> Religious Objection		<input type="checkbox"/> Not eligible to receive SSN due to alien status	<input type="checkbox"/> Applied for SSN
<input type="checkbox"/> Do not have an SSN and may only be issued an SSN for a valid non-work reason		<input type="checkbox"/> Refuse to provide SSN	
4. If you are applying for health coverage, check here <input type="checkbox"/> and answer all questions. If you are not applying for health coverage, do not answer questions 25-31 on the next page.			
5. Date of Birth (mm/dd/yyyy)		6. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
7. Do you live in Kentucky and plan to stay in Kentucky? (Only required if you want coverage) <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Home Address - <input type="checkbox"/> Check here if you do not have a Home Address. You will still have to enter a Mailing Address below.			
9. City	10. State	11. Zip Code	12. County
13. Mailing Address (Only required if different from home address)			
14. City	15. State	16. Zip Code	17. County
18. Primary Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()		19. Secondary Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell ()	
20. <input type="checkbox"/> Check here to allow kynect to send text message alerts to your primary phone number.		21. <input type="checkbox"/> Check here to allow kynect to send text message alerts to your secondary phone number.	
22. Preferred Spoken Language (if not English)		23. Preferred Written Language (if not English)	



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KHBE-110

Rev 06-01-14

24. Do you, the Responsible Party, plan to file a federal income tax return for coverage year 2014?
(You can apply for health insurance even if you don't file a federal income tax return.)

- YES.** If yes, answer questions a–d. **NO.** If no, skip to question d.
- a. What will be your filing status? Married Filing Jointly Married Filing Separately
 Single Head of Household
- b. If married, what is your spouse's name? _____
- c. Do you have any tax dependents? Yes No
If yes, list name(s) of dependent(s): _____
- d. Are you claimed as a dependent on someone else's tax return? Yes No
If yes, list the name of the tax filer: _____
How are you related to the tax filer? _____

Answer the following questions only if you want coverage:

25. Are you offered health coverage from a job (including someone else's job, like a spouse's job)?
 Yes. If yes, you will need to complete and include **Appendix A** with this application. No

26. Do you want help paying for medical bills from the last 3 months? Yes No
If yes, which month(s)? _____

27. Are you a U.S. citizen or national?
 Yes No

28. If you are not a U.S. citizen or national, do you have immigration status?

- Yes.** Answer questions a–d below.
- a. Immigration Document Type: _____
- b. Document ID Number: _____
- c. Have you lived in the U.S. since 1996? Yes No
- d. Are you a veteran or active-duty member of the U.S. military? Yes No

29. Are you of Hispanic, Latino or Spanish origin? (OPTIONAL) Yes No

30. Race - (OPTIONAL)

- | | | | | |
|--|--|-----------------------------------|--|---|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Korean | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Other Pacific Islander |

31. If you have lost a household member recently, you may be able to get help paying for his/her medical bills. Please give us the following information about the deceased family member:

Name: _____ Date of Birth: _____ Gender Male
Is this person of Hispanic, Latino or Spanish origin? (OPTIONAL) Yes No Female
Race (OPTIONAL): _____

STEP 2 Other Members of the Household

Next, you will need to give us information about the other members of your household (include all members of your household, even if they do not want health coverage). Include spouse, children, and others who live in Kentucky and plan to stay in Kentucky, are included on your tax return (even if they don't live with you), and live in your household, even if taxes are not filed. If you need to include more than four persons on this application, attach additional pages with their information.

Get started with the members of your tax household.



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KHBE-110

Rev. 06-01-14

TN No: 13-0007-MM2

Approval Date: 09/05/14

Effective Date: 01/01/14

Kentucky

S94-3

Person 2

1. First name, Middle initial, Last name & Suffix (as it appears on Social Security card)	2. Relationship to you
3. Social Security Number (SSN)	We need PERSON 2's SSN if PERSON 2 wants coverage and has a SSN. Giving us the SSN can be helpful if not applying for health coverage too since it can speed up the application process.
4. If PERSON 2 wants coverage and SSN is not provided, select reason for not providing it. <input type="checkbox"/> Religious Objection <input type="checkbox"/> Not eligible to receive SSN due to alien status <input type="checkbox"/> Applied for SSN <input type="checkbox"/> Newborn without SSN <input type="checkbox"/> Do not have an SSN and may only be issued an SSN for a valid non-work reason <input type="checkbox"/> Refuse to provide SSN	
5. If PERSON 2 is applying for health coverage, check here <input type="checkbox"/> and answer all questions. If PERSON 2 is not applying for health coverage, do not answer questions 12-17.	
6. Date of Birth (mm/dd/yyyy)	7. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
8. Does PERSON 2 live at the same address as the RESPONSIBLE PARTY? <input type="checkbox"/> Yes. If yes , do not enter an address below. <input type="checkbox"/> No. If no , enter PERSON 2's address below.	
9. Home Address	10. Mailing Address (Required if different from Home Address)
11. Does PERSON 2 plan to file a federal income tax return for coverage year 2014? (Individuals can apply for health insurance even if they don't file a federal income tax return.) <input type="checkbox"/> YES. If yes , answer questions a–d. <input type="checkbox"/> NO. If no , skip to question d. a. What will be PERSON 2's filing status? <input type="checkbox"/> Married Filing Jointly <input type="checkbox"/> Married Filing Separately <input type="checkbox"/> Single <input type="checkbox"/> Head of Household b. If married, what is the spouse's name? _____ c. Does PERSON 2 have any tax dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , list name(s) of dependent(s): _____ d. Is PERSON 2 claimed as a dependent on someone else's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please list the name of the tax filer: _____ How is PERSON 2 related to the tax filer? _____	
12. Is PERSON 2 offered health coverage from a job (including someone else's job, like a parent's or spouse's job)? <input type="checkbox"/> Yes. If yes , you will need to complete and include Appendix A with this application. <input type="checkbox"/> No	
13. Does PERSON 2 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , which month(s)? _____	
14. Is PERSON 2 a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. If not a U.S. citizen or national, does PERSON 2 have immigration status? <input type="checkbox"/> Yes. Answer questions a–d below. a. Immigration Document Type: _____ b. Document ID Number: _____ c. Has PERSON 2 lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Is PERSON 2 a veteran or active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Is PERSON 2 of Hispanic, Latino or Spanish origin? (OPTIONAL) <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Race - (OPTIONAL) <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Black or African American <input type="checkbox"/> Alaska Native <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian <input type="checkbox"/> Samoan <input type="checkbox"/> Chinese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander	



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Person 3

1. First name, Middle initial, Last name & Suffix (as it appears on Social Security card)	2. Relationship to you
3. Social Security Number (SSN)	We need PERSON 3's SSN if PERSON 3 wants coverage and has a SSN. Giving us the SSN can be helpful if not applying for health coverage too since it can speed up the application process.
4. If PERSON 3 wants coverage and SSN is not provided, select reason for not providing it. <input type="checkbox"/> Religious Objection <input type="checkbox"/> Not eligible to receive SSN due to alien status <input type="checkbox"/> Applied for SSN <input type="checkbox"/> Newborn without SSN <input type="checkbox"/> Do not have an SSN and may only be issued an SSN for a valid non-work reason <input type="checkbox"/> Refuse to provide SSN	
5. If PERSON 3 is applying for health coverage, check here <input type="checkbox"/> and answer all questions. If PERSON 3 is not applying for health coverage, do not answer questions 12-17.	
6. Date of Birth (mm/dd/yyyy)	7. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
8. Does PERSON 3 live at the same address as the RESPONSIBLE PARTY? <input type="checkbox"/> Yes. If yes , do not enter an address below. <input type="checkbox"/> No. If no , enter PERSON 3's address below.	
9. Home Address	10. Mailing Address (Required if different from Home Address)
11. Does PERSON 3 plan to file a federal income tax return for coverage year 2014? (Individuals can apply for health insurance even if they don't file a federal income tax return.) <input type="checkbox"/> YES. If yes , answer questions a-d. <input type="checkbox"/> NO. If no , skip to question d.	
a. What will be PERSON 3's filing status? <input type="checkbox"/> Married Filing Jointly <input type="checkbox"/> Married Filing Separately <input type="checkbox"/> Single <input type="checkbox"/> Head of Household	
b. If married, what is the spouse's name? _____	
c. Does PERSON 3 have any tax dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , list name(s) of dependent(s): _____	
d. Is PERSON 3 claimed as a dependent on someone else's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please list the name of the tax filer: _____ How is PERSON 3 related to the tax filer? _____	
12. Is PERSON 3 offered health coverage from a job (including someone else's job, like a parent's or spouse's job)? <input type="checkbox"/> Yes. If yes , you will need to complete and include Appendix A with this application. <input type="checkbox"/> No	
13. Does PERSON 3 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , which month(s)? _____	
14. Is PERSON 3 a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. If not a U.S. citizen or national, does PERSON 3 have immigration status? <input type="checkbox"/> Yes . Answer questions a-d below. a. Immigration Document Type: _____ b. Document ID Number: _____ c. Has PERSON 3 lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Is PERSON 3 a veteran or active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Is PERSON 3 of Hispanic, Latino or Spanish origin? (OPTIONAL) <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Race - (OPTIONAL) <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Black or African American <input type="checkbox"/> Alaska Native <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian <input type="checkbox"/> Samoan <input type="checkbox"/> Chinese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander	



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KHBE-110

Rev. 06-01-14

Person 4

1. First name, Middle initial, Last name & Suffix (as it appears on Social Security card)	2. Relationship to you
3. Social Security Number (SSN)	We need PERSON 4's SSN if PERSON 4 wants coverage and has a SSN. Giving us the SSN can be helpful if not applying for health coverage too since it can speed up the application process.
4. If PERSON 4 wants coverage and SSN is not provided, select reason for not providing it. <input type="checkbox"/> Religious Objection <input type="checkbox"/> Not eligible to receive SSN due to alien status <input type="checkbox"/> Applied for SSN <input type="checkbox"/> Newborn without SSN <input type="checkbox"/> Do not have an SSN and may only be issued an SSN for a valid non-work reason <input type="checkbox"/> Refuse to provide SSN	
5. If PERSON 4 is applying for health coverage, check here <input type="checkbox"/> and answer all questions. If PERSON 4 is not applying for health coverage, do not answer questions 12-17.	
6. Date of Birth (mm/dd/yyyy)	7. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
8. Does PERSON 4 live at the same address as the RESPONSIBLE PARTY? <input type="checkbox"/> Yes. If yes , do not enter an address below. <input type="checkbox"/> No. If no , enter PERSON 4's address below.	
9. Home Address	10. Mailing Address (Required if different from Home Address)
11. Does PERSON 4 plan to file a federal income tax return for coverage year 2014? (Individuals can apply for health insurance even if they don't file a federal income tax return.) <input type="checkbox"/> YES. If yes , answer questions a–d. <input type="checkbox"/> NO. If no , skip to question d. a. What will be Person 4's filing status? <input type="checkbox"/> Married Filing Jointly <input type="checkbox"/> Married Filing Separately <input type="checkbox"/> Single <input type="checkbox"/> Head of Household b. If married, what is the spouse's name? _____ c. Does PERSON 4 have any tax dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , list name(s) of dependent(s): _____ d. Is PERSON 4 claimed as a dependent on someone else's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please list the name of the tax filer: _____ How is PERSON 4 related to the tax filer? _____	
12. Is PERSON 4 offered health coverage from a job (including someone else's job, like a parent's or spouse's job)? <input type="checkbox"/> Yes. If yes , you will need to complete and include Appendix A with this application. <input type="checkbox"/> No	
13. Does PERSON 4 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , which month(s)? _____	
14. Is PERSON 4 a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. If not a U.S. citizen or national, does PERSON 4 have immigration status? <input type="checkbox"/> Yes. Answer questions a–d below. a. Immigration Document Type: _____ b. Document ID Number: _____ c. Has PERSON 4 lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Is PERSON 4 a veteran or active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Is PERSON 4 of Hispanic, Latino or Spanish origin? (OPTIONAL) <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Race - (OPTIONAL) <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Black or African American <input type="checkbox"/> Alaska Native <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian <input type="checkbox"/> Samoan <input type="checkbox"/> Chinese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander	



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KHBE-110

Rev. 06-01-14

STEP 3

Additional Questions

If the answer to the following questions is yes for more than one person, use additional sheets of paper to give us the details.

1. Is anyone that is applying for health coverage on this application **currently in prison or jail** or has been released in the past three months?

YES. If yes, answer questions a–d. NO. If no, go to question 2.

a. Who? _____

b. When did this person enter prison? (mm/dd/yyyy) _____

c. When did this person leave prison? (mm/dd/yyyy) _____

d. Is this person currently waiting for a decision on charges? Yes No

2. Has anyone on this application had a **pregnancy end** (giving birth or losing a pregnancy) in the past three months or is **currently pregnant**?

YES. If yes, answer questions a–d. NO. If no, go to question 3.

a. Who? _____

b. What is the due date or the last date of pregnancy? (mm/dd/yyyy) _____

c. How many children are/were expected with this pregnancy? _____

d. Would this person like to be referred to WIC (a program that offers food to women, infants & children)? Yes No

3. Is anyone on this application **American Indian or Alaska Native**?

YES. If yes, complete Appendix C and mail it with this application. NO. If no, go to question 4.

4. Does anyone applying for health coverage on this application need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home?

YES. If yes, who? _____ NO. If no, go to question 5.

5. Is anyone that is applying for coverage on this application **blind or permanently disabled**?

YES. If yes, who? _____ NO. If no, go to question 6.

6. Does anyone in your household that is applying for health coverage on this application currently have **other**

YES. If yes, answer questions a–h. NO. If no, go to question 7.

a. Who? _____ f. Policy number _____

b. Type of coverage _____ g. Coverage start date _____

c. Name of policy holder _____ h. Coverage end date _____

d. Name of insurance company _____

e. Address of insurance company _____

7. Was anyone in your household receiving Medicaid when he/she became too old to be eligible for foster care placement? YES. If yes, who? _____

In what state did he/she live? _____ How old was he/she? _____

NO. If no, go to **Step 4 on next page**.



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KHBE-110

Rev. 06-01-14

TN No: 13-0007-MM2

Approval Date: 09/05/14

Effective Date: 01/01/14

Kentucky

S94-7

STEP 4 Income and Deductions

Use additional sheets of paper if you need to add more than two jobs.

Income from Job 1		1. Who earns this income?	2. Who is this person's employer?
3. What is the gross amount this person makes (before taxes)? \$ _____		4. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly	
5. IF SELF-EMPLOYED a. Type of work _____		b. Gross Income _____	e. How often? _____
		c. Self-employment Expenses _____	
		d. NET income (Gross minus expenses) _____	

Income from Job 2		6. Who earns this income?	7. Who is this person's employer?
8. What is the gross amount this person makes (before taxes)? \$ _____		9. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly	
10. IF SELF-EMPLOYED a. Type of work _____		b. Gross Income _____	e. How often? _____
		c. Self-employment Expenses _____	
		d. NET income (Gross minus expenses) _____	

11. **Additional Income:** Give us information about any additional income that household members on this application may receive. Do not include income from child support, Supplemental Security Income (SSI), veteran's income, or Worker's Compensation. If none, leave blank.

Type of Income	Who Receives it?	How Much?	How Often?		
<input type="checkbox"/> Social Security	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Pensions	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Interest or Dividend	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Disability Payments	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Unemployment	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Other _____	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly

12. **Household Deductions:** Give us information about things that members of your household pay and that can be deducted on an income tax return. Giving us this information could make the cost of health insurance lower. If none, leave blank.

Type of Deduction	Who?	How much?	How often?		
<input type="checkbox"/> Alimony Paid	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Student Loan Interest	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Educator Expenses	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> School Tuition & Fees	_____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly

13. **Yearly Household Income:** What is your estimated **yearly** household income for the coverage year (including any monthly changes, bonuses, seasonal income, etc.)?
\$ _____



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KHBE-110

Rev. 06-01-14

STEP 5 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal and/or state law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit kynect.ky.gov or call **1-855-4kynect (459-6328)** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand that kynect will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or any other trusted source. If the information does not match, I may be asked to send proof.

Renewal of coverage in future years: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow kynect to use income data, including information from tax returns and other trusted data sources. kynect will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: (select one)

- 5 years (maximum allowed) 4 years 3 years 2 years 1 year
 Do not use information from tax returns or other data sources to renew my coverage.

Voter Registration: If I am not registered to vote or not registered where I currently live, I can choose to register to vote by checking yes below. If I check yes, I will receive a voter registration application in the mail. Checking yes or no below does not affect the outcome of this application.

- Yes**, I want to apply to register to vote. An application will be mailed to me. **No**, I don't want to register to vote.

If anyone on this application is eligible for Medicaid or KCHIP:

- I understand that if Medicaid pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid to reimburse it for the expense.
- I understand that my application may be reviewed to make sure that eligibility was determined correctly. If my application is reviewed, I must cooperate with the review.
- Does any child on this application have a parent living outside of the home? Yes No
- If yes, I give the Cabinet for Health and Family Services (CHFS), Child Support Office, the right to enforce medical support from the child's absent parent(s). If I think that cooperating with the Child Support Office will harm me or my children, I can tell CHFS and I may not have to cooperate.

Signature

Date (mm/dd/yyyy)



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call **1-855-4kynect (459-6328)**. Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KHBE-110

Rev. 06-01-14

TN No: 13-0007-MM2
Kentucky

Approval Date: 09/05/14
S94-9

Effective Date: 01/01/14



Health Coverage & Help Paying Costs Application for One Person

THINGS TO KNOW

Use this application to see what insurance choices you qualify for

- Free or low-cost insurance from Medicaid or the Kentucky Children's Health Insurance Program (KCHIP)
- Payment Assistance that can help you pay for your health coverage
- Affordable health insurance plans that offer comprehensive coverage to help you stay well

Who is this application for?

- Single individuals who:
- Live in Kentucky and plan to stay in Kentucky
 - Do not have any dependents and cannot be claimed as a dependent on someone else's tax return

Apply faster online

Apply faster online at www.kynect.ky.gov.

What you may need to apply

- Your social security number (or document number if you are a legal immigrant)
- Employer and income information (for example, paystubs, W-2 forms, or wage and tax statements)

Why do we ask for this information?

We ask about your **Social Security Number (SSN)**, your **income** and other information to see if you qualify for and if you can get any help paying for your health coverage costs.

If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

We'll keep all the information you give us private, as required by law.

What happens next?

- Mail or fax your completed, signed application to:

Office of the Kentucky Health Benefit Exchange
12 Mill Creek Park
Frankfort, KY 40601

Fax: 1-502-573-2005
- **If you don't have all the information we ask for, submit your application anyway.** We will contact you for the missing information if we cannot complete the determination based on the information you give us.
- **If we can make a determination**, we will send you detailed information about the steps you will need to follow to select a plan. You will need to go online, call us, or get assistance from an insurance agent or kynector to enroll in a plan.

To get help

- **Online:** www.kynect.ky.gov
- **By phone:** Call Customer Service at **1-855- 4kynect (459-6328)**
- **In person:** Find a list of places near where you live by visiting our website or calling us.
- **En Español:** Llame a nuestro Servicio al Cliente gratis al **1-855- 4kynect (459-6328)**
- **For TTY services call 1-855-326-4654**



Health Coverage & Help Paying Costs Application for One Person

STEP 1 Tell Us about Yourself

If someone else is helping you fill out this application, use **Appendix B** to give us that person's information.)

1. First Name, Middle initial, Last name, Suffix (as it appears on your Social Security card)

2. Social Security Number (SSN) **We need your SSN if you want coverage and have a SSN. We use SSNs to check income and other information to see if you are eligible for help with health coverage costs.**

3. If you **want coverage** and SSN is not provided, select reason for not providing it.
 Religious Objection Not eligible to receive SSN due to alien status Applied for SSN
 Does not have an SSN and may only be issued an SSN for a valid non-work reason Refuse to provide SSN

4. Date of Birth (mm/dd/yyyy) 5. Gender
 Male Female

6. Do you live in Kentucky and plan to stay in Kentucky? Yes No

7. Home Address - **Check here if you do not have a Home Address. You will still have to enter a Mailing Address below.**

8. City 9. State 10. Zip Code 11. County

12. Mailing Address (Only required if different from home address)

13. City 14. State 15. Zip Code 16. County

17. Primary Phone Number Home Work Cell 18. Secondary Phone Number Home Work Cell
 () ()

19. Check here to allow kynect to send text message alerts to your primary phone number. 20. Check here to allow kynect to send text message alerts to your secondary phone number.

21. Preferred Spoken Language (if not English) 22. Preferred Written Language (if not English)

23. Have you had a pregnancy end (giving birth or losing a pregnancy) in the past three months or are you currently pregnant? Yes. **If yes**, answer questions a–c. No
 a. What is the due date or the last date of pregnancy? (mm/dd/yyyy) _____
 b. How many children are/were expected with this pregnancy? _____
 c. Would you like to be referred to the program that offers food to Women, Infants and Children (WIC)? Yes No

24. Are you offered health coverage from a job (including someone else's job, like a parent's job)?
 Yes. **If yes**, you will need to complete and include Appendix A with this application. No

25. Do you want help paying for medical bills from the last 3 months? Yes No
If yes, which month(s)? _____



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KHBE-111

Rev. 06-01-14

26. Do you plan to file a federal income tax return for coverage year 2014?
(You can apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, answer questions a & b. **NO.** If no, go to question b.

a. Will you file as a single person with no dependents? Yes No
If No, stop using this form. Use the *Health Coverage & Help Paying Costs Application for More Than One Person* to include your tax dependents (even if you do not want to apply for health coverage for them.)

b. Are you claimed as a dependent on someone else's tax return? Yes No
If Yes, stop using this form. You will need to apply for coverage with the person claiming you on their tax return (even if that person does not want coverage.)

27. Are you a U.S. citizen or national?
 Yes No

28. If you are not a U.S. citizen or national, do you have immigration status?
 Yes. Answer questions a–d below.
a. Immigration Document Type: _____
b. Document ID Number: _____
c. Have you lived in the U.S. since 1996? Yes No
d. Are you a veteran or active-duty member of the U.S. military? Yes No

29. Are you of Hispanic, Latino or Spanish origin? (OPTIONAL) Yes No

30. Race (OPTIONAL)

- | | | | | |
|--|--|-----------------------------------|--|---|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Korean | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Other Pacific Islander |

31. Are you American Indian or Alaska Native?
 Yes. If yes, complete Appendix C and mail it with this application. No

32. Are you currently in prison or jail or have you been released in the past three months?
 Yes. If yes, answer questions a–c. No
a. When did you enter prison? (mm/dd/yyyy) _____
b. When did you leave prison? (mm/dd/yyyy) _____
c. Are you currently waiting for a decision on charges? Yes No

33. Do you need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home?
 Yes No

34. Are you blind or permanently disabled? Yes No

35. Were you receiving Medicaid when you became too old to be eligible for foster care placement? Yes No
If yes, in what state were you living? _____ How old were you? _____

36. If you are filling out this application on behalf of a person who recently passed away, enter the deceased person's date of death: _____



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KHBE-I11

Rev. 06-01-14

STEP 2

Current Job and Income Information

Use additional sheets of paper if you need to add more than two jobs.

Income from Job 1	1. Who earns this income?	2. Who is this person's employer?
3. What is the gross amount this person makes (before taxes)? \$ _____	4. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly	
5. IF SELF-EMPLOYED a. Type of work _____	b. Gross Income _____ c. Self-employment Expenses _____ d. NET income (Gross minus expenses) _____	e. How often? _____

Income from Job 2	6. Who earns this income?	7. Who is this person's employer?
8. What is the gross amount this person makes (before taxes)? \$ _____	9. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly	
10. IF SELF-EMPLOYED a. Type of work _____	b. Gross Income _____ c. Self-employment Expenses _____ d. NET income (Gross minus expenses) _____	e. How often? _____

11. **Additional Income:** List here any additional income you may receive, give the amount and how often you get it. Do not include income from child support, Supplemental Security Income (SSI), veteran's income, or Worker's Compensation. **If none, leave blank.**

Type of Income	How Much?	How Often?		
<input type="checkbox"/> Social Security	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Pensions	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Interest or Dividend	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Disability Payments	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Unemployment	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Other _____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly

12. **Household Deductions:** Give us information about things that you pay and that can be deducted on an income tax return. Giving us this information could make the cost of health insurance lower.

Type of Deduction	How Much?	How Often?		
<input type="checkbox"/> Alimony Paid	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Student Loan Interest	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Educator Expenses	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> School Tuition and Fees	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly

13. **Yearly Income:** What is your estimated **yearly** income for the coverage year (including any monthly changes, bonuses, seasonal income, etc.)?
\$ _____



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

STEP 3 Other Healthcare Coverage

Do you have health coverage now, including **dental and major medical coverage** that is not Medicaid or KCHIP?

YES. If **yes**, complete the information below.

NO.

Type of coverage _____ Policy Number _____

Name of policy holder _____ Coverage start date _____

Name of insurance company _____ Coverage end date _____

Insurance Company's Address _____

STEP 4 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit kynect.ky.gov or call **1-855-4kynect (459-6328)** to report any changes.
- If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand that kynect will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or any other trusted source. If the information does not match, I may be asked to send proof.

Renewal of coverage in future years: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow kynect to use income data, including information from tax returns and other trusted data sources. kynect will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: (select one)

5 years (maximum allowed) 4 years 3 years 2 years 1 year

Do not use information from tax returns or other data sources to renew my coverage.

Voter Registration: If I am not registered to vote or not registered where I currently live, I can choose to register to vote by checking yes below. If I check yes, I will receive a voter registration application in the mail. Checking yes or no below does not affect the outcome of this application.

Yes, I want to apply to register to vote. An application will be mailed to me. **No**, I don't want to register to vote.

If I am eligible for Medicaid:

- I understand that if Medicaid pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid to reimburse it for the expense.
- I understand that my application may be reviewed to make sure that eligibility was determined correctly. If my application is reviewed, I must cooperate with the review.

Signature

Date (mm/dd/yyyy)



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call **1-855-4kynect (459-6328)**. Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

Form KHBE-111

Rev. 06-01-14

TN No: 13-0007-MM2
Kentucky

Approval Date: 09/05/14

Effective Date: 01/01/14

S94-5

American Indian or Alaska Native (AI/AN)

Complete this appendix if you or a family member is American Indian or Alaska Native. Submit this with your application for health coverage.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, MI, Last name)	First MI	First MI
	Last	Last
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name and state _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name and state _____ <input type="checkbox"/> No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Certain money received may not be counted for Medicaid or the Kentucky Children's Health Insurance Program (KCHIP). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations) Money from selling things that have cultural significance 	\$ _____ How often? _____	\$ _____ How often? _____

If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).



Kentucky Health
Benefit Exchange



Submission Materials for Kentucky SPA approval



Kentucky Health
Benefit Exchange



As a response to the letter that accompanied the Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) transmittal KY #13-0007-MM2 Kentucky will demonstrate how we plan to address the following five issues identified regarding our application for financial assistance on kynect. These changes will be made on our Self Service Portal, Worker Portal and our paper applications.

The five items identified by CMS are:

1. Kentucky will include questions about business deductions from self-employment income in its applications to allow for a calculation of taxable self-employment income, which is the net income remaining after self-employment business expenses are deducted.
2. Kentucky will include questions about tribal income deductions allowed for American Indians and Alaska Natives (AI/ANs) in its applications.



Kentucky Health
Benefit Exchange



3. Kentucky will restructure its applications so that all applicants who are AI/ANs are asked whether they have received services from Indian Health Service organizations, tribal health providers, and urban Indian health providers (I/T/Us), rather than requesting this information from only members of federally recognized tribes.
4. Kentucky will no longer display questions about tobacco use for applicants potentially eligible for Medicaid or CHIP.
5. Kentucky will remove questions regarding absent parents who go beyond flagging whether there is an absent parent living outside the home and whether the applying parent agrees to cooperate with medical child support enforcement post-eligibility.



Kentucky Health
Benefit Exchange



#1 – Business Deductions for Self-Employment

- kynect is modifying our application to clearly call out self-employment expenses for the applicant. The Self Service Portal (SSP) and Worker Portal (WP) screens will be modified to allow the user to input their income, expenses and identify the frequency of their income/expenses. The net self-employment income will be calculated automatically based on the user's input for gross income, expenses and frequency period.



Kentucky Health
Benefit Exchange



Self Service Portal

Entered Total Household Income

\$ 0.00

Household Income - Self-Employment Income

*=Required field

Household Income Builder Progress:



How much net income (profits after expenses are paid) do these people currently make from self-employment?

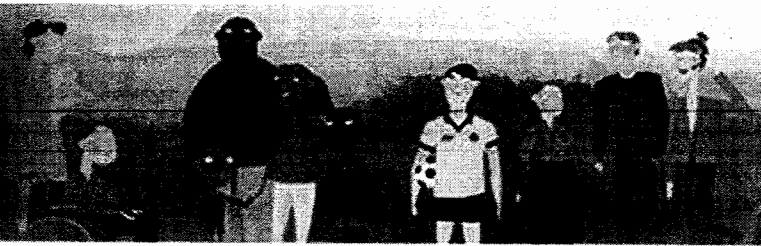
Total your self employment expenses and enter that amount in the "Self-Employment Expenses" box. The total self employment net income will be automatically calculated. (It is acceptable for your net income to be a negative number.)

Click the button Add Income Source to add details about other self-employment you have.

Member	Self-Employment Income	
JOHN	Type of Work	Annual Income Minus Expenses
		<input type="button" value="Add Income Source"/>
	* Type of Work	<input type="text"/>
	* Income and Expenses occur on this basis	--Select-- <input type="checkbox"/>
	* Gross Income \$	<input type="text"/>
	* Self-Employment Expenses \$	<input type="text"/>
	Net Self-Employment Income	<input type="text"/>
<input type="button" value="Save & Exit"/>		<input type="button" value="Back"/> <input type="button" value="Next"/>



Kentucky Health Benefit Exchange



Worker Portal

kynect

Home | Register | My Account | My Case | My Application | My Documents | My Profile | My Settings | My Search

[Back to Case Summary](#)

Application Registration | **Case Collection** | Eligibility Determination | Post Confirmation

Self-Employment Information

Individual

Name: MARY SMITH 28F Individual #: 999014765

Dates

Effective Begin Date: 02/01/2014 Effective End Date: 12/31/2014

Client Reported Date: 05/20/2014

Is the change reported and verified timely?

Date Client became aware: 05/20/2014

Verification Received Date: 05/20/2014

Self-Employment Information

Self-Employment Start Date: 05/20/2014

Self-Employment End Date: 12/31/2014

Type Of Work:

Are there any self-employment related expenses? Yes

Total self-employment expenses: \$

Self-Employment expense verification:

Post Confirmation

Status: Pending
Case Mode: InCase
Application Date: 5/20/2014
Renewal Date:

Household Members

MARY SMITH Primary
Age: 38
Individual #: 999014765
Sex: Female
Phone: 254-56-2434

LIZ SMITH Daughter
Age: 4
Individual #: 999014766
Sex: Female
Phone: 752-30-8475

Address
2345 PALM DR
LEONISTON, KY 40306 - 0001
PALETTE

Contact Info
Phone:
Email:

[Previous](#) [Next](#)



Worker Portal – screen 2

< Back to Case Summary

Application Registration

Data Collection

Eligibility Determination

Post Confirmation

Non Financial/Financial

Questions ✓

Income Summary ✓

Individual Income Type ✓

Self Employment Information ✓

Income Pay Details Simplified ✓

Income Pay Details-Simplified

Individual Information

Name	SOMENAME TESTINGAPP 33F	Individual #	100315837
Income Type	Earned	Earned/Unearned Income Type	Self Employed
Payer	job		

Dates

Effective Begin Date	3/1/2014	Effective End Date	
----------------------	----------	--------------------	--

Pay Details

Total Gross Amount*	\$	Pay Frequency*	
---------------------	----	----------------	--

Case: 1001-8830

Status Pending
Case Mode Intake
Application Date 6/2/2014
Renewal Date

Household Members

SOMENAME T... Primary
Age 33 Sex Female
Individual # 100315837
SSN

Address
12 MILL CREEK PARK
FRANKFORT, KY, 40601 - 9230
FRANKLIN

Contact Info
Phone
E-Mail



Kentucky Health
Benefit Exchange



Paper Application Changes

Family Financial Assistance Application: (page 8)

STEP 4 Income and Deductions

Use additional sheets of paper if you need to add more than two jobs.

Income from Job 1	1. Who earns this income?	2. Who is this person's employer?
	3. What is the gross amount this person makes (before taxes)? \$	4. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly
5. IF SELF-EMPLOYED a. Type of work	b. Gross Income c. Self-employment Expenses d. NET income (Gross minus expenses)	e. How often?

Single Financial Assistance Application: (page 4)

STEP 2 Current Job and Income Information

Use additional sheets of paper if you need to add more than two jobs.

Income from Job 1	1. Who earns this income?	2. Who is this person's employer?
	3. What is the gross amount this person makes (before taxes)? \$	4. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly
5. IF SELF-EMPLOYED a. Type of work	b. Gross Income c. Self-employment Expenses d. NET income (Gross minus expenses)	e. How often?



Kentucky Health
Benefit Exchange



#2 – Tribal Income Deductions

- kynect is modifying our application to allow American Indian/Alaskan Natives to have the opportunity to enter deductions from tribal income. These deductions will only be available if individuals in the application have identified themselves as American Indian/Alaskan Natives.
- For the paper applications we have adopted the style of the federal paper applications in that we will now have an appendix for American Indian/Alaskan Natives to complete. This appendix will include a section for these deductions.



Kentucky Health
Benefit Exchange



Self Service Portal – Screen 1

[Overview](#) [Applications](#) [Payments](#) [Plans & Programs](#) [Messages](#) [Assisters](#) [Settings](#)

Application

- Start Your Application
- Build Your Household
- Household Income**
- Additional Expenses
- Summary
- Next Step
- Completed

Entered Total Household Income \$ 3,720.00

Household Income - Expenses

Household Income Builder Progress:

Job Income Self-Employed Income Other Income Expenses

If anyone in your household includes deductions from page 1 of their income tax return, telling us about them could make the cost of health insurance a little lower. A few examples include:

- Alimony
- Student Loan Interest
- Educator Expenses
- Post High School Tuition and Fees (only if claimed as a tax deduction on page 1 of your tax return)

American Indian/Alaskan Native (AI/AN) income to deduct includes: Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties, payments earned from land designated as Indian land by the Department of Interior, money from selling things that have cultural significance.

Check the box next to anyone who currently pays for one of the expenses listed above.

Household Member	Has Expenses
JOHN	<input type="checkbox"/>

Save & Exit **← Back** **Next →**



Kentucky Health
Benefit Exchange



Self Service Portal – Screen 2

Application

- Start Your Application
- Build Your Household
- Household Income**
- Review Application
- Save
- Cancel
- Exit

Entered Total Household Income \$ 0.00

Household income - Expenses *Required field

Household Income Builder Progress:

Job Income Self-Employed Income Other Income Expenses

If anyone in your household includes deductions from page 1 of their income tax return, telling us about them could make the cost of health insurance a little lower. A few examples include:

- Alimony
- Student Loan Interest
- Educator Expenses
- Post High School Tuition and Fees (only if claimed as a tax deduction on page 1 of your tax return)

American Indian/Alaskan Native (AIAN) income to deduct includes: Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties, payments earned from land designated as Indian land by the Department of Interior, money from selling things that have cultural significance.

Click the button Add Expense to add details about expenses any of these people currently pay.

Member	Source	Annual Expense	Expenses
BILLY			

* Expense Amount: 5

Source:

- Alimony Paid
- Student Loan Interest
- Educator expense
- Post High School Tuition and Fees
- AIAN Tribal Income Deduct

Save & Exit **< Back** **Next >**

© Copyright 2013 f in 1-855-Kynect (459-6328)



Kentucky Health Benefit Exchange



Worker Portal

kynect

Home | Account Management | My Profile | My Applications | My Deductions | My Eligibility | My Coverage | My Claims | My Support

< Back to Case Summary

Application Registration | **Data Corrections** | Eligibility Determination | Post Confirmation

Deduction Details ?

Individual

Name* SMITH, MARY Individual # 999004765

Date

Effective Begin Date* 02/01/2014 Effective End Date 12/31/14

Client Reported Date 05/20/2014

Is the change reported and verified timely?

Date Client became aware 12/31/14

Verification Received Date 12/31/14

Deduction Information

Deduction Type*

Deduction Amount*

Deduction Monthly Amount

Incurred Date

Deduction Verification*

Deduction Start Date* 12/31/14 Deduction End Date 12/31/14

Family Members

MARY SMITH Primary
Age 28 Individual # 999004765 Sex Female

LIZ SMITH Daughter
Age 4 Individual # 999004766 Sex Female

Address

2745 PALM DR
LEXINGTON, KY 40506 - 0002
MARIETTE

Contact Info

Phone

E-Mail

Navigation: Previous Next

TN No: 13-0007-MM2
Kentucky

Approval Date: 09/05/14
S94-12

Effective Date: 01/01/14



Kentucky Health
Benefit Exchange



Paper Applications – Appendix C

<p>4. Certain money received may not be counted for Medicaid or the Kentucky Children's Health Insurance Program (KCHIP). List any income (amount and how often) reported on your application that includes money from these sources:</p> <ul style="list-style-type: none">• Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties• Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations)• Money from selling things that have cultural significance	<p>\$ _____</p> <p>How often?</p> <p>_____</p>	<p>\$ _____</p> <p>How often?</p> <p>_____</p>
--	--	--



Kentucky Health
Benefit Exchange



#3 – Indian Health Services, etc.

- kynect is modifying our application to ask all American Indians/Alaskan Natives if they have ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs. If they answer no to that question then we will also ask if this person is eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?
- For the paper applications we have adopted the style of the federal paper applications in that we will now have an appendix for American Indian/Alaskan Natives to complete. This appendix will include a section regarding these services.



Kentucky Health
Benefit Exchange



Self Service Portal

kynect My Account Browse Plans Learn More Get Help Welcome John Doe Log Out About Help ENGLISH

Overview Applications Payments Plans & Programs Messages Assisters Settings

Application

- Start Your Application
- Build Your Household**
- Household Income
- Add Family Members
- My Profile

Results Find A Plan Enrollment

American Indian, Alaskan Native Information * = Required Field

* Is any member of your household an American Indian or Alaskan Native?

Yes No

Who is an American Indian or Alaskan Native?

John Jane
 Mary Johnny

John

* Is John a member of a federally recognized tribe, band, nation, community or other group?

Yes No

* Has John ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?

Yes No

* Is John eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?

Yes No

Save & Exit **Back** **Next**

© Copyright 2012 f t You Tube in 1-855-4KYNNECT (459-6328)



Kentucky Health
Benefit Exchange



Worker Portal

NOTE – the second question regarding eligibility for Indian Health Services is only enabled if the first question regarding receipt of services is answered no.

Application Registration | Data Collection | Eligibility Determination | Post Confirmation

Individual ?

Application Information

Primary Applicant: DAVID DAVID Application #: 200010125

Individual Search

SSN: [XXXXXXXXXX] Individual #: [] Search

Identifying Information

First*: DAVID Middle Initial: []
Last*: DAVID Suffix: []
Gender*: []
Date of Birth*: [MM/DD/YYYY] [12] []
SSN: [XXXXXXXXXX] Reason for not having SSN: []
Federal Hub Verified: []

Individual Information

Race: []
Ethnicity: []
Nationality: []
Ethnicity Type: []
Spoken Language*: []
Member of a federally recognized tribe, band, nation, community, etc? []
Eligible to receive services from Indian Health Service... []
Tribe Name: []
Tribe State: []
If deceased, Date of Death: [MM/DD/YYYY] [12] []

English []
No []
No []

Previous Next



Kentucky Health
Benefit Exchange



Paper Applications – Appendix C

<p>3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
--	---	---



Kentucky Health
Benefit Exchange



#4 – Tobacco Question for Medicaid/CHIP Individuals

- As part of our application changes kynect will be developing a Post-Eligibility module. This will enable us to ask program specific questions once an individual's eligibility has been determined. The tobacco usage question will now be able to be asked of only individuals eligible to shop for Qualified Health Plans.



Kentucky Health
Benefit Exchange



Self Service Portal

The screenshot shows the Kynect Self Service Portal interface. At the top, there is a navigation bar with the Kynect logo, user name 'Welcome John Doe', and links for 'Log Out', 'About', 'Help', and 'ENGLISH'. Below this is a secondary navigation bar with 'My Account', 'Browse Plans', 'Learn More', and 'Get Help'. The main content area has a left sidebar with menu items: 'Overview', 'Applications', 'Payments', 'Plans & Programs', 'Messages', 'Assisters', and 'Settings'. Under 'Applications', there is a sub-menu with 'Application' (selected), 'Start Your Application', 'Eligibility-specific Questions', 'Results', 'Find A Plan', and 'Enrollment'. The main content area displays a message: 'Your eligibility has already been determined. You just need to answer the following program specific questions.' Below this is a section titled 'Tobacco Use Information' with the text: 'If you are eligible for payment assistance or a full-priced health insurance plan, you need to respond to these questions to view accurate rates. If you are Medicaid eligible, you do not need to respond to these questions.' The question is: 'Has any member of your household used tobacco at least 4 times a week in the past 6 months?' with radio buttons for 'Yes' (selected) and 'No'. Below the question is a section 'Who uses tobacco?' with checkboxes for 'John', 'Jane', 'Mary', and 'Johnny'. 'John' and 'Johnny' are checked. A 'Next >' button is at the bottom right. The footer contains copyright information, social media icons for Facebook, Twitter, and LinkedIn, and the phone number '1 855-KYNECT (459-6328)'.



Kentucky Health
Benefit Exchange



Worker Portal

kynect Home Application Registration Data Collection Eligibility Determination Post Confirmation

[Home](#) [Application Registration](#) [Data Collection](#) [Eligibility Determination](#) [Post Confirmation](#) [Quick Search](#)

[Back to Case Summary](#)

Application Registration **Data Collection** **Eligibility Determination** **Post Confirmation**

Eligibility Determination

- Run Eligibility ✓
- Eligibility Summary ✓
- Medicaid Questions ✓
- QHP Questions**

QHP Program Specific Questions ?

QHP Questions

In order to determine the most accurate plan costs, an individual who is eligible for payment assistance or a full-price health insurance plan must answer the question below.

Has any member of your household used tobacco at least 4 times a week in the past 6 months?

Case: 10039157

Status: Pending
Case Stage: Intake
Application Date: 3/20/2014
Renewal Date:

Household Members

	MARY SMITH	Primary
Age:	28	Sex: Female
Individual ID:	999014765	
SSN:	234-56-2456	
	LEZ SMITH	Daughter
Age:	6	Sex: Female
Individual ID:	999014766	
SSN:	752-30-9475	

Address
2345 MAIN DR
LEXINGTON, KY 40506 - 0001
MARYETTE

Contact Info
Home: (502) 555-1234
Cell: (502) 555-5678

[Previous](#) [Next](#)



Kentucky Health
Benefit Exchange



Paper Applications

- The tobacco usage question has been removed from both the family and single financial assistance application.



Kentucky Health
Benefit Exchange



#5 – Medical Support Enforcement

- kynect will modify our application to only ask the appropriate individuals MSE questions in the Pre-Eligibility component if they agree to cooperate with medical support enforcement and if answered No, they may answer if they have good cause for not cooperating.
- Then in our Post-Eligibility module we will ask additional optional questions regarding the non-custodial parent. The individual's response to these Post-Eligibility questions does not affect their eligibility. If they have good cause for not cooperating they will not be asked these Post-Eligibility questions.



Kentucky Health
Benefit Exchange



Self Service Portal – Pre-Eligibility

kynect My Account Browse Plans Learn More Get Help

Overview Applications Payments Plans & Programs Messages Assistors Settings


Application

- Start Your Application
- Build Your Household
- Household Income
- Additional Questions**
- Review
- Resign
- My Account
- My Payments

Medical Support Information

*=Required field

It looks like [NAME] has a parent that is not living in the home. Please provide details below on your willingness to cooperate with Medical Support Enforcement.



CHILD

CHILD's Mother

Cooperation with Medical Support

By accepting Medical Assistance, you assign (give) CHFS rights to enforce medical support from the child's absent parent(s). You must help CHFS find the absent parent(s) unless there is a good reason not to do so, such as domestic violence. If it is decided that you have to work with the Child Support Office to establish or enforce child support and you do not, you may lose medical assistance.

* Do you agree to cooperate with Medical Support?

* Reason for not Cooperating?

Comment

Save & Exit **← Back** **Next →**



Kentucky Health
Benefit Exchange



Self Service Portal – Post-Eligibility (optional questions)


Overview Applications Payments Plans & Programs Messages Assistants Settings

Case 100123519

Your eligibility has already been determined. You just need to answer the following program specific questions.

More About Parents *Required field

It looks like CHILD has a parent that is not living in your home. Please give us some more information.


CHILD

CHILD's Mother

If unknown, please click here

First Name MI Last Name Suffix

Date Of Birth Social Security Number(SSN)

If CHILD's mother is deceased, please click here

Place of Employment

Why is CHILD's Mother not in the home?




Current or Last Known Address

Address Line 1

Address Line 2

City State Zip Code Zip +4 Country Country

Next >

© Copyright 2013   

1-800-447-4378



Kentucky Health
Benefit Exchange



Worker Portal – Pre-Eligibility

Medical Support Information

LEZ SMITH 4F
999014766

Dates

Effective Begins Date: 02/01/2014 Effective End Date: 12/31/15

Medical Support Information

Does this child have a Non-Custodial Parent? Yes No

Is the responsible individual cooperating? Yes No

What is the Good Cause reason for non-cooperation?

Cooperation Verification

Household Members

MARY SMITH	Primary
Age: 28	Sex: Female
Individual ID: 999014765	SSN: 234-56-2436
LEZ SMITH	Daughter
Age: 4	Sex: Female
Individual ID: 999014766	SSN: 752-80-8475

Address: 2345 PALM DR, LEXINGTON, KY, 40506 - 0003, PAFETTE

* Please note that Cooperation Verification will be Client Statement – there is nothing for them to verify.



Kentucky Health Benefit Exchange



Worker Portal – Post-Eligibility (optional questions)

kynect Home Application/Case Inbox Inquiry Calendar Correspondence Hearings Tools Quick Search

Terms of Use | Privacy and Security | External Link | Sign Out

< Back to Case Summary Application Registration Data Collection Eligibility Determination Post Confirmation

Eligibility Determination

- Run Eligibility ✓
- Eligibility Summary ✓
- Medicaid Questions ✓
- QHP Questions ✓
- Non-Custodial Parent Information**

Non-Custodial Parent Information

Case: 100008153

Status: Pending
Case Mode: Intake
Application Date: 5/29/2014
Renewal Date:

Household Members

	MARY SMITH	Primary
Age: 28	Individual ID: 999014765	Sex: Female
SSN: 234-56-2456		
	LIZ SMITH	Daughter
Age: 4	Individual ID: 999014766	Sex: Female
SSN: 752-90-9475		

Address: 2345 PALM DR
LEXINGTON, KY, 40506 - 0001
FAYETTE

Contact Info

Phone
E-Mail

Reset Save

Non-Custodial Parent Summary

First Name	Last Name	Address	Actions

Non-Custodial Parent Information

Non-Custodial Parent is Unknown: Yes

First Name: Unknown Middle Initial: Suffix: Date of Birth: mm/dd/yyyy

Last Name: Unknown

SSN: XXX-XX-XXXX

Gender:

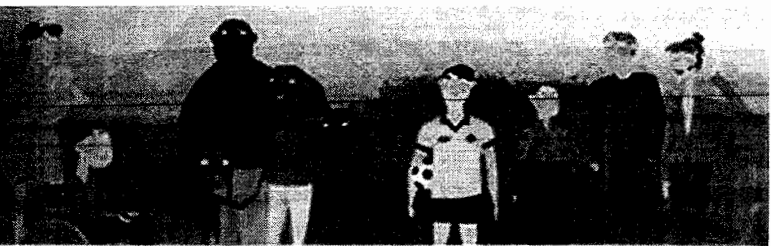
Last Known Address

Address Line 1: Address Line 2: City: State: ZIP Code: County: Country: United States

Previous Next



Kentucky Health
Benefit Exchange



Worker Portal – Post-Eligibility (optional questions screen 2)

Application Registration Date Collection **Eligibility Documentation** Post Confirmation

Non-Custodial Parent Relationship Information

LIZ SMITH 4F
999014766

Dates
Effective Begin Date: 02/01/2014 Effective End Date: 12/31/2014

Non-Custodial Parent Relationship Information

LIZ SMITH's Non-Custodial Parent is*
Non-Custodial Parent Status regarding LIZ SMITH
Is the responsible individual cooperating?* Yes
Good Cause
Cooperation Verification Consent Statement

Household Members

MARY SMITH Age: 29 Individual #: 999014765 SSN: 234-56-7456 Primary Male Female	LIZ SMITH Age: 4 Individual #: 999014766 SSN: 752-90-9476 Daughter Male Female
--	---

Address
2345 PALM DR
LEXINGTON, KY 40506-0001
PARETTE

Contact Info
Home F: Add

Relationship Summary

Child Name	Non-Custodial Parent	Non-Custodial Parent Status	Actions

Navigation: < Previous Next >

NOTE – the three questions about cooperation, good cause and cooperation verification are read only fields and are only repeated here to assist workers in remembering what was previously entered Pre-Eligibility.



Kentucky Health
Benefit Exchange



Paper Applications

- Family Financial Assistance Application

- These questions have not changed, they are in the signature portion of the paper application for families

If anyone on this application is eligible for Medicaid or KCHIP:

- I understand that if Medicaid pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid to reimburse it for the expense.
 - I understand that my application may be reviewed to make sure that eligibility was determined correctly. If my application is reviewed, I must cooperate with the review.
 - Does any child on this application have a parent living outside of the home? Yes No
 - If yes, I give the Cabinet for Health and Family Services (CHFS), Child Support Office, the right to enforce medical support from the child's absent parent(s). If I think that cooperating with the Child Support Office will harm me or my children, I can tell CHFS and I may not have to cooperate.
- Single Financial Assistance Application
 - Since this application is for a single individual there are not cooperation with medical support enforcement questions. No modifications have been made to this application.



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

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.



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

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.



Medicaid Eligibility

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

Eligibility Groups - Mandatory Coverage
Pregnant Women **S28**

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

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.



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

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.



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

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.



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

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.



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage	S50
Individuals above 133% FPL 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

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.



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

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.



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

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.



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

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.



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

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.



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

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.



Medicaid Eligibility

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

Eligibility Groups - Options for Coverage Independent Foster Care Adolescents	S57
--	------------

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

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.



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

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.

**SUPERSEDING PAGES OF
STATE PLAN MATERIAL**

TRANSMITTAL NUMBER:

13-0008-MM1

STATE:

Kentucky

Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, and S14 and related pages or sections of pages being deleted as obsolete

State Plan Section	Complete Pages Removed	Partial Pages Removed
Attachment 2.2-A	Page 1 Page 3 Page 3a Page 4 Page 4a Page 12 Page 13 Page 13a Page 14 Page 14a Page 23 Page 23b	Page 2, A.2.b Page 2, A.2.c Page 2a, A.3 Page 5, A.10 Page 9c, B.1 remove "Caretaker relatives" and "Pregnant women" Page 20, B.14 Page 23c, #19, #21 Page 25, C.4
Supplement 1 to Attachment 2.2-A	Page 1	
Attachment 2.6-A	Page 3b Page 11a Page 19 Page 19a Page 19b Page 21	Page 1, A.2.a(i) and (iii) Page 6 related to AFDC recipients, pregnant women, infants, and children Page 7, 1.a(1) and (2) Page 12, 5.e(2) Page 18, 5.e Page 25, 11.a(3)
Supplement 1 to Attachment 2.6-A	Pages 1-4	
Supplement 2 to Attachment 2.6-A	Pages 1-5	

Supplement 8a to Attachment 2.6-A		Page 2: delete for categorically needy groups for families and children
Supplement 8b to Attachment 2.6-A		Pages 1 - 3: delete for categorically needy groups for families and children
Supplement 12 to Attachment 2.6-A	Pages 1-3	

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

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.



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

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.

**SUPERSEDING PAGES OF
STATE PLAN MATERIAL**

TRANSMITTAL NUMBER:

KY-13-0010-MM3

STATE:

Kentucky

**PAGE NUMBER OF THE PLAN SECTION OR
ATTACHMENT:**

S10 - MAGI Income Methodology

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

Notwithstanding any other provisions of the Kentucky Medicaid State Plan, the financial eligibility methodologies described in State Plan Amendment KY-13-0010-MM3 will apply to all MAGI-based eligibility groups covered under Kentucky's Medicaid State Plan. The MAGI financial methodologies set forth in 42 CFR § 435.603 apply to everyone except those individuals described at 42 CFR § 435.603(j) for whom MAGI-based methods do not apply. This State Plan Amendment supersedes the current financial eligibility provisions of the Medicaid State Plan only with respect to the MAGI-based eligibility groups.



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.



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L.

Alternative Benefit Plan Populations ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name:

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s).

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory.

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

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 5 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.

V 201.30724

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP-1

Effective Date: 01/01/14



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

Voluntary Benefit Package Selection Assurances, Eligibility, Costs, and Section 1902(a)(10)(A) (b)(1)(D) of the Act **ABP2a**

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

Kentucky has reviewed the EHB's Anthem PPO and added or supplemented Medicaid benefits where necessary to at least offer the benefits for purposes of defining EHBs. The ABP that is subject to section 1937 requirements and the Medicaid State Plan are fully aligned.

PRA Disclosure Statement

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 5 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.

V.20130807

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP2a

Effective Date: 01/01/14



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

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

Select one of the following:

- The state/territory is amending one existing benefit package for the population defined in Section 1.
- The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package:

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- Secretary-Approved Coverage.
 - The state/territory offers benefits based on the approved state plan.
 - The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
 - The state/territory offers the benefits provided in the approved state plan.
 - Benefits include all those provided in the approved state plan plus additional benefits.
 - Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
 - The state/territory offers only a partial list of benefits provided in the approved state plan.
 - The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Selection of Base Benchmark Plan

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP3-1

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- Any of the largest three state employee health benefit plans by enrollment.
- Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- Largest insured commercial non-Medicaid HMO.

Plan name:

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The State assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
The State assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

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 5 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.

V 20130801

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP3-2

Effective Date: 01/01/14



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

Alternative Benefit Plan Cost-Sharing	ABP4
<input checked="" type="checkbox"/> Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.	
Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.	
The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.	<input type="checkbox"/> No
Other Information Related to Cost Sharing Requirements (optional):	
<div style="border: 1px solid black; height: 40px;"></div>	

PRA Disclosure Statement

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 5 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.

V.20130807

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP4

Effective Date: 01/01/14



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

Benefits Description	ABPS
The state/territory proposes a "Benchmark-Equivalent" benefit package. <input type="checkbox"/> No	
The state/territory is proposing "Secretary-Approved Coverage" as its section 1937 coverage option. <input type="checkbox"/> Yes	
<p>Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table</p> <p>The state/territory must provide a benefit by benefit comparison of the benefits in its proposed Secretary-Approved Alternative Benefit Plan with the benefits provided by one of the section 1937 Benchmark Benefit Packages or the standard full Medicaid state plan under Title XIX of the Act. Submit a document indicating which of these benefit packages will be used to make the comparison and include a chart comparing each benefit in the proposed Secretary-Approved benefit package with the same or similar benefit in the comparison benefit package, including any limitations on amount, duration and scope pertaining to the benefits in each benefit package.</p> <div data-bbox="574 861 1186 924" style="border: 1px solid black; text-align: center; padding: 5px;">An attachment is submitted.</div>	
<p>Benefits Included in Alternative Benefit Plan</p>	
<p>Enter the specific name of the base benchmark plan selected:</p> <div data-bbox="272 1029 1412 1113" style="border: 1px solid black; padding: 5px;">Anthem PPO</div>	
<p>Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."</p> <div data-bbox="272 1197 1412 1281" style="border: 1px solid black; padding: 5px;">Secretary-Approved</div>	



Alternative Benefit Plan

Attachment 3.1-L

Essential Health Benefit 1: Ambulatory patient services		Collapse All <input type="checkbox"/>
Benefit Provided: Physician Services	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents Physician services.		
Benefit Provided: Outpatient Hospital Services	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization is required for some services. See State Plan for complete listing.		
Benefit Provided: Clinic Services	Source: State Plan 1905(a)	
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP5-2

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		<input type="button" value="Remove"/>
<input type="text"/>		
Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Certified Pediatric or Family Nurse Practitioner"/>	<input type="text" value="State Plan 1905(a)"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:	<input type="text" value="None"/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Full State Plan Service Title: Certified pediatric or family Nurse Practitioner services"/>		
Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Family Planning Services and Supplies for Individu"/>	<input type="text" value="State Plan 1905(a)"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:	<input type="text" value="Limited to individuals of child-bearing age"/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Full State Plan Service Title: Family Planning Services and Supplies for Individuals of Child-bearing Age"/>		
Benefit Provided:	Source:	
<input type="text" value="Hospice Care"/>	<input type="text" value="State Plan 1905(a)"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="Prior Authorization"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP5-3

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

Scope Limit: Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services		Remove
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: Private duty nursing	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 2000 hours / year	Duration Limit: None	
Scope Limit: Services in an inpatient setting excluded		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: Medical care & any other type of remedial:podiatry	Source: State Plan 1905(a)	
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Limited to non-routine foot care; routine foot care excluded		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Medical care and any other type of remedial care provided by licensed practitioners: Podiatry KY State Plan Title: Medical care and any other type of remedial care Podiatry exclusions include: treatment of flatfoot; treatments undertaken for the sole purpose of correcting a subluxated structure as an isolated entity within the foot; routine footcare, except when the patient has a systemic disease of sufficient severity that unskilled performance of such procedures would be hazardous; specified methods of plethysmography. Orthopedic shoes and other supportive devices for the feet are not covered under this program element. Additional detail explanations of these exclusions are included in		



Alternative Benefit Plan

Attachment 3.1-L

the State Plan.		
This represents podiatry services		Remove
Benefit Provided:	Source:	
Medical care & any other type of remedial: Other	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Full State Plan Service Title: Medical care and any other type of remedial care provided by licensed practitioners: Other practitioner's services		
KY State Plan Title: Medical care and any other type of remedial care		
This represents services provided by other practitioners listed in the State Plan		
		Add

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABPS-5

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 2: Emergency services		Collapse All <input type="checkbox"/>
Benefit Provided: Outpatient Hospital: Emergency Department	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: Any other medical care: emergency transportation	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary This represents emergency transportation/ambulance		
		<input type="button" value="Add"/>



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 3: Hospitalization		Collapse All <input type="checkbox"/>
Benefit Provided: Inpatient Hospital Services	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Authorization is done through prior, concurrent, and retroactive authorization, depending on the type of hospital and service.		
Benefit Provided: Physician: Inpatient Services	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents Inpatient Physician Services		
		<input type="button" value="Add"/>

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP5-7

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 4: Maternity and newborn care		Collapse All <input type="checkbox"/>
Benefit Provided: Nurse-midwife Services	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 		
Benefit Provided: Inpatient Hospital Services: Maternity	Source: State Plan 1905(a)	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Authorization is done through prior, concurrent, and retroactive authorization, depending on the type of hospital and service. Services such as physician or inpatient hospital found in other EHBs are applicable here too		
Benefit Provided: Physician services: Maternity	Source: State Plan 1905(a)	
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		



Alternative Benefit Plan

Attachment 3.1-L

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This benefit is a duplicate of "outpatient surgery physician/surgical" in the base benchmark.

Remove

Add

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP5-9

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment		Collapse All <input type="checkbox"/>															
<table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 50%; padding: 5px;">Benefit Provided: Inpatient Hospital Services: IP Mental Health</td><td style="width: 50%; padding: 5px;">Source: State Plan 1905(a)</td><td style="text-align: right; padding: 5px;"><input type="button" value="Remove"/></td></tr><tr><td style="padding: 5px;">Authorization: Prior Authorization</td><td style="padding: 5px;">Provider Qualifications: Medicaid State Plan</td><td></td></tr><tr><td style="padding: 5px;">Amount Limit: None</td><td style="padding: 5px;">Duration Limit: None</td><td></td></tr><tr><td colspan="3" style="padding: 5px;">Scope Limit: IP Mental Health in an IMD is not available to individuals between the ages of 21 to 64.</td></tr><tr><td colspan="3" style="padding: 5px;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents Inpatient Mental Health services. These facilities are not IMDs.</td></tr></table>			Benefit Provided: Inpatient Hospital Services: IP Mental Health	Source: State Plan 1905(a)	<input type="button" value="Remove"/>	Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan		Amount Limit: None	Duration Limit: None		Scope Limit: IP Mental Health in an IMD is not available to individuals between the ages of 21 to 64.			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents Inpatient Mental Health services. These facilities are not IMDs.		
Benefit Provided: Inpatient Hospital Services: IP Mental Health	Source: State Plan 1905(a)	<input type="button" value="Remove"/>															
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan																
Amount Limit: None	Duration Limit: None																
Scope Limit: IP Mental Health in an IMD is not available to individuals between the ages of 21 to 64.																	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents Inpatient Mental Health services. These facilities are not IMDs.																	
<table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 50%; padding: 5px;">Benefit Provided: Rehabilitative services: OP Mental Health</td><td style="width: 50%; padding: 5px;">Source: State Plan 1905(a)</td><td style="text-align: right; padding: 5px;"><input type="button" value="Remove"/></td></tr><tr><td style="padding: 5px;">Authorization: None</td><td style="padding: 5px;">Provider Qualifications: Medicaid State Plan</td><td></td></tr><tr><td style="padding: 5px;">Amount Limit: None</td><td style="padding: 5px;">Duration Limit: None</td><td></td></tr><tr><td colspan="3" style="padding: 5px;">Scope Limit: None</td></tr><tr><td colspan="3" style="padding: 5px;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan This represents Outpatient Mental Health services.</td></tr></table>			Benefit Provided: Rehabilitative services: OP Mental Health	Source: State Plan 1905(a)	<input type="button" value="Remove"/>	Authorization: None	Provider Qualifications: Medicaid State Plan		Amount Limit: None	Duration Limit: None		Scope Limit: None			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan This represents Outpatient Mental Health services.		
Benefit Provided: Rehabilitative services: OP Mental Health	Source: State Plan 1905(a)	<input type="button" value="Remove"/>															
Authorization: None	Provider Qualifications: Medicaid State Plan																
Amount Limit: None	Duration Limit: None																
Scope Limit: None																	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan This represents Outpatient Mental Health services.																	
<table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 50%; padding: 5px;">Benefit Provided: Inpatient Hospital Services: IP Substance Use</td><td style="width: 50%; padding: 5px;">Source: State Plan 1905(a)</td><td></td></tr><tr><td style="padding: 5px;">Authorization: Prior Authorization</td><td style="padding: 5px;">Provider Qualifications: Medicaid State Plan</td><td></td></tr><tr><td style="padding: 5px;">Amount Limit: None</td><td style="padding: 5px;">Duration Limit: None</td><td></td></tr></table>			Benefit Provided: Inpatient Hospital Services: IP Substance Use	Source: State Plan 1905(a)		Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan		Amount Limit: None	Duration Limit: None							
Benefit Provided: Inpatient Hospital Services: IP Substance Use	Source: State Plan 1905(a)																
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan																
Amount Limit: None	Duration Limit: None																



Alternative Benefit Plan

Attachment 3.1-L

Scope Limit: None		Remove
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents IP Substance Use Disorder Services These facilities are not IMDs.		
Benefit Provided: Rehabilitative services: OP Substance Use	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan This represents OP Substance Use Disorder Services		
		Add



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 6: Prescription drugs		
Benefit Provided: Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.		
Prescription Drug Limits (Check all that apply.):	Authorization: <input type="text" value="Yes"/>	Provider Qualifications: <input type="text" value="State licensed"/>
<input type="checkbox"/> Limit on days supply		
<input type="checkbox"/> Limit on number of prescriptions		
<input type="checkbox"/> Limit on brand drugs		
<input type="checkbox"/> Other coverage limits		
<input checked="" type="checkbox"/> Preferred drug list		
Coverage that exceeds the minimum requirements or other:		
<input type="text" value="The Commonwealth of Kentucky's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs."/>		



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 7: Rehabilitative and habilitative services and devices		Collapse All <input type="checkbox"/>
Benefit Provided: Physical therapy & related svcs: PT	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 20 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: Physical therapy and related services 20 visits per year for physical therapy; benefit limits are aggregated between habilitation and rehabilitation services.		
Benefit Provided: Home Health: Medical supplies, equipment, and appl	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Specific restrictions and exclusions are found in the fee schedule		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Home Health: Medical supplies, equipment, and appliances suitable for use in the home KY State Plan Title: Home Health: Medical supplies suitable for use in the home Prior authorization is required for items of equipment or repairs greater than \$500 and certain other specified items.		
Benefit Provided: Prosthetics	Source: State Plan 1905(a)	
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	



Alternative Benefit Plan

Attachment 3.1-L

Amount Limit: None	Duration Limit: None	Remove
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization is required for items of equipment or repairs greater than \$500 and certain other specified items.		
Benefit Provided: Nursing Facility Services (21 and older)	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Meets level of care		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This is a nursing facility for rehabilitative purposes. The base benchmark limits the number of days in a nursing facility to 90 day.		
Benefit Provided: Medical and other types of remedial care: chiropra	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 26 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents chiropractic services		
Benefit Provided: Physical therapy & related svcs: OT	Source: State Plan 1905(a)	

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP5-14

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	Remove
Amount Limit: 20 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: Physical therapy and related services 20 visits per year for occupational therapy; benefit limits are aggregated between habilitation and rehabilitation services.		
Benefit Provided: Physical therapy & related svcs: ST	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 20 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: Physical therapy and related services 20 visits per year for speech therapy; benefit limits are aggregated between habilitation and rehabilitation services.		
Benefit Provided: Home health services: nursing, aide, and therapy	Source: State Plan 1905(a)	
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: PT/OT/ST: 20 visits each per calendar year	Duration Limit: None	
Scope Limit: None		

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP5-15

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-I.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	<input type="button" value="Remove"/>
This represents the home health visit, including PT/OT/SLT (if applicable) 20 visits each per calendar year for physical, occupational, and speech therapy; benefit rehabilitation services	
	<input type="button" value="Add"/>

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP5-16

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 8: Laboratory services		Collapse All <input type="checkbox"/>
Benefit Provided: Other Laboratory and x-Ray Services	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Some imaging services require a prior authorization. See State Plan for complete listing.		
		<input type="button" value="Add"/>

D21



Alternative Benefit Plan

Attachment 3.1-L

Essential Health Benefit 9: Preventive and wellness services and chronic disease management Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventive services	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Supplements existing benefits with any additions to comply with USPSTF, ACIP, IOM, and Bright Futures.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan This benefit includes preventive services		

Benefit Provided: Physician services: allergy	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 		

Add



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 10: Pediatric services including oral and vision care		Collapse All <input type="checkbox"/>
Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: EPSDT Prior Auth required for orthodontia		
Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Limited to children under 21 years of age		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Inpatient psychiatric facility services for individuals under 21 years of age These services are not in an IMD		
		<input type="button" value="Add"/>



Alternative Benefit Plan

Attachment 3.1-L

Other Covered Benefits from Base Benchmark

Collapse All



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Base Benchmark Benefits Not Covered due to Substitution or Duplication		Collapse All <input type="checkbox"/>
Base Benchmark Benefit that was Substituted:	Source:	
Primary Care Visit	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Patient Services.		
Base Benchmark Benefit that was Substituted:	Source:	
Specialist Visit	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Patient Services.		
Base Benchmark Benefit that was Substituted:	Source:	
Outpatient facility fee	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Clinic Services and Outpatient Hospital Services, under the EHB Ambulatory Patient Services.		
Base Benchmark Benefit that was Substituted:	Source:	
Hospice	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Hospice care, under the EHB Ambulatory services		
Base Benchmark Benefit that was Substituted:	Source:	
Home health care services	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Home Health Services, under the EHBs Ambulatory Patient Services & Rehabilitative and habilitative services and devices		
Base Benchmark Benefit that was Substituted:	Source:	
ER Services	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Outpatient Hospital Services, as well as Outpatient Hospital:		



Alternative Benefit Plan

Attachment 3.1-L

Emergency Department, under the EHB Emergency Services. Emergency hospital services are covered as outpatient hospital services in Medicaid.		Remove
Base Benchmark Benefit that was Substituted: Emergency Transportation / Ambulance	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary, under the EHB Emergency Services .		
Base Benchmark Benefit that was Substituted: Inpatient Hospital Services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Inpatient Hospital Services, under the EHB Hospitalization.		
Base Benchmark Benefit that was Substituted: Inpatient physician and surgical services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Physician Services, under the EHB Hospitalization.		
Base Benchmark Benefit that was Substituted: Skilled nursing facility	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Nursing Facility Services (21 and older) under the EHBs Rehabilitative and Habilitative Services and Devices. This benefit is limited to 90 days.		
Base Benchmark Benefit that was Substituted: Delivery and all inpatient services for maternity	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Inpatient hospital services: maternity, under the EHB Maternity and Newborn Care.		
Base Benchmark Benefit that was Substituted: Mental/behavioral health outpatient services	Source: Base Benchmark	



Alternative Benefit Plan

Attachment 3.1-L

<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health</p>		Remove
<p>Base Benchmark Benefit that was Substituted:</p> <p>Mental/behavioral health inpatient services</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Inpatient Hospital Services: IP Substance Use, and Inpatient psychiatric facility services for individuals under 21 years of age, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health, and the EPSDT EHB, respectively</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Substance Abuse Disorder Outpatient Services</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services & Rehabilitative services for pregnant women: SU, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Substance Abuse Disorder Inpatient Services</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Inpatient Hospital Services: IP Mental Health, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Generic Drugs</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Prescription drugs, Dentures, Prosthetic Devices, and Eyeglasses under the EHB Prescription Drugs</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Preferred Brand Drugs</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs</p>		



Alternative Benefit Plan

Attachment 3.1-L

Base Benchmark Benefit that was Substituted: Non-Preferred Brand Drugs	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs		
Base Benchmark Benefit that was Substituted: Specialty Drugs	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs		
Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Physical Therapy and related Services, under the EHB Rehabilitative and Habilitative Services and Devices		
Base Benchmark Benefit that was Substituted: Habilitation Services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Physical Therapy and related Services, under the EHB Rehabilitative and Habilitative Services and Devices		
Base Benchmark Benefit that was Substituted: Chiropractic Care	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Medical care and any other type of remedial care, under the Rehabilitative and Habilitative Services and Devices. This benefit is limited to 12 visits per year in the base benchmark plan.		
Base Benchmark Benefit that was Substituted: Durable Medical Equipment	Source: Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Family Planning Services and Supplies for Individuals of Child-bearing Age under the EHB for Ambulatory Services, and Home Health: Medical supplies,		



Alternative Benefit Plan

Attachment 3.1-L

equipment, and appliances suitable for use in the home, as well as Prosthetics, under the EHB Rehabilitative and Habilitative Services and Devices		Remove
Base Benchmark Benefit that was Substituted: Hearing Aides	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with EPSDT & Home Health: Medical supplies, equipment, and appliances suitable for use in the home, under the EHB Rehabilitative and Habilitative Services and Devices		
Base Benchmark Benefit that was Substituted: Diagnostic Tests (x-rays and lab work)	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Other Laboratory and X-Ray Services, under the EHB Laboratory Services		
Base Benchmark Benefit that was Substituted: Imaging (CT/PET/MRI)	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Other Laboratory and X-Ray Services, under the EHB Laboratory Services		
Base Benchmark Benefit that was Substituted: Preventive care / screening / immunization	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services, under the EHB Preventive and wellness Services and Chronic Disease Management		
Base Benchmark Benefit that was Substituted: Routine Eye Exam for Children	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care		
Base Benchmark Benefit that was Substituted: Eye glasses for children	Source: Base Benchmark	



Alternative Benefit Plan

Attachment 3.1-I-L

<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with EPSDT & Prescribed drugs, dentures, prosthetic devices, and eyeglasses, under EHB Pediatric services, including oral and vision care</p>		Remove
<p>Base Benchmark Benefit that was Substituted:</p> <p>Dental check-up for children</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Allergy treatment</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Physician Services, under the EHB Preventive and wellness services and chronic disease management</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Injectable drugs and other drugs administered in a</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>(Full benchmark benefit: Injectable drugs and other drugs administer in a providers' office or other OP setting) Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Services</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Medical supplies, equipment, and education for dia</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>(Full benchmark benefit: Medical supplies, equipment, and education for diabetes care for all diabetics) Duplication: This benefit was replaced with Prescription drugs, under the EHB Prescription drugs and Physician Services under EHB Ambulatory Services. The medical supplies and equipment for diabetes care maps to the Prescription Drugs, while the education for diabetics maps to Physician Services under Ambulatory.</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Dental services for accidental injury and other re</p>	<p>Source:</p> <p>Base Benchmark</p>	
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>(Full benchmark benefit: Dental services for accidental injury and other related medical services)</p>		



Alternative Benefit Plan

Attachment 3.1-L

Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services		Remove
Base Benchmark Benefit that was Substituted: Human organ and tissue transplant transplant servi	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Inpatient hospital services and Physician Services, under the EHB Hospitalization		
Base Benchmark Benefit that was Substituted: Human organ and tissue transplant services - trans	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Inpatient hospital services and Physician Services, under the EHB Hospitalization		
Base Benchmark Benefit that was Substituted: Human organ and tissue transplant services - unrel	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: (Full benchmark benefit: Human organ and tissue transplant services - unrelated donor search) Duplication: This benefit was replaced with Inpatient Hospital Services		
Base Benchmark Benefit that was Substituted: Autism Services for children	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care		
Base Benchmark Benefit that was Substituted: Radiation therapy	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services		
Base Benchmark Benefit that was Substituted: Chemotherapy	Source: Base Benchmark	

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP5-27

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services</p>	<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Infusion Therapy"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services</p>	<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Renal dialysis/hemodialysis"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services</p>	<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Vision correction after surgery or accident"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>This benefit was replaced with Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory patient services</p>	<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Other practitioner office visit"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Certified pediatric or family Nurse Practitioner services, under the EHB Ambulatory services</p>	<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Private duty nursing"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Private Duty Nursing, under the EHB Ambulatory Care.</p> <p>The base benchmark has a 2,000 hour limit.</p>	<input type="button" value="Remove"/>



Alternative Benefit Plan

Attachment 3.1-L

Base Benchmark Benefit that was Substituted: Urgent Care Centers	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced by Clinic Services, under the EHB Ambulatory patient services		
Base Benchmark Benefit that was Substituted: Outpatient surgery physician / surgical	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced by Physician Services, under the EHB Ambulatory patient services and Physician Services: Maternity under the Maternity and newborn care EHB.		
Base Benchmark Benefit that was Substituted: Podiatry services	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Medical care and any other type of remedial care provided by licensed practitioners: Podiatry, under the EHB Ambulatory Patient Services		
Base Benchmark Benefit that was Substituted: Other practitioner's services	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Medical care and any other type of remedial care provided by licensed practitioners: Other practitioner's services, under the EHB Ambulatory Patient Services		
Base Benchmark Benefit that was Substituted: Certified Nurse Midwife	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Nurse-midwife Services, under the EHB Maternity and Newborn Care		
Base Benchmark Benefit that was Substituted: Prescription Drug Benefits	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs under the EHB Prescription drugs and Family Planning Services and Supplies under the EHB Ambulatory services.		



Alternative Benefit Plan

Attachment 3.1-L

<input type="button" value="Add"/>



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Other Base Benchmark Benefits Not Covered		Collapse All <input type="checkbox"/>
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Non-emergency care when traveling outside the US"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="This is not permissible under federal Medicaid rules."/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Prenatal and postnatal care"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="KY pays for newborns separately from their mothers, so this benefit is not applicable for the new adult group"/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Routine eye exam"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="This benefit is not a an EHB for adults."/>		
		<input type="button" value="Add"/>



Alternative Benefit Plan

Attachment 3.1-L

Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All

Other 1937 Benefit Provided: Services in an ICF-IID	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Medicaid individuals who meet ICF-IDD patient status criteria		
Other: 		

Other 1937 Benefit Provided: Dental Services	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: 1 cleaning and 1 x-ray per year	Duration Limit: None	
Scope Limit: Dental services for adults 21 years of age or older		
Other: No authorization required		

Other 1937 Benefit Provided: Routine eye exam	Source: Section 1937 Coverage Option Benchmark Benefit Package	
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other: No authorization required		



Alternative Benefit Plan

Attachment 3.1-L

<input type="text"/>		<input type="button" value="Remove"/>
Other 1937 Benefit Provided: <input type="text" value="Family planning services and supplies"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Include counseling services, medical services and supplies"/>		
Other: <input type="text" value="In-vitro fertilization, artificial insemination, sterilization reversals, sperm banking and related services, hysterectomies, and abortions shall not be considered family planning services"/> <input type="text" value="Full State Plan Service Title: Family Planning Services and Supplies for Individuals of Child-bearing Age"/> <input type="text" value="No authorization required"/>		
Other 1937 Benefit Provided: <input type="text" value="Case management services"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Some case management services are limited to specific groups of individuals. Please see State Plan for complete listing."/>		
Other: <input type="text" value="Some case management services are limited to specific groups of individuals. Populations included:
• Children meeting the eligibility criteria of the Commission for Handicapped Children (CHC) and persons of all ages with hemophilia meeting the CHC eligibility criteria.
• Children in the custody of or at risk of being in the custody of the State; children under the supervision of the state; and adults in need of protective services.
• Children birth to three participating in the Kentucky Early Intervention Program.
• Pregnant women who are under age 20 and first time parents; and pregnant women age 20 or older who are first time parents and screen as high risk for the Health Access Nurturing Development Services (HANDS) program.
• Pregnant women, including post partum women for the 60 days after the pregnancy ends, who are receiving substance use services."/>		



Alternative Benefit Plan

Attachment 3.1-L

<ul style="list-style-type: none"> • Individuals with a moderate or severe substance use disorder diagnosis, or co-occurring substance use and mental health disorders; with need for assistance in accessing community or recovery supports or with multi-agency involvement. • Individuals with a severe emotional disability or a serious mental illness; who are at risk of out-of-home placement or institutional care. • Individuals with at least two of the following types of co-occurring disorders, which interact to complicate treatment: (1) mental health, (2) substance use, and (3) chronic or complex physical health conditions. 		Remove
Other 1937 Benefit Provided: Face-to-face Tobacco Cessation for Pregnant Women	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: 4 face-to-face sessions per quit attempt	Duration Limit: None	
Scope Limit: None		
Other: Full amount limit: 4 face-to-face sessions per quit attempt with a minimum of 2 quit attempts No authorization required.		
Other 1937 Benefit Provided: Nursing Facility Services for Long Term Care	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Meets level of care		
Other: [Empty box]		
Other 1937 Benefit Provided: Ambulatory prenatal care for pregnant women furni	Source: Section 1937 Coverage Option Benchmark Benefit Package	
Authorization: Other	Provider Qualifications: Medicaid State Plan	



Alternative Benefit Plan

Attachment 3.1-L

Amount Limit: None	Duration Limit: None	Remove
Scope Limit: None		
Other: Full State Plan Service Title: Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period No prior authorization is required.		
		Add



Alternative Benefit Plan

Attachment 3.1-L

<input type="checkbox"/> Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)	Collapse All <input type="checkbox"/>
---	---------------------------------------

PRA Disclosure Statement

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 5 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.

V.20130808



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age.

Yes

The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

Through an Alternative Benefit Plan.

Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

State/territory provides additional EPSDT benefits through fee-for-service.

State/territory contracts with a provider for additional EPSDT services.

Please specify payment method (select one):

Risk-based capitation

Administrative services contract

Other

Other Information regarding how EPSDT benefits will be provided to participants under 21 years of age (optional):

EPSDT benefits will be administered through the prior authorization process.

MCOs have been informed that they should not deny services for children because a benefit is not covered, but may deny a service if it is not medically necessary. KY regularly monitors complaints and claim denials to verify MCO compliance.

KY provides educational materials to members about EPSDT benefits

Prescription Drug Coverage Assurances

The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP7-1

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

- The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.
- The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.
- The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

- The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

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 5 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.

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP7-2

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

V.20130807

*

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP7-3

Effective Date: 01/01/14



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

Service Delivery Systems ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- Managed care.
 - Managed Care Organizations (MCO).
 - Prepaid Inpatient Health Plans (PIHP).
 - Prepaid Ambulatory Health Plans (PAHP).
 - Primary Care Case Management (PCCM).
- Fee-for-service.
- Other service delivery system.

Managed Care Options

Managed Care Assurance

- The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The following documents the steps that the Kentucky Department for Medicaid Services (DMS) is planning to take, or is taking, to implement managed care for the Alternative Benefit Plan (ABP), including member, stakeholder, and provider outreach efforts.

General

- Actuarial Analysis – Perform cost analysis for the new benefits package.
- Increased Administrative Tasks – Request additional staff for DMS.

MCO Specific Plans

- New MCO Contract for Expansion Population – Contract with a new MCO. DMS intends to contract with a new MCO in order to better serve the expanded population. The RFP for this new contractor was issued on 7/22/2013. The contract for this new vendor was negotiated and signed on 9/13/2013.
- Additional MCO Onboarding – Inform new MCO of DMS operations. DMS will need to educate providers on the new MCO's credentialing and enrollment process. Complete
- Contract with MCOs for Expansion Population – Renegotiate with existing MCOs. DMS is also re-negotiating contracts with existing MCOs. These contracts have been signed.
- DMS MCO Relations – Train DMS staff on MCO relations. DMS staff will need to be informed of the contractual requirements for each MCO. This task is complete.
- Benefits Package Communication – Inform all MCOs of new Benefit package. The new benefits package will affect all MCOs. Details of the new benefits package were finalized on 9/27/2013. DMS then sent details of the benefits package to all MCOs. DMS has answered questions for the MCOs.
- Expanding the Provider Network – Integrate the new provider network into MCOs. DMS will support the implementation of new



Alternative Benefit Plan

Attachment 3.1-L

- provider networks into all MCO systems. This began on 9/16/2013 and will be ongoing as new providers are contracted.
- MCO Member Outreach – Coordinate approval of materials and plans. DMS expects MCOs to conduct their own member outreach. Materials will need to be approved by DMS before they can be disbursed at schools, faith-based organizations, community, and health fairs. DMS began approving materials for the new MCO starting 10/1/2013.
 - MCO Call Center – Update call center with Expansion-related changes. The call center staff and scripts have been updated based on changes related to Medicaid expansion.
 - Monthly Meetings – Schedule monthly and quarterly meetings with other state agencies.
 - MCO Operations – Verify functionality of day-to-day operations for all MCOs.

Member Communication

- Member Handbook – Update and distribute member handbook. DMS is updating the member handbook with information regarding benefits coverage, cost sharing changes, and special policies and procedures by 12/15/2013. This will be posted on DMS' website.
- Member Print Materials – Create and distribute print materials. DMS is coordinating with Kentucky Health Benefit Exchange (KHBE) to produce informational cards, brochures, and fact sheets regarding Medicaid Expansion. Completed 10/1/2013. Informational Cards will be two-sided and include Medicaid-only information. Brochures will include a section on Medicaid expansion, in addition to KHBE information. A Medicaid-only fact sheet has been created. In addition, Medicaid related information will be included on other facts sheets produced by KHBE as well. All fact sheets will be available on the KHBE website (<http://healthbenefitexchange.ky.gov>) and the kynect website (<http://kynect.ky.gov>).
- Member Media and Online Materials – Coordinate media and online materials. DMS is coordinating with KHBE to include Medicaid information on television advertisements and marketing outreach efforts. These efforts were completed on 8/27/2013. In addition, DMS has added a page to its website to provide an overview of Medicaid Expansion, with links to additional information (<http://chfs.ky.gov/dms/medicaid+expansion.htm>). This was completed 9/18/2013. DMS also include information on its website regarding the new benefit plan.

Stakeholder Communication

- Stakeholder Meetings – Schedule meetings with stakeholders. DMS scheduled meetings starting 9/23/2013 with key external stakeholders to discuss the MCO implementation and Medicaid expansion. Advocates for various external groups, public health departments and other state employees will be invited to these meetings. DMS is also conducting outreach and awareness sessions for its own staff. DMS held an informational session on the ACA and Expansion for its employees on 9/19/2013. DMS has begun communications with other vendors who are affected by the new benefits plan and expansion. The DMS staff is working closely with HP (the MMIS contractor), OATS (Kentucky's Office of Administrative Technology and Services), Kentucky Health Benefit Exchange, and other state government agencies to proactively communicate and implement the coming changes.

Provider Communication

- Provider Services Training – Update scripts and train provider services staff.
 - o Provider services staff (the call center for providers within DMS) will need to be updated with new information regarding the expansion and the benefits package. This training will be completed by November 2013.
- Provider Training Sessions – Coordinate and hold provider training sessions via HP (vendor).
 - o DMS is offering provider training to communicate ACA and Medicaid Expansion changes to the providers. To do so, it has sent providers e-mail and written communication on 9/16/2013 to notify them of upcoming dates for provider training.
 - o The materials for training, including the benefit plan changes, were completed.
 - o Trainings are being offered in each of the 8 Medicaid Regions (4 sessions in each Medicaid Region) throughout the fall.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

No

- The Alternative Benefit Plan will be provided through a managed care organization (MCO) consistent with applicable managed care requirements (42 CFR Part 438, and sections 1903(m), 1932 and 1937 of the Social Security Act).

MCO Procurement or Selection Method

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP8-2

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

Indicate the method used to select MCOs:

Competitive procurement method (RFP, RFA).

Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

[Empty text box]

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization.

Yes

List the benefits or services that will be provided apart from the MCO, and explain how they will be provided. Add as many rows as needed.

	Benefit/service	Description of how the benefit/service will be provided	
+	Intermediate care facility for individuals with an intellectual disability	Service is provided through the Commonwealth's fee-for-service program	X
+	Hospice services provided to a recipient in an institution	Service is provided through the Commonwealth's fee-for-service program	X
+	Nonemergency transportation services	Service is provided through PAHP waiver	X
+	School-based health services	Service is provided through the Commonwealth's fee-for-service program	X
+	Health access nurturing development services	Service is provided through the Commonwealth's fee-for-service program	X
+	Early intervention program service	Service is provided through the Commonwealth's fee-for-service program	X
+	Nursing facility service for an enrollee	Service is provided through the Commonwealth's fee-for-service program	X

MCO service delivery is provided on less than a statewide basis.

No

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan:

No

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

Mandatory participation.

Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Members will select a MCO and enroll through Kentucky's Health Benefit Exchange - kynect. Member MCO selection, choice, and flexibility is in accordance with federal regulation.

Choose MCO through kynect



Alternative Benefit Plan

Attachment 3.1-L

If don't choose, auto assigned
90 day period to select new MCO
Auto assignment: under what circumstances; wher

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program.

No

The Alternative Benefit Plan will be provided through a prepaid ambulatory health plan (PAHP) consistent with applicable managed care requirements (42 CFR Part 438, and section 1937 of the Social Security Act).

PAHPs are paid on a risk basis.

PAHPs are paid on a non-risk basis.

PAHP Procurement or Selection Method

Indicate the method used to select PAHPs:

Competitive procurement method (RFP, RFA).

Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PAHPs:

Other PAHP-Based Service Delivery System Characteristics

List the benefits or services that will be provided apart from the PAHP, and explain how they will be provided. Add as many rows as needed.

	Benefit/service	Description of how the benefit/service will be provided	
+			X

PAHP service delivery is provided on less than a statewide basis.

PAHP Participation Exclusions

Individuals are excluded from PAHP participation in the Alternative Benefit Plan:

General PAHP Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

Mandatory participation.

Voluntary participation. Indicate the method for effectuating enrollment:

Additional Information: PAHP (Optional)



Alternative Benefit Plan

Attachment 3.1-L

Provide any additional details regarding this service delivery system (optional):

Non-Emergency Transportation Services - provides transportation to Medicaid Recipients who otherwise do not have a way to get to medical appointments.

PRA Disclosure Statement

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 5 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.

V 20130718



Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Employer Sponsored Insurance	ABPO
<p>The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.</p>	<input type="checkbox"/> Yes
<p>Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:</p> <div style="border: 1px solid black; padding: 5px;"> <p>This program is called the Health Insurance Premium Payment (HIPP) is available to all Medicaid recipients. The program will pay the cost of the premium for any Medicaid recipient that is working and has access to employer sponsored insurance and still eligible for Medicaid provided said payments would be cost effective for Medicaid. All information is entered in our MMIS system to make determination of cost effectiveness. The system looks at their age, premium cost, and claims cost to determine cost effectiveness. The benefit information is not determinable for this SPA as it varies depending on the employer insurance and insurance company. However, any services not covered by the employer sponsored insurance Medicaid does provide wrap around coverage and would pay for additional services for the eligible Medicaid recipient.</p> </div>	
<p>The state/territory otherwise provides for payment of premiums.</p>	<input type="checkbox"/> No
<p>Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:</p> <div style="border: 1px solid black; padding: 5px;"> <p>The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.</p> </div>	

PRA Disclosure Statement

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 5 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.

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP9-1

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-1

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

General Assurance	ABP10
Economy and Efficiency of Plans	
<input checked="" type="checkbox"/> The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.	
Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.	<input type="checkbox"/> Yes
Compliance with the Law	
<input checked="" type="checkbox"/> The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.	
<input checked="" type="checkbox"/> The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).	
<input checked="" type="checkbox"/> The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.	

PRA Disclosure Statement

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 5 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.

V 20130807

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP10-1

Effective Date: 01/01/14



Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Payment Methodology	ABP11
Alternative Benefit Plans - Payment Methodologies	
<input checked="" type="checkbox"/> The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.	
An attachment is submitted.	

PRA Disclosure Statement

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 5 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.

V 20130807

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABP11-1

Effective Date: 01/01/14



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

Alternative Benefit Plan Populations ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name:

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Parents and Other Caretaker Relatives	Voluntary	X
+	Transitional Medical Assistance	Voluntary	X
+	Pregnant Women	Voluntary	X
+	Deemed Newborns	Mandatory	X
+	Infants and Children under Age 19	Mandatory	X
+	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Voluntary	X
+	SSI Beneficiaries	Voluntary	X
+	Individuals Receiving Mandatory State Supplements	Voluntary	X
+	Individuals Who Are Essential Spouses	Mandatory	X
+	Institutionalized Individuals Continuously Eligible Since 1973	Voluntary	X
+	Blind or Disabled Individuals Eligible in 1973	Voluntary	X
+	Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	Voluntary	X
+	Individuals Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Voluntary	X
+	Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	Voluntary	X
+	Working Disabled under 1619(b)	Voluntary	X
+	Disabled Adult Children	Voluntary	X
+	Reasonable Classifications of Individuals under Age 21	Voluntary	X
+	Children with Non-IV-E Adoption Assistance	Voluntary	X



Alternative Benefit Plan

Attachment 3.1-L

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Optional Targeted Low Income Children	Mandatory	X
+	Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	Voluntary	X
+	Individuals Eligible for Cash except for Institutionalization	Voluntary	X
+	Individuals Receiving Home and Community Based Services under Institutional Rules	Voluntary	X
+	Optional State Supplement - 1634 States and SSI Criteria States with 1616 Agreements	Voluntary	X
+	Institutionalized Individuals Eligible under a Special Income Level	Voluntary	X
+	Individuals Receiving Hospice Care	Voluntary	X
+	Poverty Level Aged or Disabled	Voluntary	X
+	Medically Needy Pregnant Women	Voluntary	X
+	Medically Needy Children under Age 18	Voluntary	X
+	Medically Needy Aged, Blind or Disabled	Voluntary	X
+	Former Foster Care Children	Voluntary	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

Should the State Plan and ABP not be aligned in the future, the State will counsel exempt individuals on the option to select the State Plan.

PRA Disclosure Statement

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 5 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.

V 20130920



Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

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

These assurances must be made by the state/territory if the ABP Population includes any eligibility groups other than or in addition to the Adult eligibility group.

When offering voluntary enrollment in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent), prior to enrollment:

- The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.
- The state/territory assures it will effectively inform individuals who voluntary enroll of the following:
 - a) Enrollment is voluntary;
 - b) The individual may disenroll from the Alternative Benefit Plan at any time and regain immediate access to full standard state/territory plan coverage;
 - c) What the process is for disenrolling.
- The state/territory assures it will inform the individual of:
 - a) The benefits available under the Alternative Benefit Plan; and
 - b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan differs from the approved Medicaid state/territory plan.

How will the state/territory inform individuals about voluntary enrollment? (Check all that apply.)

- Letter
- Email
- Other:

Describe:

All Medicaid beneficiaries, regardless of eligibility group, will be notified in writing within 30 days of enrollment that all Kentucky Medicaid beneficiaries receive the same benefit package, whether in the ABP or State Plan, along with a brief description of that benefit package. This notification will advise beneficiaries to contact the Department for Medicaid Services (DMS) and/or their selected Managed Care Organization (MCO) if they have questions about their benefit package or specific services. A toll free telephone number will be provided in the notification. If a member requests to be moved back into the regular state plan, members will be able to do so.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about voluntary enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Within 30 days of enrollment



Alternative Benefit Plan

Attachment 3.1-L

13P

Please describe the state/territory's process for allowing voluntarily enrolled individuals to disenroll.

Upon notification to DMS or the MCO

The state/territory assures it will document in the exempt individual's eligibility file that the individual:

- a) Was informed in accordance with this section prior to enrollment;
- b) Was given ample time to arrive at an informed choice; and
- c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.

Where will the information be documented? (Check all that apply.)

- In the eligibility system.
- In the hard copy of the case record.
- Other:

Describe:

The ABP is fully aligned with Kentucky's State Plan benefit package. Since the notification described above will be a universal notification to all Medicaid beneficiaries upon enrollment, documentation will be centralized.

What documentation will be maintained in the eligibility file? (Check all that apply.)

- Copy of correspondence sent to the individual.
- Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- Other:

Describe:

The universal notification along with a description of the procedure specifying how it is to be provided to all beneficiaries.

The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in an Alternative Benefit Plan and the total number who have disenrolled.

Other Information Related to Enrollment Assurance for Voluntary Participants (optional):

As indicated KY has aligned its ABP with its State Plan. In ABP1, KY stated "Should the State Plan and ABP not be aligned in the future, the State will counsel exempt individuals on the option to select the State Plan."

PRA Disclosure Statement

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 5 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.



Alternative Benefit Plan

Attachment 3.1-L

V.20130807



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L -

Enrollment Assurances - Mandatory Participants

ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

- The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

- Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Kentucky's eligibility system identifies these individuals based on eligibility criteria.

- Self-identification

- Other

- The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.
- The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

- Review of claims data
- Self-identification
- Review at the time of eligibility redetermination
- Provider identification
- Change in eligibility group
- Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?



Alternative Benefit Plan

Attachment 3.1-L

- Monthly
- Quarterly
- Annually
- Ad hoc basis
- Other

The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

The ABP and State Plan benefits are exactly equivalent, therefore, exemption processes are not applicable.

Should the State Plan and ABP not be aligned in the future, the State will counsel exempt individuals on the option to select the State Plan. The State will verify the request for exemption using the same process used for normal eligibility determination and redetermination.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

All Medicaid beneficiaries, regardless of eligibility group, will be notified in writing within 30 days of enrollment that all Kentucky Medicaid beneficiaries receive the same benefit package, whether in the ABP or State Plan, along with a brief description of that benefit package. This notification will advise beneficiaries to contact the Department for Medicaid Services (DMS) and/or their selected Managed Care Organization (MCO) if they have questions about their benefit package or specific services. A toll free telephone number will be provided in the notification. If a member requests to be moved back into the regular state plan, members will be able to do so.

Should the State Plan and ABP not be aligned in the future, the State will counsel exempt individuals on the option to select the State Plan.

PRA Disclosure Statement

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 5 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.

V.20130807



Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3

Select one of the following:

- The state/territory is amending one existing benefit package for the population defined in Section 1.
- The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package:

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- Secretary-Approved Coverage.
 - The state/territory offers benefits based on the approved state plan.
 - The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
 - The state/territory offers the benefits provided in the approved state plan.
 - Benefits include all those provided in the approved state plan plus additional benefits.
 - Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
 - The state/territory offers only a partial list of benefits provided in the approved state plan.
 - The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Selection of Base Benchmark Plan



Alternative Benefit Plan

Attachment 3.1-L

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option.

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- Any of the largest three state employee health benefit plans by enrollment.
- Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- Largest insured commercial non-Medicaid HMO.

Plan name:

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The State assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
The State assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

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 5 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.

V.20130801



Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing

ABP4

Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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 5 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.

V.20130807



Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Benefits Description	ABP5
-----------------------------	-------------

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

The state/territory is proposing "Secretary-Approved Coverage" as its section 1937 coverage option. Yes

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

The state/territory must provide a benefit by benefit comparison of the benefits in its proposed Secretary-Approved Alternative Benefit Plan with the benefits provided by one of the section 1937 Benchmark Benefit Packages or the standard full Medicaid state plan under Title XIX of the Act. Submit a document indicating which of these benefit packages will be used to make the comparison and include a chart comparing each benefit in the proposed Secretary-Approved benefit package with the same or similar benefit in the comparison benefit package, including any limitations on amount, duration and scope pertaining to the benefits in each benefit package.

An attachment is submitted.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Anthem PPO

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved



Alternative Benefit Plan

Attachment 3.1-L

Essential Health Benefit 1: Ambulatory patient services

Collapse All

Benefit Provided:

Physician Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This represents Physician services.

Benefit Provided:

Outpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is required for some services. See State Plan for complete listing

Benefit Provided:

Clinic Services

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

Attachment 3.1-L

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		<input type="button" value="Remove"/>
<input type="text"/>		
Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Certified Pediatric or Family Nurse Practitioner"/>	<input type="text" value="State Plan 1905(a)"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:	<input type="text" value="None"/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Full State Plan Service Title: Certified pediatric or family Nurse Practitioner services"/>		
Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Hospice Care"/>	<input type="text" value="State Plan 1905(a)"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="Prior Authorization"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:	<input type="text" value="Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services"/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text"/>		
Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Private duty nursing"/>	<input type="text" value="State Plan 1905(a)"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="Prior Authorization"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="2000 hours / year"/>	<input type="text" value="None"/>	



Alternative Benefit Plan

Attachment 3.1-L

Scope Limit: <input type="text" value="Services in an inpatient setting excluded"/>		<input type="button" value="Remove"/>
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: <input type="text" value="Medical care & any other type of remedial:podiatry"/>	Source: <input type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Limited to non-routine foot care; routine foot care excluded"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Full State Plan Service Title: Medical care and any other type of remedial care provided by licensed practitioners: Podiatry"/> <input type="text" value="KY State Plan Title: Medical care and any other type of remedial care"/> <input type="text" value="Podiatry exclusions include: treatment of flatfoot; treatments undertaken for the sole purpose of correcting a subluxated structure as an isolated entity within the foot; routine footcare, except when the patient has a systemic disease of sufficient severity that unskilled performance of such procedures would be hazardous; specified methods of plethysmography. Orthopedic shoes and other supportive devices for the feet are not covered under this program element. Additional detailed explanations of these exclusions are included in the State Plan."/> <input type="text" value="This represents podiatry services"/>		
Benefit Provided: <input type="text" value="Medical care & any other type of remedial: Other"/>	Source: <input type="text" value="State Plan 1905(a)"/>	
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		



Alternative Benefit Plan

Attachment 3.1-L

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		<input type="button" value="Remove"/>
Full State Plan Service Title: Medical care and any other type of remedial care provided by licensed practitioners: Other practitioner's services		
KY State Plan Title: Medical care and any other type of remedial care		
This represents services provided by other practitioners listed in the State Plan		
Benefit Provided:	Source:	<input type="button" value="Remove"/>
Family Planning Services and Supplies for Individu	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Limited to individuals of child-bearing age		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Full State Plan Service Title: Family Planning Services and Supplies for Individuals of Child-bearing Age		
		<input type="button" value="Add"/>



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 2: Emergency services		Collapse All <input type="checkbox"/>
<hr/>		
Benefit Provided: <input type="text" value="Outpatient Hospital: Emergency department"/>	Source: <input type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
<hr/>		
Benefit Provided: <input type="text" value="Any other medical care: emergency transportation"/>	Source: <input type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Full State Plan Service Title: Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary
This represents emergency transportation/ambulance"/>		
		<input type="button" value="Add"/>



Alternative Benefit Plan

Attachment 3.1-L

Essential Health Benefit 3: Hospitalization Collapse All

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Authorization is done through prior, concurrent, and retroactive authorization, depending on the type of hospital and service.

Benefit Provided:

Physician: Inpatient Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This represents Inpatient Physician Services

Add



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 4: Maternity and newborn care		Collapse All <input type="checkbox"/>
<hr/>		
Benefit Provided: <input type="text" value="Other diagnostic, screening, preventive, and rehab"/>	Source: <input type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
<p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p> <input type="text" value="Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitation services"/> <input type="text" value="This benefit incorporates prenatal and postnatal care."/>		
<hr/>		
Benefit Provided: <input type="text" value="Nurse-midwife Services"/>	Source: <input type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
<p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p> <input type="text"/>		
<hr/>		
Benefit Provided: <input type="text" value="Inpatient Hospital Services: Maternity"/>	Source: <input type="text" value="State Plan 1905(a)"/>	
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		



Alternative Benefit Plan

Attachment 3.1-L

Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment Collapse All

Benefit Provided:

Inpatient Hospital Services: IP Mental Health

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

IP Mental Health in an IMD is not available to individuals between the ages of 21 to 64.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This represents Inpatient Mental Health services.
These facilities are not IMDs.

Benefit Provided:

Rehabilitative services: OP Mental Health

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan
This represents Outpatient Mental Health services.

Benefit Provided:

Inpatient Hospital Services: IP Substance Use

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

Attachment 3.1-L

Scope Limit:	
<input type="text" value="None"/>	<input type="button" value="Remove"/>
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	
<input type="text" value="This represents IP Substance Use Disorder Services
These facilities are not IMDs"/>	
Benefit Provided:	Source:
<input type="text" value="Rehabilitative services: ●P Substance Use"/>	<input type="text" value="State Plan 1905(a)"/>
<input type="button" value="Remove"/>	
Authorization:	Provider Qualifications:
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>
Amount Limit:	Duration Limit:
<input type="text" value="None"/>	<input type="text" value="None"/>
Scope Limit:	
<input type="text" value="None"/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	
<input type="text" value="Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan
This represents OP Substance Use Disorder Services"/>	
<input type="button" value="Add"/>	



Alternative Benefit Plan

Attachment 3.1-L

Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

The Commonwealth of Kentucky's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.



Alternative Benefit Plan

Attachment 3.1-L

Essential Health Benefit 7: Rehabilitative and habilitative services and devices Collapse All

Benefit Provided:

Physical therapy & related svcs: PT

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

20 visits per calendar year

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

State Plan Service Title: Physical therapy and related services

20 visits per year for physical therapy; benefit limits are aggregated between habilitation and rehabilitation services.

Benefit Provided:

Home Health: Medical supplies, equipment, and appl

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Specific restrictions and exclusions are found in the fee schedule

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Home Health: Medical supplies, equipment, and appliances suitable for use in the home

KY State Plan Title: Home Health: Medical supplies suitable for use in the home

Prior authorization is required for items of equipment or repairs greater than \$500 and certain other specified items.

Benefit Provided:

Prosthetics

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Attachment 3.1-L

Amount Limit: None	Duration Limit: None	Remove
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization is required for items of equipment or repairs greater than \$500 and certain other specified items.		
Benefit Provided: Nursing Facility Services (21 and older)	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Meets level of care		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This is a nursing facility for rehabilitative purposes. The base benchmark limits the number of days in a nursing facility to 90 day.		
Benefit Provided: Medical and other types of remedial care: chiropra	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 26 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents chiropractic services		
Benefit Provided: Nursing Facility Services (for individuals age 65	Source: State Plan 1905(a)	



Alternative Benefit Plan

Attachment 3.1-L

Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	Remove
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plant Service Title: Nursing Facility Services (for individuals age 65 or older in an IMD)		
Benefit Provided: Physical therapy & related svcs: OT	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 20 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: Physical therapy and related services 20 visits per year for occupational therapy; benefit limits are aggregated between habilitation and rehabilitation services.		
Benefit Provided: Physical therapy & related svcs: ST	Source: State Plan 1905(a)	
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 20 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: Physical therapy and related services		



Alternative Benefit Plan

Attachment 3.1-L

20 visits per year for speech therapy; benefit limits are aggregated between habilitation and rehabilitation services.		Remove
Benefit Provided: Home health services; nursing, aide, and therapy	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: PT/OT/ST: 20 visits each per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents the home health visit, including PT/OT/SLT (if applicable) 20 visits each per calendar year for physical, occupational, and speech therapy; benefit home health services		
		Add



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 8: Laboratory services		Collapse All <input type="checkbox"/>
Benefit Provided: Other Laboratory and x-Ray Services	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Some imaging services require a prior authorization. See State Plan for complete listing.		
		<input type="button" value="Add"/>



Alternative Benefit Plan

Attachment 3.1-L

Essential Health Benefit 9: Preventive and wellness services and chronic disease management Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:	Source:	
<input type="text" value="Preventive Services"/>	<input type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="Supplements existing benefits with any additions to comply with USPSTF, ACIP, IOM, and Bright Futures."/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan"/>		
<input type="text" value="This benefit includes preventive services"/>		

Benefit Provided:	Source:	
<input type="text" value="Physician services: allergy"/>	<input type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text"/>		



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 10: Pediatric services including oral and vision care		Collapse All <input type="checkbox"/>
Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: EPSDT Prior Auth required for orthodontia		
Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Limited to children under 21 years of age		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Inpatient psychiatric facility services for individuals under 21 years of age These services are not in an IMD		
		<input type="button" value="Add"/>



Alternative Benefit Plan

Attachment 3.1-L

<input type="checkbox"/> Other Covered Benefits from Base Benchmark	Collapse All <input type="checkbox"/>
---	---------------------------------------



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Base Benchmark Benefits Not Covered due to Substitution or Duplication		Collapse All <input type="checkbox"/>
Base Benchmark Benefit that was Substituted: <input type="text" value="Primary Care Visit"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Patient Services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Specialist Visit"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Patient Services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Outpatient facility fee"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Clinic Services and Outpatient Hospital Services, under the EHB Ambulatory Patient Services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Hospice"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Hospice care, under the EHB Ambulatory services"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Home health care services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Home Health Services, under the EHBs Ambulatory Patient Services & Rehabilitative and habilitative services and devices"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="ER Services"/>	Source: Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Outpatient Hospital Services, as well as Outpatient Hospital:"/>		



Alternative Benefit Plan

Attachment 3.1-L

Emergency department, under the EHB Emergency Services. Emergency hospital services are covered as outpatient hospital services in Medicaid.		<input type="button" value="Remove"/>
Base Benchmark Benefit that was Substituted: <input type="text" value="Emergency Transportation / Ambulance"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary, under the EHB Emergency Services ."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Inpatient Hospital Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Inpatient Hospital Services, under the EHB Hospitalization."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Inpatient physician and surgical services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physician Services, under the EHB Hospitalization."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Skilled nursing facility"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Nursing Facility Services (for individuals age 65 or older in an IMD) & Nursing Facility Services (21 and older) , under the EHBs Rehabilitative and Habilitative Services and Devices"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Prenatal and postnatal care"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services, under the EHB Maternity and Newborn Care."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Delivery and all inpatient services for maternity"/>	Source: Base Benchmark	



Alternative Benefit Plan

Attachment 3.1-L

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: This benefit was replaced with Inpatient hospital services: Maternity, under the EHB Maternity and Newborn Care."/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Mental/behavioral health outpatient services"/>	<input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services & EPSDT, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health"/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Mental/behavioral health inpatient services"/>	<input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="Duplication: This benefit was replaced with Inpatient Hospital Services: IP Substance Use, and Inpatient psychiatric facility services for individuals under 21 years of age, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health, and the EPSDT EHB, respectively"/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Substance Abuse Disorder Outpatient Services"/>	<input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services & Extended services to pregnant women, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health"/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Substance Abuse Disorder Inpatient Services"/>	<input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="Duplication: This benefit was replaced with Inpatient Hospital Services, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health"/>		
Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Generic Drugs"/>	<input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="Duplication: This benefit was replaced with Prescription drugs, Dentures, Prosthetic Devices, and Eyeglasses under the EHB Prescription Drugs"/>		



Alternative Benefit Plan

Attachment 3.1-L

Base Benchmark Benefit that was Substituted: <input type="text" value="Preferred Brand Drugs"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Non-Preferred Brand Drugs"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Specialty Drugs"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Outpatient Rehabilitation Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physical Therapy and related Services, under the EHB Rehabilitative and Habilitative Services and Devices"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Habilitation Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physical Therapy and related Services, under the EHB Rehabilitative and Habilitative Services and Devices"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Chiropractic Care"/>	Source: Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Medical care and any other type of remedial care, under the Rehabilitative and Habilitative Services and Devices. This benefit is limited to 12 visits per year in the base"/>		



Alternative Benefit Plan

Attachment 3.1-L

benchmark plan.		<input type="button" value="Remove"/>
Base Benchmark Benefit that was Substituted: <input type="text" value="Durable Medical Equipment"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Family Planning Services and Supplies for Individuals of Child-bearing Age under the EHB for Ambulatory Services, and Home Health: Medical supplies, equipment, and appliances suitable for use in the home, as well as Prosthetics, under the EHB Rehabilitative and Habilitative Services and Devices."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Hearing Aides"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with EPSDT & Home Health: Medical supplies, equipment, and appliances suitable for use in the home, under the EHB Rehabilitative and Habilitative Services and Devices."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Diagnostic Tests (x-rays and lab work)"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Other Laboratory and X-Ray Services, under the EHB Laboratory Services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Imaging (CT/PET/MRI)"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Other Laboratory and X-Ray Services, under the EHB Laboratory Services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Preventive care / screening / immunization"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services, under the EHB Preventive and wellness Services and Chronic Disease Management."/>		



Alternative Benefit Plan

Attachment 3.1-L

Base Benchmark Benefit that was Substituted: <input type="text" value="Routine Eye Exam for Children"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Eye glasses for children"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with EPSDT & Prescribed drugs, dentures, prosthetic devices, and eyeglasses, under EHB Pediatric services, including oral and vision care"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Dental check-up for children"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Allergy treatment"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physician Services, under the EHB Preventive and wellness services and chronic disease management"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Injectable drugs and other drugs administered in a"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="(Full benchmark benefit: Injectable drugs and other drugs administer in a providers' office or other OP setting)"/> <input type="text" value="Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Services"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Medical supplies, equipment, and education for dia"/>	Source: Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="(Full benchmark benefit: Medical supplies, equipment, and education for diabetes care for all diabetics)"/> <input type="text" value="Duplication: This benefit was replaced with Prescription drugs, under the EHB Prescription drugs and"/>		



Alternative Benefit Plan

Attachment 3.1-L

<p>Physician Services under EHB Ambulatory Services. The medical supplies and equipment for diabetes care maps to the Prescription Drugs, while the education for diabetics maps to Physician Services under Ambulatory.</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Dental services for accidental injury and other re</p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: (Full benchmark benefit: Dental services for accidental injury and other related medical services) Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Human organ and tissue transplant transplant servi</p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Inpatient hospital services and Physician Services, under the EHB Hospitalization</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Human organ and tissue transplant services - trans</p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Inpatient hospital services and Physician Services, under the EHB Hospitalization</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Human organ and tissue transplant services - unrel</p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: (Full benchmark benefit: Human organ and tissue transplant services - unrelated donor search) Duplication: This benefit was replaced with Inpatient Hospital Services</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Autism Services for children</p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Radiation therapy</p> <p>Source: Base Benchmark</p>	



Alternative Benefit Plan

Attachment 3.1-L

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Chemotherapy"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Infusion Therapy"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Renal dialysis/hemodialysis"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Vision correction after surgery or accident"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="This benefit was replaced with Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory patient services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Other practitioner office visit"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: This benefit was replaced with Certified pediatric or family Nurse Practitioner services, under the EHB Ambulatory services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Private duty nursing"/>	Base Benchmark	



Alternative Benefit Plan

Attachment 3.1-L

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<p>Duplication: This benefit was replaced with Private Duty Nursing, under the EHB Ambulatory Care</p> <p>The base benchmark has a 2,000 hour limit.</p>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Urgent Care Centers"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<p>Duplication: This benefit was replaced by Clinic Services, under the EHB Ambulatory patient services</p>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Outpatient surgery physician / surgical"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<p>Duplication: This benefit was replaced by Physician Services, under the EHB Ambulatory patient services and Physician Services: Maternity under the Maternity and newborn care EHB.</p>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Podiatry services"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<p>Duplication: This benefit was replaced with Medical care and any other type of remedial care provided by licensed practitioners: Podiatry, under the EHB Ambulatory Patient Services</p>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Other practitioner's services"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<p>Duplication: This benefit was replaced with Medical care and any other type of remedial care provided by licensed practitioners: Other practitioner's services, under the EHB Ambulatory Patient Services</p>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Certified Nurse Midwife"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<p>Duplication: This benefit was replaced with Nurse-midwife Services, under the EHB Maternity and Newborn Care</p>		



Alternative Benefit Plan

Attachment 3.1-L

Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Prescription Drug Benefits"/>	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs under the EHB Prescription drugs and Family Planning Services and Supplies under the EHB Ambulatory services."/>		
		<input type="button" value="Add"/>



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Other Base Benchmark Benefits Not Covered		Collapse All <input type="checkbox"/>
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Non-emergency care when traveling outside the US"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="This is not permissible under federal Medicaid rules."/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Routine eye exam"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="This benefit is not a an EHB for adults."/>		
		<input type="button" value="Add"/>



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Other 1937 Covered Benefits that are not Essential Health Benefits		Collapse All <input type="checkbox"/>
Other 1937 Benefit Provided: <input type="text" value="Services in an ICF-IID"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Medicaid individuals who meet ICF-IDD patient status criteria"/>		
Other: <input type="text"/>		
Other 1937 Benefit Provided: <input type="text" value="Dental Services"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="1 cleaning and 1 x-ray per year"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Dental services for adults 21 years of age or older"/>		
Other: <input type="text" value="No authorization required"/>		
Other 1937 Benefit Provided: <input type="text" value="Routine eye exam"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other: <input type="text" value="No authorization required"/>		



Alternative Benefit Plan

Attachment 3.1-L

<input type="text"/>		<input type="button" value="Remove"/>
Other 1937 Benefit Provided: <input type="text" value="Case management services"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Some case management services are limited to specific groups of individuals. Please see State Plan for complete listing."/>		
Other: <input type="text" value="Some case management services are limited to specific groups of individuals. Populations included:
• Children meeting the eligibility criteria of the Commission for Handicapped Children (CHC) and persons of all ages with hemophilia meeting the CHC eligibility criteria.• Children in the custody of or at risk of being in the custody of the State; children under the supervision of the state; and adults in need of protective services.• Children birth to three participating in the Kentucky Early Intervention Program.• Pregnant women who are under age 20 and first time parents; and pregnant women age 20 or older who are first time parents and screen as high risk for the Health Access Nurturing Development Services (HANDS) program.• Pregnant women, including post partum women for the 60 days after the pregnancy ends, who are receiving substance use services.• Individuals with a moderate or severe substance use disorder diagnosis, or co-occurring substance use and mental health disorders; with need for assistance in accessing community or recovery supports or with multi-agency involvement.• Individuals with a severe emotional disability or a serious mental illness; who are at risk of out-of-home placement or institutional care.• Individuals with at least two of the following types of co-occurring disorders, which interact to complicate treatment: (1) mental health, (2) substance use, and (3) chronic or complex physical health conditions."/>		
Other 1937 Benefit Provided: <input type="text" value="Face-to-face Tobacco Cessation for Pregnant Women"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="4 face-to-face sessions per quit attempt"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		



Alternative Benefit Plan

Attachment 3.1-L

Other: Full amount limit: 4 face-to-face sessions per quit attempt with a minimum of 2 quit attempts No authorization required		Remove
Other 1937 Benefit Provided: Nursing Facility Services for Long Term Care	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Meets level of care		
Other: 		
Other 1937 Benefit Provided: Ambulatory prenatal care for pregnant women furni	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other: Full State Plan Service Title: Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period No prior authorization is required.		
		Add



Alternative Benefit Plan

Attachment 3.1-L

<input type="checkbox"/> Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)	Collapse All <input type="checkbox"/>
---	---------------------------------------

PRA Disclosure Statement

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 5 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.

V 20130808



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

Benefits Assurances

ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

- Through an Alternative Benefit Plan.
- Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

- State/territory provides additional EPSDT benefits through fee-for-service.
- State/territory contracts with a provider for additional EPSDT services.

Please specify payment method (select one):

- Risk-based capitation
- Administrative services contract
- Other

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

EPSDT benefits will be administered through the prior authorization process.

MCOs have been informed that they should not deny services for children because a benefit is not covered, but may deny a service if it is not medically necessary. KY regularly monitors complaints and claim denials to verify MCO compliance.

KY provides educational materials to members about EPSDT benefits

Prescription Drug Coverage Assurances

The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.



Alternative Benefit Plan

Attachment 3.1-L

- The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.
- The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.
- The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

- The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

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 5 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.



Alternative Benefit Plan

Attachment 3.1-L

V.20130807

TN No: 13-021
Kentucky

Approval Date: 12/20/13
ABP7-3

Effective Date: 01/01/14



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

Service Delivery Systems

ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- Managed care.
 - Managed Care Organizations (MCO).
 - Prepaid Inpatient Health Plans (PIHP).
 - Prepaid Ambulatory Health Plans (PAHP).
 - Primary Care Case Management (PCCM).

Fee-for-service.

Other service delivery system.

Managed Care Options

Managed Care Assurance

- The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

As authorized in the existing 1915(b) waiver KY-07.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

Yes

The managed care program is operating under (select one):

- Section 1915(a) voluntary managed care program.
- Section 1915(b) managed care waiver.
- Section 1932(a) mandatory managed care state plan amendment.
- Section 1115 demonstration.
- Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:



Alternative Benefit Plan

Attachment 3.1-L

Describe program below:

KY-07 allows for mandatory enrollment for Medicaid beneficiaries into managed care. Beneficiaries have the choice of two to four managed care organizations depending on the region of state in which they reside.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program.

Yes

The managed care program is operating under (select one):

- Section 1915(a) voluntary managed care program.
- Section 1915(b) managed care waiver.
- Section 1115 demonstration.
- Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:

Describe program below:

Non-Emergency Transportation Services: KY-06 provides transportation under a capitated arrangement with regional transportation brokers for eligible Medicaid members requiring transportation to and from approved non-emergency medical services.

Additional Information: PAHP (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

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 5 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.

V.20130718



Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

Yes

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

This program is called the Health Insurance Premium Payment (HIPP) is available to all Medicaid recipients. The program will pay the cost of the premium for any Medicaid recipient that is working and has access to employer sponsored insurance and still eligible for Medicaid provided said payments would be cost effective for Medicaid. All information is entered in our MMIS system to make determination of cost effectiveness. The system looks at their age, premium cost, and claims cost to determine cost effectiveness. The benefit information is not determinable for this SPA as it varies depending on the employer insurance and insurance company. However, any services not covered by the employer sponsored insurance Medicaid does provide wrap around coverage and would pay for additional services for the eligible Medicaid recipient.

The state/territory otherwise provides for payment of premiums.

No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

PRA Disclosure Statement

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 5 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.



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

General Assurances

ABP10

Economy and Efficiency of Plans

- The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.

Yes

Compliance with the Law

- The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.
- The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).
- The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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 5 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.

V 20130807

TN No: 13-021
Kentucky

Approval Date: 12/20/13
ABP10-1

Effective Date: 01/01/14



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

Payment Methodology

ABP11

Alternative Benefit Plans - Payment Methodologies

- The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

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 5 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.

V 20130807

State Plan Under Title XIX of the Social Security Act

State: KENTUCKY

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 02/25/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	Relevant Population Group Income Standard	Resource Proxy	Enrollment Cap	Special Circumstances	Other Adjustments
	<p>For each population group, indicate the lower of:</p> <ul style="list-style-type: none"> The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or 133% FPL. <p>If a population group was not covered as of 12/1/09, enter "Not covered".</p>	<p>Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.</p>			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	N/A	No	No
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	N/A	No	No
Disabled Persons, institutionalized	Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	N/A	No	No
Children Age 19 or 20	Not Covered	N/A	N/A	N/A	N/A
Childless Adults	No Covered	N/A	N/A	N/A	N/A

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

The state:

Applies existing state data from periods before January 1, 2014.

Applies data obtained through a post-eligibility statistically valid sample of individuals.

Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. An enrollment cap adjustment is applied by the state (complete items 2 through 4).

An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).
3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:
 Yes. The combined enrollment cap adjustment is described in Attachment C
 No.
4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:
 Applies a special circumstances adjustment(s).
 Does not apply a special circumstances adjustment.
2. The state:
 Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).
 Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).
3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

- Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.
- The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

- Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)
- Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated _____.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

- Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).
- Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

- A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.
- B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- Attachment A – Conversion Plan Standards Referenced in Table 1
- Attachment B – Resource Criteria Proxy Methodology
- Attachment C – Enrollment Cap Methodology
- Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- Attachment E – Transition Methodologies

PRA Disclosure Statement

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 4 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.

Most Recent Updated Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan*
KENTUCKY

02/25/2014

	Population Group A	Net standard as of 12/1/09 B	Converted standard for FMAP claiming C	Same as converted eligibility standard? (yes, no, or n/a) D	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan) E	Data source for Conversion (SIPP or state data) F
Conversions for FMAP Claiming Purposes						
1	Parents/Caretaker Relatives				Part 1 of approved state MAGI conversion plan	SIPP
	Dollar standards by family size					
	1	\$217	\$235			
	2	\$267	\$291			
	3	\$308	\$338			
	4	\$383	\$419	no		
	5	\$450	\$492			
	6	\$508	\$556			
	7	\$567	\$621			
8	\$627	\$687				
add-on	\$60	\$66				
2	Noninstitutionalized Disabled Persons	100%	103%	n/a	new SIPP conversion	SIPP
	SSI FBR%					
3	Institutionalized Disabled Persons	300%	300%	n/a	ABD conversion template	n/a
	SSI FBR%					
4	Children Age 19-20	n/a	n/a	n/a	n/a	n/a
5	Childless Adults	n/a	n/a	n/a	n/a	n/a
	FPL %					

n/a: Not applicable.

The number in this summary chart will be updated automatically in the case of modifications in the CMS approved MAGI Conversion Plan

(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
42 CFR
430.10

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

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.

TN No. 94-18
Supersedes
TN No. None

Approval Date: 2-1-95

Effective Date: 10-1-94

(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.

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

(14)

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.

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

State/Territory: Kentucky

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

- 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 (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 (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.

State: Kentucky

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

1905(a)(26) and 1934 Program of All-Inclusive Care of the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies services provided to each covered group of 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 for conditions that may complicate the pregnancy.

TN No. 98-08
Supersedes
TN No. None

Approval Date 11-12-98

Effective Date 1-1-99

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

(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

Citation

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

1905(a)(26)
and 1934

Program of All-Inclusive Care of the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically 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 for conditions that may complicate the pregnancy.

TN No. 98-08
Supersedes
TN No. None

Approval Date 11-12-98

Effective Date 1-1-99

<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.

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

Approval Date NOV 14 1994

Effective Date 1-1-92

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	(c) <u>Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations</u> 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. 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).
1902(a) (10) (F) of the Act	(d) <input type="checkbox"/> The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

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)	<p data-bbox="515 398 954 421">1. Exception from 3 year look back period</p> <p data-bbox="576 450 1123 600">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."</p> <p data-bbox="576 629 1123 701">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.</p> <p data-bbox="576 730 1123 824">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"</p> <ul data-bbox="576 853 1123 1283" style="list-style-type: none"><li data-bbox="576 853 1123 1003">• 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.<li data-bbox="576 1032 1123 1104">• A five year look back period is consistent with the record requirement period by other licensing and regulatory agencies.<li data-bbox="576 1133 1123 1283">• 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.

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)

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

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

- (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).

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 suppliers 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.

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

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: Kentucky

Citation 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: KentuckyCitation 4.1442 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:
- 18 or older
 - 19 or older
 - 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:
 - 18orolder
 - 19orolder
 - 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.

TN No. 90-37
Supersedes
TN No. 87-15

Approval Date: NOV 14 1994

Effective Date: 10/1/90

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>
--	-----------------	--

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.

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
- 1927(g) (3) (B)
42 CFR 456.716
(A) AND (B)
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.

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

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

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. None

Approval 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

State/Territory: Kentucky

- (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

1902(a)(69) of
the Act,
P.L. 109-171
(section 6034)

4.43 Cooperation with Medicaid Integrity Program Efforts.

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

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. 12-002
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.: 12-002
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.: 12-002

Supersedes

TN No.: None

Approval Date 3/14/2012

Effective Date; 1/1/ 2012

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 o 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 rot 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: Kentucky

Citation	7.4	<u>State Governor's Review</u>
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.	
	<input checked="" type="checkbox"/>	Not Applicable. The Governor-
	<input checked="" type="checkbox"/>	Does not wish to review any plan material.
	<input type="checkbox"/>	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: February 8, 2016

Stephen P. Miller, Commissioner
Department for Medicaid Services

TN#: 16-002
Supersedes
TN#: 16-001

Approval Date: 02-12-16Effective Date: February 8, 2016

State of Kentucky

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

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

administering the plan.

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

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

supervising the administration of the plan by local political subdivisions.

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

(statutory citation)

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

(statutory citation)

March 27, 1986
DATE

David Armstrong
Signature (See original document for signature)

Attorney General
Title

ORGANIZATION AND FUNCTION OF THE STATE AGENCY

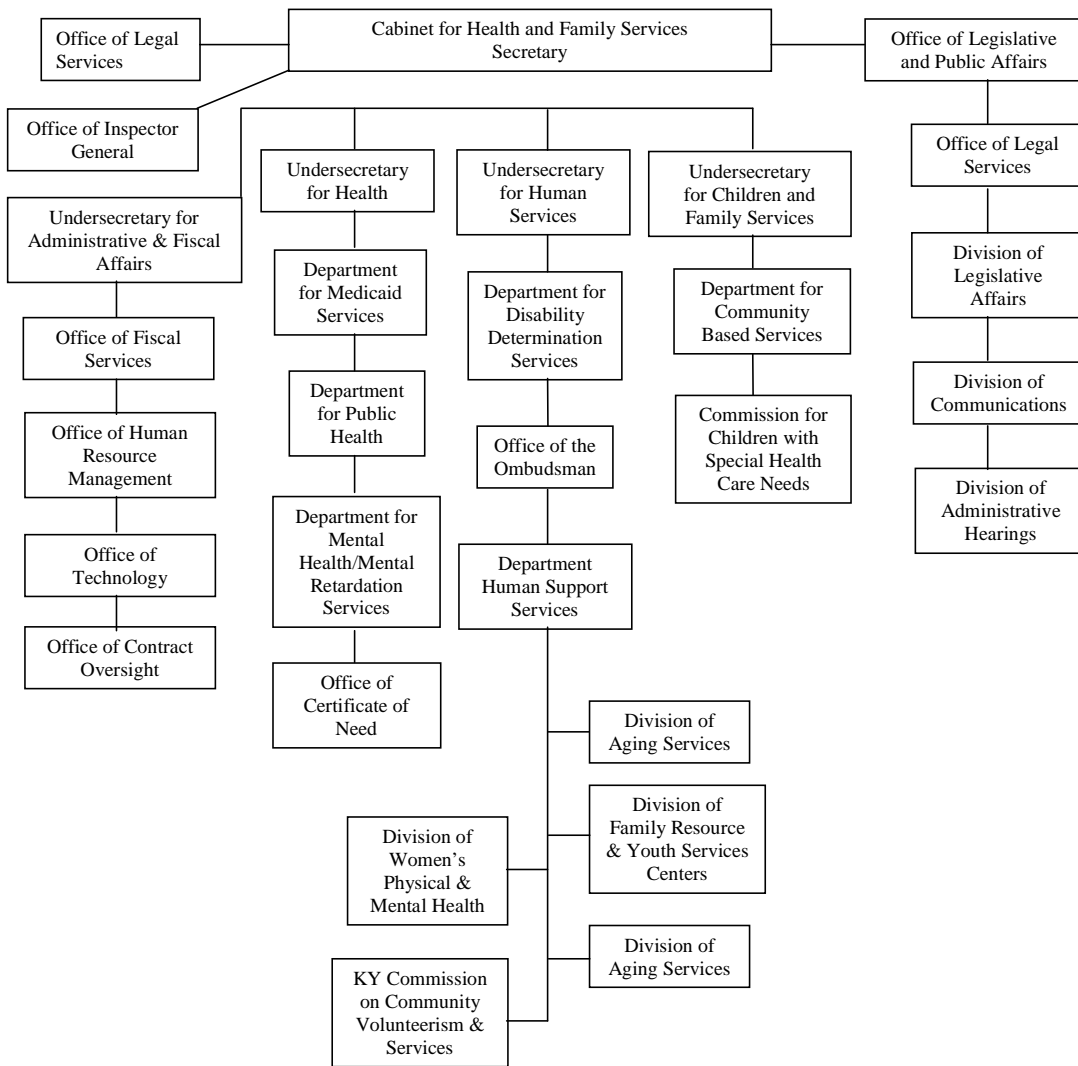
The Cabinet for Health and Family Services is the primary agency in state government responsible for the development and operation of health programs, including all federal programs in which the Commonwealth elects to participate. The Secretary of the Cabinet is the chief executive and administrative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

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

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

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

Cabinet for Health and Family Services

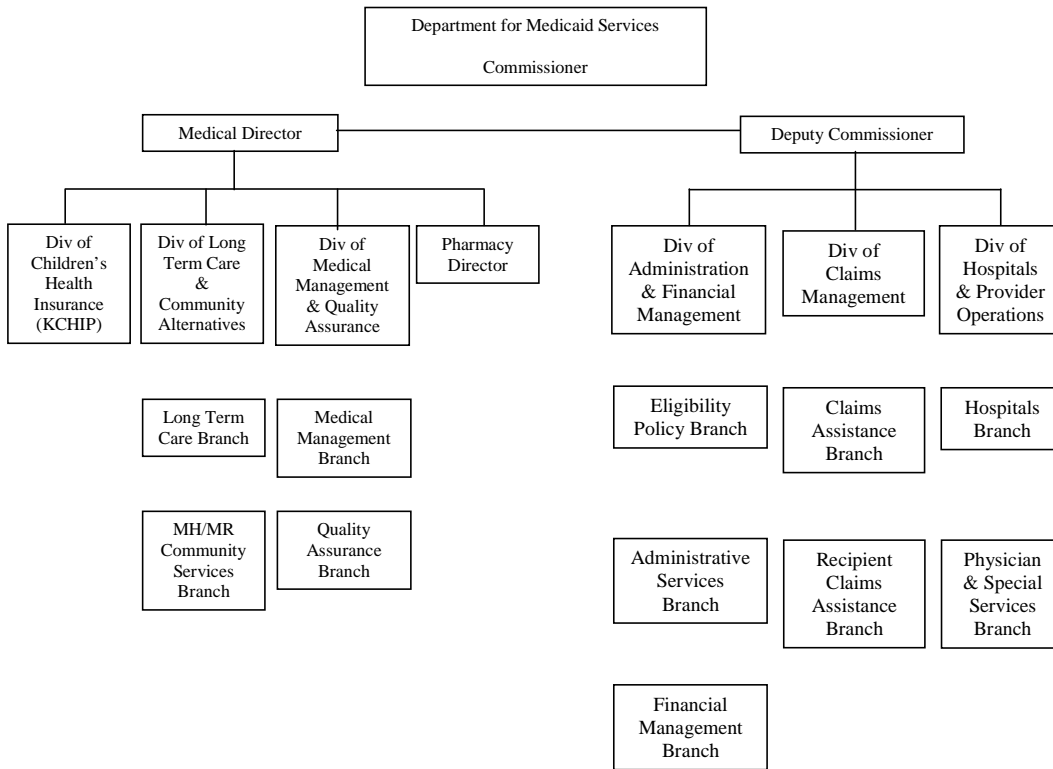


ORGANIZATION AND FUNCTION OF THE STATE AGENCY

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

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

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



ORGANIZATION AND FUNCTION OF THE STATE AGENCY

ORGANIZATIONAL DESCRIPTION

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

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

FUNCTIONS OF THE UNIT

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

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

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

ORGANIZATION AND FUNCTION OF THE STATE AGENCY

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

ORGANIZATION AND FUNCTION OF THE STATE AGENCY

III. MISSION STATEMENTS FOR DIVISIONS AND SUBORDINATE UNITS

A. OFFICE OF THE COMMISSIONER

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

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

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

C. DIVISION OF LONG TERM CARE AND COMMUNITY ALTERNATIVES

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

ORGANIZATION AND FUNCTION OF THE STATE AGENCY

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

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

D. DIVISION OF MEDICAL MANAGEMENT AND QUALITY ASSURANCE

ORGANIZATION AND FUNCTION OF THE STATE AGENCY

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

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

E. DIVISION OF ADMINISTRATION AND FINANCIAL MANAGEMENT

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

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

ORGANIZATION AND FUNCTION OF THE STATE AGENCY

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

F. DIVISION OF CLAIMS MANAGEMENT

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

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

ORGANIZATION AND FUNCTION OF THE STATE AGENCY

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

G. DIVISION OF HOSPITALS AND PROVIDER OPERATIONS

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

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

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

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

Medical Director - (1) Office of the Commissioner

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

Pharmacy Director - (1) Office of the Commissioner

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Assistant Director - (1) Division of Claims Management

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

Administrative Branch Manager - (1) Division of Claims Management

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

Administrative Secretary I - (1) Division of Claims Management

Provides administrative support for functions of an information technology branch.

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

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

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

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

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

Systems Consultant IT - (1) Division of Claims Management

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

Systems Consultant IT - (1) Division of Claims Management

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

Medicaid Specialist I - (1) Division of Claims Management

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

Medicaid Specialist II - (1) Division of Claims Management

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

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

Medicaid Specialist III - (1) Division of Claims Management

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

State: Kentucky

ELIGIBILITY DETERMINATIONS

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

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

The interagency agreement shall include the following:

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

TN No.: 09-004
Supersedes
TN No.: 04-004

Approval Date: 07/31/09

Effective Date: 7/09/04

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

The following groups are covered under this plan.

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

42 CFR 435.110

1. Recipients of AFDC

IV-A

The approved State AFDC plan includes:

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

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

42 CFR 435.115

2. Deemed Recipients of AFDC

IV-A

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

* Agency that determines eligibility for coverage.

State: Kentucky

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

* Agency that determines eligibility for coverage.

State: Kentucky

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

* Agency that determines eligibility for coverage.

State: Kentucky

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

* Agency that determines eligibility for coverage.

State: Kentucky

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

* Agency that determines eligibility for coverage.

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

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

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

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

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

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

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

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

Children born after

September 30, 1979
(Specify optional earlier date)

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

*Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

*Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s) Groups Covered

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

1619(b) (3)
of the Act

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

*Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

*Agency that determines eligibility for coverage.

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

ATTACHMENT 2.2-A
Page 6e.1
OMB NO.: 0938-

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

*Agency that determines eligibility for coverage.

TN No. 92-1
Supersedes
TN No. None

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7983E

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State/Territory: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

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

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

TN # 03-10
Supersedes
TN # 92-2

Approval Date: NOV 18 2003

Effective Date: 8/13/03

State/Territory: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

S

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

B. Optional Groups Other Than the Medically Needy (Continued)

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

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

* Agency that determines eligibility for coverage.

State: Kentucky

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

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

B. Optional Groups Other Than the Medically Needy (Continued)

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

- Yes.
- No.

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

* Agency that determines eligibility for coverage.

State: Kentucky

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

* Agency that determines eligibility for coverage.

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

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7984E

State: Kentucky

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

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

B. Optional Groups Other Than the Medically Needy (Continued)

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

Yes

No

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

* Agency that determines eligibility for coverage.

State: Kentucky

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

* Agency that determines eligibility for coverage.

State: Kentucky

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

* Agency that determines eligibility for coverage.

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

ATTACHMENT 2.2-A
Page 21
OMB NO.: 0938-

State: Kentucky

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

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

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7984E

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

Revised
Attachment 2.2-A
Page 22
OMB No.: 0938-

State: Kentucky

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

* Agency that determines eligibility for coverage.

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

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

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

* Agency that determines eligibility for coverage.

State/Territory: Kentucky

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

* Agency that determines eligibility for coverage.

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

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

State: Kentucky

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

State/Territory: Kentucky

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

State Kentucky

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

State: Kentucky

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

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

State: Kentucky

Agency*	Citation(s)	Groups Covered
---------	-------------	----------------

C. Optional Coverage of the Medically Needy (Continued)

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

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7984E

State: Kentucky

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

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7984E

State: Kentucky

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

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

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

TN No.: 05-008
Supersedes
TN No. N/A

Approval Date: 10/31/05

Effective Date: 07/01/05

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

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

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7984E

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

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

TN No. 92-1
Supersedes
TN No. None

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7984E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

State: Kentucky

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

State: Kentucky

42 CFR 435.403
1902(b) of the Act

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

State has interstate residency agreement with the following States:

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

State has open agreement(s).

Not applicable; no residency requirement

State: Kentucky

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

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

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

State: Kentucky

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

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

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

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

State/Territory: Kentucky

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

TN No. 92-22
Supersedes
TN No. None

Approval Date: 2-11-93

Effective Date 2-1-93

HCFA ID: 7985E

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

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

Citation(s)	Condition or Requirement
1924 of the Act	<p data-bbox="576 327 970 349">For the following persons with greater need:</p> <p data-bbox="576 378 1163 501">Supplement 12a to <u>Attachment 2.6-A</u> describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and where appropriate; identifies the organizational unit which determines that a criterion is met.</p> <p data-bbox="432 528 1165 602">3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:</p> <p data-bbox="504 629 1165 801">a. The monthly income allowance for the community spouse, calculated using the formula in §1 924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924(d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.</p> <p data-bbox="576 831 1165 904"><input checked="" type="checkbox"/> The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.</p> <p data-bbox="576 931 1165 1032"><input type="checkbox"/> The poverty level component is calculated using a percentage greater than the applicable percentage, equal to ___%, of the official poverty level (still subject to maximum maintenance needs standard).</p> <p data-bbox="576 1059 1165 1133"><input type="checkbox"/> The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).</p> <p data-bbox="647 1160 1165 1305">Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court ordered support.</p>

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

Citation(s)	Condition or Requirement
	<ul style="list-style-type: none"><li data-bbox="576 349 1165 427">(i) Medicaid, Medicare and other health insurance premiums, deductibles, or coinsurance charges, or copayments.<li data-bbox="576 450 1165 555">(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to <u>ATTACHMENT 2.6-A</u>)

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	<p data-bbox="360 477 612 506">C. <u>Financial Eligibility</u></p> <p data-bbox="432 528 1165 651">For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r) (2) of the Act, as specified below.</p> <p data-bbox="432 678 1165 752">For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.</p> <p data-bbox="432 779 1165 981"><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i) (VI), 1902(a) (10) (A) (i) (VII), end 1902(a)(10)(A)(ii)(1X) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a) (10) (E)(i) of the Act.</p>

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

State: Kentucky

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

TN No. 08-009
Supersedes
TN No. None

Approval Date 10/17/2008

Effective Date 7/14/2008

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY AC

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

State: Kentucky

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

State: Kentucky

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

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

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

State: Kentucky

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

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

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

State: Kentucky

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

State: Kentucky

Citation(s)	Condition or Requirement
1902(u) of the Act	<p data-bbox="504 376 898 400">h. <u>COBRA Continuation Beneficiaries</u></p> <p data-bbox="576 427 1161 474">In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:</p> <ul data-bbox="576 501 1161 651" style="list-style-type: none"><li data-bbox="576 501 959 526"><input type="checkbox"/> The disregards of the SSI program;<li data-bbox="576 553 1161 651"><input type="checkbox"/> The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6—A. <p data-bbox="576 678 1161 804">NOTE: For COBRA continuation beneficiaries specified at 1902(u) (4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b) (4) (B) (ii).</p>

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

State/Territory: Kentucky

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

TN No: 08-004

Supersedes

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

State/Territory: Kentucky

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

TN No: 08-004

Supersedes

TN No: None

Approval Date: 05/13/08

Effective Date: 01/01/2008

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	<p data-bbox="572 403 783 430"><u>Income Methodologies</u></p> <p data-bbox="572 452 1165 504">In determining whether an individual meets the income standard described above, the agency uses the following methodologies.</p> <ul style="list-style-type: none"> <li data-bbox="572 528 1070 555"><input checked="" type="checkbox"/> The income methodologies of the SSI program. <li data-bbox="572 604 1165 705"><input type="checkbox"/> The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6 – A. <li data-bbox="572 730 1165 806"><input type="checkbox"/> The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	<p data-bbox="576 403 799 430"><u>Resource Methodologies</u></p> <p data-bbox="576 454 1163 506">In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.</p> <p data-bbox="576 530 1163 725">Unless one of the following items is checked, the agency, under the authority of 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.</p> <ul data-bbox="576 750 1163 927" style="list-style-type: none"> <li data-bbox="576 750 1163 808"><input type="checkbox"/> The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans. <li data-bbox="576 833 1163 927"><input type="checkbox"/> The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

TN No: 08-004

Supersedes

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

State/Territory: Kentucky

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

TN No: 08-004

Supersedes

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

State/Territory: Kentucky

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

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	<p data-bbox="576 403 783 425"><u>Income Methodologies</u></p> <p data-bbox="576 450 1161 501">In determining whether an individual meets the income standard described above, the agency uses the following methodologies.</p> <ul data-bbox="576 526 1161 801" style="list-style-type: none"><li data-bbox="576 526 1070 548"><input type="checkbox"/> The income methodologies of the SSI program.<li data-bbox="576 602 1161 701"><input type="checkbox"/> The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4to Attachment 2.6-A.<li data-bbox="576 728 1161 801"><input type="checkbox"/> The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

TN No: 08-004
Supersedes
TN No: None

Approval Date: 05/13/08

Effective Date: 01/01/2008

State/Territory: Kentucky

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

TN No: 08-004

Supersedes

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

State/Territory: Kentucky

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

TN No: 08-004
Supersedes
TN No: None

Approval Date: 05/13/08

Effective Date: 01/01/2008

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) and 1905(v)(2) of the Act.	<p data-bbox="576 403 1161 450"><u>Definition of Employed – Employed Medically Improved Individuals – TWWIA</u></p> <ul style="list-style-type: none"><li data-bbox="576 477 1161 546"><input type="checkbox"/> The agency uses the statutory definition of “employed”, i.e., earning at least the minimum wage, and working at least 40 hours per month.<li data-bbox="576 575 1161 678"><input type="checkbox"/> The agency uses an alternative definition of “employed” that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency’s threshold criteria is described below:

TN No: 08-004
Supersedes
TN No: None

Approval Date: 05/13/08

Effective Date: 01/01/2008

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A)(ii)(XIII) (XV), (XVI), and 1916(g) of the Act	<p data-bbox="576 403 1050 425"><u>Payment of Premiums or Other Cost Sharing Charges</u></p> <p data-bbox="576 452 1161 501">For individuals eligible under the BBA eligibility group described in No. 24 on page 23e of Attachment 2.2 A:</p> <p data-bbox="576 528 1161 629"><input type="checkbox"/> The agency requires payment of premiums or other cost sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied are described below:</p>

State/Territory: Kentucky

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

TN No: 08-004

Supersedes

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

State/Territory: Kentucky

Citation(s)	Condition or Requirement								
Sections 1902(a)(10)(A)(ii)(XV), (XVI), and 1916(g) of the Act (cont.)	<p data-bbox="572 400 959 427"><u>Premiums and Other Cost Sharing Charges</u></p> <p data-bbox="572 450 1165 526">For the Basic Coverage Group, the agency's premium and other cost sharing charges, and how they are applied, are described below.</p> <p data-bbox="572 548 1165 624">Medicaid Works individuals with income from 101-250% of the FPL will be required to pay a premium in accordance with the following:</p> <table data-bbox="628 651 1082 804"> <thead> <tr> <th data-bbox="628 651 831 678">Federal Poverty Level</th> <th data-bbox="863 651 1082 728">Monthly Premium per Medicaid Works Individual</th> </tr> </thead> <tbody> <tr> <td data-bbox="628 728 724 754">101-150%</td> <td data-bbox="863 728 903 754">\$35</td> </tr> <tr> <td data-bbox="628 754 724 781">151-200%</td> <td data-bbox="863 754 903 781">\$45</td> </tr> <tr> <td data-bbox="628 781 724 808">201-250%</td> <td data-bbox="863 781 903 808">\$55</td> </tr> </tbody> </table>	Federal Poverty Level	Monthly Premium per Medicaid Works Individual	101-150%	\$35	151-200%	\$45	201-250%	\$55
Federal Poverty Level	Monthly Premium per Medicaid Works Individual								
101-150%	\$35								
151-200%	\$45								
201-250%	\$55								

TN No: 08-004
Supersedes
TN No: None

Approval Date: 05/13/08

Effective Date: 01/01/2008

State Kentucky

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

State: Kentucky

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

State: Kentucky

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

TN No. 92-1
Supersedes
TN No. None

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7985E

State: Kentucky

Citation(s)	Condition or Requirement
42 CFR 435.732	<p data-bbox="432 376 906 398">b. <u>Categorically Needy - Section 1902 (f) States</u></p> <p data-bbox="504 427 1165 501">The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:</p> <ol data-bbox="504 528 1165 927" style="list-style-type: none"><li data-bbox="504 528 804 551">(1) Any SSI benefit received.<li data-bbox="504 577 1165 680">(2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.<li data-bbox="504 707 1165 781">(3) Increases in OASDI that are deducted under 435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.<li data-bbox="504 808 1165 853">(4) Other deductions from income described in this plan at <u>Attachment 2.6-A, Supplement 4</u>.<li data-bbox="504 880 1165 927">(5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a) (17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

State: Kentucky

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

TN No. 92-1
Supersedes
TN No. None

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7985E

State: Kentucky

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

State: Kentucky

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

State: Kentucky

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

State: Kentucky

Citation(s)	Condition or Requirement
1902 (a) (10) (A), 1902 (a) (10) (C), 1902(m) (1) (B) and (C), and 1902(r) (2) of the Act	<p>d. <u>Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act.</u> The agency uses the following methods for the treatment of resources:</p> <p><input type="checkbox"/> The methods of the SSI program.</p> <p><input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p><input type="checkbox"/> Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in <u>Supplement 5 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902 (1) (3) and 1902(r) (2) of the Act	<p>e. <u>Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a) (10) (A) (ii) (IX) (A) of the Act.</u></p> <p>The agency uses the following methods in the treatment of resources.</p> <p><input type="checkbox"/> The methods of the SSI program only.</p> <p><input type="checkbox"/> The methods of the SSI program and/or any more liberal methods described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p>

State: Kentucky

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY' CONDITIONS AND REQUIREMENTS

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

State: Kentucky

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

State: Kentucky

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

State Kentucky

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

State: Kentucky

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

State: Kentucky

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

State: Kentucky

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

State: Kentucky

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

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

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

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

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

STATE PLAN UNDER TITLE XX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS (Continued)

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

1. Pregnant Women and Infants

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS (Continued)

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

2. Children under age 19

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

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

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

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS (Continued)

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

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

1. NON-SECTION 1902(f) STATES

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

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

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

Eff. Jan. 1, 1991: 100 percent

Eff. Jan. 1, 1992: 100 percent

b. Levels:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS (Continued)

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

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

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

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

b. Levels:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME LEVELS (Continued)

E. Optional Groups Other Than the Medically Needy

1. Institutionalized Individuals Under Special Income Levels as follows:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

RESOURCE LEVELS

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

1. Pregnant Women

a. Mandatory Groups

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

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

b. Optional Groups

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

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

* All Resources are disregarded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

2. Infants

a. Mandatory Group of Infants

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

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

* All resources are disregarded

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

b. Optional Group of Infants

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

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

* All resources are disregarded

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

3. Children

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

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

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

* All resources are disregarded

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

b. Optional Group of Child

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

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

* All resources are disregarded

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

4. Aged and Disabled Individuals

- Same as SSI resource levels.
- More restrictive than SSI levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u> </u>
<u>2</u>	<u> </u>
<u>3</u>	<u> </u>
<u>4</u>	<u> </u>
<u>5</u>	<u> </u>

- Same as medically needy resource levels (applicable only if State has a medically needy program)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups —

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

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

State: Kentucky

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

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

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

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

Approval Date: 5/11/06

Effective Date: 4/1/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

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

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

Not applicable

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

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

Not applicable

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

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

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

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

Not applicable

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

State: Kentucky

Standards for Optional State Supplementary Payments

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

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

Approval Date: 10/12/84

Effective Date: 7-1-84

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

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

Not applicable

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

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

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

SUPPLEMENT 8 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

RESOURCE STANDARDS FOR 1902(f) STATES – CATEGORICALLY NEEDY

Not applicable

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

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

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

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

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

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

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

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

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

Revision: HCFA-PM-00-1
February 2000

Revised
Supplement 8A to
Attachment 2.6-A
Page 2

State: Kentucky

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

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

Approval Date: AUG 24 2001

Effective Date: 6/1/01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

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

State: Kentucky

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

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

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

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

More Liberal Resource Methodologies Protected

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

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

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

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

* In currently approved state plan.

More Liberal Resource Methodologies Protected

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

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

* In currently approved state plan

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

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

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

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

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

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

TN No. 08-009
Supersedes
TN No.: None

Approval Date: 10/17/08

Effective Date: 7/14/2008

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

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

TN No: 08-009
Supersedes
TN No: None

Approval Date: 10/17/08

Effective Date: 7/14/2008

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

SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

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

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7985E

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

SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 2
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

TN No. 92-1
Supersedes
TN No. 88-15

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7985E

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

SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 3
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

TN No. 92-1
Supersedes
TN No. 85-12

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7985E

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

SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 5
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

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

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7985E

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

SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 5
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

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

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7985E

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

SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 6
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

TN No. 92-1
Supersedes
TN No. 88-15

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7985E

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

SUPPLEMENT 9 TO ATTACHMENT 2.6-A
Page 7
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

TN No. 92-1
Supersedes
TN No. 88-15

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

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

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

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

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

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

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

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

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

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

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

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

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

State: Kentucky

TRANSFER OF ASSETS

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

State: Kentucky

TRANSFER OF ASSETS

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

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

State: Kentucky

Transfer of Assets

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

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

10. Treatment of income as an asset --

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

- The agency will impose partial month penalty periods.

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

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

State: Kentucky

Transfer of Assets

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

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

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

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

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

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

Nursing facility services;

Nursing facility level of care provided in a medical institution;

Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled

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

2. Non-institutionalized individuals:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

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

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

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;
- The State uses the first day of the month in which the assets were transferred
- The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

4. Penalty Period - Institutionalized Individuals--

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

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

5. Penalty Period – Non-institutionalized Individuals—

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

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

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

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

8. Treatment of a transfer of income-

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

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

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

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

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

10. Procedures for Undue Hardship Waivers

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

which an adverse determination can be appealed.

TN No: 08-009
Supersedes
TN No. 06-014

Approval Date: 10/17/08

Effective Date: 7/14/2008

Revision: HCFA-PM-95-1 (MB)
March 1995

Revised
Supplement 10 to Attachment 2.6-A
Page 1

State: Kentucky

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

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

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

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

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

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

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

TN No. 95-6
Supersedes
TN No. None

Approval Date: 12/15/97

Effective Date: 4/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES

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

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

A. Cost Effectiveness

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

B. Cost Effectiveness Review.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

Family Alternatives Diversion payments are excluded as income.

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

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

Interest and dividend income shall be excluded.

\$1,000 in resources shall be excluded.

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

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

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

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

Total resources could not exceed \$1000.

Interest and dividend income was considered.

All non-liquid resources were considered unless specifically excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

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

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

“Personal Needs Allowance - Individuals with Greater Needs”

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

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

TN No. 98-03
Supersedes
TN No. None

Approval Date 4/20/98

Effective Date 1/1/98

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: KENTUCKY

SECTION 1924 PROVISIONS

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

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

Citation	Condition or Requirement
----------	--------------------------

“Personal Needs Allowance - Individuals with Greater Needs”

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

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

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

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

The amount chosen by the State is _____

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ASSET VERIFICATION SYSTEM

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

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

Approval Date: 06-25-10

Effective Date: 01/01/2010

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ASSET VERIFICATION SYSTEM

2. System Development

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ASSET VERIFICATION SYSTEM

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

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

State/Territory: Kentucky

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

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

*Description provided on attachment.

State/Territory: Kentucky

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

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

*Description provided on attachment.

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

Commonwealth Global Choices

b. Optometrists' services.

Provided: No limitations With limitations* Not Provided.

c. Chiropractors' services.

Provided: No limitations With limitations* Not provided.

d. Other Practitioners' Services

Provided: No limitations With limitations* Not provided.

7. Home Health Services

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

Provided: No limitations With limitations* Not provided.

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

Provided: No limitations With limitations* Not provided.

c. Medical supplies suitable for use in the home.

Provided: No limitations With limitations* Not provided.

*Description provided on attachment

TN No.: 11-003

Supersedes

TN No.: 06-007Approval Date: 05-12-11Effective Date: January 1, 2011

State/Territory: Kentucky

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

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

Provided: No limitations With limitations* Not Provided.

8. Private duty nursing services.

Provided: No limitations With limitations* Not Provided.

*Description provided on attachment.

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

9. Clinic Services.

Provided: No limitations With limitations* Not Provided.

10. Dental Services.

Provided: No limitations With limitations* Not Provided.

11. Physical therapy and related services.

a. Physical therapy.

Provided: No limitations With limitations* Not Provided.

b. Occupational therapy.

Provided: No limitations With limitations* Not Provided.

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

Provided: No limitations With limitations* Not Provided.

*Description provided on attachment.

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

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

*Description provided on attachment.

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

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

*Description provided on attachment.

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

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

*Description provided on attachment.

TELEHEALTH

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Inpatient Hospital Services

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

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

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

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

2 Outpatient Hospital Services

- a. Outpatient Hospital Services are provided in accordance with 42 CFR 440.20. Hospital outpatient services are limited to therapeutic and diagnostic services as ordered by a physician or if applicable, a dentist; to emergency room services in emergency situations; and to drugs, biologicals, or injections administered in the outpatient hospital setting (excluding "take home" drugs and those drugs deemed less-than-effective by the Food and Drug Administration).
- b. Abortion services are reimbursable under the Medical Assistance Program only when the woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.

2 b. Rural Health Clinic Services

1) Covered Services

Other ambulatory services furnished by a rural health clinic shall have the same limitations when provided by the rural health clinic as when provided by the usual ambulatory care provider as specified in the relevant subsections of Attachment 3.1-A pertaining to those ambulatory services.

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

Rural Health Clinic (RHC) Services are authorized in Medicaid under section 1905(a)(2)(B) of the Social Security Act (the Act) and defined in section 1861(aa) of the Act. RHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nurses and other ambulatory services included in the state plan. RHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and, as applicable, for visiting nurse care, related medical supplies other than drugs and biologicals.

2) Limitations

- a) Other ambulatory services furnished in the FQHC have the same limitations as defined for those services in the state plan.
- b) One visit limit per day unless the beneficiary presents later in the day with a condition unrelated to the first visit.

3) Exclusions

The following services shall not be covered if provided by an RHC:

- a) Services provided in a hospital as defined in 42 U.S.C. 1395x(e);
- b) Institutional services;
- c) Housekeeping, babysitting, or other similar homemaker services;
- d) Services which are not provided in accordance with restrictions imposed by law or a administrative regulation

4) Assurances

Other state plan limitations on physician services, physician assistant services, nurse practitioner services, clinical psychologist services, and clinical social worker services do not apply to these providers in the RHC setting

2 c. Federal Qualified Health Center Services

1) Covered Services

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

Federally Qualified Health Center (FQHC) Services are authorized in Medicaid under section 1905(a)(2)(C) of the Act of the Social Security Act (the Act) and defined in section 1861(aa). FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nurses and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and, as applicable, for visiting nurse care, related medical supplies other than drugs and biologicals.

2) Limitations

- a) Other ambulatory services furnished in the FQHC have the same limitations as defined for those services in the state plan.
- b) One visit limit per day unless the beneficiary presents later in the day with a condition unrelated to the first visit.

3) Exclusions

The following services shall not be covered if provided by an FQHC, or FQHC look-alike:

- a) Services provided in a hospital as defined in 42 U.S.C. 1395x(e);
- b) Institutional services;
- c) Housekeeping, babysitting, or other similar homemaker services;
- d) Services which are not provided in accordance with restrictions imposed by law or a administrative regulation

4) Assurances

Other state plan limitations on physician services, physician assistant services, nurse practitioner services, clinical psychologist services, and clinical social worker services do not apply to these providers in the FQHC setting

3. Other Lab and X-Ray Services

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

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

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

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

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

C. Provider Participation Conditions.

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

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

A. Definitions:

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

B. Services:

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

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

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

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

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

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

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

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

(1) Out of Hospital Dental Services

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

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

(2) In Hospital Dental Services

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

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

(3) Oral Surgery Dental Services

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

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

Commonwealth Global Choices

B. Hearing Services

(1) **Audiological Benefits**

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

Commonwealth Global Choices

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

(2) Hearing Aid Benefits

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

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

C. Vision Care Services

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

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

4.b EPSDT Services (continued)

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

Neonatal Related Diagnoses

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

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

E. Medicaid Services Provided in Schools

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

(a) Audiology

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

Assessment services:

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

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

Treatment services:

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

Auditory training, speech reading and augmentative communication

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

(b) Occupational Therapy

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

Assessment services

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

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

Treatment services

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

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

Qualifications of Providers:

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

(c) Physical Therapy Services

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

Assessment services

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

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

Treatment services

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

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

Qualifications of Providers:

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

(d) Behavioral Health Services

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

Assessment services

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

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

Treatment services

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

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

Qualifications of Providers:

Minimum qualifications for providing services are licensure as follows:

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

(e) Speech

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

Assessment services

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

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

Treatment services

Service includes one or more of the following as appropriate:

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

Qualifications of Providers

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

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

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

(f) Nursing Services:

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

Qualifications of Providers:

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

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

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

(g) Respiratory Therapy Services:

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

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

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

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

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

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

4.b. EPSDT Services (continued)

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

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

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

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

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

Face-to-face counseling services shall be provided:

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

5. Physicians' Services

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

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

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

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

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

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

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

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

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

6. Medical care and any other type of Remedial Care

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

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

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

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

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

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

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

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

TN # 84-10
Supersedes
TN # None

Approval
Date 12/7/1984

Effective
Date 11/1/1984

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

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

Covered methods include:

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

Noncovered methods include:

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

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

- (6) Medical care and Any Other Type of Remedial Care
- B. Optometry services are only provided to recipients under age twenty-one (21).
 - C. Chiropractic services are provided with the following limitations
 - (1) Twenty-six (26) chiropractic visits per year for all recipients (this limit may be exceeded based on medical necessity with prior authorization).

6. Medical Care and Any Other Type of Remedial Care

d. Other practitioner's services

Advanced Practice Registered Nurse (APRN) Services

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

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

Commonwealth Global Choices

Other Licensed Practitioners' Services (continued)

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

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

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

7. Home Health Services

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

a. Intermittent or Part-time Nursing Service

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

b. Home health Aide Services

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

c. Medical Supplies Suitable for Use in the Home.

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

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

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

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

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

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

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

Qualification of Providers

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

8. Private Duty Nursing Services

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

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

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

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

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

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

9. Clinic Services

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

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

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

5b. Specialized Children's Services Clinics

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

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

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

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

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

13. Dental Services

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

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

A. Outpatient Physical, Occupational and Speech Therapy

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

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

Qualification of Providers

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

B. Inpatient Physical, Occupational and Speech Therapy

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

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

Qualification of Providers

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

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

C. Limitations

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

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

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

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

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

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

a. Prescribed Drugs

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

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

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

(7) Supplemental Rebate Program:

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

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

Commonwealth Global Choices

B. Dentures

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

C. Prosthetics

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

D. Eyeglasses The following limitations are applicable:

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

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

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

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

13a. Diagnostic Services

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

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

13b. Screening Services

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

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

13c. Preventive Services

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

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

No cost sharing shall be applied to preventive services.

This Page Intentionally Left Blank

TN # 14-001
Supersedes
TN # 13-018

Approval Date: 04-25-14

Effective Date: 01/01/2014

This Page Intentionally Left Blank

TN # 14-001
Supersedes
TN # 13-018

Approval Date: 04-25-14

Effective Date: 01/01/2014

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

13d. Rehabilitative Services

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

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

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

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

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

Diagnoses shall be recorded in the health record within three (3) visits, in order to receive Medicaid payment. The exception is for crisis services, screening, and assessment.

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

1. Limitations on Amount, Duration or Scope of Services

Unless a diagnosis is made and documented in the medical record within three (3) visits, the service will not be covered. The exception is for crisis services, screening, and assessment. An appropriate mental health or substance use disorder diagnosis is required for coverage, with the exception for crisis services, screening, and assessment.

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

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

13d. Rehabilitative Services

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

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

The following services will NOT be covered by Medicaid under this State Plan Amendment:

- (a) Services provided to residents of:
 - (1) nursing facilities;
 - (2) hospital;
 - (3) Intermediate Care Facility – Individual with Intellection Disability (ICF-IID)
 - (4) Psychiatric Residential Treatment Facility (PRTF)
- (b) Services provided to inmates of local, state or federal jails, detention centers or prisons
- (c) Services to those with developmental and intellectual disabilities, without documentation of an additional psychiatric diagnosis
- (d) Psychological assessment or testing for other agencies such as courts or schools, which does not result in the recipient receiving psychiatric intervention or therapy from the independent provider. If the testing results in behavioral health treatment, then the testing was medically necessary and would be covered. School services included in a child's Individual Education Plan (IEP) may be coverable under the Medicaid School-Based Services Program.
- (e) Consultation or educational services provided to Medicaid recipients or others
- (f) Collateral Outpatient therapy for ages 21 and over
- (g) Consultation or third party contacts shall be outside the scope of covered benefits, except for consultation provided as a part of collateral outpatient therapy or family outpatient therapy. Covered services require direct patient contact except collateral services for children under age twenty-one (21), when a part of the treatment plan
- (h) Telephone calls, emails, texts or other electronic contacts (excluding telehealth, as described on page 7.1 of the State Plan)
- (i) Travel time
- (j) Field trips, recreational, social, and physical exercise activity groups
- (k) Any applicable exclusion listed under the description of each service.

2. Eligible Recipients

All services, except for the following six services are considered mental health, substance use, or co-occurring mental health and substance use services. These services are available for all Medicaid beneficiaries who meet the medical necessity criteria for these services:

- (a) Service Planning (mental health only);
- (b) Residential Services for Substance Use Disorders (substance use only);
- (c) Screening, Brief Intervention and Referral to Treatment (substance use only);

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

13d. Rehabilitative Services

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

3. Categories of Providers

- (d) Assertive Community Treatment (mental health only);
- (e) Comprehensive Community Support Services (mental health only); and
- (f) Therapeutic Rehabilitation Program (mental health only).

Except where indicated, all services will apply to both children and adults.

Kentucky defines the following categories of providers:

- (a) Individual Practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill Kentucky Medicaid.
- (b) Provider group: A group of more than one individually licensed practitioner who forms a business entity to render behavioral health services and bill Kentucky Medicaid.
- (c) Licensed organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render behavioral health services and bill Kentucky Medicaid. This organization must also meet the following criteria:
 - (1) Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
 - (2) Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
 - (3) Have the administrative capacity to provide quality of services in accordance with state and federal requirements;
 - (4) Use a financial management system that provides documentation of services and costs; and
 - (5) Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.

All providers must operate within the scope of their license. Providing services to Medicaid recipients outside a provider's licensure is considered fraud.

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

13d. Rehabilitative Services

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

4. Rendering Providers

Service	LP	LPA*	LPP	LCSW	CSW*	LPCC	LPCA*	LPAT	LPATA*	LMFT	MFTA*	MD	Psychiatrist	APRN	PA*	CADC*	LADC	LADCA*	Peer Support*	SU Peer Support*	Prevention Specialists*	CSA*	LBA	LABA*	LO	CMHC	Provider Group
A. Screening	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆							✓	✓	✓
B. Assessment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆							✓	✓	✓
C. Psychological Testing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆						✓	✓	✓	✓
D. Crisis Intervention	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆					✓	✓	✓	✓	✓
E. Mobile Crisis	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	✓	✓	
F. Residential Crisis Stabilization	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	✓	✓	
G. Day Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆	◆	◆	◆		✓	✓	✓	✓	✓
H. Peer Support																			◆	◆					✓	✓	✓
I. Parent/Family Peer Support																			◆	◆					✓	✓	✓
J. Intensive Outpatient Program (IOP)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆						✓	✓	✓
K. Individual Outpatient Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆					✓	✓	✓	✓	✓
L. Group Outpatient Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆					✓	✓	✓	✓	✓
M. Family Outpatient Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆					✓	✓	✓	✓	✓
N. Collateral Outpatient Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆					✓	✓	✓	✓	✓

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

13d. Rehabilitative Services

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

4. Rendering Providers

Service	LP	LPA*	LPP	LCSW	CSW*	LPC	LPCA*	LPAT	LPATA*	LMFT	MFTA*	MD	Psychiatrist	APRN	PA*	CADC*	LCADC	LADCA*	Peer Support*	SU Peer Support*	Prevention Specialist*	CSA	LBA	LABA*	LO	CMHC	Provider Group
O. Partial Hospitalizations	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆			◆	◆	✓	✓	✓
P. Service Planning (Mental Health Only)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓								✓	✓	✓	✓	✓
Q. Residential Services for SUD (Substance use only)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆				✓	✓	
R. SBIRT (Substance Use Only)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆	◆	◆	◆	◆			✓	✓	✓
S. Assertive Community Treatment (Mental Health Only)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆							◆	◆	◆	◆	✓	✓
T. Comprehensive Community Support Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							◆	✓	✓	✓	✓	✓
U. Therapeutic Rehabilitation Program (Mental Health Only)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				◆	◆					✓	✓	✓

- * Billed through supervisor
- ✓ Individual Practitioner, Provider Group or Licensed Organization
- ◆ Rendering Practitioners practicing as part of a Licensed Organizations

LADC, LADCA, and CADC can only provide services for recipients with substance use disorders and within the scope of their practice.

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

13d. Rehabilitative Services

5. Billing Providers

- a. Individual Practitioners
 - (1) Licensed Psychologist (LP)
 - (2) Licensed Psychological Practitioner (LPP)
 - (3) Licensed Clinical Social Worker (LCSW)
 - (4) Licensed Professional Clinical Counselor (LPCC)
 - (5) Licensed Professional Art Therapist (LPAT)
 - (6) Licensed Marriage and Family Therapist (LMFT)
 - (7) Licensed Behavioral Analyst (LBA)
 - (8) Physician
 - (9) Psychiatrist
 - (10) Advanced Practice Registered Nurse (APRN)
 - (11) Licensed Alcohol Drug Counselors (LADC)
- b. Provider Groups
 - (1) Licensed Psychologist LP
 - (2) Licensed Psychological Practitioner LPP
 - (3) Licensed Clinical Social Worker LCSW
 - (4) Licensed Professional Clinical Counselor LPCC
 - (5) Licensed Professional Art Therapist LPAT
 - (6) Licensed Marriage and Family Therapist LMFT
 - (7) Licensed Behavioral Analyst LBA
 - (8) Physician
 - (9) Psychiatrist
 - (10) Advanced Practice Registered Nurse (APRN)
 - (11) Licensed Alcohol Drug Counselors (LADC)
 - (12) Behavioral Health Multi-Specialty Group
- c. Licensed Organizations

6. Covered Services

The following services, as defined by the Kentucky Department for Medicaid Services, are considered Medicaid mental health, substance use, or co-occurring mental health and substance use services, unless otherwise indicated:

- (a) [Screening](#)
- (b) [Assessment](#)
- (c) [Psychological Testing](#)
- (d) [Crisis Intervention](#)
- (e) [Mobile crisis](#)

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

13d. Rehabilitative Services

- (f) [Residential Crisis Stabilization](#)
- (g) [Day Treatment](#)
- (h) [Peer Support](#)
- (i) [Parent/Family Peer Support](#)
- (j) [Intensive Outpatient Program \(IOP\)](#)
- (k) [Individual Outpatient Therapy](#)
- (l) [Group Outpatient Therapy](#)
- (m) [Family Outpatient Therapy](#)
- (n) [Collateral Outpatient Therapy](#)
- (o) [Partial Hospitalization](#)
- (p) [Service Planning](#) (Mental health only)
- (q) [Residential Services for Substance Use Disorders](#) (Substance use only)
- (r) [SBIRT – Screening, Brief Intervention and Referral to Treatment](#) (Substance use only)
- (s) [Assertive Community Treatment](#) (Mental health only)
- (t) [Comprehensive Community Support Services](#) (Mental health only)
- (u) [Therapeutic Rehabilitation Program \(TRP\)](#) (Mental health only)

(a) **Screening**

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

(b) **Assessment**

Assessment shall include gathering information and engaging in a process with the recipient that enables the provider to establish the presence or absence of a mental health disorder, substance use disorder or co-occurring disorders; determine the recipient's readiness for change; identify recipient's strengths or problem areas that may affect the processes of treatment and recovery; and engage the recipient in the development of an appropriate treatment relationship. The purpose of an assessment is to establish (or rule out) the existence of a clinical disorder or service need and to work with the recipient to develop a treatment and service plan, if a clinical disorder or service need is assessed. Also includes functional behavioral assessment utilized when problem behaviors (e.g. aggression, self-injury, destruction of property) are present to identify the reason(s) behavior(s) occur and the skills and strategies necessary to decrease them. This service also includes interpretation and written report of assessment findings. This does not include psychological evaluations or assessments.

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

13d. Rehabilitative Services

(c) Psychological Testing

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

(d) Crisis Intervention

Crisis Intervention shall be a therapeutic intervention provided for the purpose of immediately reducing or eliminating risk of physical or emotional harm to the recipient, or others. This service shall be provided as an immediate relief to the presenting problem or threat. Crisis Intervention must consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization, interventions, or crisis prevention activities for individuals. It must be followed by non-crisis service referral as appropriate. It must be provided in the provider's office in a face-to-face, one-on-one encounter between the provider and the recipient.

Crisis intervention may include further service prevention planning such as lethal means reduction for suicide risk or substance use relapse prevention or verbal de-escalation, risk assessment, or cognitive therapy.

(e) Mobile Crisis

Mobile crisis is a multi-disciplinary team based intervention that ensures access to acute mental health and substance use services and supports. The service aims to effect symptom or harm reduction, or to safely transition an individual in acute crisis to the appropriate least restrictive level of care. Mobile crisis services are provided face-to-face and available in locations outside the provider's facility (e.g., home or community) 24 hours per day, 7 days per week and 365 days per year. This service is provided in duration of less than 24 hours. Mobile crisis involves all supports and services necessary to provide integrated crisis prevention, assessment and disposition, intervention, continuity of care recommendations, and follow-up services.

Authorized Providers

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

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

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

13d. Rehabilitative Services

(f) **Residential Crisis Stabilization**

Residential Crisis Stabilization services are provided in Crisis Stabilization Units. Crisis Stabilization Units are community-based, residential programs that offer an array of services including screening, assessment, treatment planning, individual, group, and family therapy, and peer support in order to stabilize a crisis and divert the individual from a higher level of care. It is not part of a hospital. They are used when individuals in a behavioral health emergency cannot be safely accommodated within the community, are not in need of hospitalization but need overnight care.

The purpose is to stabilize the individual, provide treatment for acute withdrawal, when appropriate, and re-integrate him back into the community, or other appropriate treatment setting, in a timely fashion. These units provide a non-hospital residential setting and services 24-hours per day, seven (7) days per week, 365 days a year. The estimated length of stay for children is three (3) to five (5) days. The estimated length of stay for adults is seven (7) to 10 days. The component services of crisis stabilization units are screening, assessment, service planning, psychiatric services, individual therapy, family therapy, group therapy, and peer support.

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

KY Medicaid will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds except for services furnished pursuant to the state plan benefit “inpatient psychiatric services for individuals under 21” (section 1905(a)(16) of the Act; 42 CFR 440.160) or pursuant to an exclusion for individuals age 65 or older who reside in institutions that are IMDs (section 1905(a) of the Act; 42 CFR 440.140.)

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

13d. Rehabilitative Services

Authorized Providers

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

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

(g) Day Treatment

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

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

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

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

Day treatment may focus on resolving multiple mental health and/or substance use issues and is typically provided as an alternative to a school or other traditional day time setting for children.

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

13d. Rehabilitative Services

Day treatment services shall be provided:

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

(h) **Peer Support**

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

Peer support services must incorporate the following core components:

-
- Supervision – Peer support specialists must be supervised regularly by a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADC, a LADC, a LADCA a LPAT, or a LPATA.
- Care coordination - Peer support services must be coordinated within the context of a comprehensive, individualized treatment plan which is developed through a person-centered planning process. The peer support services must be identified on each recipient's individual treatment plan, and must be designed to directly contribute to the participant's individualized goals, as specified in the plan.
- Training - Peer Support Specialists have a minimum educational requirement of a high school diploma or a General Educational Development (GED) certificate and must successfully complete training approved by the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID).

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

13d. Rehabilitative Services

Pursuant to KRS 309.0831, Registered Alcohol and Drug Peer Support Specialists are exempt from the DBHDID training required in 908 KAR 2:220, 230 and 240.

Authorized Providers

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

- Must employ qualified peer support specialists who successfully completed the training/exam as outlined in the Kentucky Administrative Regulation;
- Must provide supervision by a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADC, a LADC, a LADCA a LPAT, or a LPATA;
- Must have the capacity to provide on-going continuing education and technical assistance to peer support specialists; and
- Must have demonstrated experience serving the behavioral health population (mental health, substance use or co-occurring mental health and substance use disorders) and age range served (youth or adult peers or parent-to-parent).
- Registered Alcohol and Drug Peer Support Specialist

(i) Parent/Family Peer Support

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

- have demonstrated the capacity to provide the core elements of parent or family peer support services for the behavioral health population being served including the age range of the population being served;
- employ family peer support specialists who are qualified to provide family peer support services in accordance with state regulations; and
- use an approved behavioral health services provider to supervise family peer support specialists.

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

13d. Rehabilitative Services

Peer support services must incorporate the following core components:

- Supervision – Peer support specialists must be supervised regularly by a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADC, a LADC, a LADCA a LPAT, or a LPATA.
- Care coordination - Peer support services must be coordinated within the context of a comprehensive, individualized treatment plan which is developed through a person-centered planning process. The peer support services must be identified on each recipient's individual treatment plan, and must be designed to directly contribute to the participant's individualized goals, as specified in the plan.
- Training - Peer Support Specialists have a minimum educational requirement of a high school diploma or a General Educational Development (GED) certificate and must successfully complete training approved by DBHDID.

Authorized Providers

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

- Must employ qualified peer support specialists who successfully completed the training/exam as outlined in the Kentucky Administrative Regulation;
- Must provide supervision by a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADC, a LADC, a LADCA a LPAT, or a LPATA;
- Must have the capacity to provide on-going continuing education and technical assistance to peer support specialists; and
- Must demonstrate experience serving the behavioral health population (mental health, substance use or co-occurring mental health and substance use disorders) and age range served (youth or adult peers or parent-to-parent).

(j) Intensive Outpatient Program (IOP)

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

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

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

13d. Rehabilitative Services

Programming must include individual outpatient therapy, group outpatient therapy, and family outpatient therapy unless contraindicated, crisis intervention as it would occur in the setting where IOP is being provided, and psycho-education. Psycho-education is one component of outpatient therapy for mental health conditions. During psycho-education, the recipient or their family is provided with knowledge about his diagnosis, the causes of that condition, and the reasons why a particular treatment might be effective for reducing his symptoms. Recipients and their families gain empowerment to understand and accept the diagnosis and learn to cope with it in a successful manner).

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

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

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

- Access to a board-certified or board-eligible psychiatrist for consultation;
- Access to a psychiatrist, other physician or Advanced Practice Registered Nurse (APRN) for medication management;
- Adequate staffing to assure a minimum recipient-to-program staff ratio of ten (10) recipients to one (1) staff member;
- Capacity to provide services utilizing a recognized intervention protocol based on nationally accepted treatment principles when serving adults with mental health, substance use disorder or co-occurring disorders and the System of Care Principles when serving a recipient under the age of 21 with mental health, substance use disorder or co-occurring disorders;
- Capacity to employ required practitioners and coordinate service provision among rendering practitioners;
- Capacity to provide the full range of services included in the Intensive Outpatient service definition;
- Demonstrated experience in serving individuals with behavioral health disorders;
- The administrative capacity to ensure quality of services;
- A financial management system that provides documentation of services and costs; and
- The capacity to document and maintain individual case records.

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

13d. Rehabilitative Services

(k) **Individual Outpatient Therapy**

Individual Outpatient Therapy shall consist of a face-to-face, one-on-one encounter between the provider and the recipient. The therapy shall be a behavioral health therapeutic intervention provided in accordance with a recipient's identified treatment plan and is aimed at the reduction of adverse symptoms and improved functioning and reducing or eliminating the presenting problem of the recipient. Individual therapy, family therapy and group therapy services shall be limited to a maximum of a combined three (3) hours per day, per recipient, which can be exceeded based on medical necessity.

(l) **Group Outpatient Therapy**

Group therapy shall be therapeutic intervention provided to a group of unrelated persons, with the exception of multi-family group therapy. Group therapy shall consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan. Group outpatient therapy shall not solely include physical exercise, a recreational activity or an educational activity, or a social activity. The subject of the group outpatient therapy shall be related to each recipient participating in the group. A group consists of no more than twelve persons. It is usually for a limited time period (generally 1 to 1 ½ hours in duration). Group therapy focuses on psychological needs of the recipients as evidenced in each recipient's plan of treatment. Group therapy centers on goals such as building and maintaining healthy relationships, personal goal setting, and the exercise of personal judgment. The group shall have a deliberate focus and must have a defined course of treatment. Individual notes must be written for each recipient within the group and be kept in that individual's medical record.

Individual therapy, family therapy and group therapy services shall be limited to a maximum of a combined three (3) hours per day, per recipient, which can be exceeded based on medical necessity.

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

13d. Rehabilitative Services

(m) **Family Outpatient Therapy**

Family Therapy shall consist of a face-to-face therapeutic intervention provided through scheduled therapeutic visits between the therapist and the recipient and one or more members of a recipient's family or household member of the recipient to address issues interfering with the relational functioning of the family and improve interpersonal relationships within the home environment.

The need for family therapy shall be so stated in the recipient's plan of treatment. Family therapy services shall be for the benefit of the recipient.

Individual therapy, family therapy and group therapy services shall be limited to a maximum of a combined three (3) hours per day, per recipient, but can be exceeded based on medical necessity.

(n) **Collateral Outpatient Therapy**

Collateral services shall be limited to recipients under the age of twenty-one, who are recipients of the rendering provider. A collateral service shall be a face-to-face encounter with a parent/caregiver, household member of a recipient, legal representative/guardian, school personnel or other person in a position of custodial control or supervision of the recipient, for the purpose of providing counseling or consultation on behalf of a recipient in accordance with an established plan of treatment. The parent or legal representative in a role of supervision of the recipient shall give written approval for this service. This written approval shall be kept in the recipient's medical record. This service is only reimbursable for a recipient under age 21.

(o) **Partial Hospitalization**

Partial Hospitalization is a short-term (average of four (4) to six (6) weeks), less than 24-hour, intensive treatment program for individuals experiencing significant impairment to daily functioning due to substance use disorders, mental health disorders, or co-occurring mental health and substance use disorders. Partial Hospitalization may be provided to adults or children. This service is designed for individuals who cannot effectively be served in community-based therapies or IOP.

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

13d. Rehabilitative Services

The program consists of individual, group, family therapies and medication management. Educational, vocational, or job training services that may be provided as part of Partial Hospitalization are not reimbursed by Medicaid. The program has an agreement with the local educational authority to come into the program to provide all educational components and instruction which are not Medicaid billable or reimbursable. Services in a Medicaid-eligible child's Individual Education Plan (IEP) are coverable under Medicaid.

Partial Hospitalization is typically provided for at least four (4) hours per day. Partial Hospitalization is typically focused on one primary presenting problem (i.e., Substance use, sexual reactivity, etc.).

Authorized Providers

Partial Hospitalization – Practitioners must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- An Advanced Practice Registered Nurse (APRN), Physician Assistant (PA) or Physician available on-site and a board-certified or board-eligible psychiatrist available for consultation;
- Capacity to provide services utilizing a recognized intervention protocol based on Recovery Principles;
- Capacity to employ required practitioners and coordinate service provision among rendering practitioners; and
- Capacity to provide the full range of services included in the Partial Hospitalization definition.

(p) Service Planning TREATMENT OF MENTAL HEALTH ONLY

Service planning involves assisting the recipient in creating an individualized plan for services needed for maximum recovery of symptoms associated with a mental health disorder and restoration of a recipient to his best possible functional level. A person-centered planning process is required. The plan is directed by the recipient and must include practitioners of the recipient's choosing. The providers include more than licensed professionals – it may include the recipient (and his guardian if applicable), care coordinator, other service providers, family members or other individuals that the recipient chooses. Service Planning may include a mental health advance directive being filed with a local hospital; crisis plan or a relapse prevention strategy or plan.

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

13d. Rehabilitative Services

(q) **Residential Services for Substance Use Disorders (SUDS) TREATMENT FOR SUBSTANCE USE ONLY**

Residential services for substance use disorders is residential treatment (24 hour/day) that may be short-term or long-term for the purposes of providing intensive treatment and skills building, in a structured and supportive environment, to assist individuals (children and adults) to enter into alcohol/drug addiction recovery. This service is provided in a 24-hour live-in facility that offers a planned and structured regimen of care that aims to treat persons with addictions or substance use disorders and assists them in making the necessary changes in their lives that will enable them to live drug or alcohol free lives.

Services must:

- 1) Be provided under the medical direction of a physician;
- 2) Provide continuous nursing services in which a registered nurse shall be:
 - a) On-site during traditional first shift hours, Monday through Friday;
 - b) Continuously available by phone after hours; and
 - c) On-site as needed in follow-up to telephone consultation after hours.

Individuals must have been assessed and meet criteria for approval of residential services, utilizing a nationally recognized assessment tool (e.g., American Society of Addiction Medicine (ASAM)) as approved by the Kentucky Department of Behavioral Health, Development and Intellectual Disabilities (DBHDID).

KY Medicaid will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds except for services furnished pursuant to the state plan benefit "inpatient psychiatric services for individuals under 21" (section 1905(a)(16) of the Act; 42 CFR 440.160) or pursuant to an exclusion for individuals age 65 or older who reside in institutions that are IMDs (section 1905(a) of the Act; 42 CFR 440.140.)

Residential treatment services shall be based on individual need and may include:

- Screening
- Assessment
- Service Planning
- Individual Therapy
- Group Therapy
- Family Therapy
- Peer Support

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

13d. Rehabilitative Services

There are two levels of residential treatment:

- Short term –length of stay less than 30 days
- Long term- length of stay 30- 90 days

Short Term

Short term services should have a duration of less than thirty (30) days, but can be exceeded based on medical necessity. 24 hour staff as required by licensing regulations. Short term services should have planned clinical program activities constituting at least 15 hours per week of structured professionally directed treatment services to stabilize and maintain a person's substance use disorder and to help him to develop and apply recovery skills.

Long Term

Long term services should have 24 hour staff as required by licensing regulations, as well as planned clinical program activities constituting 40 hours per week of structured professionally directed treatment services to stabilize and maintain a person's substance use and or substance use and mental health disorder and to help him or her to develop and apply recovery skills.

Residential SUD treatment programs do not include, and Federal Financial Participation (FFP) is not available for, room and board services; educational, vocational and job training services; habilitation services; services to inmates in public institutions as defined in 42 CFR §435.1010; services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010; recreational and social activities; and services that must be covered elsewhere in the state Medicaid plan.

KY Medicaid will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds except for services furnished pursuant to the state plan benefit "inpatient psychiatric services for individuals under 21" (section 1905(a)(16) of the Act; 42 CFR 440.160) or pursuant to an exclusion for individuals age 65 or older who reside in institutions that are IMDs (section 1905(a) of the Act; 42 CFR 440.140.)

Limitations

To provide residential services for substance use disorders, a behavioral health services organization shall:

- a. Have the capacity to employ staff authorized to provide services in accordance with this section and to coordinate the provision of services among team members; and
- b. Be licensed as a non-medical and non-hospital based alcohol and other drug abuse treatment program in accordance with state licensing regulations

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

13d. Rehabilitative Services

(r) **Screening, Brief Intervention, and Referral to Treatment (SBIRT) TREATMENT OF SUBSTANCE USE ONLY**

SBIRT is an evidence-based early intervention approach that targets individuals with non-dependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. SBIRT consists of three major components:

Screening – Assessing an individual for risky substance use behaviors using standardized screening tools;

Brief Intervention – Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and

Referral to Treatment – Provides a referral to additional mental health, substance use, or co-occurring mental health and substance use disorder services to patients who screen in need of additional services to address substance use. The Referral to Treatment is part of the Brief Intervention and thus referral to a behavioral health service.

(s) **Assertive Community Treatment (ACT) TREATMENT OF MENTAL HEALTH ONLY**

Assertive community treatment (ACT) is an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for consumers with serious mental illnesses. ACT uses a multidisciplinary team of professionals including psychiatrists, nurses, case managers, therapists and peer support specialists.

Component services include assessment, person centered treatment planning, case management, individual outpatient therapy, family outpatient therapy, and group outpatient therapy, peer support, mobile crisis intervention, mental health consultation, medication monitoring, family support and basic living skills training. Mental health consultation involves brief, collateral interactions with other treating professionals who may have information for the purposes of treatment planning and service delivery.

Family support involves the ACT team working with the recipient's natural support systems to improve family relations in order to reduce conflict and increase recipient autonomy and independent functioning. Basic living skills training shall be rehabilitative services focused on restoring activities of daily living to reduce disability and improve function (i.e., taking medications, housekeeping, meal preparation, hygiene, interacting with neighbors) necessary to maintain independent functioning and community living.

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

13d. Rehabilitative Services

Services are provided by a multidisciplinary team of providers whose backgrounds and training include social work, rehabilitation, counseling, nursing. Providers of ACT services consist of multidisciplinary staff organized as a team in which members function interchangeably to provide treatment, rehabilitation and support.

Authorized Providers

Assertive Community Treatment (ACT) – Team members must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Must employ one or more teams led by an approved behavioral health services provider and including, at a minimum, four (4) full time equivalents including 1.0 FTE therapist, 1.0 Case Manager, .5 Peer Support Specialist, .5 FTE nurse (medication and health management) and 1.0 of the team's choosing with access to a prescriber.
- Adequate staffing to assure a caseload size no greater than ten (10) participants per team member, not including the prescriber or administrative support; Have the capacity to:
 - (i) Employ staff authorized to provide assertive community treatment services in accordance with this paragraph;
 - (ii) Coordinate the provision of services among team members;
 - (iii) Provide the full range of assertive community treatment services as stated in this paragraph; and
 - (iv) Document and maintain individual case records; and
 - (v) Demonstrate experience in serving individuals with persistent and serious mental illness who have difficulty living independently in the community.

(t) Comprehensive Community Support Services TREATMENT OF MENTAL HEALTH ONLY

Comprehensive Community Support Services covers activities necessary to allow individuals with mental illnesses to live with maximum independence in the community. Activities are intended to assure successful community living through utilization of skills training as identified in the individual treatment plan. Skills training is designed to reduce symptoms associated with a mental health disorder and restore the recipient to his best possible functional level. Comprehensive community support services consists of using a variety of psychiatric rehabilitation techniques to improve daily living skills, self-monitoring of symptoms and side effects, improve emotional regulation skills, crisis coping skills and developing and enhancing interpersonal skills.

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

13d. Rehabilitative Services

- To provide comprehensive community support services, a licensed organization shall:
- Have the capacity to employ staff authorized pursuant to 908 KAR 2:250 to provide comprehensive community support services in accordance with subsection (2)(k) of this section and to coordinate the provision of services among team members; and
- Meet the requirements for comprehensive community support services established in 908 KAR 2:250.

(u) Therapeutic Rehabilitation Program **TREATMENT OF MENTAL HEALTH ONLY**

A Therapeutic Rehabilitation Program is a rehabilitative service for adults with serious mental illnesses and recipients under the age of twenty-one years who have a serious emotional disability designed to maximize reduction of the symptoms associated with a mental health disorder and restoration of the recipient's best possible functional level. Services shall be designed for the reduction in disabilities related to social, personal, and daily living skills, as well as the restoration of these skills. The recipient establishes his own rehabilitation goals within the person centered service plan. Component services are delivered using a variety of psychiatric rehabilitation techniques and focus on improving daily living skills, self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and interpersonal skills. Services may be delivered individually or in a group.

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

13d. Rehabilitative Services

8. Community Mental Health Centers (CMHC)

CMHCs provide a comprehensive range of coordinated mental health and substance use rehabilitation services. Reimbursement is available for all rehabilitation services described above under covered services subject to the following:

1. Medicaid will reimburse for community mental health center rehabilitation services when provided to persons diagnosed with a mental health, substance use or co-occurring mental health and substance use disorder when provided by qualified mental health professionals listed below. Service limitations applicable to other provider types are also applicable to CMHCs.
2. Professionals qualified to provide mental health or substance use rehabilitation services in the CMHCs include:
 - Licensed Psychologist (LP)
 - Licensed Psychological Practitioner (LPP)
 - Licensed Clinical Social Worker (LCSW)
 - A psychiatric social worker with a master's degree from an accredited school
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Marriage and Family Therapist (LMFT)
 - Psychiatrist
 - Physician
 - Licensed Professional Art Therapist (LPAT)
 - Licensed Behavior Analyst (LBA)
 - A psychiatric nurse licensed in the Commonwealth of Kentucky with one of the following combination of education and experience:
 - i. Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.
 - ii. Bachelor of Science in Nursing and 1 year of experience in a mental health setting.
 - iii. A graduate of a three-year educational program with 2 years of experience in a mental health setting.
 - iv. A graduate of a two-year educational program (Associate degree) with 3 years of experience in a mental health setting.
 - Licensed Alcohol and Drug Counselor (LADC)
 - Licensed Alcohol and Drug Counselor Associates* (LADCA)

* Requires Supervision

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

13d. Rehabilitative Services

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

8. Community Mental Health Centers (CMHC) (continued)

- A professional equivalent, through education in a behavioral health field and experience in a behavioral health setting, qualified to provide behavioral health services. Professional equivalents may include practitioners obtaining experience to qualify for licensure in their behavioral health profession or individuals with a bachelor's degree or greater, with experience in behavioral health. Education and experience are as follows:
 - i. Bachelor's degree and three (3) years of full-time supervised experience.
 - ii. Master's degree and six (6) months of full-time supervised experience.
 - iii. Doctoral degree. No experience.
- The following professionals may provide services with appropriate supervision:
 - i. A mental health associate with a minimum of a Bachelor's degree in psychology, sociology, social work, or human services under supervision of one of the above professionals;
 - ii. A licensed psychological associate;
 - iii. A licensed professional counselor associate;
 - iv. A certified social worker, Master Level;
 - v. A marriage and family therapy associate;
 - vi. A physician assistant working under the supervision of a physician;
 - vii. Peer Support Specialist working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LADC, a LADCA, CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, or a LPATA;
 - viii. A certified alcohol and drug counselor (CADC) working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LPAT, or a LPATA with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center;
 - ix. A community support associate who is working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LADC, a LADCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, a LPATA, or a LBA;

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

13d. Rehabilitative Services

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

8. Community Mental Health Centers (CMHC) (continued)

- x. A Licensed Professional Art Therapist Associate (LPATA);
- xi. A licensed assistant behavior analyst.
- xii. Licensed Alcohol and Drug Counselor (LADC)
- xiii. Licensed Alcohol and Drug Counselor Associate (LADCA)

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

13d. Rehabilitative Services

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

9. Qualifications of Providers

Qualified providers are approved practitioners, licensed or certified under state law, operating within the scope of their licensures (or under the appropriate supervision).

a. Advanced Practice Registered Nurse (APRN) – KRS 314.042 states that an applicant for licensure to practice as an advanced practice registered nurse shall:

(1) File with the board a written application for licensure and submit evidence, verified by oath, that the applicant has completed an approved organized post basic program of study and clinical experience; has fulfilled the requirements of KRS 214.615(1); is certified by a nationally established organization or agency recognized by the board to certify registered nurses for advanced practice registered nursing; and is able to understandably speak and write the English language and to read the English language with comprehension.

(a) The board may issue a license to practice advanced practice registered nursing to an applicant who holds a current active registered nurse license issued by the board or holds the privilege to practice as a registered nurse in this state and meets the qualifications of subsection (1) of this section. An APRN shall be:

i. Designated by the board as a certified nurse anesthetist, certified nurse midwife, certified nurse practitioner, or clinical nurse specialist; and

ii. Certified in a least one (1) population focus.

(b) An APRN shall maintain a current active registered nurse license issued by the board or hold the privilege to practice as a registered nurse in this state and maintain current certification by the appropriate national organization or agency recognized by the board.

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- (c) Before an APRN engages in the prescribing or dispensing of nonscheduled legend drugs as authorized by KRS 314.011(8), the APRN shall enter into a written "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Nonscheduled Legend Drugs" (CAPA-NS) with a physician that defines the scope of the prescriptive authority for nonscheduled legend drugs.
- (d) Before an APRN engages in the prescribing of Schedules II through V controlled substances as authorized by KRS 314.011(8), the APRN shall enter into a written "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Controlled Substances" (CAPA-CS) with a physician that defines the scope of the prescriptive authority for controlled substances.

b. Certified Social Worker, Master Level – KRS 335.08 states the board shall issue a license as "certified social worker" to an applicant who meets the following requirements:

- (1) Is at least eighteen years of age;
- (2) Is a person of good moral character;
- (3) Has received a master's degree or doctorate degree in social work from an educational institution approved by the board;
- (4) Has passed an examination prepared by the board; and
- (5) Has not, within the preceding three months failed to pass an examination given by the board.

A Certified Social Worker, Master Level may engage in the practice of clinical social work by contracting, in writing, with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the Certified Social Worker, Masters Level. The supervising licensed behavioral health professional shall assume responsibility for and supervise the CSW's practice.

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- c. Licensed Clinical Social Worker (LCSW) – KRS 335.100 states that the LCSW must:
- (1) Have received a master's degree or doctoral degree in social work from an educational institution approved by the board;
 - (2) Have had a minimum of two (2) years of full time post-master's experience, consisting of at least thirty (30) hours per week, or three (3) years of part time, consisting of at least twenty (20) hours per week, post-master's degree experience acceptable to the board in the use of specialty methods and measures to be employed in clinical social work practice, the experience having been acquired under appropriate supervision as established by the board by promulgation of an administrative regulation;
 - (3) Have paid to the board an examination fee established by the board by promulgation of an administrative regulation;
 - (4) Have passed an examination prepared by the board for this purpose; and
 - (5) Have not, within the preceding three (3) months, failed to pass an examination given by the board.
- d. Licensed Marriage and Family Therapist (LMFT) – KRS 335.330 states the LMFT has:
- (1) Completed a master's or doctoral degree program in marriage and family therapy, from a regionally-accredited educational institution, or a master's, post-master's, or doctoral program approved by the Commission on Accreditation for Marriage and Family Therapy Education or any of its successor organizations, or an equivalent course of study as defined by the board by promulgation of administrative regulations.
 - (a) The degree or equivalent course of study shall contain specific coursework on psychopathology and the Diagnostic and Statistical Manual; and
 - (b) In determining equivalency, the board shall use the criteria for marriage and family therapy education and clinical training approved by the United States Department of Education.

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- (2) Completed each of the following:
 - (a) At least two (2) years' experience in the practice of marriage and family therapy, acceptable to the board and subsequent to being granted a master's degree; and
 - (b) A minimum of two hundred (200) hours of clinical supervision acceptable to the board and subsequent to being granted a master's degree; and
 - (3) Passed a written examination prescribed by the board by promulgation of administrative regulations.
- e. Marriage and Family Therapist Associate (MFTA) – KRS 335.332 states the LMFT has
- (1) Completed a master's or doctoral degree program in marriage and family therapy, from a regionally-accredited educational institution, or a master's, post-master's, or doctoral program approved by the Commission on Accreditation for Marriage and Family Therapy Education or any of its successor organizations, or an equivalent course of study as defined by the board by promulgation of administrative regulations.
 - (a) The degree or equivalent course of study shall contain specific coursework on psychopathology and the Diagnostic and Statistical Manual; and
 - (b) In determining equivalency, the board shall use the criteria for marriage and family therapy education and clinical training approved by the United States Department of Education; and
 - (2) A MFTA shall engage in the practice of marriage and family therapy while receiving qualifying experience by contracting, in writing, with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the MFTA. The supervising licensed behavioral health professional shall assume responsibility for and supervise the MFTA's practice.

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- f. Licensed Professional Clinical Counselor – KRS 335.525 states that the board shall issue a "professional clinical counselor" license to an applicant who:
- (1) Has paid the application fee and the appropriate examination fee to the board;
 - ii. Is of good moral character;
 - (2) Has received a master's, specialist, or doctoral degree in counseling or a related field from a regionally accredited institution;
 - (3) Has completed a minimum of sixty (60) graduate semester hours in the following:
 - (a) The helping relationship, including counseling theory and practice;
 - (b) Human growth and development;
 - (c) Lifestyle and career development;
 - (d) Group dynamics, process, counseling, and consulting;
 - (e) Assessment, appraisal, and testing of individuals;
 - (f) Social and cultural foundations, including multicultural issues;
 - (g) Principles of etiology, diagnosis, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior;
 - (h) Research and evaluation; and
 - (i) Professional orientation and ethics;
 - (4) Has completed a minimum of four thousand (4,000) hours of experience in the practice of counseling, all of which must have been obtained since obtaining the master's degree and must be under approved supervision and shall include but not be limited to a minimum of one thousand six hundred (1,600) hours of direct counseling with individuals, couples, families, or groups and a minimum of one hundred (100) hours of individual, face-to-face clinical supervision with an approved supervisor.

Each applicant is encouraged to include as part of the total hours of experience a minimum of ten (10) hours of direct counseling with individuals in a jail or corrections setting. All applicants shall complete an organized practicum or internship consisting of at least four hundred (400) hours; and
 - (5) Has achieved passing scores on all portions of the examinations required by the board.

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- g. Licensed Professional Counselor Associate – KRS 335.525 states that the board shall issue a "professional clinical counselor" license to an applicant who:
- (1) Has completed all requirements under paragraphs (a) to (d) as outlined under Licensed Professional Counselor above;
 - (2) Has not met the requirements of paragraphs (e) or (f) as outlined under Licensed Professional Counselor above; and
 - (3) Has obtained a board-approved supervisor of record.

A licensed professional counselor associate shall maintain ongoing supervision with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the Licensed Professional Counselor Associate. The supervising licensed behavioral health professional shall assume responsibility for and supervise the LPCA's practice.

- h. Licensed Psychological Associate – KRS 319.064 states a licensed psychological associate shall:
- (1) Have received a master's degree in psychology from a regionally accredited educational institution;
 - (2) Have passed an examination procedure in psychology; and
 - (3) A licensed psychological associate shall not practice independently, except under the employment and supervision of any board-approved licensed psychologist.
- i. Licensed Psychological Practitioner – KRS 319.053 states a person holding a credential as a certified psychologist or as a licensed psychological associate may apply for a license to perform certain functions within the practice of psychology without supervision and use the title of "licensed psychological practitioner" when all of the following conditions are met:
- (1) Submission of three (3) letters of endorsement to the board to sit for the examination:
 - (a) One of the letters shall be from the applicant's current board approved supervisor of record and shall include a statement describing the scope of practice demonstrated in the clinical experience of the applicant; and
 - (b) Two letters shall be from licensed mental health professionals who are acceptable to the board and who are familiar with the clinical work of the applicant.

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- (2) Documentation of at least sixty (60) semester hours of graduate study in psychology or a related field or its equivalent acceptable to the board; and
 - (3) Completion, after credentialing by the board as a certified psychologist, psychological associate, or licensed psychological associate, of the equivalent of five full-time years of professional experience under the supervision of a board-approved licensed psychologist.
 - (4) An applicant for licensure shall be required by the board to pass the national objective examination known as the EPPP, with an equal to or exceeding the score required for the passage for a licensed psychologist candidate at the doctoral level at the time the examination is taken.
 - (5) The board shall require an applicant for licensure under this section to pass an examination of psychological practice, ethical principles and the law.
- j. Licensed Psychologist – Per KRS 319.050, a licensed psychologist shall pass an examination in psychology and fulfill all requirements for supervised experience.
- (1) The psychologist shall:
 - (a) Have received a doctoral degree in psychology that is acceptable to the board from a regionally accredited educational institution; provided, however, the board may grant a license to an individual otherwise qualified under this chapter who has received a doctoral degree in psychology that is acceptable to the board from an educational institution outside the United States, if the educational institution would otherwise be accredited by a regional accrediting body if located in the United States;
 - (b) Have passed the national EPPP examination at the doctoral level; and
 - (c) Have had at least two (2) years of supervised professional experience satisfactory to the board, one (1) year of which shall be an internship.

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- (2) Upon acceptance of the application to sit for the examination in psychology, the applicant may practice psychology under the supervision of a licensed psychologist under conditions of supervision and temporary licensure established by the board. The board shall establish a grace period not to exceed sixty (60) days to allow for the employment and supervision of the applicant by an agency from the time the applicant's degree requirements are completed to the submission of the complete application. During this period of supervision, the applicant for licensure may not supervise certified psychologists, licensed psychological associates, other applicants for licensure, or temporarily licensed persons, nor shall he engage in an independent practice, except under the employment of his supervising psychologist. Upon certification to the board of completion of the two (2) years of supervision satisfactory to the board, the applicant shall be examined on psychological practice, ethical principles, and the law.
 - (3) Licensed psychologists may function independently without supervision. Licensed psychologists who have the designation "health service provider" may retain that designation and may employ and supervise certified psychologists and licensed psychological associates. Licensed psychologists who have the designation "health service provider" may supervise no more than a total of six (6) certified psychologists, licensed psychological associates, or applicants for licensure at one (1) time.
- k. Physician – KRS 311.571 states that any applicant who is a graduate of a medical or osteopathic school shall be eligible for a regular license to practice medicine in the Commonwealth if they:
- (1) Are able to understandably speak, read, and write the English language;
 - (2) Has graduated from an accredited college or university or has satisfactorily completed a collegiate course of study necessary for entry into an approved medical or osteopathic school or college;
 - (3) Has graduated from a prescribed course of instruction in a medical or osteopathic school or college situated in the United States or Canada and approved by the board;
 - (4) Has satisfactorily completed a prescribed course of postgraduate training of a duration to be established by the board in an administrative regulation; and
 - (5) Has successfully completed an examination prescribed by the board.

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- l. Physician Assistant – Has graduated from a physician assistant or surgeon assistant program accredited by the Accreditation Review Commission on Education for Physician Assistants or its predecessor or successor agencies and has passed the certifying examination administered by the National Commission on Certification of Physician Assistants or its predecessor or successor agencies; or Possesses a current physician assistant certificate issued by the board prior to July 15, 2002.
- m. Psychiatrist – Licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties, who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc.
- n. KY Credentialed Peer Support Specialist – Kentucky regulation states that an applicant shall:
 - (1) Be eighteen (18) years of age or older;
 - (2) Have personal or family lived experience with mental health diagnosis and treatment (as specified by relevant peer support regulation);
 - (3) Have attained a high school diploma or general equivalency diploma (GED) certificate;
 - (3) Complete the relevant DBHDID peer specialist training program(s);
 - (4) Successfully complete the DBHDID peer specialist examination(s);
 - (5) Complete and maintain documentation of a minimum of six (6) hours of job related training or education in each subsequent year of employment; and
 - (6) Deliver services working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADC, a LPAT, or a LPATA.
 - (7) Demonstrated the capacity to provide the core elements of peer support services for the behavioral health population being served, including the age range of the population being served.
- o. Certified Alcohol and Drug Counselor (CADC): KRS 309.083 states that a Certified Alcohol and Drug Counselor shall:
 - (1) Be at least eighteen (18) years of age;
 - (2) Have obtained a baccalaureate degree;
 - (3) Have completed six thousand (6,000) hours of board-approved experience working with alcohol or drug dependent persons, three hundred (300) hours of which shall have been under the direct supervision of a certified alcohol and drug counselor who has at least two (2) years of post-certification experience; (4) Have completed at least two hundred seventy (270) classroom hours of board-approved curriculum;
 - (4) Have passed a written examination that has been approved by the International Certification Reciprocity Consortium on Alcoholism and Drug Abuse and an oral examination approved by the board;

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- (5) Have signed an agreement to abide by the standards of practice and code of ethics approved by the board;
 - (6) Have completed at least six (6) hours of ethics training and two (2) hours of training in the transmission, control, treatment, and prevention of the human immunodeficiency virus;
 - (7) Have completed three (3) hours of domestic violence training;
 - (8) Have submitted two (2) letters of reference from certified alcohol and drug counselors; and
 - (9) Work under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LPAT, or a LPATA with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center.
- p. Licensed clinical alcohol and drug counselor – KRS 309.0832 states that a licensed clinical alcohol and drug counselor shall:
- (1) Be at least eighteen (18) years of age;
 - (2) Have obtained from a regionally accredited college or university or a college or university accredited by an agency recognized by the United States Department of Education:
 - (a) A sixty (60) hour master's degree in a behavioral science with clinical application;
 - (b) A thirty (30) hour advanced placement master's degree in a behavioral science with clinical application; or
 - (c) A doctoral degree in a behavioral science with clinical application;
 - (3) Have completed at least one hundred eighty (180) classroom hours of alcohol and drug counselor specific board-approved curriculum;
 - (4) Have passed a written examination as specified by the board in administrative regulation;
 - (5) Have signed an agreement to abide by the standards of practice and code of ethics approved by the board;

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- (6) Have completed at least six (6) hours of ethics training; three (3) hours of domestic violence training; and two (2) hours training in the transmission, control, treatment, and prevention of the human immunodeficiency virus, in addition to the educational requirements in subsection (2) of this section;
 - (7) Have submitted two (2) letters of reference from certified alcohol and drug counselors or licensed clinical alcohol and drug counselors;
 - (8) Live or work at least a majority of the time in Kentucky;
 - (9) Have complied with the requirements for the training program in suicide assessment, treatment, and management in KRS 210.366 and any administrative regulations promulgated thereunder; and
 - (10) Have completed two thousand (2,000) hours of board-approved experience working with persons having a substance use disorder, three hundred (300) hours of which shall have been under the direct supervision of a licensed clinical alcohol and drug counselor.
- q. Licensed clinical alcohol and drug counselor associate – KRS 309.0833 states that a licensed clinical alcohol and drug counselor associate shall:
- (1) An applicant for licensure as a licensed clinical alcohol and drug counselor associate shall:
 - (a) Pay the board the initial fee for licensure;
 - (b) Complete the requirements under KRS 309.0832(1) to (9) [as indicated above for the Licensed clinical alcohol and drug counselor]; and
 - (c) Obtain a board-approved supervisor of record.
 - (2) Upon completion of the hours of board-approved experience specified in KRS 309.0832(10), a licensed clinical alcohol and drug counselor associate may apply to the board for licensure as a licensed clinical alcohol and drug counselor.
- r. Community Support Associate: 908 KAR 2:250 states that a Community Support Associate shall:
- (1) Be eighteen (18) years of age or older;
 - (2) Have a high school diploma, a general equivalency diploma (GED), or qualifying documentation from a comparable educational entity;
 - (3) Have one (1) year of full-time experience working with individuals who receive services for treatment of a mental health disorder; and

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- (4) Successfully complete within six (6) months of hire a training program approved by the Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) described in Section 3 of 908 KAR 2:250 and
 - (5) Work under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADC, a LPAT, a LPATA, or a LBA; and
 - (6) Meet face-to-face no less than one (1) time every two (2) weeks with his or her supervisor as described in paragraph (e) of this subsection.
- s. Licensed Professional Art Therapist: KRS 309.130 states that a Licensed Professional Art Therapist shall:
- (1) Have completed a master's or doctoral degree program in art therapy, or an equivalent course of study, from an accredited educational institution; and
 - (2) Have been issued a license by the board for the independent practice of art therapy.
- t. Licensed Professional Art Therapist Associate: KRS 309.130 states that a Licensed Professional Art Therapist Associate shall:
- (1) Have completed a master's or doctoral degree program in art therapy, or an equivalent course of study, from an accredited educational institution; and
 - (2) Have been issued a license by the board to practice art therapy under an approved clinical supervisor authorized by the board.
- u. Licensed Behavior Analyst: KRS 319C.080 states that a Licensed Behavior Analyst shall:
- (1) Have met the education requirements of the Board Certified Behavior Analyst (BCBA) standards, has passed the BCBA examination, and is credentialed as a behavior analyst by the certification board;
 - (2) Maintain active status and fulfill all requirements for renewal and recertification with the certification board as a Board Certified Behavior Analyst (BCBA);
 - (3) Conduct his or her professional activities in accordance with accepted standards as required by administrative regulations promulgated by the board in accordance with KRS 319C.050(1); and
 - (4) Comply with all applicable administrative regulations promulgated by the board.

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

13d. Rehabilitative Services

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

9. Qualifications of Providers (continued)

- v. Licensed Assistant Behavior Analyst: KRS 319C.080 states that a Licensed Assistant Behavior Analyst shall:
- (1) Have met the education requirements of the Board Certified Assistant Behavior Analyst (BCaBA) standards, has passed the BCaBA examination, and is credentialed as an assistant behavior analyst by the certification board;
 - (2) Maintain active status and fulfills all requirements for renewal and recertification with the certification board as a Board Certified Assistant Behavior Analyst;
 - (3) Conduct his professional activities in accordance with accepted standards as required by administrative regulations promulgated by the board in accordance with KRS 319C.050(1);
 - (4) Comply with all applicable administrative regulations promulgated by the board; and
 - (5) Be supervised by a certified behavior analyst in a manner consistent with the certification board requirements for supervision of Board Certified Assistant Behavior Analysts.

14.b. Nursing Facility Services for Individuals Age 65 or Older in and Institutions for Mental Diseases.

C.

A. Definitions:

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

B. Services:

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

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

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

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

15.a. Services in an Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (Other Than Such Services in an Institution for Mental Diseases) for Persons Determined, in Accordance with Section 1902(a) (31) (A) of the Act, to be in Need of Such Care

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

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

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

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

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age

A. Covered Inpatient Admissions

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's treatment plan shall specify the amount and frequency of services needed;

- 1) A covered admission for a Level I PRTF shall be prior authorized by a review agency.
- 2) A covered admission for a Level II PRTF shall be prior authorized;

B. PRTF Covered Inpatient Services.

- 1) The following services shall be available to all eligible recipients:
 - a. Diagnostic and assessment services;
 - b. Treatment plan development, review, or revision;
 - c. Psychiatric services;
 - d. Nursing services which shall be provided in compliance with 902 KAR 20:320;
 - e. Medication which shall be provided in compliance with 907 KAR 1:019;
 - f. Evidence-based treatment interventions;
 - g. Individual therapy which shall comply with 902 KAR 20:320;
 - h. Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - i. Group therapy which shall comply with 902 KAR 20:320;
 - j. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - k. Substance abuse education;
 - l. Activities that:
 - (1) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - (2) Support and encourage the parent's ability to re-integrate the child into the home;
 - m. Emergency interventions pursuant to the restraint and seclusion requirements at:
 - (1) 42 C.F.R. 483.350 through 376; and
 - (2) 902 KAR 20:320;
 - n. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - o. Educational activities; or
 - p. Non-medical transportation services as needed to accomplish objectives;

-
16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age
- 2) A Level I PRTF service listed in a above shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Medically necessary; and
 - d. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
 - 3) A Level I PRTF service listed in g, h, i, k, or m. above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
 - 4) A Level II PRTF service listed shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Provided at least once a week:
 - (1) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - (2) Except for diagnostic and assessment services which shall have no weekly minimum requirement;
 - d. Medically necessary; and
 - e. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
 - 5) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.
- C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.
- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
 - 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
 - 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
 - 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
 - 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state psychiatric hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state psychiatric hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.
- 1) The department shall cover a bed reserve day for an acute hospital admission, a state psychiatric hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state psychiatric hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital.
 - 2) Based on medical necessity, with a prior authorization, the five (5) day limit may be extended.
 - 3) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.

Page intentionally left blank

TN No. 13-028
Supersedes
TN No. 99-08

Approval Date 01-21-14

Effective Date 01/01/2014

18. Hospice

A. Benefits

The Kentucky Medicaid Hospice Program follows the amount, duration, and scope of services specified in the Medicare Hospice Program.

Any terminally ill Medicaid recipient may elect hospice coverage (where hospice care is provided by a participating hospice program in his service area) Each recipient will be required to make his voluntary selection in writing, and must present a statement from a physician (or such statement must be available) to show that the recipient's illness is terminal and that death is expected to occur within six (6) months. In doing so, the recipient waives rights to other Medicaid services that are related to the treatment of his or her terminal illness(es) with the exception of individuals less than 21 years of age. Individuals less than 21 years of age may receive concurrent hospice and acute care treatment. The recipient has the right to cancel the election at any time without forfeiting additional Medicaid hospice coverage at a later time. The recipient does not waive rights to Medicaid services for conditions not related to the terminal condition.

Medicaid beneficiaries under the age of 21 may receive hospice benefits, including curative treatment without foregoing any other service to which the child is entitled under the Medicaid program, pursuant to Section 2302 of the Patient Protection and Affordable Care Act of 2010.

B. Limitations

Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services.

-
24. Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary.
- A. Transportation
1. Definitions.
- a. Ambulance transportation includes air and ground transportation provided at advanced life support level or basic life support levels by an appropriately licensed carrier.
- b. Medical service area is made up of the recipient's county of residence or a contiguous county.
2. Ambulance Services.
- a. An emergency ambulance service shall be provided without prior authorization to and from the nearest hospital emergency room. If a hospital emergency room is not available, a statement from an attending physician associated with the facility from which the patient receives services verifying medical necessity of stretcher ambulance services and the nature of the emergency services provided to the patient shall be required.
- b. A non-emergency ambulance service to a hospital, clinic, physician's office or other medical facility for provision of a Medicaid covered service exclusive of a pharmacy service, shall be covered upon referral from a licensed medical professional for a recipient whose medical condition warrants transport by stretcher.
- c. When it is determined by the attending physician that ground ambulance is not appropriate, a referral may be made for air ambulance transport to a medical facility beyond the recipient's county of residence or state boundaries. Medically necessary air travel will be covered within the parameters of the allowed reimbursement amounts specified in Attachment 4.19-B, page 20.11. Special authorization by the Commissioner or his designated representative is required for air transportation provided at a cost in excess of these amounts.
- d. Ground ambulance transport for in-state non-emergency ambulance travel outside the medical service area shall be covered if prescribed by the attending physician.
- e. Ground ambulance transport for out-of-state non-emergency ambulance transport shall only be covered if prior approval is obtained from the Department.
- f. Only the least expensive available transportation suitable for the recipient's needs shall be approved.

3. Specially Authorized Non-emergency Medical Transportation

- a. A specially authorized transportation service is non-emergency transportation necessary under extraordinary circumstances in which the recipient is required to travel out-of-state for medical treatment unavailable in-state.
- b. The Department assures provision of necessary transportation to and from a provider if the recipient has no other transportation resources.
- c. If transportation is not available free of charge, the Department will cover the least expensive means of appropriate transportation.
- d. Prior approval is required for all specially authorized transportation. When the recipient's medical needs cannot be met within the state, the Department will only approve travel to the nearest facility where those needs can be met.
- e. The Department will cover the following specially authorized transportation services:
 - (1) Transportation for a recipient;
 - (2) Lodging for a recipient, and a parent or attendant, if necessary;
 - (3) Meals, when necessary for the recipient to remain away from home and outside a medical facility while receiving treatment;
 - (4) Transportation and meals for one parent or guardian to accompany a dependent child receiving covered medical services, when treatment requires the child to remain away from home; and
 - (5) Transportation and meals for an attendant who accompanies a recipient receiving medical services, when there is a justifiable need for an attendant. The attendant can be a parent.

23.d. Nursing Facility Services for Patients Under 21 Years Age

A. Definitions:

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

B. Services:

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

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

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

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

23.e. Emergency Hospital Services

Coverage is limited to the provision of emergency services provided in hospitals which have been determined to meet Title XVIII's definition of an emergency hospital.

TN No. 90-36
Supersedes
TN No. None

Approval Date: 11-14-1994

Effective Date 10-1-90

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

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with Section 1905(a)(19) or section 1915(g) of the Act).

Provided: With limitations Not provided.

20. Extended services to pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Provided: + Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

Provided: + Additional coverage ++ Not provided.

c. Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy to individuals covered under section 1902(a)(i0)(A)(ii)(IX) of the Act.

Provided: + Additional coverage ++ Not provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

State/Territory: Kentucky

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

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).
 Provided: No limitations With Limitations* Not provided.
22. Respiratory care services (in accordance with section 1902 (e)(9)(A) through (C) of the Act).
 Provided: No limitations With Limitations* Not provided.
23. Certified pediatric or family nurse practitioners services.
 Provided: No limitations With Limitations* Not provided.

See item 6d for limitations.

* Description provided on attachment.

State/Territory: Kentucky

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

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.
 Provided: No limitations With Limitations* Not provided.
- b. Services provided in Religious Nonmedical Health Care Institutions.
 Provided: No limitations With Limitations* Not provided.
- c. Reserved
- d. Nursing facilities for patients under 21 years of age.
 Provided: No limitations With Limitations* Not provided.
- e. Emergency hospital services.
 Provided: No limitations With Limitations* Not provided.
- f. Personal care services in recipient's home prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
 Provided: No limitations With Limitations* Not provided.

* Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

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

24. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

a 1. Transportation

- No limitations
 With limitations

Transportation is limited to individuals requesting transportation who lack access to free transportation that meets their medical needs. Transportation is only authorized for a Medicaid-covered service that has been determined medically necessary.

a 2. Brokered Transportation

- Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

- (1) statewideness (indicate areas of State that are covered)
 (10)(B) comparability (indicate participating beneficiary groups)
 (23) freedom of choice (indicate mandatory population groups)

All Medicaid recipients covered under Kentucky's State Plan, excluding Qualified Medicare Beneficiaries, are eligible for the non-emergency medical transportation benefit. Recipients are restricted to using the regional broker and the provider assigned by the broker for the recipient's trip.

(2) Transportation services provided will include:

- wheelchair van
 taxi

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

- stretcher car
- bus passes
- tickets
- secured transportation
- such other transportation as the Secretary determines appropriate (please describe):
Private automobiles, non-profit transit system, specialty carriers for non-emergency ambulatory disoriented persons, and specialty carriers using lift equipped vehicles in compliance with the Americans with Disabilities Act certified to transport non-emergency, non-ambulatory persons.

Private auto providers enroll via the same enrollment and credentialing process as other Medicaid providers and submit additional enrollment documents specific to the transportation program including vehicle registration, vehicle insurance coverage and a valid driver's license. This category of provider is defined in Kentucky Revised Statute 281.873.

Private auto providers are reimbursed the Kentucky State Employee mileage rate in effect for the given time period.

- (3) The State assures that transportation services will be provided under a contract with a broker who:
 - (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
 - (ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;
 - (iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;
 - (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);
- (4) The broker contract will provide transportation to the following categorically needy mandatory populations:
 - Low-income families with children (section 1931)
 - Low-income pregnant women
 - Low-income infants
 - Low-income children 1 through 5
 - Low-income children 6-19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

-
- Qualified pregnant women
 - Qualified children
 - IV-E Federal foster care and adoption assistance children
 - TMA recipients (due to employment)
 - TMA recipients (due to child support)
 - SSI recipients
- (5) The broker contract will provide transportation to the following categorically needy optional populations:
- Optional low-income pregnant women
 - Optional low-income in
 - Optional targeted low-income children
 - Individuals under 21 who are under State adoption assistance agreements
 - Individuals under age 21 who were in foster care on their 18th birthday
 - Individuals who meet income and resource requirements of AFDC or SSI
 - Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
 - Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
 - Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
 - Individuals infected with TB
 - Individuals screened for breast or cervical cancer by CDC program
 - Individuals receiving COBRA continuation benefits
 - Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
 - Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution
 - Individuals terminally ill if in a medical institution and will receive hospice care
 - Individuals aged or disabled with income not above 100% FPL
 - Individuals receiving only an optional State supplement in a 209(b) State
 - Individuals working disabled who buy into Medicaid (BBA working disabled group)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

-
- Employed medically improved individuals who buy into Medicaid under TWWIA Medical Improvement Group
- Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)
- (6) The State will pay the contracted broker by the following method:
- (i) risk capitation
- (ii) non-risk capitation
- (iii) other (e.g., brokerage fee and direct payment to providers)

Under a brokerage system, Kentucky is divided into fifteen (15) Non-Emergency Medical Transportation Regions which were established based upon regional medical utilization and referral patterns. The broker contract for each region is bid separately; however, a broker may be a successful bidder for more than one region. Each region has a single per member per month (PMPM) capitation rate which is paid to the regional broker for all transportation eligible recipients in that region. A single payment for each broker is made each month on a prospective basis. In the event one broker gains the contract in multiple regions, a blended PMPM rate is paid for all regions served by that broker.

The PMPM rate for each region is established based on historical utilization and cost patterns for the region. The PMPM rate for each region may be updated annually effective July 1st of each year if encounter data trends indicate that a region has experienced an increase in transportation utilization and/or cost which was outside of the control of the broker. PMPM rates may also be adjusted on an as needed basis if programmatic changes (i.e. State Plan or waiver changes) would result in a change in transportation utilization or if transportation cost factors (i.e. gas prices) result in a change in the projected cost of transportation.

If for any reason, a broker's contract is terminated before a replacement broker can be procured, non-emergency transportation reimbursement will revert to the methods applicable to non-emergency transportation described in Attachment 4.19-B, Section VII of the State Plan.

TN No.: 06-008
Supersedes
TN No.: New

Approval Date: 05/03/06

Effective Date: 06/01/06

State: Kentucky

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

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

provided not provided

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

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

provided not provided

State/Territory: Kentucky

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

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

Provided: No limitations With limitations* Not provided.

*Description provided on attachment

TN No. 03-06
Supersedes
TN No. None

Approval Date 10/31/2003

Effective Date 01-01-03

State/Territory Kentucky

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

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to withstand repeated use. Coverage of an item of durable medical equipment, medical supplies, prosthetics and orthotics shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; and shall be medically necessary and reasonable.

- a. A provider must be Medicare and Medicaid certified. Items must be medically necessary and, if required, prior authorized.
- b. All miscellaneous codes require prior authorization. Any item that does not have a designated HCPCS code and is determined by the department to be a covered item will use the designated miscellaneous HCPCS code from the HCPCS Coding Book and require prior authorization.
- c. Any item designated by a covered HCPCS code being reimbursed at \$150.00 or more will require prior authorization.
- d. All items of durable medical equipment, prosthetic, orthotic, or medical supply will require a Certificate of Medical Necessity to be kept on file at the provider's office for five (5) years.
- e. The following general types of durable medical equipment, medical supply, prosthetics or orthotics are excluded from coverage under the durable medical equipment program:
 1. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
 2. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
 3. Physical fitness equipment, such as exercycles and treadmills;
 4. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators;
 5. Items needed as a resident of an inpatient program of a hospital, or nursing facility, and
 6. Items considered educational or recreational.
- f. A cast or splint shall be limited to two (2) per ninety (90) day period for the same injury or condition.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

TN No.: 05-010
Supersedes
TN No.: NEW

Approval Date: 11/25/05

Effective Date: 01/01/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1927(d)(2) and 1935(d)(2)	<p>1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.</p> <p>— The following excluded drugs are covered:</p> <ul style="list-style-type: none"><input type="checkbox"/> (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)<input type="checkbox"/> (b) agents when used to promote fertility (see specific drug categories below)<input type="checkbox"/> (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)<input type="checkbox"/> (d) agents when used for the symptomatic relief cough and colds (see specific drug categories below)<input type="checkbox"/> (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)<input checked="" type="checkbox"/> (f) nonprescription drugs (see specific drug categories below)

TN No.: 05-010
Supersedes
TN No.: NEW

Approval Date: 11/25/05

Effective Date: 01/01/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation(s)	Provision(s)
1927(d)(2) and 1935(d)(2)	<input type="checkbox"/> (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below) (The Medicaid agency lists specific category of drugs below) Kentucky Medicaid will cover all nonprescription drug categories for full benefit dual eligible beneficiaries, which is consistent with Kentucky's policy of covering all nonprescription drug categories for non-dual recipients. Herbal products are not covered.
	<input type="checkbox"/> No excluded drugs are covered.

TN No. 13-026
Supersedes
TN No.: 11-011

Approval Date 1/23/2014

Effective Date: October 1, 2013

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

- Provided No limitations With limitations
 None licensed or approved

28. (ii) Licensed or Otherwise State-recognized covered professionals providing services in the Freestanding Birth Center.

- Provided No limitations With limitations
 Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

- A. Target Groups: By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Aged 0-21 and meet the medical eligibility criteria of Commission for Handicapped Children, the state's Title V Crippled Children's Agency, and
 2. Persons of all ages meeting the medical eligibility criteria of the Commission for Handicapped Children and having a diagnosis of hemophilia.
- The individuals in the target groups may not be receiving case management services under an approved waiver program.
- B. Areas of State in which services will be provided:
- Entire State.
- Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is involved to provide services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 a (23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

(continued on next page)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

D. Definition of Services: (Continued)

1. Assessment of client's medical, social, and functional status and identification of client service needs;
2. Arranging for service delivery from the client's chosen provider to insure access to required services;
3. Insure access to needed services by explaining the need and importance of services in relation to the client's condition;
4. Insure access, quality and delivery of necessary services, and
5. Preparation and maintenance of case record documentation to include service plans, forms, reports, and narratives, as appropriate.

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management
 - (a) assessment
 - (b) care/services plan development
 - (c) linking/coordination of services
 - (d) reassessment/follow up
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. An administrative capacity to insure quality of services in accordance with state and federal requirements.
5. A financial management system that provides documentation of services and costs.
6. Capacity to document and maintain individual case records in accordance with state and federal requirements.
7. Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
8. Demonstrated capacity to meet the case management service needs of the target population.

(Continued on next Page)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

E. Qualifications of Providers (continued)

Qualifications of Case Manager (Only the following can be case managers)

1. Registered Nurse - Must be licensed as a Registered Nurse or possess a valid work permit issued by the Kentucky Board of Nursing.
2. Social Worker - A master's degree in social work supplemented by one year of professional social work experience; or a graduate of a college or university with a bachelor's degree supplemented by two years of professional social work experience.

F. The State that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

This Page is Intentionally Left Blank

This Page is Intentionally Left Blank

This Page is Intentionally Left Blank

State Kentucky

Targeted Case Management Services for Children in the Custody of or at Risk of Being in the Custody of the State, and for Children under the Supervision of the State, and for Adults in Need of Protective Services

- A. Target Groups: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Age 0-21 and meet the state's conditions and circumstances to be defined as a child in the custody of or at risk of being in the custody of the state, or a child who is under the supervision of the state, and
 2. Adults who meet the state's conditions and circumstances to be defined as an adult in need of protective services.
- B. Areas of State in which services will be provided:
- Entire State.
- Only in the following geographic areas (authority of Section 191 5(g)(1) of the act is invoked to provide services less than statewide):
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 191 5(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service that allows providers to assist eligible individuals in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1 902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services they are referred to. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

- (1) A written assessment of the child or adults needs;
- (2) Arranging for the delivery of the needed services as identified in the assessment;
- (3) Assisting the child and his family, or the adult, in accessing services needed by the individual child or adult.
- (4) Monitoring the child or adults progress by making referrals, tracking the child or adult's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child or adult's changing needs;
- (5) Performing advocacy activities on behalf of the adult, or the child and his family, to assure that the individual adult or child gains access to the services he or she needs.
- (6) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child or adult's progress, etc following provision of service to the child or the adult on behalf of the child or adult.
- (7) Providing case consultation (i.e., consulting with the service provider/collateral's in determining the child or adult's status and progress); and
- (8) Performing crisis assistance (i.e., intervention on behalf of the child or adult, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

- (1) Demonstrated capacity to provide all core elements of case management including
 - (a) assessment;
 - (b) care/services plan development;
 - (c) linking/coordination of services; and
 - (d) reassessment/follow-up.
- (2) Demonstrated case management experience in coordinating and linking such community resources as required by one of the target populations.

- (3) Demonstrated experience with one of the target populations.
- (4) An administrative capacity to insure quality of services in accordance with state and federal requirements.
- (5) Have a financial management system that provides documentation of services and costs.
- (6) Capacity to document and maintain individual case records in accordance with state and federal requirements.
- (7) Demonstrated ability to assure a referral process consistent with Section 1 902(a)(23) of the Act, freedom of choice of provider.
- (8) Demonstrated capacity to meet the case management service needs of the target population.

Qualifications of Case Manager (Only the following can be case managers)

Each case manager must be employed by an enrolled Medicaid provider or by an approved subcontractor of an enrolled Medicaid provider and must meet the following minimum requirements:

- (1) Have a Bachelor of Arts or Bachelor of Sciences degree in any of the social/behavioral sciences or related fields from an accredited institution; and
 - (2) Have one (1) year of experience working directly with the targeted case management population or performing case management services or have a master's degree in a human service field.
- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the providers of case management services.
 - (2) Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Targeted Case Management Services for children birth to 3 participating in the Kentucky Early Intervention Program

- A. Target Groups: By invoking the exception to comparability allowed by 1915(g)(i) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Children birth to three years of age who have developmental disabilities and who meet the eligibility criteria of and are participants in the Kentucky Early Intervention Program.
- The individuals in the target groups may not be receiving case management services under an approved waiver program.
- B. Areas of State in which services will be provided:
- Entire State
 - Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provided services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
 - Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, educational, and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by a case manager to assist and enable a child eligible for services under the Kentucky Early Intervention Program in gaining access to needed medical, social, educational and other services. There are two parts to case management: Initial Service Coordination and Primary Service Coordination. Initial Service Coordination assists the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs-identified Individualized Family Services Plan (IFSP). Primary Service Coordination assists the child and child's family, as it relates to the child's needs, with ongoing service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized. A child would only have one service coordinator at a time.

These activities include:

- (1) Assessment of child's medical, social and functional status and identification of service needs;
- (2) Initial service coordination from notice of referral through initial IFSP development;
- (3) Assuring that all procedural safeguards are met during intake and IFSP development;
- (4) Arranging for and coordinating the development of the child's IFSP;
- (5) Arranging for the delivery of the needed services as identified in the IFSP;
- (6) Assisting the child and his family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs;
- (7) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs;
- (8) Performing activities to enable an eligible individual to gain access to needed services;
- (9) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
- (10) Providing case consultation (i.e., with the service providers/collaterals in determining child's status and progress);

-
- (11) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services); and
 - (12) Facilitating and coordinating development of the child's transition plan.

E. Qualifications of Providers:

As provided for in Section 1915 (g)(1) of the Social Security Act, qualified providers shall be the Title V agencies and their subcontractors who meet the following Medicaid criteria in order to ensure that case managers for the children with developmental disabilities target group are capable of ensuring that such individuals receive needed services:

1. Demonstrated capacity to provide all core elements of case management including:
 - a) assessment;
 - b) care/services plan development;
 - c) linking/ coordination of services; and
 - d) reassessment/follow-up
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population;
3. Demonstrated experience with targeted population;
4. An administrative capacity to insure quality of services in accordance with state and federal requirements; and
5. A financial management system that provides documentation of services End costs.

Qualifications of Case Manager (only the following can be case managers)

Each case manager must be a Kentucky Early Intervention Program certified service provider, and:

- A. Have a Bachelor's degree; and
- (1) 2 years experience in service coordination for children with disabilities up to age 18; or
 - (2) 2 years experience in service provision to children under six years of age; or
- B. Meet one of the following professional criteria:
1. Audiologist - Licensed or Certified,
 2. Family Therapist - M.A. and Certified,
 3. Developmental Interventionist - Certified or working toward an Interdisciplinary Early Childhood Certificate as demonstrated by implementing a professional development plan approved by the Cabinet for Health Services,
 4. Developmental Associate,
 5. Registered Nurse,
 6. Advanced Registered Nurse Practitioner,
 7. Dietitian - Licensed,
 8. Occupational Therapist - Licensed,
 9. Occupational Therapist Assistant - B.S. and Licensed,
 10. Orientation and Mobility Specialist - Certified,
 11. Physical Therapist - Licensed,
 12. Psychologist - Licensed or Certified,
 13. Speech Language Pathologist - Licensed or Certified,
 14. Speech Language Assistance - Licensed,
 15. Social worker - Licensed,
 16. Physician, Licensed,
 17. Nutritionist, Licensed

- F. The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the available providers of case management services.
 - (2) Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

- A. Target Group: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Pregnant women who have not reached their twentieth birthday and will be first time parents;
 2. Pregnant women who are twenty years of age or older, will be first time parents, and screen positive for the home visitation program which shall be called Health Access Nurturing Development Services (HANDS). High risk screening factors include: first time mothers who are single, separated or divorced; those who had late, sporadic or no prenatal care; those who sought or attempted an unsuccessful abortion; partner unemployed; inadequate income or no source of income; unstable housing; no phone; education less than 12 years; inadequate emergency contacts; treatment of or current substance abuse; treatment of abortion; treatment of psychiatric care; relinquishment for adoption, sought or attempted; marital or family problems; treatment of or current depression;
 3. Infants and toddlers up to their third birthday who are children in families described in A.1 and A.2 of this subsection;
 4. First born infants up to twelve (12) weeks of age whose families were not identified prenatally and who assess into the program.
- B. Areas of State in which services will be provided:
- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than state wide:
- C. Comparability of Services:
- Services are provided in accordance with 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of 1902(a)(10)(B).
- D. Definition of Services

Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education, and other services. Consistent with the requirement of Section 1902(a)(23) of the Act, the providers will monitor client treatment to

assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by case managers to assess and enable first time mothers and infants/toddlers who are eligible for services under the Kentucky HANDS (Health Access Nurturing Development Services) Program. There are two phases to case management - assessment and home "visitation. Both phases include assisting the infant/toddler, mother, or family in accessing needed services, developing a treatment plan, coordinating needed services, monitoring progress, preparing and maintaining case records, providing case consultation as specified by the plan, and providing follow-up and evaluation.

The service activities include:

1. Assessment
 - a) Provided by a Registered Nurse, Social Worker or Early Childhood Development Specialist;
 - b) Conducts a face-to-face needs assessment with the child, mother and family. The assessment shall include:
 - 1) parent's childhood experience;
 - 2) lifestyle behaviors and mental health status;
 - 3) parenting experience;
 - 4) stressors, coping skills and support system for the new family;
 - 5) anger management skills;
 - 6) expectations of infant's developmental milestones and behaviors;
 - 7) perception of new infant, and bonding and attachment issues;
 - 8) plans for discipline; and
 - 9) family environment and support system.
 - c) Develops a written report of the findings and a service plan for the family.
 - d) Assigns home visitor and arranges for the delivery of the needed services by other Medicaid and community providers as identified in the treatment plan.

2. Home Visitation

- a) A public health nurse, social worker, or family support worker who is supervised by a public health nurse, social worker or early childhood development specialist may perform a home visit;
- b) Assist the child and family, as it relates to the treatment plan, in accessing needed services and coordinating services with other programs;
- b) Monitor progress by making referrals, tracking the appointments, performing follow-up services, and performing periodic evaluation of the changing needs;
- c) Perform activities to enable the child and family to gain access to needed services;
- d) Prepare and maintain case records documenting contacts, services needed, reports, progress;
- e) Provide case consultation (i.e., with the service providers/collaterals in determining child's status and progress); and
- f) Perform crisis assistance (i.e., intervention on behalf of the child, making arrangement for emergency referrals, and coordinating other needed emergency service).

E. Qualifications of Providers:

1. Providers must be certified as a Medicaid provider meeting the following criteria:

- a) Demonstrated capacity to contract statewide for the case management services for the targeted population;
- b) Demonstrated capacity to ensure all components of case management including:
 - 1) screening,
 - 2) assessment,
 - 3) treatment plan development,
 - 4) home visiting,
 - 5) linking/coordination of services, and
 - 6) follow-up and evaluation;
- c) Demonstrated experience in coordinating and linking such community resources as required by the target population;
- d) Demonstrated experience with the target population;

-
- e) Administrative capacity to insure quality of services in accordance with state and federal requirements;
 - f) Demonstrated capacity to provide certified training and technical assistance to case managers;
 - g) Financial management system that provides documentation of services and costs;
 - h) Capacity to document and maintain individual case records in accordance with state and federal requirements;
 - i) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider; and
 - j) Demonstrated capacity to meet the case management service needs of the target population.

2. Qualifications of Case Manager

The case manager shall meet one of the following professional criteria:

- a) Registered Nurse – Must have a valid Kentucky Board of Nursing license as a registered nurse or advanced registered nurse practitioner.
- b) Social Worker – Meet the requirement of KRS Chapter 335 for licensure by the State Board of Examiners of Social Work, have a masters degree in social work, or have a bachelors degree in social work from an accredited institution.
- c) Early Childhood Development Specialist – have a bachelors degree in Family Studies, Early Childhood Education, Early Childhood Special Education, or a related Early Childhood Development Curriculum.
- d) Family Support Worker (FSW) – Have a high school diploma or GED, be 18 years of age or older, and have received core training prior to having family contact on assessment of family strengths and needs, service plan development, home visitor process, home visitor role, supporting growth in families, observing parent-child interactions, knowing indicators of parent-infant attachment, keeping home visit records, conducting service coordination and reassessment. In addition to the core training the family support worker receives continuing training on selected topics including confidentiality, community resources, developmental milestones, family violence, substance abuse, ethical issues, communication skills, HIV/AIDS training, and interviewing techniques. The FSW must be supervised by a registered nurse or social worker.

- F. The state assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

Targeted Case Management services for pregnant women including postpartum women for sixty (60) day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

- A. By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
- (1) Women diagnosed as a pregnant woman or postpartum woman up to the end of the month of sixty days following the date of delivery who has applied for or is receiving substance abuse services through Medicaid.
- B. Areas of State in which services will be provided:
- Entire State
- Only in the following geographic areas (authority of Section 191 5(g)(1) of the Act is involved to provided services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education, and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.
- (1) Substance abuse case management services.
 - (a) Case management shall be:
 1. A face-to-face or telephone contact between or on behalf of an individual and a qualified substance abuse professional; and
 2. For the purpose of reducing or eliminating an individual's substance abuse problem by assisting an individual in gaining access to needed medical, social, educational and other support services.
 - (b) Case management services shall include:
 1. The development of a service plan that identifies an individual's case management needs and projected outcomes; and
 2. Activities that support the implementation of an individual's service plan
 - (c) Case management services shall not be connected with a specific type of substance abuse treatment but shall follow an individual across the array of substance abuse treatment services identified in an individual's treatment plan.

(d) Service limitations. The following activities shall not be reimbursed by Medicaid:

1. An outreach or case-finding activity to secure a potential individual for services;
2. Administrative activities associated with Medicaid eligibility determinations; and
3. The actual provision of a service other than a case management service.

A. Qualifications of Providers:

- 1) Services are covered when provided by any mental health center, and their subcontractors, and any other qualified providers, licensed in accordance with applicable state laws and regulations.
- 2) Demonstrated capacity to provide all core elements of case management including: Assessment skills, care/services plan development, linking/coordination of services, reassessment/follow-up, training specific to the target population, an administrative capacity to insure quality of services in accordance with state and federal requirements and a financial system that provides documentation of services and costs.
- 3) The provider shall employ or have a contractual agreement with a physician licensed in Kentucky.
- 4) A provider must have staff available to provide emergency services for the immediate evaluation and care of an individual in a crisis situation on a twenty-four (24) hour a day, seven (7) day a week basis.
- 5) Qualifications for case management services:
 - (a) An alcohol and drug counselor certified by the Kentucky Board of Certification for Alcohol and Drug Counselors;
 - (b) An individual who has a bachelor's degree or greater in any field, from an accredited college or university who meets the training, documentation and supervision requirements;
 - (c) A Kentucky licensed physician.
 - (d) A psychiatrist who is licensed in Kentucky.
 - (e) A psychologist licensed or certified by the Kentucky Board of Examiners of Psychology;
 - (f) A psychological associate certified by the Kentucky Board of Examiners of Psychology;

- (g) A social worker licensed or certified in Kentucky;
 - (h) A Kentucky licensed registered nurse with the following combinations education and work experience:
 - 1. A registered nurse with a masters degree in psychiatric nursing from an accredited college or university;
 - 2. A bachelor of science degree in nursing from an accredited college or university and one year of clinical work experience in the substance abuse or mental health field;
 - 3. A diploma graduate in nursing and two years of clinical work experience in the substance or mental health field; or
 - 4. An associate degree in nursing from an accredited college or university and three years of clinical work experience in the substance abuse or mental health field;
 - (i) A Kentucky licensed advanced registered nurse practitioner;
 - (j) A marriage and family therapist licensed by the Kentucky Board of Licensure of Marriage and Family Therapists;
 - (k) A Kentucky-certified professional counselor; or
 - (l) A Kentucky-certified professional art therapist.
- F. The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1 902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the available providers of case management services.
 - (2) Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use Disorders

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

- A. The target group includes adults and children who:
1. Have a primary moderate or severe substance use disorder diagnosis or co-occurring substance use disorder and mental health diagnoses; and one or more of the following: (a) Lack of access to recovery supports; (b) Need for assistance with access to housing, vocational, medical, social, educational or other community services and supports; or (c) Involvement with one or more child welfare or criminal justice agencies, but are not inmates of a public institution (e.g., Youth who are awaiting adjudication in the community; individuals on probation or parole; and youth who are committed to the Department of Juvenile Justice and not placed in a public institution, are eligible for receipt of TCM services. Youth who are 'committed to the DJJ' are youth who are in the custody of DJJ but who are placed with their parents, other relatives or "foster" caregivers and not in a DJJ detention Center).
 - Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 30 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)
- B. Areas of State in which services will be provided (§1915(g)(1) of the Act):
- Entire State
 Only in the following geographic areas:
- C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
- Services are provided in accordance with §1902(a)(10)(B) of the Act.
 Services are not comparable in amount duration and scope (§1915(g)(1)).
- D. Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:
1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - a. taking client history;
 - b. identifying the individual's needs and completing related documentation; and
 - c. gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - d. a face-to-face assessment or reassessment must be completed at least annually, or more often if needed based on changes in the individual's condition.

TN # 14-002 - A

Supersedes

TN #: NEW

Approval Date: 6-19-14

Effective Date: 07/1/2014

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use Disorders

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - a. specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - b. includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - c. identifies a course of action to respond to the assessed needs of the eligible individual.
 3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - a. activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
 4. Monitoring and follow-up activities:
 - a. activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - (1) services are being furnished in accordance with the individual's care plan;
 - (2) services in the care plan are adequate; and
 - (3) changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
 - (4) monitoring shall occur no less than once every three (3) months and shall be face-to-face.
- Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use Disorders

- E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
1. Case management services for this target group may be provided by enrolled Kentucky Medicaid providers in any of the following categories:
 - a. Individual practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill Kentucky Medicaid.
 - b. Provider group: A group of more than one individually licensed practitioners who forms a business entity to render health services and bill Kentucky Medicaid.
 - c. Licensed organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render health services and bill Kentucky Medicaid.
 2. Providers must meet the following criteria:
 - a. Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
 - b. Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
 - c. Have the administrative capacity to provide quality of services in accordance with state and federal requirements;
 - d. Use a financial management system that provides documentation of services and costs;
 - e. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements;
 - f. Demonstrate programmatic and administrative experience in providing comprehensive case management services; and
 - g. Demonstrate referral systems and linkages and referral ability with essential social and health services agencies.
 3. Each case manager shall be required to meet the following minimum requirements:
 - a. Bachelor of Arts or Sciences degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services); and
 - b. A minimum of one (1) year of full-time employment working directly with adolescents or adults in a human service setting after completion of educational requirements or a master's degree in a behavioral science, as defined above, may substitute for the one (1) year of experience;
 - c. Successful completion of case management training approved by the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KBHDID) within six (6) months of employment, and completion of recertification requirements approved by KBHDID every three (3) years; and
 - d. Supervision by a behavioral health professional, who has completed case management training approved by KBHDID, shall occur at least two (2) times per month. At least one of these supervisory contacts shall be on an individual basis and face-to-face. Behavioral health professional is defined as:

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use Disorders

- (1) Individuals that are licensed and have autonomous functioning:

- Advanced Practice Registered Nurse (APRN)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor
- Licensed Psychological Practitioner
- Licensed Psychologist
- Licensed Professional Art Therapist
- Physician
- Psychiatrist
- Certified Alcohol and Drug Counselor (CADC)

Or

- (2) Master's level Individuals listed below under supervision:

- Certified Psychologist
- Licensed Psychological Associate
- Licensed Marriage and Family Therapy Associate.
- Certified Social Worker, Master Level
- Licensed Professional Counselor Associate
- Licensed Professional Art Therapist Associate
- Registered nurse licensed by the Kentucky Board of Nursing

Or

- (3) Bachelor's level with the following requirements:

- Registered nurse licensed by the Kentucky Board of Nursing; OR
- A Bachelor's degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services) AND
- Five (5) years of documented full-time experience providing specialized case management within target population.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use Disorders

F. Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

- Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

H. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

I. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use Disorders

J. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

K. Limitations:

1. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
2. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
3. FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))
4. The individuals in the target groups may not be receiving case management services under an approved waiver program.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health IssuesTarget Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

- A. The target group includes adults and children who:
1. Have at least one of the following types disorders:
 - a. A primary moderate or severe substance use disorder diagnosis;
 - b. A severe mental illness (SMI) diagnosed based on the criteria included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, with clinically significant symptoms which have persisted in the individual for a continuous period of at least two (2) years, or that the individual has been hospitalized for mental illness more than once in the last two (2) years, and that the individual is presently significantly impaired in his ability to function socially or occupationally or both [KRS 210.005(3)];
 - c. A severe emotional disability diagnosed based on the criteria included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, that presents substantial limitations that have persisted for at least one (1) year or are judged by a mental health professional to be at high risk of continuing for one (1) year without professional intervention in at least two (2) of the following five (5) areas:
 - (1) self-care,
 - (2) interpersonal relationships,
 - (3) family life,
 - (4) self-direction, and education,
 - (5) or has been removed from the child's home by the Department for Community-Based Services and has been unable to be maintained in a stable setting due to behavioral or emotional disturbance [KRS 200.503(2)]; and
 2. Have a chronic or complex physical health issue; and
 3. Need assistance with access to housing, vocational, medical, social, educational or other community services and supports; or
 4. Involvement with one or more child welfare or criminal justice agency (not including inmates of public institutions) (e.g., Youth who are awaiting adjudication in the community; individuals on probation or parole; and youth who are committed to the Department of Juvenile Justice and not placed in a public institution, are eligible for receipt of TCM services. Youth who are 'committed to the DJJ' are youth who are in the custody of DJJ but who are placed with their parents, other relatives or "foster" caregivers and not in a DJJ detention Center); or
 5. Are in the custody of the Department for Community-Based Services or at risk of out-of-home placement; or are at risk of in-patient mental health treatment.
 - Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 30 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

- B. Areas of State in which services will be provided (§1915(g)(1) of the Act):
- Entire State
 - Only in the following geographic areas:
- C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
- Services are provided in accordance with §1902(a)(10)(B) of the Act.
 - Services are not comparable in amount duration and scope (§1915(g)(1)).
- D. Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:
1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - a. taking client history;
 - b. identifying the individual's needs and completing related documentation; and
 - c. gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - d. A face-to-face assessment or reassessment must be completed at least annually, or more often if needed based on changes in the individual's condition.
 2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - a. specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - b. includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - c. identifies a course of action to respond to the assessed needs of the eligible individual.
 3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - a. activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

4. Monitoring and follow-up activities:
 - a. activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - (1) services are being furnished in accordance with the individual's care plan;
 - (2) services in the care plan are adequate; and
 - (3) changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
 - (4) Monitoring shall occur no less than once every three (3) months and shall be face-to-face.
 - Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))
- E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
 1. Case management services for this target group may be provided by enrolled Kentucky Medicaid providers in any of the following categories:
 - a. Individual practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill Kentucky Medicaid.
 - b. Provider group: A group of more than one individually licensed practitioners who forms a business entity to render health services and bill Kentucky Medicaid.
 - c. Licensed organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render health services and bill Kentucky Medicaid.
 2. Providers must meet the following criteria:
 - a. Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
 - b. Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
 - c. Have the administrative capacity to provide quality of services in accordance with state and federal requirements;

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

- d. Use a financial management system that provides documentation of services and costs;
 - e. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements;
 - f. Demonstrate programmatic and administrative experience in providing comprehensive case management services; and
 - g. Demonstrate referral systems and linkages and referral ability with essential social and health services agencies.
3. Each case manager shall be required to meet the following minimum requirements:
- a. Master's degree in social work, family studies, clinical counseling, psychology, nursing or related human services field approved by the Department for Medicaid Services; and a minimum of two (2) years' experience providing service coordination or linking/referring for community based services for individuals with complex behavioral health needs and co-occurring physical or behavioral health disorders or multi-agency involvement; or
 - b. A Bachelor's degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services) and five (5) years' experience providing service coordination or linking/referring for community based services for individuals with complex behavioral health needs and co-occurring physical or behavioral health disorders or multi-agency involvement; and
 - c. Successful completion of case management training approved by the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KBHDID) within six (6) months of employment, and completion of recertification requirements approved by KBHDID every three (3) years; and
 - d. Bachelor's level staff shall be supervised by a behavioral health professional, who has completed case management training approved by KBHDID. Supervision shall occur at least three (3) times per month. At least two of these supervisory contacts shall be on an individual basis and face-to-face. Behavioral health professional is defined as:
 - (1) Individuals that are licensed and have autonomous functioning:
 - Advanced Practice Registered Nurse (APRN)
 - Licensed Clinical Social Worker (LCSW)
 - Licensed Marriage and Family Therapist (LMFT)
 - Licensed Professional Clinical Counselor
 - Licensed Psychological Practitioner
 - Licensed Psychologist
 - Licensed Professional Art Therapist
 - Physician
 - Psychiatrist
 - Certified Alcohol and Drug Counselor (CADC)

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

Or

- (2) Master's level Individuals listed below under supervision:
- Certified Psychologist
 - Licensed Psychological Associate
 - Licensed Marriage and Family Therapy Associate.
 - Certified Social Worker, Master Level
 - Licensed Professional Counselor Associate
 - Licensed Professional Art Therapist Associate
 - Registered nurse licensed by the Kentucky Board of Nursing

Or

- (3) Bachelor's level with the following requirements:
- Registered nurse licensed by the Kentucky Board of Nursing; OR
 - A Bachelor's degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services) AND
 - Five (5) years of documented full-time experience providing specialized case management within target population.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

F. Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

- Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

H. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

I. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

J. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

K. Limitations:

1. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
2. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c)).
3. FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))
4. The individuals in the target groups may not be receiving case management services under an approved waiver program.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental IllnessTarget Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

- A. The target group adults and children individuals who:
1. Have a severe mental illness (SMI) diagnosed based on the criteria included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, with clinically significant symptoms which have persisted in the individual for a continuous period of at least two (2) years, or that the individual has been hospitalized for mental illness more than once in the last two (2) years, and that the individual is presently significantly impaired in his ability to function socially or occupationally or both [KRS 210.005(3)]; or
 2. Are age 20 or younger and have a severe emotional disability diagnosed based on the criteria included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, that presents substantial limitations that have persisted for at least one (1) year or are judged by a mental health professional to be at high risk of continuing for one (1) year without professional intervention in at least two (2) of the following five (5) areas:
 - a. self-care,
 - b. interpersonal relationships,
 - c. family life,
 - d. self-direction,
 - e. and education; or
 3. Has been removed from the child's home by the Department for Community-Based Services and has been unable to be maintained in a stable setting due to behavioral or emotional disturbance [KRS 200.503(2)]; and
 4. Are in the custody of the Department for Community-Based Services, or at risk of out-of-home placement; or are children or adults at risk of in-patient mental health treatment.
- Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 30 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)
- B. Areas of State in which services will be provided (§1915(g)(1) of the Act):
- Entire State
 Only in the following geographic areas:
- C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
- Services are provided in accordance with §1902(a)(10)(B) of the Act.
 Services are not comparable in amount duration and scope (§1915(g)(1)).

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental Illness

- D. Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:
1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - a. taking client history;
 - b. identifying the individual's needs and completing related documentation; and
 - c. gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - d. An assessment or reassessment must be completed at least annually, or more often if needed based on changes in the individual's condition.
 2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - a. specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - b. includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - c. identifies a course of action to respond to the assessed needs of the eligible individual.
 3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - a. activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
 4. Monitoring and follow-up activities:
 - a. activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - (1) services are being furnished in accordance with the individual's care plan;
 - (2) services in the care plan are adequate; and
 - (3) changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
 - (4) Monitoring shall occur no less than once every three (3) months and shall be face-to-face.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental Illness

- Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. Case management services for this target group may be provided by enrolled Kentucky Medicaid providers in any of the following categories:
 - a. Individual practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill Kentucky.
 - b. Provider group: A group of more than one individually licensed practitioners who forms a business entity to render health services and bill Kentucky Medicaid.
 - c. Licensed organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render health services and bill Kentucky Medicaid.
2. Providers must meet the following criteria:
 - a. Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
 - b. Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
 - c. Have the administrative capacity to provide quality of services in accordance with state and federal requirements;
 - d. Use a financial management system that provides documentation of services and costs;
 - e. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements;
 - f. Demonstrate programmatic and administrative experience in providing comprehensive case management services; and
 - g. Demonstrate referral systems and linkages and referral ability with essential social and health services agencies.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental Illness

3. Each case manager shall be required to meet the following minimum requirements:
 - a. Bachelor of Arts or Sciences degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services); and
 - b. A minimum of one (1) year of full-time employment working directly with individuals with behavioral health needs after completion of educational requirements or a master's degree in a behavioral science, as defined above, may substitute for the one (1) year of experience;
 - c. Successful completion of case management training approved by the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KBHDID) within six (6) months of employment, and completion of recertification requirements approved by KBHDID every three (3) years; and
 - d. Supervision by a behavioral health professional, who has completed case management training approved by KBHDID, shall occur at least two (2) times per month. At least one of these supervisory contacts shall be on an individual basis and face-to-face. Behavioral health professional is defined as:
 - (1) Individuals that are licensed and have autonomous functioning:
 - Advanced Practice Registered Nurse (APRN)
 - Licensed Clinical Social Worker (LCSW)
 - Licensed Marriage and Family Therapist (LMFT)
 - Licensed Professional Clinical Counselor
 - Licensed Psychological Practitioner
 - Licensed Psychologist
 - Licensed Professional Art Therapist
 - Physician
 - Psychiatrist
 - Certified Alcohol and Drug Counselor (CADC)
 - Or
 - (2) Master's level Individuals listed below under supervision:
 - Certified Psychologist
 - Licensed Psychological Associate
 - Licensed Marriage and Family Therapy Associate.
 - Certified Social Worker, Master Level
 - Licensed Professional Counselor Associate
 - Licensed Professional Art Therapist Associate
 - Registered nurse licensed by the Kentucky Board of Nursing

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental Illness

Or

- (3) Bachelor's level with the following requirements:
- Registered nurse licensed by the Kentucky Board of Nursing; OR
 - A Bachelor's degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services) AND
 - Five (5) years of documented full-time experience providing specialized case management within target population.

F. Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

- Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

H. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental Illness

I. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

J. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

K. Limitations:

1. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
2. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
3. FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))
4. The individuals in the target groups may not be receiving case management services under an approved waiver program.

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

PACE SERVICES

The State of Kentucky has not entered into any valid program agreements with a PACE provider and the Secretary of the Department of Health and Human Services.

The State of _____ has entered into a valid program agreement(s) with a PACE provider(s) and secretary, as follows:

Name of PACE provider: _____

Service area: _____

Maximum number of individuals to be enrolled: _____

This information should be provided for all PACE providers with which the State Administering Agency for PACE and the Secretary have entered into valid program agreements.)

AMOUNT DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

The following ambulatory services are provided:

Physician's Services
Rural Health Clinic
Outpatient Hospital
Laboratory and X-Ray
EPSDT
Physical Therapy
Dental
Hearing
Vision
Home Health
Clinic
Emergency Hospital
Transportation
Nurse-midwife Services
Hospice Care
Case Management
Federally Qualified Health Center Services
Chiropractic Services

*Description provided on attachment.

TN No.: 03-017
Supersedes
TN No: 90-11

Approval Date: 2/20/2004

Effective Date: 10/16/2003

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP (5): ALL

1. Inpatient hospital services other than those provided in an institution for mental diseases.
- Provided: No limitations With limitations*
- 2.a. Outpatient hospital services.
- Provided: No limitations With limitations*
- b. Rural health clinic services and other ambulatory services furnished by a rural clinic (which are otherwise covered under the plan).
- Provided: No limitations With limitations*
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
- Provided: No limitations With limitations*
3. Other laboratory and x-ray services.
- Provided: No limitations With limitations*
- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- Provided: No limitations With limitations*
- b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.
- Provided:
- c. Family planning services and supplies for individuals of childbearing age.
- Provided: No limitations With limitations*
- d 1) Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women
- Provided: No limitations With limitations*

* Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: No limitations With limitations:

*Description provided on attachment.

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

Commonwealth Global Choices

6. Medical care and any other type of remedial care recognized under State Law, furnished by licensed practitioners within the scope of their practice as defined by State Law.
- a. Podiatrists services.
- Provided: No limitations With Limitations* Not provided
- b. Optometrists' services.
- Provided: No limitations With Limitations* Not provided
- c. Chiropractics' services.
- Provided: No limitations With Limitations* Not provided
- d. Other Practitioners' Services
- Provided: No limitations With Limitations* Not provided
7. Home Health Services
- a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in area.
- Provided: No limitations With Limitations* Not provided
- b. Home health aide services provided by a home health agency.
- Provided: No limitations With Limitations* Not provided
- c. Medical supplies suitable for use in the home.
- Provided: No limitations With Limitations* Not provided
- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
- Provided: No limitations With Limitations* Not provided

*Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

-
8. Private duty nursing services.
- Provided: No limitations With limitations*
9. Clinic services.
- Provided: No limitations With limitations*
10. Dental services.
- Provided: No limitations With limitations*
11. Physical therapy and related services.
- a. Physical therapy.
- Provided: No limitations With limitations*
- b. Occupational therapy.
- Provided: No limitations With limitations*
- c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.
- Provided: No limitations With limitations*
12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
- a. Prescribed drugs.
- Provided: No limitations With limitations*
- b. Dentures.
- Provided: No limitations With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED MEDICALLY NEEDY GROUP(S): ALL

- c. Prosthetic devices.
 Provided: No limitations With limitations*
- d. Eyeglasses.
 Provided: No limitations With limitations*
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.
- a. Diagnostic services.
 Provided: No limitations With limitations*
- b. Screening services.
 Provided: No limitations With limitations*
- c. Preventive services.
 Provided: No limitations With limitations*
- d. Rehabilitative services.
 Provided: No limitations With limitations*
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services.
 Provided: No limitations With limitations*
- b. Nursing facility services.
 Provided: No limitations With limitations*

*Description of limitations provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S)

- c. Intermediate Care Facility Services.
- Provided: No limitations With limitations*
15. a. Services in an Intermediate Care Facility for the Mentally Retarded (other than such services in an institution for mental disease) for persons determined in accordance with Section 1902(a)(31)(A) of the Act, to be in need of such care.
- Provided: No limitations With limitations*
16. Inpatient psychiatric facility services for individuals under 22 years of age.
- Provided: No limitations With limitations*
17. Nurse-midwife Services
- Provided: No limitations With limitations*
18. Hospice care (in accordance with section 1905(o) of the Act).
- Provided: No limitations Provided in accordance with Section 2302 of the Affordable Care Act
- With limitations*

*Description provided on attachment

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

-
19. Case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A (in accordance with Section 1905(a)(19) or section 1915(g) of the Act).
- Provided: With limitations Not provided
20. Extended services for pregnant women.
- a. Pregnancy-related and postpartum services for a 60-day period after pregnancy ends and for any remaining days in the month in which the 60th day falls.
- Provided+: Additional coverage ++
- b. Services for any other medical conditions that may complicate pregnancy.
- Provided+: Additional coverage ++ Not Provided
21. Certified pediatric or family nurse practitioners' services
- Provided: No Limitations With limitations
P&I HCFA 11-14-94 (handwritten)
See item 6d for limitations
- + Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.
- ++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/ Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP (S): ALL

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).
- Provided: No limitations With limitations* Not provided.
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary
- a. Transportation.
- Provided: No limitations With limitations* Not provided.
- b. Services provided in Religious Nonmedical Health Care Institutions.
- Provided: No limitations With limitations* Not provided
- c. Reserved
- d. Nursing facility services for individuals under 21 years of age.
- Provided: No limitations With limitations* Not provided
- e. Emergency hospital services.
- Provided: No limitations With limitations* Not provided.
- f. Personal care services in a recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
- Provided: No limitations With limitations* Not provided.

* Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

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

23. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

- a 1. Transportation
 No limitations
 With limitations

Transportation is limited to individuals requesting transportation who lack access to free transportation that meets their medical needs. Transportation is only authorized for a Medicaid-covered service that has been determined medically necessary.

- a 2. Brokered Transportation
 Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

- (1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);
 (1) statewideness (indicate areas of State that are covered)
 (10)(B) comparability (indicate participating beneficiary groups)
 (23) freedom of choice (indicate mandatory population groups)

All Medicaid recipients covered under Kentucky's State Plan, excluding Qualified Medicare Beneficiaries, are eligible for the non-emergency medical transportation benefit. Recipients are restricted to using the regional broker and the provider assigned by the broker for the recipient's trip.

- (2) Transportation services provided will include:
 wheelchair van
 taxi

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

-
- stretcher car
 - bus passes
 - tickets
 - secured transportation
 - such other transportation as the Secretary determines appropriate (please describe): Private automobiles, non-profit transit system, specialty carriers for non-emergency ambulatory disoriented persons, and specialty carriers using lift equipped vehicles in compliance with the Americans with Disabilities Act certified to transport non-emergency, non-ambulatory persons.

Private auto providers enroll via the same enrollment and credentialing process as other Medicaid providers and submit additional enrollment documents specific to the transportation program including vehicle registration, vehicle insurance coverage and a valid driver's license. This category of provider is defined in Kentucky Revised Statute 281.873. Private auto providers are reimbursed the Kentucky State Employee mileage rate in effect for the given time period.

- (3) The State assures that transportation services will be provided under a contract with a broker who:
 - (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
 - (ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;
 - (iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;
 - (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);
- (4) The broker contract will provide transportation to the following medically needy populations under section 1905(a)(i) – (xiii):
 - Under age 21, or under age 21, 19, or 18 as the State may choose
 - Relatives specified in section 406(b)(1) with whom a child is living if child is a dependent child under part A of title IV
 - Aged (65 years of age or older)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

-
- Blind with respect to States eligible to participate, under title XVI
 - Permanently or totally disabled individuals 18 or older, under title XVI
 - Persons essential to recipients under title I, X, XIV, or XVI
 - Blind or disabled as defined in section 1614 with respect to States not eligible to participate in the State plan program under title XVI
 - Pregnant women
 - Individuals provided extended benefits under section 1925
 - Individuals described in section 1902(u)(1)
 - Employed individuals with a medically improved disability (as defined in section V)
 - Individuals described in section 1902(aa)
 - Individuals screened for breast or cervical cancer by CDC program
 - Individuals receiving COBRA continuation benefits.

(5) The State will pay the contracted broker by the following method:

- (i) risk capitation
- (ii) non-risk capitation
- (iii) other (e.g., brokerage fee and direct payment to providers)

Under a brokerage system, Kentucky is divided into fifteen (15) Non-Emergency Medical Transportation Regions which were established based upon regional medical utilization and referral patterns. The broker contract for each region is bid separately; however, a broker may be a successful bidder for more than one region. Each region has a single per member per month (PMPM) capitation rate which is paid to the regional broker for all transportation eligible recipients in that region. A single payment for each broker is made each month on a prospective basis. In the event one broker gains the contract in multiple regions, a blended PMPM rate is paid for all regions served by that broker.

The PMPM rate for each region is established based on historical utilization and cost patterns for the region. The PMPM rate for each region may be updated annually effective July 1st of each year if encounter data trends indicate that a region has experienced an increase in transportation utilization and/or cost which was outside of the control of the broker. PMPM rates may also be adjusted on an as needed basis if programmatic changes (i.e. State Plan or waiver changes) would result in a change in transportation utilization or if transportation cost factors (i.e. gas prices) result in a change in the projected cost of transportation.

Revision: CMS
3/17/2006

ATTACHMENT 3.1-B
Page 8d
OMB No.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

If for any reason, a broker's contract is terminated before a replacement broker can be procured, non-emergency transportation reimbursement will revert to the methods applicable to non-emergency transportation described in Attachment 4.19-B, Section VII of the State Plan.

TN No.: 06-008
Supersedes
TN No.: New

Approval Date: 05/03/06

Effective Date: 06/01/06

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Provided Not Provided

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY
NEEDY GROUP(S):

25. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).
- Provided No limitations With limitations Not provided
26. Program of All-inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.
- Provided Not provided
28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers
- Provided No limitations With limitations
- None licensed or approved
28. (ii) Licensed or Otherwise State-recognized covered professionals providing services in the Freestanding Birth Center.
- Provided No limitations With limitations
- Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

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

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

Provided No limitations With Limitations* Not Provided

*Description provided on attachment.

TN No. 03-06
Supersedes
TN No. None

Approval Date: 10/31/2003

Effective Date: 01-01-03

TELEHEALTH

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

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

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

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

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

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

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

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

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

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

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

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

NON-COVERED SERVICES: If a service is not covered in a face-to-face setting, it is also not covered if provided through telehealth. A service provided through telehealth is subject to the same program restrictions, limitations and coverage which exist for the service when not provided through telehealth.

TELEHEALTH AUTHORIZED PRACTITIONERS OR THOSE FUNCTIONING AS AGENTS OF AN AUTHORIZED PROVIDER FOR SERVICES NOT PROVIDED IN A COMMUNITY MENTAL HEALTH CENTER:

1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician*;
7. An ARNP*;
8. Speech-language pathologist*;
9. Occupational therapist*;

TN No.: 09-008

Approval Date: 03-09-11

Effective Date: 10/01/2009

Supersedes

TN No.: None

10. Physical therapist*;
11. Licensed dietitian or certified nutritionist*; or
12. Registered nurse or dietician*

*Certain restrictions apply for these providers and are outlined in the Kentucky Administrative Regulation, which can be found at: <http://www.lrc.ky.gov/kar/907/003/170.htm>

TELEHEALTH AUTHORIZED PRACTITIONERS OR THOSE FUNCTIONING AS AGENTS OF AN AUTHORIZED PROVIDER FOR SERVICES PROVIDED IN A COMMUNITY MENTAL HEALTH CENTER:

1. A psychiatrist;
2. A physician;
3. Psychologist with a license in accordance with KRS 319.010(5);
4. A licensed marriage and family therapist;
5. A licensed professional clinical counselor;
6. A psychiatric medical resident;
7. A psychiatric registered nurse;
8. A licensed clinical social worker;
9. An advanced registered nurse practitioner;

1. Inpatient Hospital Services

- a. Payment is made for inpatient hospital care as medically necessary. Each admission must have prior approval of appropriateness by the designated peer review organization in order for the admission to be covered under the Medicaid program, this requirement does not apply to emergency admissions. Weekend stays associated with a Friday or Saturday admission will not be reimbursed unless an emergency exists. Covered admissions are limited to those admissions primarily indicated in the management of acute or chronic illness, injury, or impairment, or for maternity care that could not be rendered on an outpatient basis. Admissions relating to only observation or only diagnostic purposes or for elective cosmetic surgery shall not be covered. Laboratory tests not specifically ordered by a Physician and not done on a preadmission basis where feasible will not be covered unless an emergency exists which precludes such preadmission testing
- b. A recipient may transfer from one hospital to another hospital when such transfer is necessary for the patient to receive medical care which is not available in the first hospital. In such situations, the admission resulting from the transfer is an allowable admission.

-
- c. The following listed surgical procedures are not covered on an inpatient basis, except when a life threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a hospital:
- (a) Biopsy: breast, cervical node, cervix, lesions (skin, subcutaneous, submucous), lymph node (except high axillary excision, etc.), and muscle.
 - (b) Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts/condylomas, anterior nose bleeds, and cervix.
 - (c) Circumcision.
 - (d) Dilation: dilation and curettage (diagnostic and or therapeutic non—obstetrical); dilation/probing of lacrimal duct.
 - (e) Drainage by incision or aspiration: cutaneous, subcutaneous, and joint.
 - (f) Exam under anesthesia (pelvic).
 - (g) Excision: bartholing cyst, cyndylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, and subcutaneous fistulas.
 - (h) Extraction: foreign body, and teeth (per existing policy).
 - (i) Graft, skin (pinch, splint of full thickness up to defect size 3/4 inch diameter).
 - (j) Hymenotomy.
 - (k) Manipulation and/or reduction with or without x—ray; cast change: dislocations depending upon the joint and indication for procedure, and fractures.
 - (l) Meatotomy/urethral dilation, removal calculus and drainage of bladder without incision.
 - (m) Myringotomy with or without tubes, otoplasty.
 - (n) Oscopy with or without biopsy (with or without salpinqogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, qastroscopy, hysteroscopy, laryngoscopy, peritoneoscopy, otoscopy, and sigmoidoscopy or procto sidmoidoscopy.
 - (o) Removal: IUD, and fingernail or toenails.
 - (p) Tenotomy hand or foot.
 - (q) Vasectomy.
 - (r) Z-plasty for relaxation of scar/contracture.

-
- d. Abortion services are reimbursable under the Medical Assistance Program only when the woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.

2 a. Outpatient Hospital Services

Outpatient Hospital Services are provided in accordance with 42 CFR 440.20. Hospital outpatient services are limited to therapeutic and diagnostic service as ordered by a physician or if applicable, a dentist; to emergency room services in emergency situations; and to drugs, biologicals, or injections administered in the outpatient hospital setting (excluding "take home" drugs and those drugs deemed less-than-effective by the Food and Drug Administration)

Abortion services are reimbursable under the Medical Assistance Program only when the woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.

2 b. Rural Health Clinic Services

1) Covered Services

Other ambulatory services furnished by a rural health clinic shall have the same limitations when provided by the rural health clinic as when provided by the usual ambulatory care provider as specified in the relevant subsections of Attachment 3.1-A pertaining to those ambulatory services.

With regard to services provided on or after October 1, 1988, rural health clinics will be allowed to secure drugs for specified immunizations from the Department for Public Health free to provide immunizations for Medicaid recipients. The specified immunizations are: diphtheria and tetanus toxoids and pertussis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any types(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

Rural Health Clinic (RHC) Services are authorized in Medicaid under section 1905(a)(2)(B) of the Social Security Act (the Act) and defined in section 1861(aa) of the Act. RHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nurses and other ambulatory services included in the state plan. RHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and, as applicable, for visiting nurse care, related medical supplies other than drugs and biologicals.

2) Limitations

- a) Other ambulatory services furnished in the FQHC have the same limitations as defined for those services in the state plan.
- b) One visit limit per day unless the beneficiary presents later in the day with a condition unrelated to the first visit.

3) Exclusions

The following services shall not be covered if provided by an RHC:

- a) Services provided in a hospital as defined in 42 U.S.C. 1395x(e);
- b) Institutional services;
- c) Housekeeping, babysitting, or other similar homemaker services;
- d) Services which are not provided in accordance with restrictions imposed by law or an administrative regulation

4) Assurances

Other state plan limitations on physician services, physician assistant services, nurse practitioner services, clinical psychologist services, and clinical social worker services do not apply to these providers in the RHC setting

TN# 90-11

2 c. Federal Qualified Health Center Services

1) Covered Services

Federally qualified health center (FQHC) services are limited to FQHC services as defined in the Social Security Act including ambulatory services offered by a FQHC and which are included in the state plan.

Federally Qualified Health Center (FQHC) Services are authorized in Medicaid under section 1905(a)(2)(C) of the Act of the Social Security Act (the Act) and defined in section 1861(aa). FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nurses and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and, as applicable, for visiting nurse care, related medical supplies other than drugs and biologicals.

2) Limitations

- a) Other ambulatory services furnished in the FQHC have the same limitations as defined for those services in the state plan.
- b) One visit limit per day unless the beneficiary presents later in the day with a condition unrelated to the first visit.

3) Exclusions

The following services shall not be covered if provided by an FQHC, or FQHC look-alike:

- a) Services provided in a hospital as defined in 42 U.S.C. 1395x(e);
- b) Institutional services;
- c) Housekeeping, babysitting, or other similar homemaker services;
- d) Services which are not provided in accordance with restrictions imposed by law or a administrative regulation

4) Assurances

Other state plan limitations on physician services, physician assistant services, nurse practitioner services, clinical psychologist services, and clinical social worker services do not apply to these providers in the FQHC setting

3. Other Lab and X-Ray Services**A. Coverage.**

- (1) The department shall reimburse for a procedure provided by an independent laboratory if the procedure:
 - (a) Is one that the laboratory is certified to provide by Medicare and in accordance with state regulation.
 - (b) Is a covered service within the CPT code range of 80047 – 89356 except as indicated in Section B.
 - (c) Is prescribed in writing or by electronic request by a physician, podiatrist, dentist, oral surgeon, advanced registered nurse practitioner, or optometrist; and
 - (d) Is supervised by a laboratory director; and
 - (e) Is independent of an institutional setting.
- (2) The department shall reimburse for a radiological service if the service:
 - (a) Is provided by a facility that:
 - 1) Is licensed to provide radiological services;
 - 2) Meets the requirements established in 42 CFR 440.30;
 - 3) Is certified by Medicare to provide the given service;
 - 4) Meets the requirements established in 42 CFR 493 regarding laboratory certification, registration, or other accreditation as appropriate; and
 - (b) Is prescribed in writing or by electronic request by a physician, oral surgeon, dentist, podiatrist, optometrist, advanced registered nurse practitioner, or a physician's assistant;
 - (c) Is provided under the direction or supervision of a licensed physician; and
 - (d) Is a covered service within the CPT code range of 70010 – 78999.

B. Exclusions. The department shall not reimburse for an independent laboratory or radiological service for the following services or procedures:

- (1) A procedure or service with a CPT code of 88300 through 88399;
- (2) A procedure or service with a CPT code of 89250 through 89356;
- (3) A service provided to a resident of a nursing facility or an intermediate care facility for individuals with mental retardation or a developmental disability; or
- (4) A court-ordered laboratory or toxicology test. The court-ordered exclusion does not apply when medically necessary and in the scope of the Medicaid program.

C. Provider Participation Conditions.

-
- (1) To be reimbursed by the department for a service provided in accordance with this administrative regulation, a provider of independent laboratory services or radiological services shall:
- (a) Be a Medicaid-enrolled provider;
 - (b) Be a Medicare participating facility;
 - (c) Comply with state regulations on Non-duplication of Payments and Claims processing;
 - (d) Comply with the requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d-8 and 45 C.F.R. parts 160 and 164; and
 - (e) Annually submit documentation of:
 - 1) Current CLIA certification to the department if the provider is an independent laboratory; and
 - 2) A current radiological license to the department if the provider provides radiological services.
- (2) A provider may bill a recipient for a service not covered by the department if the provider informed the recipient of noncoverage prior to providing the service.

4. b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions FoundB. Dental Services

Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity of the EPSDT services on a case by case basis through prior authorization.

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(1) Out of Hospital Dental Services

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(4) In Hospital Dental Services

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(5) Oral Surgery Dental Services

A listing of oral surgery dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

Commonwealth Global Choices

B. Hearing Services

Audiological Benefits

- (a) Coverage is available only for recipients under age 21 and is limited to the following services provided by certified audiologists:
- i. Complete hearing evaluation one time per year;
 - ii. Hearing aid evaluation one time per year;
 - iii. A maximum of three follow-up visits within the six month period immediately following fitting of a hearing aid such visits to be related to the proper fit and adjustment of that hearing aid; and
 - iv. One follow-up visit six months following fitting of a hearing aid, to assure a patient's successful use of the aid.

Services not listed above will be provided when medically necessary upon appropriate pre-authorization.

Commonwealth Global Choices

(b) Exception to the above limitations may be made through preauthorization if need is indicated in the individual case.

(2) Hearing Aid Benefits

(a) Coverage is provided only for recipients under age 21 on a pre-authorized basis for any hearing aid model recommended by a certified audiologist so long as that model is available through a participating hearing aid dealer.

(b) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

C. Vision Care Services

(1) Optometrists' services are provided to children under 21 years of age. Coverage includes writing of prescriptions, services to frames and lenses, and diagnostic services provided by ophthalmologists and optometrists, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program.

(2) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

4.b EPSDT Services (continued)

- D. Discretionary Services under EPSDT. For neonatal care related to any of the following diagnoses, an infant (i.e., child not more than twelve (12) months of age) EPSDT eligible recipient may transfer from a hospital with a level III neonatal unit to a different hospital with a level II or level I neonatal unit with the transfer considered a new admission. A "level III neonatal unit" means a unit able to provide the full range of resources and expertise required for the management of any complication of the newborn; a nurse/patient ratio of 1:2 is required. A "level II neonatal unit" means a unit able to provide care to the moderately ill infant who requires various support services; a nurse/patient ratio of 1:4 is required. A "level I neonatal unit" means a unit providing care to infants with uncomplicated conditions; normal nursery staffing is required

Neonatal Related Diagnoses

- (1) Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy.
- (2) Fetus or newborn affected by maternal complications of pregnancy.
- (3) Fetus or newborn affected by complications of placenta, cord, and membranes.
- (4) Fetus or newborn affected by other complications of labor and delivery.
- (5) Slow fetal growth and fetal malnutrition.
- (6) Disorders relating to short gestation and unspecified low birth weight.
- (7) Disorders relating to long gestation and high birth weight.
- (8) Birth Trauma
- (9) Intrauterine hypoxia and birth asphyxia.
- (10) Respiratory distress syndrome.
- (11) Other respiratory conditions of fetus and newborn.
- (12) Infections specific to the perinatal period.
- (13) Fetal and neonatal hemorrhage.
- (14) Hemolytic disease of fetus or newborn, due to isoimmunization.
- (15) Other perinatal jaundice.
- (16) Endocrine and metabolic disturbances specific to the fetus and newborn.
- (17) Hematological disorders of fetus and newborn.
- (18) Perinatal disorders of digestive system.
- (19) Conditions involving the integument and temperature regulation of fetus and newborn
- (20) Congenital anomalies and related surgical procedures.
- (21) Other and ill-defined conditions originating in the perinatal period.

4.b. Early and periodic screening and diagnosis of individuals under 21 years of age and treatment of conditions found.

E. Medicaid Services Provided in Schools

Individuals receiving Medicaid Services in schools have freedom of choice of qualified licensed providers as established in 1902(a)(23) of the Act.

(a) Audiology

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services:

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Auditory sensitivity, including pure tone air and bone conduction, speech detection, and speech reception thresholds, auditory discrimination in quiet and noise, impedance audiometry including tympanometry and acoustic reflex, hearing aid evaluation, central auditory function and auditory brainstem evoked response

Treatment services:

Service may include one or more of the following as appropriate:

Auditory training, speech reading and augmentative communication

Qualifications of Providers: Providers must meet the applicable requirements of 42 CFR 440.110. A provider shall have a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists.

(b) Occupational Therapy

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Activities of daily living assessment, sensorimotor assessment, neuromuscular assessment, fine motor assessment, feeding/oral motor assessment, visual perceptual assessment, perceptual motor development assessment, musculo-skeletal assessment, gross motor assessment, and functional mobility assessment.

Treatment services

Service may include one or more of the following as appropriate:

Activities of daily living training, sensory integration, neuromuscular development, muscle strengthening, and endurance training, feeding/oral motor training, adaptive equipment application, visual perceptual training, facilitation of gross motor skills, facilitation of fine motor skills, fabrication and application of splinting and orthotic devices, manual therapy techniques, sensorimotor training, functional mobility training, perceptual motor training.

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Occupational therapy assessment services must be provided by a licensed occupational therapist. Occupational therapy treatment services must be provided by a licensed occupational or a licensed occupational therapist assistant under the supervision of a licensed occupational therapist.

(c) Physical Therapy Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Neuromotor assessment, range of motion, joint integrity and functional mobility, flexibility assessment, gait, balance, and coordination assessment, posture and body mechanics assessment, soft tissue assessment, pain assessment, cranial nerve assessment, clinical electromyographic assessment, nerve conduction, latency and velocity assessment, manual muscle test, activities of daily living assessment, cardiac assessment, pulmonary assessment, sensory motor assessment and feeding/oral motor assessment

Treatment services

Service may include one or more of the following as appropriate:

Manual therapy techniques, fabrication and application of orthotic devices, therapeutic exercise, functional training, facilitation of motor milestones, sensory motor training, cardiac training, pulmonary enhancement, adaptive equipment application, feeding/oral motor training, activities of daily living training, gait training, posture and body mechanics training, muscle strengthening, gross motor development, modalities, therapeutic procedures, hydrotherapy, manual manipulation

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Physical therapy assessment services must be provided by a licensed physical therapist. Physical therapy treatment services must be provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.

(d) Behavioral Health Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Cognitive, emotional/personality, adaptive behavior, behavior and perceptual or visual motor

Treatment services

Service may include one or more of the following as appropriate:

Cognitive-behavioral therapy, rational-emotive therapy, family therapy, individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non verbal communication and sensory integrative therapy

Qualifications of Providers:

Minimum qualifications for providing services are licensure as follows:

1. An individual currently licensed by the Kentucky Board of Examiners of Psychology as a licensed psychologist, licensed psychological practitioner, certified psychologist with autonomous functioning, certified psychologist, or licensed psychological associate;
2. A licensed clinical social worker currently licensed by the Kentucky Board of Social Work;
3. A licensed social worker currently licensed by the Kentucky Board of Social Work;
4. A certified social worker currently licensed by the Kentucky Board of Social Work;
5. An advanced registered nurse practitioner who has a specialty area in accordance with the American Nurses' Association Statement on Psychiatric Mental Health Clinical Nursing Practice and Standards of Psychiatric Mental Health Clinical Nursing Practice.

(e) Speech

Services must be medically necessary and appear in the child's Individualized Education Plan.

Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for all the following areas of functioning and shall yield a written report:

Receptive and expressive language, auditory memory, discrimination, and processing, vocal quality and resonance patterns, phonological development, pragmatic language, rhythm/fluency, oral mechanism, swallowing assessment, augmentative communication and hearing status based on pass/fail criteria

Treatment services

Service includes one or more of the following as appropriate:

Articulation therapy, language therapy; receptive and expressive language, augmentative communication training, auditory processing, discrimination, and training, fluency training, disorders of speech flow, voice therapy, oral motor training; swallowing therapy and speech reading.

Qualifications of Providers: Treatment services may be performed by a Speech/Language Pathologist with the following qualifications:

1. Current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA);
2. Current license as Speech Language Pathologist from KY Board of Speech Language Pathology and Audiology;

As of August 1, 2011, Speech Therapy services will only be performed by individuals meeting applicable requirements of 42 CFR 440.110, including the possession of a Speech/Language Pathologist with a current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA).

(f) Nursing Services:

Services must be medically necessary. The services may be provided in accordance with an Individualized Education Program or an Individual Family Service Plan. Nursing services must be those services that are in a written plan of care based on a physician, physician assistant or nurse practitioner's written order. The plan of care must be developed by a licensed registered nurse. Services include but are not limited to: assessments including referrals based on results, bladder catheterizations, suctioning, medication administration and management including observation for adverse reactions, response or lack of response to medication, informing the student about their medications, oxygen administration via tracheostomy and ventilator care, enteral feedings, emergency interventions, individual health counseling and instructions, and other treatments ordered by the physician and outlined in the plan of care.

Qualifications of Providers:

The Licensed Practical Nurse and Registered Nurse shall be licensed by the State of Kentucky to provide the services and practice within the Kentucky Nursing Practice Act. Nursing services can be provided under 42 CFR 440.60 and on a restorative basis under 42 CFR 440.130 (d) including services delegated in accordance with the Nurse Practice Act and the Kentucky School Health Program Manual to individuals trained to perform delegated acts by a Registered Nurse.

Services provided by a health aide may only be provided under the following conditions:

1. Is under the supervision of an advanced registered nurse practitioner or a registered nurse;
2. Has been trained by an advanced registered nurse practitioner or registered nurse for the specific nursing service provided to a specific recipient; or
3. An advanced registered nurse practitioner or registered nurse has verified in writing that the aide has appropriate training and skills to perform the specific service in a safe, effective manner.

(g) Respiratory Therapy Services:

1. Respiratory therapy are the procedures employed in the therapy, management, rehabilitation, gathering of assessment information, or other procedures administered to patients with deficiencies or abnormalities which affect their cardiopulmonary system and associated aspects of cardiopulmonary and other systems functions.

Respiratory therapy services are provided by a practitioner certified by the Kentucky Board of Respiratory Care.

- (h) Specialized Transportation Services: Specialized transportation services include transportation to receive Medicaid approved school health services. This service is limited to transportation of covered, prior authorized services.
- 1) The special transportation is Medicaid reimbursable if:
 - (a) It is provided to a Medicaid eligible EPSDT child who is a student in a public school in Kentucky.
 - (b) It is being provided on a day when the child receives a prior authorized covered service;
 - (c) The student's need for specialized transportation service is documented in the child's plan of care; and
 - (d) The driver has a valid driver's license.
 - 2) Specialized transportation services are defined as transportation that requires a specially equipped vehicle, or the use of specialized equipment to ensure a child is taken to and from the child's residence to school or to a community provider's office for prior authorized health related services.
 - (a) Transportation provided by or under contract with the school, to and from the student's place of residence, to the school where the student receives one of the health related services covered by Title XIX;
 - (b) Transportation provided by or under contract with the school, to and from the student's place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX; or
 - (c) Transportation provided by or under contract with the school from the student's place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX and returns to school.
 - 3) Specialized transportation services will not be Medicaid reimbursable if the child does not receive a Medicaid covered service on the same day. When claiming these costs as direct services, each school district is responsible for maintaining written documentation, such as a trip log, for individual trips provided. No payment will be made to, or for parents providing transportation.

4.b. EPSDT Services (continued)

- E. The Medicaid program shall provide such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the state plan.

4.c. Family planning services and supplies for individuals of child-bearing age

Family planning services shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy. In-vitro fertilization, artificial insemination, sterilization reversals, sperm banking and related services, hysterectomies, and abortions shall not be considered family planning services.

4.d. Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women

Tobacco Cessation Counseling Services for Pregnant Women shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to quit tobacco. This shall include four (4) face-to-face counseling sessions per quit attempt, with a minimum of two (2) quit attempts per twelve (12) month period.

Face-to-face counseling services shall be provided:

- (i) By or under supervision of a physician;
- (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or
- (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations.

5. Physicians' Services

All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist.

- A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management home or custodial care services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

- B. Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per year, per physician. If this limit is exceeded, then DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.
- C. Outpatient psychiatric service procedures rendered by other than board-eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.
- D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

The professional component of laboratory procedures performed by board certified pathologists in a hospital setting or an outpatient surgical clinic are covered so long as the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

-
- E. The cost of preparations used in injections is not considered a covered benefit, except for the following:
- (1) The Rhogarn injection.
 - (2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
 - (3) Depo Provera provided in the physician office setting.
 - (4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).
 - (5) Long acting injectable risperidone.
 - (6) An injectable, infused or inhaled drug or biological that is:
 - a. Not typically self-administered;
 - b. Not listed as a noncovered immunization or vaccine; and
 - c. Requires special handling, storage, shipping, dosing or administration.
- F. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.
- G. Telephone contact between a physician and patient is not a covered service.
- H. Coverage of a physician service is contingent upon direct physician/patient interaction except in the following cases:
- (1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.
 - (2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

-
- J. Reimbursement for induced abortions is provided when the physician certifies that the pregnancy was a result of rape or incest or the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition cause or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
- K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.
- L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.
- M. Epidural or spinal injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.
- N. Anesthesia Service limits are soft limits which means the service can be covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.
- O. Coverage for an evaluation and assessment service, provided by a physician or physician assistant with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per calendar year.
1. The evaluation and assessment service shall be:
 - a. Performed face-to-face with the recipient;
 - b. Be performed over a period of at least ten (10) minutes.
 2. The evaluation and assessment service shall include:
 - a. Asking the recipient about tobacco use;
 - b. Advising the recipient to quit using tobacco;
 - c. Assessing the recipient's readiness to quit using tobacco products
 - d. Compiling a tobacco usage, medical, and psychosocial history of the recipient;
 - e. Incorporating a review of the recipient's coping skills and barriers to quitting; and
 - f. Providers obtaining of a signed and dated Tobacco Cessation Referral Form from the recipient declaring the recipient's intent to quit using tobacco.
- P. Allergy testing, shots and allergy treatment for all Medicaid recipients, when medically necessary.

6. Medical Care and Any Other Type of Remedial Care

- a. Podiatry services are provided to both the categorically needy and medically needy in accordance with the following limitations.

- (1) Coverage. The Medical Assistance (Medicaid) Program will cover medical and/or surgical services provided to eligible Medicaid recipients by licensed, participating podiatrists when such services fall within the scope of the practice of podiatry except as otherwise provided for herein. The scope of coverage generally parallels the coverage available under the Medicare program with the addition of wart removal.
- (2) Exclusions from Coverage; Exceptions. The following areas of care are not covered except as specified.

Treatment of flatfoot: services directed toward the care or correction of such a service are not covered.

Treatment of subluxations of the foot: surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure as an isolated entity within the foot are not covered; this exclusion of coverage does not apply to reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunions), tendonitis, etc., that result from or are associated with partial displacement of foot structures, or to surgical correction that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition.

Orthopedic shoes and other supportive devices for the feet are not covered under this program element.

Routine foot care: services characterized as routine foot care are generally not covered; this includes such services as the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot. Notwithstanding the preceding, payment may be made for routine foot care such as

TN # 90-25
Supersedes
TN # 84-10

Approval
Date: 10/17/1990

Effective
Date: 7/1/1990

cutting or removing corns, calluses or nails when the patient has a systemic disease of sufficient severity that unskilled performance of such procedures would be hazardous; the patient's condition must have been the result of severe circulatory embarrassment or because of areas of desensitization in the legs or feet. Although not intended as a comprehensive list, the following metabolic, neurological, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying systemic conditions contemplated and which would justify coverage; where the patient's condition is one (1) of those designated by an asterisk (*), routine procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy for such a condition, and this doctor's name must appear on the claim form:

- *Diabetes mellitus;
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis);
- Buerger's disease (thromboangitis obliterans);
- Chronic thrombophlebitis;
- Peripheral neuropathies involving the feet:
 1. *Associated with malnutrition and vitamin deficiency, such as: malnutrition (general, pellagra); alcoholism; malabsorption (celiac disease, tropical sprue); and pernicious anemia;
 2. *Associated with carcinoma;
 3. *Associated with diabetes mellitus;
 4. *Associated with drugs and toxins;
 5. *Associated with multiple sclerosis;
 6. *Associated with uremia (chronic renal disease);
 7. Associated with traumatic injury;
 8. Associated with leprosy or neurosyphilis; and
 9. Associated with hereditary disorders, such as: hereditary sensory radicular neuropathy, angiokeratoma corporis; and diffusum (Fabry's), amyloid neuropathy.

Services ordinarily considered routine are also covered if they are performed as a necessary and integral part of otherwise covered services, such as the diagnosis and treatment of diabetic ulcers, wounds, and infections. Diagnostic and treatment services for foot infections are also covered as they are considered outside the scope of "routine."

- (3) Provision relating to Special Diagnostic Tests. Plethysmography is a recognized tool for the preoperative podiatric evaluation of the diabetic patient or one who has intermittent claudication or other signs or symptoms indicative of peripheral vascular disease which would have a bearing on the patient's candidacy for foot surgery. The method of plethysmography determines program coverage.

Covered methods include:

- Segmental, including regional, differential, recording oscillometer, and pulse volume recorder;
- Electrical impedance; and
- Ultrasonic measure of blood flow (Doppler).

Noncovered methods include:

- Inductance;
- Capacitance;
- Strain gauge;
- Photoelectric; and
- Mechanical oscillometry.

Venous occlusive pneumoplethysmography would be appropriate only in the setting of a hospital vascular laboratory.

(6) Medical care and Any Other Type of Remedial Care

B. Optometry services are only provided to recipients under age twenty-one (21).

C. Chiropractic services are provided with the following limitations

- (1) Twenty-six (26) chiropractic visits per year for all recipients (this limit may be exceeded based on medical necessity with prior authorization).

6. Medical Care and Any Other Type of Remedial Care

d. Other practitioner's services

Advanced Practice Registered Nurse (APRN) Services

- (1) An APRN covered service shall be a medically necessary service provided within the legal scope of practice of the APRN and furnished through direct practitioner-patient interaction so long as that service is eligible for reimbursement by Kentucky Medicaid.
- (2) APRN's participating as nurse-midwives or nurse anesthetists shall comply with the service requirements of those components for participation and reimbursement, as appropriate.
- (3) An APRN desiring to participate in the Medical Assistance Program shall:
 - (a) Meet all applicable requirements of state laws and conditions for practice as a licensed APRN;
 - (b) Enter into a provider agreement with the Department for Medicaid Services to provide services;
 - (c) Accompany each participation application with a current copy of the APRN's license: and
 - (d) Provide and bill for services in accordance with the terms and conditions of the provider participation agreement.
- (4) Administration of anesthesia by an APRN is a covered service.
- (5) The cost of the following injectables administered by an APRN in a physician or other independent practitioner's office shall be covered:
 - (a) Rho (D) immune globulin injection;
 - (b) Injectable anticancer chemotherapy administered to a recipient with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare;
 - (c) Depo-Provera contraceptive injection;
 - (d) Penicillin G and ceftriaxone injectable antibiotics; and
 - (e) Epidural injections administered for pain control.
- (6) An outpatient laboratory procedure by an APRN who has been certified in accordance with 42 CFR, Part 493 shall be covered.

-
- (7) An obstetrical and gynecological service provided by an APRN shall be covered as follows:
- (a) An annual gynecological examination;
 - (b) An insertion of an intrauterine device (IUD), including the cost of the device, or removal of the IUD;
 - (c) The insertion of an implantable contraceptive capsule, including the cost of the contraceptive capsule and related supplies, or removal of the capsule;
 - (d) Prenatal care;
 - (e) A routine newborn service to an infant born to a Kentucky Medicaid eligible recipient; and
 - (f) A delivery service, which shall include:
 - 1. Admission to the hospital;
 - 2. Admission history;
 - 3. Physical examination,
 - 4. Anesthesia;
 - 5. Management of uncomplicated labor;
 - 6. Vaginal delivery; and
 - 7. Postpartum care.
- (8) An EPSDT screening service provided in compliance with a periodicity schedule developed in conjunction with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health shall be covered.
- (9) A limitation on a service provided by a physician as described in Attachment 3. I-B, pages 21, 22 and 22.1(a) shall also apply if the service is provided by an ARNP.
- (10) The same service provided by an APRN and a physician on the same day within a common practice shall be considered as one (1) covered service.
- (11) Coverage for an evaluation and assessment services with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per year.
- 1. The evaluation and assessment service shall be:
 - a. Performed face-to-face with the recipient;
 - b. Be performed over a period of at least thirty (30) minutes.
 - 2. The evaluation and assessment service shall include:
 - a. Asking the recipient about tobacco use;
 - b. Advising the recipient to quit using tobacco;
 - c. Assessing the recipient's readiness to quit using tobacco products
 - d. Compiling a tobacco usage, medical, and psychosocial history of the recipient;
 - e. Incorporating a review of the recipient's coping skills and barriers to quitting; and
 - f. Providers obtaining of a signed and dated Tobacco Cessation Referral Form from the recipient declaring the recipient's intent to quit using tobacco.

Commonwealth Global Choices

Other Licensed Practitioners' Services (continued)

- (d) Ophthalmic dispensers' services, limited to dispensing service or a repair service (for eyeglasses provided to eligible recipients), are covered. The following limitations are also applicable:
 - (1) Telephone contacts are not covered;
 - (2) Contact lens are not covered;
 - (3) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

- (e) Pharmacist - Administration of the H1N1 vaccine by a pharmacist who is employed by a pharmacy participating in the Kentucky Medicaid Program.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO THE MEDICALLY NEEDY

7. Home Health Services

Home health services must be provided by a home health agency that is Medicare and Medicaid certified. The service must be medically necessary, ordered by a physician, prior authorized, provided in accordance with approved plan of care and provided in the individual's residence. A hospital, nursing facility or intermediate care facility for mentally retarded shall not be considered as an individual's place of residence. Prior authorization must be conducted by the Department and is based on medical necessity; physician's orders; the recipient's needs, diagnosis, condition; the plan of care; and cost- effectiveness when compared with other care options.

7a. Intermittent or Part-time Nursing Service

Intermittent or part-time nursing services must be ordered by a physician, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

7b. Home Health Aide Services

Home health aide services must be ordered by a physician, prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence.

7c. Medical Supplies Suitable for Use in the Home

Each provider desiring to participate as a medical supplier provider must be a participating Medicare provider and sign a provider agreement with the Department for Medicaid Services.

1. Coverage of medical supplies for use by patients in the home, is based on medical necessity.
2. Coverage criteria established by the Medicare program will be used as a guide in determining medical necessity but will be subject to a medical necessity override.
3. The criteria used in the determination of medical necessity includes an assessment of whether the item is:
 - a. Provided in accordance with 42 CFR 440.230;
 - b. Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition;
 - c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;
 - d. Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver, or the provider;
 - e. Provided in the recipient's place of residence, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
4. Coverage of an item of medical supply shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; shall be appropriate for use in the home; and shall be medically necessary, and reasonable.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO THE MEDICALLY NEEDY

7. D. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Physical therapy, occupational therapy, speech pathology services, or speech/hearing/language therapy services provided by a home health agency must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of treatment, which shall be developed by the appropriate qualified therapist and physician.

Occupational therapy, physical therapy and speech pathology services and speech/hearing/language therapy are limited to twenty visits per calendar year. Rehabilitative and habilitative services have a combined twenty visit limit per type of therapy. Additional visits may be granted based on medical necessity.

Audiology services are not provided under this component. Physical therapy, occupational therapy, speech pathology, or speech/hearing/language therapy services provided by a medical rehabilitation facility are not provided under this component.

Qualification of Providers

Providers performing physical, occupational or speech therapy must meet requirements defined in 42 C.F.R. 484.4. A qualified physical therapist assistant, occupational therapist assistant or speech therapy assistant must be under the direct supervision of a qualified physical, occupational or speech therapist.

8. Private Duty Nursing Services

Medically necessary private duty nursing (PDN) services for up to two thousand (2,000) hours are provided under the direction of the recipient's physician in accordance with 42 CFR 440.80 and with prior approval by the Department for Medicaid Services, or its designee. These limits may be exceeded based on medical necessity with prior authorization.

Recipients in personal care homes are not eligible for this service. In addition, recipients in hospitals, nursing facilities, intermediate care facilities for the intellectually disabled, rehabilitation centers, and other institutional settings are not eligible for this service. PDN services are not covered while an individual is being observed or treated in a hospital emergency room or similar environment.

This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services.

Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services.

Medicaid Payments for PDN are made only to agencies enrolled with the Department for Medicaid Services as providers for the service. An enrolled provider must be a State licensed home health or private duty nursing agency within Kentucky that is approved in its license to provide nursing services within the State. PDN services shall be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the Kentucky Board of Nursing and employed by a licensed home care agency.

A member of the patient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) or a legally responsible person who maintains their primary residence with the recipient may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.

State: Kentucky

9. Clinic Services

Coverage for clinic services is limited to services provided by the following clinics and includes:

1. Mental health centers licensed in accordance with applicable state laws and regulations. However, services rendered by community mental health centers to skilled nursing or intermediate care facility patients/residents are not covered.
2. Family planning clinics.
3. Clinics engaging in screening for the purposes of the early and periodic screening, diagnosis, and treatment component of the Medicaid Program.
4. Outpatient surgical clinics.
5. Other clinics authorized under 42 CFR 440.90.

TN No. 01-05
Supersedes
TN No. None

Approval Date JUN 26 2001

Effective Date 1/1/2001

- 5 a. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of the physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with federal court order in the case of *Hope vs. Childers*. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

5 b. Specialized Children's Services Clinics

Specialized Children's Services Clinics provide a comprehensive interdisciplinary evaluation, assessment, and treatment of sexually and physically abused children under the age of 18. A team of professionals representing a variety of medical, social, and legal disciplines and advocates assesses the child and coordinates and/or provides needed services. Sexual abuse examinations are available to children from 18 to 20 years of age through Medicaid providers who deliver and bill for the separate components of the service (physical examination and mental health screening) through the physician and mental health components of the state plan.

Medicaid coverage of services provided by clinics is limited to a sexual abuse medical exam which includes the following components:

1. A physical exam provided by a licensed physician who has received specialized training in providing medical exams of sexually abused children and the use of a colposcope; and
2. A mental health screening provided by a mental health professional under the direct supervision of a physician. Mental health professionals shall include, but not be limited to the following: social workers, psychologists, art therapists, ARNPs and other qualified therapists who are required to have specialized training in the screening and assessment of sexually abused children. Under direct supervision means the physician shall assume professional responsibility for the service provided by the mental health professional.

Providers of clinic services are employed by, under contract, or have a signed affiliation agreement with the clinic.

Reimbursement methodology is described in Attachment 4.19-B, Section XXXII.

10. Dental Services

- A. A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.

- B. Out-of-Hospital Dental Services

A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.

- C. In-Hospital Care

A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.

- D. Oral Surgery

A listing of oral surgery dental services available to Medicaid recipients is maintained at the central office the single state agency.

11. Physical Therapy and Related Services – Other than Therapy Services Provided by Home Health Agencies for Rehabilitative and Habilitative Services

A. Outpatient Physical, Occupational and Speech Therapy

Physical therapy, occupational therapy, speech pathology services, or speech/hearing/language therapy services provided must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of treatment, which shall be developed by the appropriate qualified therapist and physician.

Audiology services are not provided under this component. Physical therapy, occupational therapy, speech pathology, or speech/hearing/language therapy services provided by a medical rehabilitation facility are not provided under this component.

Qualification of Providers

Providers performing physical, occupational or speech therapy must meet requirements defined in 42 C.F.R. 484.4. A qualified physical therapist assistant, occupation therapist assistant or speech therapy assistant must be under the direct supervision of a qualified physical, occupational or speech therapist.

B. Inpatient Physical, Occupational and Speech Therapy

Services shall be provided to inpatients of acute participating hospitals and skilled nursing facilities or to residents of intermediate care facilities for individuals with mental retardation or developmental disabilities under the following conditions:

Physical therapy, occupational therapy, speech pathology services, or speech/hearing/language therapy services provided must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of treatment, which shall be developed by the appropriate qualified therapist and physician.

Qualification of Providers

Providers performing physical, occupational or speech therapy must meet requirements defined in 42 C.F.R. 484.4. A qualified physical therapist assistant, occupation therapist assistant or speech therapy assistant must be under the direct supervision of a qualified physical, occupational or speech therapist.

11. Physical Therapy and Related Services – Other than Therapy Services Provided by Home Health Agencies for Rehabilitative and Habilitative Services

C. Limitations

There is a limit of twenty (20) visits per calendar year combined for inpatient and outpatient physical therapy.

There is a limit of twenty (20) visits per calendar year combined for inpatient and outpatient occupational therapy

There is a limit of twenty (20) visits per calendar year combined for inpatient and outpatient speech therapy.

If medical necessity requires additional visits, the provider must request additional visits via prior authorization guidelines in effect for recipient.

12. Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses

If medical necessity is established, limitations in this section do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

a. Prescribed Drugs

- (1) Coverage is provided for drugs included in the Medicaid drug lists that are prescribed for outpatient use by a physician, osteopath, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner. Drugs added to the Preferred Drug List (PDL) are based on recommendations submitted by the Pharmacy and Therapeutics Advisory Committee to the Commissioner of the Kentucky Department for Medicaid Services for approval. Drugs requiring prior authorization must follow the process listed below. Approval of prior authorization is based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature.
- (2) Kentucky will provide reimbursement for covered outpatient drugs when prescribed by an enrolled licensed provider within the scope of their license and practice as allowed by State law and in accordance with Section 1927 of the Social Security Act. This will apply to drugs of any manufacturer that has entered into a rebate agreement with the Centers for Medicare and Medicaid Services (CMS). All drugs covered by the National Drug Rebate Agreements remain available to Medicaid beneficiaries, although some may require prior authorization. The prior authorization process complies with the requirements of Section 1927 of the Social Security Act and provides for a 24-hour turnaround by either telephone or other telecommunications device from receipt of request and provides for a 72- hour supply of drugs in emergency circumstances. The preferred drug list meets the formulary requirements that are specified in Section 1 927(d)(4) of the Social Security Act.
- (3) The drugs or classes of drugs listed in 42 USC 1396r-8(d)(2) are excluded from coverage unless specifically placed, either individually or by drug class, on the Medicaid drug lists or prior authorized based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature. The following drugs are excluded from coverage through the Outpatient Pharmacy Program:
 - (a) A drug for which the FDA has issued a “less than effective (LTE)” rating or a drug “identical, related, or similar (IRS)” to an LTE drug;
 - (b) A drug that has reached the termination date established by the drug manufacturer;
 - (c) A drug for which the drug manufacturer has not entered into or has not complied with a rebate agreement in accordance with 42 USC 1396r-8(a) unless there has been a review and determination by the department that it shall be in the best interest of Medicaid recipients for the department to make payment for the non-rebated drug. Note: Because federal financial participation is not generally available for a non-rebated drug, state funds will be used to cover such drugs if necessary to protect the health of a Medicaid recipient and no other appropriate options exist;

- (d) A drug provided to a recipient in an institution in which drugs are considered a part of the reasonable allowable costs under the Kentucky Medicaid Program;
 - (e) A drug or its medical use in one (1) of the following categories unless the drug or its medical use is designated as covered in the drug list:
 - 1. A drug if used for anorexia, weight loss, or weight gain;
 - 2. A drug if used to promote fertility;
 - 3. A drug if used for cosmetic purposes or hair growth;
 - 4. A drug if used for the symptomatic relief of cough and colds;
 - 5. Vitamin or mineral products other than prenatal vitamins and fluoride preparations;
 - 6. An over-the-counter drug provided to a Medicaid nursing facility service recipient if included in the nursing facility's standard price;
 - 7. A drug which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; or
 - 8. A drug utilized for erectile dysfunction therapy unless the drug is used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the United States Food and Drug Administration;
 - (f) A drug dispensed as part of, or incident to and in the same setting as, an inpatient hospital service, an outpatient hospital service, or an ambulatory surgical center service. However, a legend drug may be provided through prior authorization to a recipient admitted to an inpatient facility that does not bill patients, Medicaid, or other third-party payers for health care services.
 - (g) A drug for which the department requires prior authorization if prior authorization has not been approved; and
- (4) Except for emergencies, a recipient "locked-in" to one pharmacy due to over-utilization may receive prescriptions:
- (a) Only from his/her designated lock-in pharmacy and prescribed by his/her lock-in provider; or
 - (b) For specified controlled substances prescribed by his/her designated controlled substance lock-in prescriber.
- (5) If authorized by the prescriber, a prescription for a controlled substance in Schedule III-V may be refilled up to five times within a six month period from the date the prescription was written or ordered; a non-controlled substance may be refilled up to 11 times within a 12 month period from the date the prescription was written or ordered. In addition, a prescription fill for a maintenance drug may be dispensed in a 92-day supply if a recipient has demonstrated stability on the maintenance drug. However, a 92-day supply of a maintenance drug shall not be dispensed if a prescribing provider specifies that the quantity should be less. Also, individuals receiving supports for community living services, long term care, and personal care shall not be subject to the 92-day supply requirement.

- (6) A refill of a prescription shall not be covered unless at least 90 percent of the prescription time period has elapsed. However, a refill may be covered before 90 percent of the prescription time period has elapsed if the prescribing provider or dispensing pharmacy submits a prior authorization request by phone, fax, or web submission. Medicaid recipients residing in a long-term care facility or personal care home will be exempt from the 90 percent requirement and remain at the current 80 percent.

- (7) Supplemental Rebate Program:

The state is in compliance with Section 1927 of the Social Security Act. The state has the following policies for the Supplemental Rebate Program for the Medicaid population:

- (a) CMS has authorized the Commonwealth of Kentucky to enter into the Michigan multi-state pooling agreement (MMSPA) also referred to as the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on January 6, 2005 have been authorized for pharmaceutical manufacturers' existing agreements through their current expiration dates. The updated NMPI SRA (submitted to CMS on December 10, 2013) has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.
- (b) CMS has authorized Kentucky's collection of supplemental rebates through the NMPI.
- (c) Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal Government on the same percentage basis as applied under the national drug rebate agreement.
- (d) All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provision of the national drug rebate agreement.
- (e) Any contracts not authorized by CMS will be submitted for CMS approval in the future.
- (f) As specified in Section 1927(b)(3)(D) of the Act, notwithstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the state for purposes other than rebate invoicing and verification.

Commonwealth Global Choices

b. Dentures

Dentures are not covered for adults. Dentures may be covered for children through the Early, Periodic, Screening, Diagnosis and Treatment Program (EPSDT).

c. Prosthetics

Prosthetic devices are covered under durable medical equipment in accordance with Attachment 3.1-A, page 13.

d. Eyeglasses The following limitations are applicable:

- 1) Eyeglasses are provided only to recipients under age twenty-one (21). Coverage for eyeglasses is limited to no more than \$200 per year per member.
- 2) Contact lenses are not covered.
- 3) Telephone contacts are not covered.
- 4) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the slate agency.
- 5) If medically necessary, prisms shall be added within the cost of the lenses.

If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

Diagnostic, screening, preventive, and rehabilitative services are covered when provided by qualified providers, licensed in accordance with applicable state laws and regulations. Reimbursement for services under this authority will not be made when delivered in a long-term care environment as such services are reimbursable as a routine cost to the institution.

13a. Diagnostic Services

Diagnostic Services are described under other sections of this State Plan.

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13b. Screening Services

Screening Services are described under other sections of this State Plan.

13. Other diagnostic, screening, preventive and, rehabilitative services, ie. other than those provided elsewhere in this plan.

13c. Preventive Services

- A. Eligible preventive services include all of the preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF), and all approved adult vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). Such services are provided in accordance with Section 4106 of the Affordable Care Act. The state has documentation available to support the claim of the enhanced FMAP for preventive services beginning January 1, 2014. The state assures that it has a method to ensure that, as changes are made to USPSTF or ACIP recommendations, the state will update their coverage and billing codes to comply with those revisions.

In conjunction with the above and in compliance with Section 2713 of the Public Health Service Act, eligible preventive services also include preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program project, and additional preventive services for women recommended by the Institute of Medicine.

No cost sharing shall be applied to preventive services.

This Page Intentionally Left Blank

TN # 14-001
Supersedes
TN # 13-018

Approval Date: 04-25-14

Effective Date: 01/01/2014

This Page Intentionally Left Blank

TN # 14-001
Supersedes
TN # 13-018

Approval Date: 04-25-14

Effective Date: 01/01/2014

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

Rehabilitative substance use and mental health services are medical or remedial services that have been recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice, under Kentucky State Law and consistent with federal regulations at 42 CFR 440.130(d).

Each medical professional is given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his medical care.

When the Department makes payment for a covered service and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full except any applicable co-payment; and no bill for the same service shall be sent to the recipient for any amount above the Medicaid allowed charges (with the exception of any applicable co-payments). The provider may bill the recipient for services not covered by Kentucky Medicaid; however, the provider must make the recipient aware of the non-covered services prior to rendering those services.

Providers of medical service attest by their signatures that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and/or imprisonment.

Diagnoses shall be recorded in the health record within three (3) visits, in order to receive Medicaid payment. The exception is for crisis services, screening, and assessment.

A billable unit of service is the actual time spent face-to-face delivering an actual service. Time spent in traveling to and from an off-site visit shall not be billed.

1. Limitations on Amount, Duration or Scope of Services

Unless a diagnosis is made and documented in the medical record within three (3) visits, the service will not be covered. The exception is for crisis services, screening, and assessment. An appropriate mental health or substance use disorder diagnosis is required for coverage, with the exception for crisis services, screening, and assessment.

Some rehabilitative services are furnished with limitations on amount, duration, or scope of service. The limitations of these services are indicated in the service description. If there is no limitation noted within the description of the service, there are no limits on the amount, duration or scope of the service. All services must meet medical necessity. All services, including those without specific limitations, with the exception of crisis services, screening, and assessment must be provided in accordance with a documented diagnosis and plan of treatment.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

1. Limitations on Amount, Duration or Scope of Services (continued)

The following services will NOT be covered by Medicaid under this State Plan Amendment:

- (a) Services provided to residents of:
 - (1) nursing facilities;
 - (2) hospital;
 - (3) Intermediate Care Facility – Individual with Intellectual Disability (ICF-IID)
 - (4) Psychiatric Residential Treatment Facility (PRTF)
- (b) Services provided to inmates of local, state or federal jails, detention centers or prisons
- (c) Services to those with developmental and intellectual disabilities, without documentation of an additional psychiatric diagnosis
- (d) Psychological assessment or testing for other agencies such as courts or schools, which does not result in the recipient receiving psychiatric intervention or therapy from the independent provider. If the testing results in behavioral health treatment, then the testing was medically necessary and would be covered. School services included in a child's Individual Education Plan (IEP) may be coverable under the Medicaid School-Based Services Program.
- (e) Consultation or educational services provided to Medicaid recipients or others
- (f) Collateral Outpatient therapy for ages 21 and over
- (g) Consultation or third party contacts shall be outside the scope of covered benefits, except for consultation provided as a part of collateral outpatient therapy or family outpatient therapy. Covered services require direct patient contact except collateral services for children under age twenty-one (21), when a part of the treatment plan
- (h) Telephone calls, emails, texts or other electronic contacts (excluding telehealth, as described on page 7.1 of the State Plan)
- (i) Travel time
- (j) Field trips, recreational, social, and physical exercise activity groups
- (k) Any applicable exclusion listed under the description of each service.

2. Eligible Recipients

All services, except for the following six services are considered mental health, substance use, or co-occurring mental health and substance use services. These services are available for all Medicaid beneficiaries who meet the medical necessity criteria for these services:

- (a) Service Planning (mental health only);
- (b) Residential Services for Substance Use Disorders (substance use only);
- (c) Screening, Brief Intervention and Referral to Treatment (substance use only);

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

3. Categories of Providers

- (d) Assertive Community Treatment (mental health only);
- (e) Comprehensive Community Support Services (mental health only); and
- (f) Therapeutic Rehabilitation Program (mental health only).

Except where indicated, all services will apply to both children and adults.

Kentucky defines the following categories of providers:

- (a) Individual Practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill Kentucky Medicaid.
- (b) Provider group: A group of more than one individually licensed practitioner who forms a business entity to render behavioral health services and bill Kentucky Medicaid.
- (c) Licensed organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render behavioral health services and bill Kentucky Medicaid. This organization must also meet the following criteria:
 - (1) Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
 - (2) Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
 - (3) Have the administrative capacity to provide quality of services in accordance with state and federal requirements;
 - (4) Use a financial management system that provides documentation of services and costs; and
 - (5) Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.

All providers must operate within the scope of their license. Providing services to Medicaid recipients outside a provider's licensure is considered fraud.

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.
 13d. Rehabilitative Services
 A. Treatment Services for Substance Use Disorders and Mental Health Disorders
 4. Rendering Providers

Service	LP	LPA*	LPP	LCSW	CSW*	LPCC	LPCA*	LPAT	LPATA*	LMFT	MFTA*	MD	Psychiatrist	APRN	PA*	CADC*	LADC	LADCA*	Peer Support*	SU Peer Support*	Prevention Specialist*	CSA*	LBA	LABA*	LO	CMHC	Provider Group
V. Screening	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆						✓	✓	✓	✓
W. Assessment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆					✓	✓	✓	✓	✓
X. Psychological Testing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆					✓	✓	✓	✓	✓
Y. Crisis Intervention	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆					✓	✓	✓	✓	✓
Z. Mobile Crisis	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆			◆	◆	✓	✓	
AA. Residential Crisis Stabilization	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆			◆	◆	✓	✓	
BB. Day Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆	◆	◆			✓	✓	✓	✓	✓
CC. Peer Support																				◆	◆			✓	✓	✓	✓
DD. Parent/Family Peer Support																				◆	◆			✓	✓	✓	✓
EE. Intensive Outpatient Program (IOP)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆						✓	✓	✓
FF. Individual Outpatient Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆					✓	✓	✓	✓	✓
GG. Group Outpatient Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆					✓	✓	✓	✓	✓
HH. Family Outpatient Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆						✓	✓	✓	✓
II. Collateral Outpatient Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆					✓	✓	✓	✓	✓

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Rendering Providers

Service	LP	LPA*	LPP	LCSW	CSW*	LPCC	LPCA*	LPAT	LPATA*	LMFT	MFTA*	MD	Psychiatrist	APRN	PA*	CADC*	LCADC	LADCA*	Peer Support*	SU Peer Support*	Prevention Specialist*	CSA	LBA	LABA*	LO	CMHC	Provider Group
JJ. Partial Hospitalizations	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆			◆	◆	✓	✓	✓
KK. Service Planning (Mental Health Only)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓								✓	✓	✓	✓	✓
LL. Residential Services for SUD (Substance use only)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆					✓	✓	
MM. SBIRT (Substance Use Only)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	◆	◆	◆	◆	◆	◆	◆			✓	✓	✓
NN. Assertive Community Treatment (Mental Health Only)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆					◆	◆	◆	◆	◆	✓	✓	
OO. Comprehensive Community Support Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓							◆	✓	✓	✓	✓	✓
PP. Therapeutic Rehabilitation Program (Mental Health Only)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				◆	◆					✓	✓	✓

* Billed through supervisor

✓ Individual Practitioner, Provider Group or Licensed Organization

◆ Rendering Practitioners practicing as part of a Licensed Organizations

LADC, LADCA, and CADC can only provide services for recipients with substance use disorders and within the scope of their practice.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

5. Billing Providers

- a. Individual Practitioners
- (1) Licensed Psychologist (LP)
 - (2) Licensed Psychological Practitioner (LPP)
 - (3) Licensed Clinical Social Worker (LCSW)
 - (4) Licensed Professional Clinical Counselor (LPCC)
 - (5) Licensed Professional Art Therapist (LPAT)
 - (6) Licensed Marriage and Family Therapist (LMFT)
 - (7) Licensed Behavioral Analyst (LBA)
 - (8) Physician
 - (9) Psychiatrist
 - (10) Advanced Practice Registered Nurse (APRN)
 - (11) Licensed Alcohol Drug Counselors (LADC)
- b. Provider Groups
- (1) Licensed Psychologist LP
 - (2) Licensed Psychological Practitioner LPP
 - (3) Licensed Clinical Social Worker LCSW
 - (4) Licensed Professional Clinical Counselor LPCC
 - (5) Licensed Professional Art Therapist LPAT
 - (6) Licensed Marriage and Family Therapist LMFT
 - (7) Licensed Behavioral Analyst LBA
 - (8) Physician
 - (9) Psychiatrist
 - (10) Advanced Practice Registered Nurse (APRN)
 - (11) Licensed Alcohol Drug Counselors (LADC)
 - (12) Behavioral Health Multi-Specialty Group
- c. Licensed Organizations

6. Covered Services

The following services, as defined by the Kentucky Department for Medicaid Services, are considered Medicaid mental health, substance use, or co-occurring mental health and substance use services, unless otherwise indicated:

- (a) [Screening](#)
- (b) [Assessment](#)
- (c) [Psychological Testing](#)
- (d) [Crisis Intervention](#)
- (e) [Mobile crisis](#)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

- (f) [Residential Crisis Stabilization](#)
- (g) [Day Treatment](#)
- (h) [Peer Support](#)
- (i) [Parent/Family Peer Support](#)
- (j) [Intensive Outpatient Program \(IOP\)](#)
- (k) [Individual Outpatient Therapy](#)
- (l) [Group Outpatient Therapy](#)
- (m) [Family Outpatient Therapy](#)
- (n) [Collateral Outpatient Therapy](#)
- (o) [Partial Hospitalization](#)
- (p) [Service Planning](#) (Mental health only)
- (q) [Residential Services for Substance Use Disorders](#) (Substance use only)
- (r) [SBIRT](#) – Screening, Brief Intervention and Referral to Treatment (Substance use only)
- (s) [Assertive Community Treatment](#) (Mental health only)
- (t) [Comprehensive Community Support Services](#) (Mental health only)
- (u) [Therapeutic Rehabilitation Program](#) (TRP) (Mental health only)

(a) **Screening**

Screening shall be the determination of the likelihood that a person has a mental health, substance use, or co-occurring mental health and substance use disorder. The purpose is not to establish the presence or specific type of such a disorder but to establish the need for an in-depth assessment.

(b) **Assessment**

Assessment shall include gathering information and engaging in a process with the recipient that enables the provider to establish the presence or absence of a mental health disorder, substance use disorder or co-occurring disorders; determine the recipient's readiness for change; identify recipient's strengths or problem areas that may affect the processes of treatment and recovery; and engage the recipient in the development of an appropriate treatment relationship. The purpose of an assessment is to establish (or rule out) the existence of a clinical disorder or service need and to work with the recipient to develop a treatment and service plan, if a clinical disorder or service need is assessed. Also includes functional behavioral assessment utilized when problem behaviors (e.g. aggression, self-injury, destruction of property) are present to identify the reason(s) behavior(s) occur and the skills and strategies necessary to decrease them. This service also includes interpretation and written report of assessment findings. This does not include psychological evaluations or assessments.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

(c) Psychological Testing

Psychological testing for individuals with mental health, substance use, or co-occurring mental health and substance use disorders may include psychodiagnostic assessment of personality, psychopathology, emotionality, and/or intellectual disabilities. The service also includes interpretation and written report of testing results.

(d) Crisis Intervention

Crisis Intervention shall be a therapeutic intervention provided for the purpose of immediately reducing or eliminating risk of physical or emotional harm to the recipient, or others. This service shall be provided as an immediate relief to the presenting problem or threat. Crisis Intervention must consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization, interventions, or crisis prevention activities for individuals. It must be followed by non-crisis service referral as appropriate. It must be provided in the provider's office in a face-to-face, one-on-one encounter between the provider and the recipient.

Crisis intervention may include further service prevention planning such as lethal means reduction for suicide risk or substance use relapse prevention or verbal de-escalation, risk assessment, or cognitive therapy.

(e) Mobile Crisis

Mobile crisis is a multi-disciplinary team based intervention that ensures access to acute mental health and substance use services and supports. The service aims to effect symptom or harm reduction, or to safely transition an individual in acute crisis to the appropriate least restrictive level of care. Mobile crisis services are provided face-to-face and available in locations outside the provider's facility (e.g., home or community) 24 hours per day, 7 days per week and 365 days per year. This service is provided in duration of less than 24 hours. Mobile crisis involves all supports and services necessary to provide integrated crisis prevention, assessment and disposition, intervention, continuity of care recommendations, and follow-up services.

Authorized Providers

The Mobile Crisis practitioners must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Capacity to employ required practitioners and coordinate service provision among the rendering practitioners
- Capacity to provide the full range of mobile crisis services on a 24/7/365 basis
- Access to a board-certified or board-eligible psychiatrist on a 24/7/365 basis

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

(f) **Residential Crisis Stabilization**

Residential Crisis Stabilization services are provided in Crisis Stabilization Units. Crisis Stabilization Units are community-based, residential programs that offer an array of services including screening, assessment, treatment planning, individual, group, and family therapy, and peer support in order to stabilize a crisis and divert the individual from a higher level of care. It is not part of a hospital. They are used when individuals in a behavioral health emergency cannot be safely accommodated within the community, are not in need of hospitalization but need overnight care.

The purpose is to stabilize the individual, provide treatment for acute withdrawal, when appropriate, and re-integrate him back into the community, or other appropriate treatment setting, in a timely fashion. These units provide a non-hospital residential setting and services 24-hours per day, seven (7) days per week, 365 days a year. The estimated length of stay for children is three (3) to five (5) days. The estimated length of stay for adults is seven (7) to 10 days. The component services of crisis stabilization units are screening, assessment, service planning, psychiatric services, individual therapy, family therapy, group therapy, and peer support.

Residential crisis stabilization does not include, and federal financial participation (FFP) is not available for, room and board services; educational, vocational and job training services; habilitation services; services to inmates in public institutions as defined in 42 CFR §435.1010; services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010; recreational and social activities; and services that must be covered elsewhere in the state Medicaid plan.

KY Medicaid will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds except for services furnished pursuant to the state plan benefit “inpatient psychiatric services for individuals under 21” (section 1905(a)(16) of the Act; 42 CFR 440.160) or pursuant to an exclusion for individuals age 65 or older who reside in institutions that are IMDs (section 1905(a) of the Act; 42 CFR 440.140.)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

Authorized Providers

The Residential Crisis Stabilization providers must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Capacity to employ practitioners and coordinate service provision among rendering providers
- Capacity to provide the full range of services included in the Residential Crisis Stabilization service definition
- Ability to provide Residential Crisis Stabilization services on a 24/7/365 basis
- Access to a board-certified or board-eligible psychiatrist on a 24/7/365 basis

(g) Day Treatment

Day Treatment is a non-residential, intensive treatment program designed for children/youth under the age of 21 who have a mental health, substance use, or co-occurring mental health and substance use disorder, and who are at high risk of out-of-home placement due to behavioral health issues. Intensive coordination/linkage with schools and or other child serving agencies is included.

Intensive coordination is needed in order to successfully transition youth recipients to a lower level of care. See below for basic components of the required linkage agreement between the provider and the local education authority that specifies the responsibility of the authority and the provider for:

- Appropriately licensed teachers and provisions for their professional development;
- Educational supports including classroom aides and textbooks;
- Educational facilities;
- Physical education and recreational therapies;
- Transportation; and
- Transition planning.

Day treatment services do not include services covered in a child's Individualized Education Plan (IEP).

Day treatment may focus on resolving multiple mental health and/or substance use issues and is typically provided as an alternative to a school or other traditional day time setting for children.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

Day treatment services shall be provided:

- In collaboration with the education services of the Local Education Authority (LEA) including those provided through IDEA and/or Section 504;
- On school days and during scheduled breaks;
- In coordination with the recipient's IEP, if the recipient has an IEP;
- With a linkage agreement to other behavioral health services with the LEA that specifies the responsibilities of the LEA and the day treatment provider.

(h) Peer Support

Peer Support is social and emotional support that is provided by an individual who is employed by a provider group or licensed organization and who has experienced a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder to a recipient sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change. It is an evidence-based practice. Peer Support Services are structured and scheduled non-clinical therapeutic activities with an individual recipient or a group or recipients and are provided by a self-identified consumer of mental health, substance use, or co-occurring mental health and substance use disorder services who has been trained and certified in accordance with state regulations. Services should promote socialization, recovery, self-advocacy, preservation and enhancement of community living skills for the recipient.

Peer support services must incorporate the following core components:

-
- Supervision – Peer support specialists must be supervised regularly by a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADC, a LADC, a LADCA a LPAT, or a LPATA.
- Care coordination - Peer support services must be coordinated within the context of a comprehensive, individualized treatment plan which is developed through a person-centered planning process. The peer support services must be identified on each recipient's individual treatment plan, and must be designed to directly contribute to the participant's individualized goals, as specified in the plan.
- Training - Peer Support Specialists have a minimum educational requirement of a high school diploma or a General Educational Development (GED) certificate and must successfully complete training approved by the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID).

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

Pursuant to KRS 309.0831, Registered Alcohol and Drug Peer Support Specialists are exempt from the DBHDID training required in 908 KAR 2:220, 230 and 240.

Authorized Providers

Peer Support – Peer support specialists must be either employed by a provider group or a licensed organization that meet the following additional criteria:

- Must employ qualified peer support specialists who successfully completed the training/exam as outlined in the Kentucky Administrative Regulation;
- Must provide supervision by a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADC, a LADC, a LADCA a LPAT, or a LPATA;
- Must have the capacity to provide on-going continuing education and technical assistance to peer support specialists; and
- Must have demonstrated experience serving the behavioral health population (mental health, substance use or co-occurring mental health and substance use disorders) and age range served (youth or adult peers or parent-to-parent).
- Registered Alcohol and Drug Peer Support Specialist

(i) Parent/Family Peer Support

Parent/Family Peer Support is emotional support that is provided by a parent or family member, who is employed by a provider group or licensed organization, of a child who has experienced a mental health disorder, substance use disorder, or a co-occurring mental health and substance use disorder to a parent or family member with a child sharing a similar mental health, substance use, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change. It is an evidence-based practice. Peer Support Services are structured and scheduled non-clinical therapeutic activities with individuals or groups provided by a self-identified parent /family member of a child/youth consumer of mental health, substance use, or co-occurring mental health and substance use disorder services who has been trained and certified in accordance with state regulations. Services should promote socialization, recovery, self-advocacy, preservation and enhancement of community living skills for the recipient. To provide parent or family peer support services a provider shall:

- have demonstrated the capacity to provide the core elements of parent or family peer support services for the behavioral health population being served including the age range of the population being served;
- employ family peer support specialists who are qualified to provide family peer support services in accordance with state regulations; and
- use an approved behavioral health services provider to supervise family peer support specialists.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

Peer support services must incorporate the following core components:

- Supervision – Peer support specialists must be supervised regularly by a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADDC, a LADC, a LADCA a LPAT, or a LPATA.
- Care coordination - Peer support services must be coordinated within the context of a comprehensive, individualized treatment plan which is developed through a person-centered planning process. The peer support services must be identified on each recipient's individual treatment plan, and must be designed to directly contribute to the participant's individualized goals, as specified in the plan.
- Training - Peer Support Specialists have a minimum educational requirement of a high school diploma or a General Educational Development (GED) certificate and must successfully complete training approved by DBHDID.

Authorized Providers

Peer Support – Peer support specialists must be either employed by a provider group or a licensed organization that meet the following additional criteria:

- Must employ qualified peer support specialists who successfully completed the training/exam as outlined in the Kentucky Administrative Regulation;
- Must provide supervision by a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADDC, a LADC, a LADCA a LPAT, or a LPATA;
- Must have the capacity to provide on-going continuing education and technical assistance to peer support specialists; and
- Must demonstrate experience serving the behavioral health population (mental health, substance use or co-occurring mental health and substance use disorders) and age range served (youth or adult peers or parent-to-parent).

(j) Intensive Outpatient Program (IOP)

Intensive Outpatient Program (IOP) is an alternative to or transition from inpatient hospitalization or partial hospitalization for mental health or substance use disorders. An IOP must offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient, group outpatient therapy, and family outpatient therapies.

IOP services must be provided at least three (3) hours per day and at least three (3) days per week.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

Programming must include individual outpatient therapy, group outpatient therapy, and family outpatient therapy unless contraindicated, crisis intervention as it would occur in the setting where IOP is being provided, and psycho-education. Psycho-education is one component of outpatient therapy for mental health conditions. During psycho-education, the recipient or their family is provided with knowledge about his diagnosis, the causes of that condition, and the reasons why a particular treatment might be effective for reducing his symptoms. Recipients and their families gain empowerment to understand and accept the diagnosis and learn to cope with it in a successful manner).

All treatment plans must be individualized, focusing on stabilization and transition to a lesser level of care.

The State does not claim IOP that is located in a hospital as a rehabilitative service.

Intensive Outpatient Services - Practitioners must be employed by a provider group or licensed organization that meets the criteria of a provider group or licensed organization and the following additional criteria:

- Access to a board-certified or board-eligible psychiatrist for consultation;
- Access to a psychiatrist, other physician or Advanced Practice Registered Nurse (APRN) for medication management;
- Adequate staffing to assure a minimum recipient-to-program staff ratio of ten (10) recipients to one (1) staff member;
- Capacity to provide services utilizing a recognized intervention protocol based on nationally accepted treatment principles when serving adults with mental health, substance use disorder or co-occurring disorders and the System of Care Principles when serving a recipient under the age of 21 with mental health, substance use disorder or co-occurring disorders;
- Capacity to employ required practitioners and coordinate service provision among rendering practitioners;
- Capacity to provide the full range of services included in the Intensive Outpatient service definition;
- Demonstrated experience in serving individuals with behavioral health disorders;
- The administrative capacity to ensure quality of services;
- A financial management system that provides documentation of services and costs; and
- The capacity to document and maintain individual case records.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

(k) **Individual Outpatient Therapy**

Individual Outpatient Therapy shall consist of a face-to-face, one-on-one encounter between the provider and the recipient. The therapy shall be a behavioral health therapeutic intervention provided in accordance with a recipient's identified treatment plan and is aimed at the reduction of adverse symptoms and improved functioning and reducing or eliminating the presenting problem of the recipient. Individual therapy, family therapy and group therapy services shall be limited to a maximum of a combined three (3) hours per day, per recipient, which can be exceeded based on medical necessity.

(l) **Group Outpatient Therapy**

Group therapy shall be therapeutic intervention provided to a group of unrelated persons, with the exception of multi-family group therapy. Group therapy shall consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan. Group outpatient therapy shall not solely include physical exercise, a recreational activity or an educational activity, or a social activity. The subject of the group outpatient therapy shall be related to each recipient participating in the group. A group consists of no more than twelve persons. It is usually for a limited time period (generally 1 to 1 ½ hours in duration). Group therapy focuses on psychological needs of the recipients as evidenced in each recipient's plan of treatment. Group therapy centers on goals such as building and maintaining healthy relationships, personal goal setting, and the exercise of personal judgment. The group shall have a deliberate focus and must have a defined course of treatment. Individual notes must be written for each recipient within the group and be kept in that individual's medical record.

Individual therapy, family therapy and group therapy services shall be limited to a maximum of a combined three (3) hours per day, per recipient, which can be exceeded based on medical necessity.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

(m) **Family Outpatient Therapy**

Family Therapy shall consist of a face-to-face therapeutic intervention provided through scheduled therapeutic visits between the therapist and the recipient and one or more members of a recipient's family or household member of the recipient to address issues interfering with the relational functioning of the family and improve interpersonal relationships within the home environment.

The need for family therapy shall be so stated in the recipient's plan of treatment. Family therapy services shall be for the benefit of the recipient.

Individual therapy, family therapy and group therapy services shall be limited to a maximum of a combined three (3) hours per day, per recipient, but can be exceeded based on medical necessity.

(n) **Collateral Outpatient Therapy**

Collateral services shall be limited to recipients under the age of twenty-one, who are recipients of the rendering provider. A collateral service shall be a face-to-face encounter with a parent/caregiver, household member of a recipient, legal representative/guardian, school personnel or other person in a position of custodial control or supervision of the recipient, for the purpose of providing counseling or consultation on behalf of a recipient in accordance with an established plan of treatment. The parent or legal representative in a role of supervision of the recipient shall give written approval for this service. This written approval shall be kept in the recipient's medical record. This service is only reimbursable for a recipient under age 21.

(o) **Partial Hospitalization**

Partial Hospitalization is a short-term (average of four (4) to six (6) weeks), less than 24-hour, intensive treatment program for individuals experiencing significant impairment to daily functioning due to substance use disorders, mental health disorders, or co-occurring mental health and substance use disorders. Partial Hospitalization may be provided to adults or children. This service is designed for individuals who cannot effectively be served in community-based therapies or IOP.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

The program consists of individual, group, family therapies and medication management. Educational, vocational, or job training services that may be provided as part of Partial Hospitalization are not reimbursed by Medicaid. The program has an agreement with the local educational authority to come into the program to provide all educational components and instruction which are not Medicaid billable or reimbursable. Services in a Medicaid-eligible child's Individual Education Plan (IEP) are coverable under Medicaid.

Partial Hospitalization is typically provided for at least four (4) hours per day. Partial Hospitalization is typically focused on one primary presenting problem (i.e., Substance use, sexual reactivity, etc.).

Authorized Providers

Partial Hospitalization – Practitioners must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- An Advanced Practice Registered Nurse (APRN), Physician Assistant (PA) or Physician available on-site and a board-certified or board-eligible psychiatrist available for consultation;
- Capacity to provide services utilizing a recognized intervention protocol based on Recovery Principles;
- Capacity to employ required practitioners and coordinate service provision among rendering practitioners; and
- Capacity to provide the full range of services included in the Partial Hospitalization definition.

(p) Service Planning TREATMENT OF MENTAL HEALTH ONLY

Service planning involves assisting the recipient in creating an individualized plan for services needed for maximum recovery of symptoms associated with a mental health disorder and restoration of a recipient to his best possible functional level. A person-centered planning process is required. The plan is directed by the recipient and must include practitioners of the recipient's choosing. The providers include more than licensed professionals – it may include the recipient (and his guardian if applicable), care coordinator, other service providers, family members or other individuals that the recipient chooses. Service Planning may include a mental health advance directive being filed with a local hospital; crisis plan or a relapse prevention strategy or plan.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

(q) **Residential Services for Substance Use Disorders (SUDS) TREATMENT FOR SUBSTANCE USE ONLY**

Residential services for substance use disorders is residential treatment (24 hour/day) that may be short-term or long-term for the purposes of providing intensive treatment and skills building, in a structured and supportive environment, to assist individuals (children and adults) to enter into alcohol/drug addiction recovery. This service is provided in a 24-hour live-in facility that offers a planned and structured regimen of care that aims to treat persons with addictions or substance use disorders and assists them in making the necessary changes in their lives that will enable them to live drug or alcohol free lives.

Services must:

- 1) Be provided under the medical direction of a physician;
- 2) Provide continuous nursing services in which a registered nurse shall be:
 - a) On-site during traditional first shift hours, Monday through Friday;
 - b) Continuously available by phone after hours; and
 - c) On-site as needed in follow-up to telephone consultation after hours.

Individuals must have been assessed and meet criteria for approval of residential services, utilizing a nationally recognized assessment tool (e.g., American Society of Addiction Medicine (ASAM)) as approved by the Kentucky Department of Behavioral Health, Development and Intellectual Disabilities (DBHDID).

KY Medicaid will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds except for services furnished pursuant to the state plan benefit "inpatient psychiatric services for individuals under 21" (section 1905(a)(16) of the Act; 42 CFR 440.160) or pursuant to an exclusion for individuals age 65 or older who reside in institutions that are IMDs (section 1905(a) of the Act; 42 CFR 440.140.)

Residential treatment services shall be based on individual need and may include:

- Screening
- Assessment
- Service Planning
- Individual Therapy
- Group Therapy
- Family Therapy
- Peer Support

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

There are two levels of residential treatment:

- Short term –length of stay less than 30 days
- Long term- length of stay 30- 90 days

Short Term

Short term services should have a duration of less than thirty (30) days, but can be exceeded based on medical necessity. 24 hour staff as required by licensing regulations. Short term services should have planned clinical program activities constituting at least 15 hours per week of structured professionally directed treatment services to stabilize and maintain a person's substance use disorder and to help him to develop and apply recovery skills.

Long Term

Long term services should have 24 hour staff as required by licensing regulations, as well as planned clinical program activities constituting 40 hours per week of structured professionally directed treatment services to stabilize and maintain a person's substance use and or substance use and mental health disorder and to help him or her to develop and apply recovery skills.

Residential SUD treatment programs do not include, and Federal Financial Participation (FFP) is not available for, room and board services; educational, vocational and job training services; habilitation services; services to inmates in public institutions as defined in 42 CFR §435.1010; services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010; recreational and social activities; and services that must be covered elsewhere in the state Medicaid plan.

KY Medicaid will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds except for services furnished pursuant to the state plan benefit "inpatient psychiatric services for individuals under 21" (section 1905(a)(16) of the Act; 42 CFR 440.160) or pursuant to an exclusion for individuals age 65 or older who reside in institutions that are IMDs (section 1905(a) of the Act; 42 CFR 440.140.)

Limitations

To provide residential services for substance use disorders, a behavioral health services organization shall:

- a. Have the capacity to employ staff authorized to provide services in accordance with this section and to coordinate the provision of services among team members; and
- b. Be licensed as a non-medical and non-hospital based alcohol and other drug abuse treatment program in accordance with state licensing regulations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

(r) **Screening, Brief Intervention, and Referral to Treatment (SBIRT) TREATMENT OF SUBSTANCE USE ONLY**

SBIRT is an evidence-based early intervention approach that targets individuals with non-dependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. SBIRT consists of three major components:

Screening – Assessing an individual for risky substance use behaviors using standardized screening tools;

Brief Intervention – Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and

Referral to Treatment – Provides a referral to additional mental health, substance use, or co-occurring mental health and substance use disorder services to patients who screen in need of additional services to address substance use. The Referral to Treatment is part of the Brief Intervention and thus referral to a behavioral health service.

(s) **Assertive Community Treatment (ACT) TREATMENT OF MENTAL HEALTH ONLY**

Assertive community treatment (ACT) is an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for consumers with serious mental illnesses. ACT uses a multidisciplinary team of professionals including psychiatrists, nurses, case managers, therapists and peer support specialists.

Component services include assessment, person centered treatment planning, case management, individual outpatient therapy, family outpatient therapy, and group outpatient therapy, peer support, mobile crisis intervention, mental health consultation, medication monitoring, family support and basic living skills training. Mental health consultation involves brief, collateral interactions with other treating professionals who may have information for the purposes of treatment planning and service delivery.

Family support involves the ACT team working with the recipient's natural support systems to improve family relations in order to reduce conflict and increase recipient autonomy and independent functioning. Basic living skills training shall be rehabilitative services focused on restoring activities of daily living to reduce disability and improve function (i.e., taking medications, housekeeping, meal preparation, hygiene, interacting with neighbors) necessary to maintain independent functioning and community living.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

Services are provided by a multidisciplinary team of providers whose backgrounds and training include social work, rehabilitation, counseling, nursing. Providers of ACT services consist of multidisciplinary staff organized as a team in which members function interchangeably to provide treatment, rehabilitation and support.

Authorized Providers

Assertive Community Treatment (ACT) – Team members must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Must employ one or more teams led by an approved behavioral health services provider and including, at a minimum, four (4) full time equivalents including 1.0 FTE therapist, 1.0 Case Manager, .5 Peer Support Specialist, .5 FTE nurse (medication and health management) and 1.0 of the team's choosing with access to a prescriber.
- Adequate staffing to assure a caseload size no greater than ten (10) participants per team member, not including the prescriber or administrative support; Have the capacity to:
 - (i) Employ staff authorized to provide assertive community treatment services in accordance with this paragraph;
 - (ii) Coordinate the provision of services among team members;
 - (iii) Provide the full range of assertive community treatment services as stated in this paragraph; and
 - (iv) Document and maintain individual case records; and
 - (v) Demonstrate experience in serving individuals with persistent and serious mental illness who have difficulty living independently in the community.

(t) Comprehensive Community Support Services TREATMENT OF MENTAL HEALTH ONLY

Comprehensive Community Support Services covers activities necessary to allow individuals with mental illnesses to live with maximum independence in the community. Activities are intended to assure successful community living through utilization of skills training as identified in the individual treatment plan. Skills training is designed to reduce symptoms associated with a mental health disorder and restore the recipient to his best possible functional level. Comprehensive community support services consists of using a variety of psychiatric rehabilitation techniques to improve daily living skills, self-monitoring of symptoms and side effects, improve emotional regulation skills, crisis coping skills and developing and enhancing interpersonal skills.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

- To provide comprehensive community support services, a licensed organization shall:
- Have the capacity to employ staff authorized pursuant to 908 KAR 2:250 to provide comprehensive community support services in accordance with subsection (2)(k) of this section and to coordinate the provision of services among team members; and
- Meet the requirements for comprehensive community support services established in 908 KAR 2:250.

(u) Therapeutic Rehabilitation Program **TREATMENT OF MENTAL HEALTH ONLY**

A Therapeutic Rehabilitation Program is a rehabilitative service for adults with serious mental illnesses and recipients under the age of twenty-one years who have a serious emotional disability designed to maximize reduction of the symptoms associated with a mental health disorder and restoration of the recipient's best possible functional level. Services shall be designed for the reduction in disabilities related to social, personal, and daily living skills, as well as the restoration of these skills. The recipient establishes his own rehabilitation goals within the person centered service plan. Component services are delivered using a variety of psychiatric rehabilitation techniques and focus on improving daily living skills, self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and interpersonal skills. Services may be delivered individually or in a group.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

8. Community Mental Health Centers (CMHC)

CMHCs provide a comprehensive range of coordinated mental health and substance use rehabilitation services. Reimbursement is available for all rehabilitation services described above under covered services subject to the following:

1. Medicaid will reimburse for community mental health center rehabilitation services when provided to persons diagnosed with a mental health, substance use or co-occurring mental health and substance use disorder when provided by qualified mental health professionals listed below. Service limitations applicable to other provider types are also applicable to CMHCs.
2. Professionals qualified to provide mental health or substance use rehabilitation services in the CMHCs include:
 - Licensed Psychologist (LP)
 - Licensed Psychological Practitioner (LPP)
 - Licensed Clinical Social Worker (LCSW)
 - A psychiatric social worker with a master's degree from an accredited school
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Marriage and Family Therapist (LMFT)
 - Psychiatrist
 - Physician
 - Licensed Professional Art Therapist (LPAT)
 - Licensed Behavior Analyst (LBA)
 - A psychiatric nurse licensed in the Commonwealth of Kentucky with one of the following combination of education and experience:
 - i. Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.
 - ii. Bachelor of Science in Nursing and 1 year of experience in a mental health setting.
 - iii. A graduate of a three-year educational program with 2 years of experience in a mental health setting.
 - iv. A graduate of a two-year educational program (Associate degree) with 3 years of experience in a mental health setting.
 - Licensed Alcohol and Drug Counselor (LADC)
 - Licensed Alcohol and Drug Counselor Associates* (LADCA)

* Requires Supervision

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

8. Community Mental Health Centers (CMHC) (continued)

- A professional equivalent, through education in a behavioral health field and experience in a behavioral health setting, qualified to provide behavioral health services. Professional equivalents may include practitioners obtaining experience to qualify for licensure in their behavioral health profession or individuals with a bachelor's degree or greater, with experience in behavioral health. Education and experience are as follows:
 - i. Bachelor's degree and three (3) years of full-time supervised experience.
 - ii. Master's degree and six (6) months of full-time supervised experience.
 - iii. Doctoral degree. No experience.
- The following professionals may provide services with appropriate supervision:
 - ix. A mental health associate with a minimum of a Bachelor's degree in psychology, sociology, social work, or human services under supervision of one of the above professionals;
 - x. A licensed psychological associate;
 - xi. A licensed professional counselor associate;
 - xii. A certified social worker, Master Level;
 - xiii. A marriage and family therapy associate;
 - xiv. A physician assistant working under the supervision of a physician;
 - xv. Peer Support Specialist working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LADC, a LADCA, CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, or a LPATA;
 - xvi. A certified alcohol and drug counselor (CADC) working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LPAT, or a LPATA with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center;
 - ix. A community support associate who is working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LADC, a LADCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, a LPATA, or a LBA;

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

8. Community Mental Health Centers (CMHC) (continued)

- x. A Licensed Professional Art Therapist Associate (LPATA);
- xi. A licensed assistant behavior analyst.
- xii. Licensed Alcohol and Drug Counselor (LADC)
- xiii. Licensed Alcohol and Drug Counselor Associate (LADCA)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers

Qualified providers are approved practitioners, licensed or certified under state law, operating within the scope of their licensures (or under the appropriate supervision).

a. Advanced Practice Registered Nurse (APRN) – KRS 314.042 states that an applicant for licensure to practice as an advanced practice registered nurse shall:

(1) File with the board a written application for licensure and submit evidence, verified by oath, that the applicant has completed an approved organized post basic program of study and clinical experience; has fulfilled the requirements of KRS 214.615(1); is certified by a nationally established organization or agency recognized by the board to certify registered nurses for advanced practice registered nursing; and is able to understandably speak and write the English language and to read the English language with comprehension.

(a) The board may issue a license to practice advanced practice registered nursing to an applicant who holds a current active registered nurse license issued by the board or holds the privilege to practice as a registered nurse in this state and meets the qualifications of subsection (1) of this section. An APRN shall be:

i. Designated by the board as a certified nurse anesthetist, certified nurse midwife, certified nurse practitioner, or clinical nurse specialist; and

ii. Certified in a least one (1) population focus.

(b) An APRN shall maintain a current active registered nurse license issued by the board or hold the privilege to practice as a registered nurse in this state and maintain current certification by the appropriate national organization or agency recognized by the board.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- (c) Before an APRN engages in the prescribing or dispensing of nonscheduled legend drugs as authorized by KRS 314.011(8), the APRN shall enter into a written "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Nonscheduled Legend Drugs" (CAPA-NS) with a physician that defines the scope of the prescriptive authority for nonscheduled legend drugs.
- (d) Before an APRN engages in the prescribing of Schedules II through V controlled substances as authorized by KRS 314.011(8), the APRN shall enter into a written "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Controlled Substances" (CAPA-CS) with a physician that defines the scope of the prescriptive authority for controlled substances.

b. Certified Social Worker, Master Level – KRS 335.08 states the board shall issue a license as "certified social worker" to an applicant who meets the following requirements:

- (1) Is at least eighteen years of age;
- (2) Is a person of good moral character;
- (3) Has received a master's degree or doctorate degree in social work from an educational institution approved by the board;
- (4) Has passed an examination prepared by the board; and
- (5) Has not, within the preceding three months failed to pass an examination given by the board.

A Certified Social Worker, Master Level may engage in the practice of clinical social work by contracting, in writing, with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the Certified Social Worker, Masters Level. The supervising licensed behavioral health professional shall assume responsibility for and supervise the CSW's practice.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- c. Licensed Clinical Social Worker (LCSW) – KRS 335.100 states that the LCSW must:
- (1) Have received a master's degree or doctoral degree in social work from an educational institution approved by the board;
 - (2) Have had a minimum of two (2) years of full time post-master's experience, consisting of at least thirty (30) hours per week, or three (3) years of part time, consisting of at least twenty (20) hours per week, post-master's degree experience acceptable to the board in the use of specialty methods and measures to be employed in clinical social work practice, the experience having been acquired under appropriate supervision as established by the board by promulgation of an administrative regulation;
 - (3) Have paid to the board an examination fee established by the board by promulgation of an administrative regulation;
 - (4) Have passed an examination prepared by the board for this purpose; and
 - (5) Have not, within the preceding three (3) months, failed to pass an examination given by the board.
- d. Licensed Marriage and Family Therapist (LMFT) – KRS 335.330 states the LMFT has:
- (1) Completed a master's or doctoral degree program in marriage and family therapy, from a regionally-accredited educational institution, or a master's, post-master's, or doctoral program approved by the Commission on Accreditation for Marriage and Family Therapy Education or any of its successor organizations, or an equivalent course of study as defined by the board by promulgation of administrative regulations.
 - (a) The degree or equivalent course of study shall contain specific coursework on psychopathology and the Diagnostic and Statistical Manual; and
 - (b) In determining equivalency, the board shall use the criteria for marriage and family therapy education and clinical training approved by the United States Department of Education.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- (2) Completed each of the following:
 - (a) At least two (2) years' experience in the practice of marriage and family therapy, acceptable to the board and subsequent to being granted a master's degree; and
 - (b) A minimum of two hundred (200) hours of clinical supervision acceptable to the board and subsequent to being granted a master's degree; and
 - (3) Passed a written examination prescribed by the board by promulgation of administrative regulations.
- e. Marriage and Family Therapist Associate (MFTA) – KRS 335.332 states the LMFT has
- (1) Completed a master's or doctoral degree program in marriage and family therapy, from a regionally-accredited educational institution, or a master's, post-master's, or doctoral program approved by the Commission on Accreditation for Marriage and Family Therapy Education or any of its successor organizations, or an equivalent course of study as defined by the board by promulgation of administrative regulations.
 - (a) The degree or equivalent course of study shall contain specific coursework on psychopathology and the Diagnostic and Statistical Manual; and
 - (b) In determining equivalency, the board shall use the criteria for marriage and family therapy education and clinical training approved by the United States Department of Education; and
 - (2) A MFTA shall engage in the practice of marriage and family therapy while receiving qualifying experience by contracting, in writing, with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the MFTA. The supervising licensed behavioral health professional shall assume responsibility for and supervise the MFTA's practice.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- f. Licensed Professional Clinical Counselor – KRS 335.525 states that the board shall issue a "professional clinical counselor" license to an applicant who:
- (1) Has paid the application fee and the appropriate examination fee to the board;
 - ii. Is of good moral character;
 - (2) Has received a master's, specialist, or doctoral degree in counseling or a related field from a regionally accredited institution;
 - (3) Has completed a minimum of sixty (60) graduate semester hours in the following:
 - (a) The helping relationship, including counseling theory and practice;
 - (b) Human growth and development;
 - (c) Lifestyle and career development;
 - (d) Group dynamics, process, counseling, and consulting;
 - (e) Assessment, appraisal, and testing of individuals;
 - (f) Social and cultural foundations, including multicultural issues;
 - (g) Principles of etiology, diagnosis, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior;
 - (h) Research and evaluation; and
 - (i) Professional orientation and ethics;
 - (4) Has completed a minimum of four thousand (4,000) hours of experience in the practice of counseling, all of which must have been obtained since obtaining the master's degree and must be under approved supervision and shall include but not be limited to a minimum of one thousand six hundred (1,600) hours of direct counseling with individuals, couples, families, or groups and a minimum of one hundred (100) hours of individual, face-to-face clinical supervision with an approved supervisor.

Each applicant is encouraged to include as part of the total hours of experience a minimum of ten (10) hours of direct counseling with individuals in a jail or corrections setting. All applicants shall complete an organized practicum or internship consisting of at least four hundred (400) hours; and
 - (5) Has achieved passing scores on all portions of the examinations required by the board.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- g. Licensed Professional Counselor Associate – KRS 335.525 states that the board shall issue a "professional clinical counselor" license to an applicant who:
- (1) Has completed all requirements under paragraphs (a) to (d) as outlined under Licensed Professional Counselor above;
 - (2) Has not met the requirements of paragraphs (e) or (f) as outlined under Licensed Professional Counselor above; and
 - (3) Has obtained a board-approved supervisor of record.

A licensed professional counselor associate shall maintain ongoing supervision with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the Licensed Professional Counselor Associate. The supervising licensed behavioral health professional shall assume responsibility for and supervise the LPCA's practice.

- h. Licensed Psychological Associate – KRS 319.064 states a licensed psychological associate shall:
- (1) Have received a master's degree in psychology from a regionally accredited educational institution;
 - (2) Have passed an examination procedure in psychology; and
 - (3) A licensed psychological associate shall not practice independently, except under the employment and supervision of any board-approved licensed psychologist.
- i. Licensed Psychological Practitioner – KRS 319.053 states a person holding a credential as a certified psychologist or as a licensed psychological associate may apply for a license to perform certain functions within the practice of psychology without supervision and use the title of "licensed psychological practitioner" when all of the following conditions are met:
- (1) Submission of three (3) letters of endorsement to the board to sit for the examination:
 - (a) One of the letters shall be from the applicant's current board approved supervisor of record and shall include a statement describing the scope of practice demonstrated in the clinical experience of the applicant; and
 - (b) Two letters shall be from licensed mental health professionals who are acceptable to the board and who are familiar with the clinical work of the applicant.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- (2) Documentation of at least sixty (60) semester hours of graduate study in psychology or a related field or its equivalent acceptable to the board; and
 - (3) Completion, after credentialing by the board as a certified psychologist, psychological associate, or licensed psychological associate, of the equivalent of five full-time years of professional experience under the supervision of a board-approved licensed psychologist.
 - (4) An applicant for licensure shall be required by the board to pass the national objective examination known as the EPPP, with an equal to or exceeding the score required for the passage for a licensed psychologist candidate at the doctoral level at the time the examination is taken.
 - (5) The board shall require an applicant for licensure under this section to pass an examination of psychological practice, ethical principles and the law.
- j. Licensed Psychologist – Per KRS 319.050, a licensed psychologist shall pass an examination in psychology and fulfill all requirements for supervised experience.
- (1) The psychologist shall:
 - (a) Have received a doctoral degree in psychology that is acceptable to the board from a regionally accredited educational institution; provided, however, the board may grant a license to an individual otherwise qualified under this chapter who has received a doctoral degree in psychology that is acceptable to the board from an educational institution outside the United States, if the educational institution would otherwise be accredited by a regional accrediting body if located in the United States;
 - (b) Have passed the national EPPP examination at the doctoral level; and
 - (c) Have had at least two (2) years of supervised professional experience satisfactory to the board, one (1) year of which shall be an internship.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- (2) Upon acceptance of the application to sit for the examination in psychology, the applicant may practice psychology under the supervision of a licensed psychologist under conditions of supervision and temporary licensure established by the board. The board shall establish a grace period not to exceed sixty (60) days to allow for the employment and supervision of the applicant by an agency from the time the applicant's degree requirements are completed to the submission of the complete application. During this period of supervision, the applicant for licensure may not supervise certified psychologists, licensed psychological associates, other applicants for licensure, or temporarily licensed persons, nor shall he engage in an independent practice, except under the employment of his supervising psychologist. Upon certification to the board of completion of the two (2) years of supervision satisfactory to the board, the applicant shall be examined on psychological practice, ethical principles, and the law.
 - (3) Licensed psychologists may function independently without supervision. Licensed psychologists who have the designation "health service provider" may retain that designation and may employ and supervise certified psychologists and licensed psychological associates. Licensed psychologists who have the designation "health service provider" may supervise no more than a total of six (6) certified psychologists, licensed psychological associates, or applicants for licensure at one (1) time.
- k. Physician – KRS 311.571 states that any applicant who is a graduate of a medical or osteopathic school shall be eligible for a regular license to practice medicine in the Commonwealth if they:
- (1) Are able to understandably speak, read, and write the English language;
 - (2) Has graduated from an accredited college or university or has satisfactorily completed a collegiate course of study necessary for entry into an approved medical or osteopathic school or college;
 - (3) Has graduated from a prescribed course of instruction in a medical or osteopathic school or college situated in the United States or Canada and approved by the board;
 - (4) Has satisfactorily completed a prescribed course of postgraduate training of a duration to be established by the board in an administrative regulation; and
 - (5) Has successfully completed an examination prescribed by the board.

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- l. Physician Assistant – Has graduated from a physician assistant or surgeon assistant program accredited by the Accreditation Review Commission on Education for Physician Assistants or its predecessor or successor agencies and has passed the certifying examination administered by the National Commission on Certification of Physician Assistants or its predecessor or successor agencies; or Possesses a current physician assistant certificate issued by the board prior to July 15, 2002.
- m. Psychiatrist – Licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties, who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc.
- n. KY Credentialed Peer Support Specialist – Kentucky regulation states that an applicant shall:
 - (1) Be eighteen (18) years of age or older;
 - (2) Have personal or family lived experience with mental health diagnosis and treatment (as specified by relevant peer support regulation);
 - (3) Have attained a high school diploma or general equivalency diploma (GED) certificate;
 - (3) Complete the relevant DBHDID peer specialist training program(s);
 - (4) Successfully complete the DBHDID peer specialist examination(s);
 - (5) Complete and maintain documentation of a minimum of six (6) hours of job related training or education in each subsequent year of employment; and
 - (6) Deliver services working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADC, a LPAT, or a LPATA.
 - (7) Demonstrated the capacity to provide the core elements of peer support services for the behavioral health population being served, including the age range of the population being served.
- o. Certified Alcohol and Drug Counselor (CADC): KRS 309.083 states that a Certified Alcohol and Drug Counselor shall:
 - (1) Be at least eighteen (18) years of age;
 - (2) Have obtained a baccalaureate degree;
 - (3) Have completed six thousand (6,000) hours of board-approved experience working with alcohol or drug dependent persons, three hundred (300) hours of which shall have been under the direct supervision of a certified alcohol and drug counselor who has at least two (2) years of post-certification experience; (4) Have completed at least two hundred seventy (270) classroom hours of board-approved curriculum;
 - (4) Have passed a written examination that has been approved by the International Certification Reciprocity Consortium on Alcoholism and Drug Abuse and an oral examination approved by the board;

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- (5) Have signed an agreement to abide by the standards of practice and code of ethics approved by the board;
 - (6) Have completed at least six (6) hours of ethics training and two (2) hours of training in the transmission, control, treatment, and prevention of the human immunodeficiency virus;
 - (7) Have completed three (3) hours of domestic violence training;
 - (8) Have submitted two (2) letters of reference from certified alcohol and drug counselors; and
 - (9) Work under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LPAT, or a LPATA with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center.
- p. Licensed clinical alcohol and drug counselor – KRS 309.0832 states that a licensed clinical alcohol and drug counselor shall:
- (1) Be at least eighteen (18) years of age;
 - (2) Have obtained from a regionally accredited college or university or a college or university accredited by an agency recognized by the United States Department of Education:
 - (a) A sixty (60) hour master's degree in a behavioral science with clinical application;
 - (b) A thirty (30) hour advanced placement master's degree in a behavioral science with clinical application; or
 - (c) A doctoral degree in a behavioral science with clinical application;
 - (3) Have completed at least one hundred eighty (180) classroom hours of alcohol and drug counselor specific board-approved curriculum;
 - (4) Have passed a written examination as specified by the board in administrative regulation;
 - (5) Have signed an agreement to abide by the standards of practice and code of ethics approved by the board;

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- (6) Have completed at least six (6) hours of ethics training; three (3) hours of domestic violence training; and two (2) hours training in the transmission, control, treatment, and prevention of the human immunodeficiency virus, in addition to the educational requirements in subsection (2) of this section;
 - (7) Have submitted two (2) letters of reference from certified alcohol and drug counselors or licensed clinical alcohol and drug counselors;
 - (8) Live or work at least a majority of the time in Kentucky;
 - (9) Have complied with the requirements for the training program in suicide assessment, treatment, and management in KRS 210.366 and any administrative regulations promulgated thereunder; and
 - (10) Have completed two thousand (2,000) hours of board-approved experience working with persons having a substance use disorder, three hundred (300) hours of which shall have been under the direct supervision of a licensed clinical alcohol and drug counselor.
- q. Licensed clinical alcohol and drug counselor associate – KRS 309.0833 states that a licensed clinical alcohol and drug counselor associate shall:
- (1) An applicant for licensure as a licensed clinical alcohol and drug counselor associate shall:
 - (a) Pay the board the initial fee for licensure;
 - (b) Complete the requirements under KRS 309.0832(1) to (9) [as indicated above for the Licensed clinical alcohol and drug counselor]; and
 - (c) Obtain a board-approved supervisor of record.
 - (2) Upon completion of the hours of board-approved experience specified in KRS 309.0832(10), a licensed clinical alcohol and drug counselor associate may apply to the board for licensure as a licensed clinical alcohol and drug counselor.
- r. Community Support Associate: 908 KAR 2:250 states that a Community Support Associate shall:
- (1) Be eighteen (18) years of age or older;
 - (2) Have a high school diploma, a general equivalency diploma (GED), or qualifying documentation from a comparable educational entity;
 - (3) Have one (1) year of full-time experience working with individuals who receive services for treatment of a mental health disorder; and

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- (4) Successfully complete within six (6) months of hire a training program approved by the Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) described in Section 3 of 908 KAR 2:250 and
 - (5) Work under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a CADC, a LPAT, a LPATA, or a LBA; and
 - (6) Meet face-to-face no less than one (1) time every two (2) weeks with his or her supervisor as described in paragraph (e) of this subsection.
- s. Licensed Professional Art Therapist: KRS 309.130 states that a Licensed Professional Art Therapist shall:
- (1) Have completed a master's or doctoral degree program in art therapy, or an equivalent course of study, from an accredited educational institution; and
 - (2) Have been issued a license by the board for the independent practice of art therapy.
- t. Licensed Professional Art Therapist Associate: KRS 309.130 states that a Licensed Professional Art Therapist Associate shall:
- (1) Have completed a master's or doctoral degree program in art therapy, or an equivalent course of study, from an accredited educational institution; and
 - (2) Have been issued a license by the board to practice art therapy under an approved clinical supervisor authorized by the board.
- u. Licensed Behavior Analyst: KRS 319C.080 states that a Licensed Behavior Analyst shall:
- (1) Have met the education requirements of the Board Certified Behavior Analyst (BCBA) standards, has passed the BCBA examination, and is credentialed as a behavior analyst by the certification board;
 - (2) Maintain active status and fulfill all requirements for renewal and recertification with the certification board as a Board Certified Behavior Analyst (BCBA);
 - (3) Conduct his or her professional activities in accordance with accepted standards as required by administrative regulations promulgated by the board in accordance with KRS 319C.050(1); and
 - (4) Comply with all applicable administrative regulations promulgated by the board.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

9. Qualifications of Providers (continued)

- v. Licensed Assistant Behavior Analyst: KRS 319C.080 states that a Licensed Assistant Behavior Analyst shall:
- (1) Have met the education requirements of the Board Certified Assistant Behavior Analyst (BCaBA) standards, has passed the BCaBA examination, and is credentialed as an assistant behavior analyst by the certification board;
 - (2) Maintain active status and fulfills all requirements for renewal and recertification with the certification board as a Board Certified Assistant Behavior Analyst;
 - (3) Conduct his professional activities in accordance with accepted standards as required by administrative regulations promulgated by the board in accordance with KRS 319C.050(1);
 - (4) Comply with all applicable administrative regulations promulgated by the board; and
 - (5) Be supervised by a certified behavior analyst in a manner consistent with the certification board requirements for supervision of Board Certified Assistant Behavior Analysts.

14.b. Nursing Facility Services for Individuals Age 65 or Older in Institutions for Mental Diseases.
and
C.

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.
2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.
3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds. The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).
- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, and ventilator use.

15.a. Services in an Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (Other Than Such Services in an Institution for Mental Diseases) for Persons Determined, in Accordance with Section 1902(a) (31) (A) of the Act, to be in Need of Such Care

Program benefits are limited to eligible recipients who require active treatment. These services must be preauthorized and must be reevaluated every six (6) months, lithe reevaluation of care reveals that the patient no longer requires skilled, nursing facility level of care, or intermediate care for the mentally retarded and developmentally-disabled services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds

The following services are payable by the Medicaid program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19- D Exhibit B for a detailed explanation of each service or item.)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).
- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x- ray, oxygen and oxygen supplies, and ventilator use.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age

A. Covered Inpatient Admissions

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's treatment plan shall specify the amount and frequency of services needed;

- 1) A covered admission for a Level I PRTF shall be prior authorized by a review agency.
- 2) A covered admission for a Level II PRTF shall be prior authorized;

B. PRTF Covered Inpatient Services.

- 1) The following services shall be available to all eligible recipients:
 - a. Diagnostic and assessment services;
 - b. Treatment plan development, review, or revision;
 - c. Psychiatric services;
 - d. Nursing services which shall be provided in compliance with 902 KAR 20:320;
 - e. Medication which shall be provided in compliance with 907 KAR 1:019;
 - f. Evidence-based treatment interventions;
 - g. Individual therapy which shall comply with 902 KAR 20:320;
 - h. Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - i. Group therapy which shall comply with 902 KAR 20:320;
 - j. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - k. Substance abuse education;
 - l. Activities that:
 - (1) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - (2) Support and encourage the parent's ability to re-integrate the child into the home;
 - m. Emergency interventions pursuant to the restraint and seclusion requirement at:
 - (1) 42 C.F.R. 483.350 through 376; and
 - (2) 902 KAR 20:320;
 - n. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - o. Educational activities; or
 - p. Non-medical transportation services as needed to accomplish objectives;

-
16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age
- 2) A Level I PRTF service listed in a above shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Medically necessary; and
 - d. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
 - 3) A Level I PRTF service listed in g, h, i, k, or m. above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
 - 4) A Level II PRTF service listed shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Provided at least once a week:
 - (1) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - (2) Except for diagnostic and assessment services which shall have no weekly minimum requirement;
 - d. Medically necessary; and
 - e. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
 - 5) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.
- C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.
- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
 - 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
 - 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
 - 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
 - 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state psychiatric hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state psychiatric hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.
- 1) The department shall cover a bed reserve day for an acute hospital admission, a state psychiatric hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state psychiatric hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital.
 - 2) Based on medical necessity, with a prior authorization, the five (5) day limit may be extended.
 - 3) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.

18. Hospice

A. Benefits

The Kentucky Medicaid Hospice Program follows the amount, duration, and scope of services specified in the Medicare Hospice Program.

Any terminally ill Medicaid recipient may elect hospice coverage (where hospice care is provided by a participating hospice program in his service area) Each recipient will be required to make his voluntary selection in writing, and must present a statement from a physician (or such statement must be available) to show that the recipient's illness is terminal and that death is expected to occur within six (6) months. In doing so, the recipient waives rights to other Medicaid services that are related to the treatment of his or her terminal illness(es) with the exception of individuals less than 21 years of age. Individuals less than 21 years of age may receive concurrent hospice and acute care treatment. The recipient has the right to cancel the election at any time without forfeiting additional Medicaid hospice coverage at a later time. The recipient does not waive rights to Medicaid services for conditions not related to the terminal condition.

Medicaid beneficiaries under the age of 21 may receive hospice benefits, including curative treatment without foregoing any other service to which the child is entitled under the Medicaid program, pursuant to Section 2302 of the Patient Protection and Affordable Care Act of 2010.

B. Limitations

Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services.

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

-
23. Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary.
- A. Transportation
1. Definitions.
- a. Ambulance transportation includes air and ground transportation provided at advanced life support level or basic life support levels by an appropriately licensed carrier.
- b. Medical service area is made up of the recipient's county of residence or a contiguous county.
2. Ambulance Services.
- a. An emergency ambulance service shall be provided without prior authorization to and from the nearest hospital emergency room. If a hospital emergency room is not available, a statement from an attending physician associated with the facility from which the patient receives services verifying medical necessity of stretcher ambulance services and the nature of the emergency services provided to the patient shall be required.
- b. A non-emergency ambulance service to a hospital, clinic, physician's office or other medical facility for provision of a Medicaid covered service, exclusive of a pharmacy service, shall be covered upon referral from a licensed medical professional for a recipient whose medical condition warrants transport by stretcher.
- c. When it is determined by the attending physician that ground ambulance is not appropriate, a referral may be made for air ambulance transport to a medical facility beyond the recipient's county of residence or state boundaries. Medically necessary air travel will be covered within the parameters of the allowed reimbursement amounts specified in Attachment 4.19-B, page 20.11. Special authorization by the Commissioner or his designated representative is required for air transportation provided at a cost in excess of these amounts.
- d. Ground ambulance transport for in-state non-emergency ambulance travel outside the medical service area shall be covered if prescribed by the attending physician.
- e. Ground ambulance transport for out-of-state non-emergency ambulance transport shall only be covered if prior approval is obtained from the Department.
- f. Only the least expensive available transportation suitable for the recipients needs shall be approved.

3. Specially Authorized Non-emergency Medical Transportation

- a. A specially authorized transportation service is non-emergency transportation necessary under extraordinary circumstances in which the recipient is required to travel out-of-state for medical treatment unavailable in-state.
- b. The Department assures provision of necessary transportation to and from a provider if the recipient has no other transportation resources.
- c. If transportation is not available free of charge, the Department will cover the least expensive means of appropriate transportation.
- d. Prior approval is required for all specially authorized transportation. When the recipient's medical needs cannot be met within the state, the Department will only approve travel to the nearest facility where those needs can be met.
- e. The Department will cover the following specially authorized transportation services:
 - (1) Transportation for a recipient;
 - (2) Lodging for a recipient, and a parent or attendant, if necessary;
 - (3) Meals, when necessary for the recipient to remain away from home and outside a medical facility while receiving treatment;
 - (4) Transportation and meals for one parent or guardian to accompany a dependent child receiving covered medical services, when treatment requires the child to remain away from home; and
 - (5) Transportation and meals for an attendant who accompanies a recipient receiving medical services, when there is a justifiable need for an attendant. The attendant can be a parent.

23.e. Emergency Hospital Services

Coverage is limited to the provision of emergency services provided in hospitals which have been determined to meet Title XVIII's definition of an emergency hospital.

TN No. 90-36
Supersedes
TN No. None

Approval Date: Nov 14, 1994

Effective Date 10-1-90

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE
MEDICALLY NEEDY

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to withstand repeated use. Coverage of an item of durable medical equipment, medical supplies, prosthetics and orthotics shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; and shall be medically necessary and reasonable.

- a. A provider must be Medicare and Medicaid certified. Items must be medically necessary and, if required, prior authorized.
- b. All miscellaneous codes require prior authorization. Any item that does not have a designated HCPCS code and is determined by the department to be a covered item will use the designated miscellaneous HCPCS code from the HCPCS Coding Book and require prior authorization.
- c. Any item designated by a covered HCPCS code being reimbursed at \$150.00 or more will require prior authorization.
- d. All items of durable medical equipment, prosthetic, orthotic, or medical supply will require a Certificate of Medical Necessity to be kept on file at the provider's office for five (5) years.
- e. The following general types of durable medical equipment, medical supply, prosthetics or orthotics are excluded from coverage under the durable medical equipment program:
 1. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
 2. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
 3. Physical fitness equipment, such as exercycles and treadmills;
 4. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators;
 5. Items needed as a resident of an inpatient program of a hospital, or nursing facility, and
 6. Items considered educational or recreational.
- f. A cast or splint shall be limited to two (2) per ninety (90) day period for the same injury or condition.

TN No: 06-013
Supersedes
TN No: 03-006

Approval Date: 06-12-08

Effective Date: 07/01/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

Citation

Provision(s)

1935(d)(1)

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

TN No.: 05-010
Supersedes
TN No.: NEW

Approval Date: 11/25/05

Effective Date: 01/01/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

Citation(s)	Provision(s)
1927(d)(2) and 1935(d)(2)	<p>1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit -Part D.</p> <p>The following excluded drugs are covered:</p> <ul style="list-style-type: none"><input type="checkbox"/> (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)<input type="checkbox"/> (b) agents when used to promote fertility(see specific drug categories below)<input type="checkbox"/> (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)<input type="checkbox"/> (d) agents hen used for the symptomatic relief cough and colds (see specific drug categories below)<input type="checkbox"/> (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)<input checked="" type="checkbox"/> (f) nonprescription drugs (see specific drug categories below)

TN No.: 05-010
Supersedes
TN No.: NEW

Approval Date: 11/25/05

Effective Date: 01/01/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation(s)	Provision(s)
1927(d)(2) and 1935(d)(2)	<input type="checkbox"/> (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below) (The Medicaid agency lists specific category of drugs below) Kentucky Medicaid will cover all nonprescription drug categories for full benefit dual eligible beneficiaries, which is consistent with Kentucky's policy of covering all nonprescription drug categories for non-dual recipients. Herbal products are not covered.
	<input type="checkbox"/> No excluded drugs are covered.

TN No. 13-026
Supersedes
TN No.: 11-011

Approval Date: 1/23/2014

Effective Date: October 1, 2013

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

- A. Target Groups: By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Aged 0-21 and meet the medical eligibility criteria of Commission for Handicapped Children, the state's Title V Crippled Children's Agency, and
 2. Persons of all ages meeting the medical eligibility criteria of the Commission for Handicapped Children and having a diagnosis of hemophilia.
- The individuals in the target groups may not be receiving case management services under an approved waiver program.
- B. Areas of State in which services will be provided:
- Entire State.
- Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is invoked to provide services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(I) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 a(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

STATE PLAN UNDER TITLE XIX OF TITLE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

D. Definition of Services: (Continued)

1. Assessment of client's medical, social, and functional status and identification of client service needs;
2. Arranging for service delivery from the client's chosen provider to insure access to required services;
3. Insure access to needed services by explaining the need and importance of services in relation to the client's condition;
4. Insure access, quality and delivery of necessary services, and
5. Preparation and maintenance of case record documentation to include service plans, forms, reports, and narratives, as appropriate. •

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management
 - (a) assessment
 - (b) care/services plan development
 - (c) linking/coordination of services
 - (d) reassessment/followup
2. Demonstrated case management experience in coordinating and linking such co=unity resources as required by the target population.
3. Demonstrated experience with the target population. -
4. An administrative capacity to insure quality of services in accordance with state and federal requirements.
5. A financial management system that provide8 documentation of services and costs.
6. Capacity to document and maintain individual case records in accordance with state and federal requirements.
7. Demonstrated ability to assure a referral process consistent with Section 1902 a(23), freedom of choice of provider.
8. Demonstrated capacity to meet the case management service needs of the target population.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

E. Qualifications of Providers (continued)

Qualifications of Case Manager (Only the following can be case managers)

1. Registered Nurse - Must be licensed as a Registered Nurse or possess a valid work permit issued by the Kentucky Board of Nursing.
2. Social Worker - A master's degree in social work supplemented by one year of professional social work experience; or a graduate of a college or university with a bachelor's degree supplemented by two years of professional social work experience.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

This Page is Intentionally Left Blank

This Page is Intentionally Left Blank

This Page is Intentionally Left Blank

State Kentucky

Targeted Case Management Services for Children in the Custody of or at Risk of Being in the Custody of the State, and for Children under the Supervision of the State, and for Adults in Need of Protective Services

- A. Target Groups: By invoking the exception to comparability allowed by 191 5(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Age 0-21 and meet the state's conditions and circumstances to be defined as a child in the custody of or at risk of being in the custody of the state, or a child who is under the supervision of the state, and
 2. Adults who meet the state's conditions and circumstances to be defined as an adult in need of protective services.
- B. Areas of State in which services will be provided:
- Entire State.
- Only in the following geographic areas (authority of Section 1915(g)(1) of the act is invoked to provide services less than statewide):
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 191 5(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service that allows providers to assist eligible individuals in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1 902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services they are referred to. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

- (1) A written assessment of the child or adult's needs;
- (2) Arranging for the delivery of the needed services as identified in the assessment;
- (3) Assisting the child and his family, or the adult, in accessing services needed by the individual child or adult;
- (4) Monitoring the child or adults progress by making referrals, tracking the child or adult's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child or adult's changing needs;
- (5) Performing advocacy activities on behalf of the adult, or the child and his family, to assure that the individual adult or child gains access to the services he or she needs;
- (6) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child or adult's progress, etc. following provision of service to the child or the adult on behalf of the child or adult;
- (7) Providing case consultation (i.e., consulting with the service provider/collateral's in determining the child or adult's status and progress); and
- (8) Performing crisis assistance (i.e., intervention on behalf of the child or adult, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

- (1) Demonstrated capacity to provide all core elements of case management including
 - (a) assessment;
 - (b) care/services plan development;
 - (c) linking/coordination of services; and
 - (d) reassessment/follow-up.
- (2) Demonstrated case management experience in coordinating and linking such community resources as required by one of the target populations.

State Kentucky

- (3) Demonstrated experience with one of the target populations.
- (4) An administrative capacity to insure quality of services in accordance with state and federal requirements.
- (5) A financial management system that provides documentation of services and costs.
- (6) Capacity to document and maintain individual case records in accordance with state and federal requirements.
- (7) Demonstrated ability to assure a referral process consistent with Section 1 902(a)(23) of the Act, freedom of choice of provider.
- (8) Demonstrated capacity to meet the case management service needs of one of the target populations.

Qualifications of Case Manager (Only the following can be case managers)

Each case manager must be employed by an enrolled Medicaid provider or by an approved subcontractor of an enrolled Medicaid provider and must meet the following minimum requirements:

- (1) Have a Bachelor of Arts or Bachelor of Sciences degree in any of the social/behavioral sciences or related fields from an accredited institution; and
 - (2) Have one (1) year of experience working directly with the targeted case management population or performing case management services or have a master's degree in a human service field.
- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1 902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the providers of case management services.
 - (2) Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Targeted Case Management Services for children birth to 3 Participating in the Kentucky Early Intervention Program

- A. Target Groups: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Children birth to three years of age who have developmental disabilities and who meet the eligibility criteria of and are participants in the Kentucky Early Intervention Program.
- The individuals in the target groups may not be receiving case management services under an approved waiver program.
- B. Areas of State in which services will be provided:
- Entire State
 - Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provided services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
 - Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, educational, and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by a case manager to assist and enable a child eligible for services under the Kentucky Early Intervention Program in gaining access to needed medical, social, educational and other services. There are two parts to case management: Initial Service Coordination and Primary Service Coordination. Initial Service Coordination assists the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs-identified Individualized Family Services Plan (IFSP). Primary Service Coordination assists the child and child's family, as it relates to the child's needs, with ongoing service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized. A child would only have one service coordinator at a time.

These activities include:

- (1) Assessment of child's medical, social and functional status and identification of service needs;
- (2) Initial service coordination from notice of referral through initial IFSP development;
- (3) Assuring that all procedural safeguards are met during intake and IFSP development;
- (4) Arranging for and coordinating the development of the child's IFSP;
- (5) Arranging for the delivery of the needed services as identified in the IFSP;
- (6) Assisting the child and his family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs;
- (7) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs;
- (8) Performing activities to enable an eligible individual to gain access to needed services; -
- (9) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
- (10) Providing case consultation (i.e., with the service providers/collaterals in determining child's status and progress);

-
- (11) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services); and
 - (12) Facilitating and coordinating development of the child's transition plan.

E. Qualifications of Providers:

As provided for in Section 1915 (g)(1) of the Social Security Act, qualified providers shall be the Title V agencies and their subcontractors who meet the following Medicaid criteria in order to ensure that case managers for the children with developmental disabilities target group are capable of ensuring that such individuals receive needed services:

1. Demonstrated capacity to provide all core elements of case management including:
 - a) assessment;
 - b) care/services plan development;
 - c) linking/coordination of services; and
 - d) reassessment/follow-up
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population;
3. Demonstrated experience with targeted population;
4. An administrative capacity to insure quality of services in accordance with state and federal requirements; and
5. A financial management system that provides documentation of services and costs.

Qualifications of Case Manager (only the following can be case managers)

Each case manager must be a Kentucky Early Intervention Program certified service provider, and:

- A. Have a Bachelor's degree; and
 - (1) 2 years experience in service coordination for children with disabilities up to age 18; or
 - (2) 2 years experience in service provision to children under six years of age; or

- B. Meet one of the following professional criteria:
 - 1. Audiologist - Licensed or Certified,
 - 2. Family Therapist - M.A. and Certified,
 - 3. Developmental Interventionist - Certified or working toward an Interdisciplinary Early Childhood Certificate as demonstrated by implementing a professional development plan approved by the Cabinet for Health Services,
 - 4. Developmental Associate,
 - 5. Registered Nurse,
 - 6. Advanced Registered Nurse Practitioner,
 - 7. Dietitian - Licensed,
 - 8. Occupational Therapist - Licensed,
 - 9. Occupational Therapist Assistant - B.S. and Licensed,
 - 10. Orientation and Mobility Specialist - Certified,
 - 11. Physical Therapist - Licensed,
 - 12. Psychologist - Licensed or Certified,
 - 13. Speech Language Pathologist - Licensed or Certified,
 - 14. Speech Language Assistance - licensed,
 - 15. Social worker - Licensed,
 - 16. Physician, Licensed,
 - 17. Nutritionist, Licensed

- F. The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the available providers of case management services.
 - (2) Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

- A. Target Group: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Pregnant women who have not reached their twentieth birthday and will be first time teen parents;
 2. Pregnant women who are twenty years of age or older, will be first time parents, and screen positive for the home visitation program, Health Access Nurturing Development Services (HANDS). High risk screening factors include: first time mothers who are single, separated or divorced; those who had late, sporadic or no prenatal care; those who sought or attempted an unsuccessful abortion; partner unemployed; inadequate income or no source of income; unstable housing; no phone; education less than 12 years; inadequate emergency contacts; treatment of or current substance abuse; treatment of abortion; treatment of psychiatric care; relinquishment for adoption, sought or attempted; marital or family problems; treatment of or current depression;
 3. Infants and toddlers up to their third birthday who are children in families described in A.1 and A.2 of this subsection;
 4. First born infants up to twelve (12) weeks of age whose families were not identified prenatally and who assess into the program.
- B. Areas of State in which services will be provided:
- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than state wide:
- C. Comparability of Services:
- Services are provided in accordance with 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of 1902(a)(10)(B).
- D. Definition of Services
- Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education, and other services. Consistent with the

requirement of Section 1 902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by case managers to assess and enable first time mothers and infants/toddlers who are eligible for services under the Kentucky HANDS (Health Access Nurturing Development Services) Program. There are two phases to case management - assessment and home visitation. Both phases include assisting the infant/toddler, mother, or family in accessing needed services, developing a treatment plan, coordinating needed services, monitoring progress, preparing and maintaining case records, providing case consultation as specified by the plan, and providing follow-up and evaluation.

The service activities include:

1. Assessment
 - a) Provided by a Registered Nurse, Social Worker or Early Childhood Development Specialist;
 - b) Conducts a face-to-face needs assessment with the child, mother and family. The assessment shall include:
 - 1) parent's childhood experience;
 - 2) lifestyle behaviors and mental health status;
 - 3) parenting experience;
 - 4) stressors, coping skills and support system for the new family;
 - 5) anger management skills;
 - 6) expectations of infant's developmental milestones and behaviors;
 - 7) perception of new infant, and bonding and attachment issues;
 - 8) plans for discipline; and
 - 9) family environment and support system.
 - c) Develops a written report of the findings and a service plan for the family.
 - d) Assigns home visitor and arranges for the delivery of the needed services by other Medicaid and community providers as identified in the treatment plan.

2. Home Visitation

- a) A public health nurse, social worker, or family support worker who is supervised by a public health nurse, social worker, or early childhood development specialist may perform a home visit;
- b) Assist the child and family, as it relates to the treatment plan, in accessing needed services and coordinating services with other programs;
- c) Monitor progress by making referrals, tracking the appointments, performing follow-up services, and performing periodic evaluation of the changing needs;
- d) Perform activities to enable the child and family to gain access to needed services;
- e) Prepare and maintain case records documenting contacts, services needed, reports, progress;
- f) Provide case consultation (i.e., with the service providers/collaterals in determining child's status and progress); and
- g) Perform crisis assistance (i.e., intervention on behalf of the child, making arrangement for emergency referrals, and coordinating other needed emergency service).

E. Qualifications of Providers:

1. Providers must be certified as a Medicaid provider meeting the following criteria:

- a) Demonstrated capacity to contract statewide for the case management services for the targeted population;
- b) Demonstrated capacity to ensure all components of case management including:
 - 1) screening,
 - 2) assessment,
 - 3) treatment plan development,
 - 4) home visiting,
 - 5) linking/coordination of services, and
 - 6) follow-up and evaluation:
- c) Demonstrated experience in coordinating and linking such community resources as required by the target population:
- d) Demonstrated experience with the target population;

-
- e) Administrative capacity to insure quality of services in accordance with state and federal requirements;
 - f) Demonstrated capacity to provide certified training and technical assistance to case manager;
 - g) Financial management system that provides documentation of services and costs;
 - h) Capacity to document and maintain individual case records in accordance with state and federal requirements;
 - i) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider; and
 - j) Demonstrated capacity to meet the case management service needs of the target population.

2. Qualifications of Case Manager

The case manager shall meet one of the following professional criteria:

- a) Registered Nurse - Must have a valid Kentucky Board of Nursing license as a registered nurse or advanced registered nurse practitioner.
- b) Social Worker - Meet the requirement of KRS Chapter 335 for licensure by the State Board of Examiners of Social Work, have a masters degree in social work, or have a bachelors degree in social work from an accredited institution.
- c) Early Childhood Development Specialist - have a bachelors degree in Family Studies, Early Childhood Education, Early Childhood Special Education, or a related Early Childhood Development Curriculum.
- d) Family Support Worker (FSW) - Have a high school diploma or GED, be 18 years of age or older, and have received core training prior to having family contact on assessment of family strengths and needs, service plan development, home visitor process, home visitor role, supporting growth in families, observing parent-child interactions, knowing indicators of parent-infant attachment, keeping home visit records, conducting service coordination and reassessment. In addition to the core training the family support worker receives continuing training on selected topics including confidentiality, community resources, developmental milestones, family violence, substance abuse, ethical issues, communication skills, I-H V/ training, and interviewing techniques. The FSW must be supervised by a registered nurse or social worker.

- F. The state assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

Targeted Case Management services for pregnant women including postpartum women for sixty (60) day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

- A. By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
- (1) Women diagnosed as a pregnant woman or postpartum woman up to the end of the month of sixty days following the date of delivery who has applied for or is receiving substance abuse services through Medicaid.
- B. Areas of State in which services will be provided:
- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provided services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.
- D. Definition of Services Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education, and other services. Consistent with the requirements of Section 1 902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred
- (1) Substance abuse case management services.
 - (a) Case management shall be.
 1. A face-to-face or telephone contact between or on behalf of an individual and a qualified substance abuse professional; and
 2. For the purpose of reducing or eliminating an individual's substance abuse problem by assisting an individual in gaining access to needed medical, social, educational and other support services
 - (b) Case management services shall include:
 1. The development of a service plan that identifies an individual's case management needs and projected outcomes; and
 2. Activities that support the implementation of an individual's service plan
 - (c) Case management services shall not be connected with a specific type of substance abuse treatment but shall follow an individual across the array of substance abuse treatment services identified in an individual's treatment plan.

-
- (d) Service limitations. The following activities shall not be reimbursed by Medicaid:
1. An outreach or case-finding activity to secure a potential individual for services;
 2. Administrative activities associated with Medicaid eligibility determinations; and
 3. The actual provision of a service other than a case management service.

A. Qualifications of Providers:

- (1) Services are covered when provided by any mental health center, and their subcontractors, and any other qualified providers, licensed in accordance with applicable state laws and regulations.
- (2) Demonstrated capacity to provide all core elements of case management including: Assessment skills, care/services plan development, linking/coordination of services, reassessment/follow-up, training specific to the target population, an administrative capacity to insure quality of services in accordance with state and federal requirements and a financial system that provides documentation of services and costs.
- (3) The provider shall employ or have a contractual agreement with a physician licensed in Kentucky.
- (4) A provider must have staff available to provide emergency services for the immediate evaluation and care of an individual in a crisis situation on a twenty-four (24) hour a day, seven (7) day a week basis.
- (5) Qualifications for case management services:
 - (a) An alcohol and drug counselor certified by the Kentucky Board of Certification for Alcohol and Drug Counselors;
 - (b) An individual who has a bachelors degree or greater in any field, from an accredited college or university who meets the training, documentation and supervision requirements;
 - (c) A Kentucky licensed physician.
 - (d) A psychiatrist who is licensed in Kentucky.
 - (e) A psychologist licensed or certified by the Kentucky Board of Examiners of Psychology;
 - (f) A psychological associate certified by the Kentucky Board of Examiners of Psychology;

- (g) A social worker licensed or certified in Kentucky;
 - (h) A Kentucky licensed registered nurse with the following combinations education and work experience:
 - 1. A registered nurse with a masters degree in psychiatric nursing from an accredited college or university;
 - 2. A bachelor of science degree in nursing from an accredited college or university and one year of clinical work experience in the substance abuse or mental health field;
 - 3. A diploma graduate in nursing and two years of clinical work experience in the substance or mental health field; or
 - 4. An associate degree in nursing from an accredited college or university and three years of clinical work experience in the substance abuse or mental health field;
 - (i) A Kentucky licensed advanced registered nurse practitioner;
 - (j) A marriage and family therapist licensed by the Kentucky Board of Licensure of Marriage and Family Therapists;
 - (k) A Kentucky-certified professional counselor; or
 - (l) A Kentucky-certified professional art therapist.
- F The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the available providers of case management services.
 - (2) Eligible recipients will have free choice of the available providers of other medical care under the plan
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use DisordersTarget Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

- A. The target group includes adults and children who:
1. Have a primary moderate or severe substance use disorder diagnosis or co-occurring substance use disorder and mental health diagnoses; and one or more of the following: (a) Lack of access to recovery supports; (b) Need for assistance with access to housing, vocational, medical, social, educational or other community services and supports; or (c) Involvement with one or more child welfare or criminal justice agencies, but are not inmates of a public institution (e.g., Youth who are awaiting adjudication in the community; individuals on probation or parole; and youth who are committed to the Department of Juvenile Justice and not placed in a public institution, are eligible for receipt of TCM services. Youth who are 'committed to the DJJ' are youth who are in the custody of DJJ but who are placed with their parents, other relatives or "foster" caregivers and not in a DJJ detention Center).
 - Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 30 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)
- B. Areas of State in which services will be provided (§1915(g)(1) of the Act):
- Entire State
 Only in the following geographic areas:
- C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
- Services are provided in accordance with §1902(a)(10)(B) of the Act.
 Services are not comparable in amount duration and scope (§1915(g)(1)).
- D. Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:
1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - a. taking client history;
 - b. identifying the individual's needs and completing related documentation; and
 - c. gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - d. a face-to-face assessment or reassessment must be completed at least annually, or more often if needed based on changes in the individual's condition.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use Disorders

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - a. specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - b. includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - c. identifies a course of action to respond to the assessed needs of the eligible individual.
 3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - a. activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
 4. Monitoring and follow-up activities:
 - a. activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - (1) services are being furnished in accordance with the individual's care plan;
 - (2) services in the care plan are adequate; and
 - (3) changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
 - (4) monitoring shall occur no less than once every three (3) months and shall be face-to-face.
- Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use Disorders

- E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
1. Case management services for this target group may be provided by enrolled Kentucky Medicaid providers in any of the following categories:
 - a. Individual practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill Kentucky Medicaid.
 - b. Provider group: A group of more than one individually licensed practitioners who forms a business entity to render health services and bill Kentucky Medicaid.
 - c. Licensed organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render health services and bill Kentucky Medicaid.
 2. Providers must meet the following criteria:
 - a. Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
 - b. Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
 - c. Have the administrative capacity to provide quality of services in accordance with state and federal requirements;
 - d. Use a financial management system that provides documentation of services and costs;
 - e. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements;
 - f. Demonstrate programmatic and administrative experience in providing comprehensive case management services; and
 - g. Demonstrate referral systems and linkages and referral ability with essential social and health services agencies.
 3. Each case manager shall be required to meet the following minimum requirements:
 - a. Bachelor of Arts or Sciences degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services); and
 - b. A minimum of one (1) year of full-time employment working directly with adolescents or adults in a human service setting after completion of educational requirements or a master's degree in a behavioral science, as defined above, may substitute for the one (1) year of experience;
 - c. Successful completion of case management training approved by the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KBHDID) within six (6) months of employment, and completion of recertification requirements approved by KBHDID every three (3) years; and
 - d. Supervision by a behavioral health professional, who has completed case management training approved by KBHDID, shall occur at least two (2) times per month. At least one of these supervisory contacts shall be on an individual basis and face-to-face. Behavioral health professional is defined as:

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use Disorders

- (1) Individuals that are licensed and have autonomous functioning:
- Advanced Practice Registered Nurse (APRN)
 - Licensed Clinical Social Worker (LCSW)
 - Licensed Marriage and Family Therapist (LMFT)
 - Licensed Professional Clinical Counselor
 - Licensed Psychological Practitioner
 - Licensed Psychologist
 - Licensed Professional Art Therapist
 - Physician
 - Psychiatrist
 - Certified Alcohol and Drug Counselor (CADC)

Or

- (2) Master's level Individuals listed below under supervision:
- Certified Psychologist
 - Licensed Psychological Associate
 - Licensed Marriage and Family Therapy Associate.
 - Certified Social Worker, Master Level
 - Licensed Professional Counselor Associate
 - Licensed Professional Art Therapist Associate
 - Registered nurse licensed by the Kentucky Board of Nursing

Or

- (3) Bachelor's level with the following requirements:
- Registered nurse licensed by the Kentucky Board of Nursing; OR
 - A Bachelor's degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services) AND
 - Five (5) years of documented full-time experience providing specialized case management within target population.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use Disorders

F. Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

- Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

H. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

I. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Substance Use Disorders

J. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

K. Limitations:

1. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
2. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
3. FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))
4. The individuals in the target groups may not be receiving case management services under an approved waiver program.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health IssuesTarget Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

- A. The target group includes adults and children who:
1. Have at least one of the following types disorders:
 - a. A primary moderate or severe substance use disorder diagnosis;
 - b. A severe mental illness (SMI) diagnosed based on the criteria included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, with clinically significant symptoms which have persisted in the individual for a continuous period of at least two (2) years, or that the individual has been hospitalized for mental illness more than once in the last two (2) years, and that the individual is presently significantly impaired in his ability to function socially or occupationally or both [KRS 210.005(3)];
 - c. A severe emotional disability diagnosed based on the criteria included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, that presents substantial limitations that have persisted for at least one (1) year or are judged by a mental health professional to be at high risk of continuing for one (1) year without professional intervention in at least two (2) of the following five (5) areas:
 - (1) self-care,
 - (2) interpersonal relationships,
 - (3) family life,
 - (4) self-direction, and education,
 - (5) or has been removed from the child's home by the Department for Community-Based Services and has been unable to be maintained in a stable setting due to behavioral or emotional disturbance [KRS 200.503(2)]; and
 2. Have a chronic or complex physical health issue; and
 3. Need assistance with access to housing, vocational, medical, social, educational or other community services and supports; or
 4. Involvement with one or more child welfare or criminal justice agency (not including inmates of public institutions) (e.g., Youth who are awaiting adjudication in the community; individuals on probation or parole; and youth who are committed to the Department of Juvenile Justice and not placed in a public institution, are eligible for receipt of TCM services. Youth who are 'committed to the DJJ' are youth who are in the custody of DJJ but who are placed with their parents, other relatives or "foster" caregivers and not in a DJJ detention Center); or
 5. Are in the custody of the Department for Community-Based Services or at risk of out-of-home placement; or are at risk of in-patient mental health treatment.
 - Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 30 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

- B. Areas of State in which services will be provided (§1915(g)(1) of the Act):
- Entire State
 - Only in the following geographic areas:
- C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
- Services are provided in accordance with §1902(a)(10)(B) of the Act.
 - Services are not comparable in amount duration and scope (§1915(g)(1)).
- D. Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:
1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - a. taking client history;
 - b. identifying the individual's needs and completing related documentation; and
 - c. gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - d. A face-to-face assessment or reassessment must be completed at least annually, or more often if needed based on changes in the individual's condition.
 2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - a. specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - b. includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - c. identifies a course of action to respond to the assessed needs of the eligible individual.
 3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - a. activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

4. Monitoring and follow-up activities:
 - a. activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - (1) services are being furnished in accordance with the individual's care plan;
 - (2) services in the care plan are adequate; and
 - (3) changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
 - (4) Monitoring shall occur no less than once every three (3) months and shall be face-to-face.
 - Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))
- E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
 1. Case management services for this target group may be provided by enrolled Kentucky Medicaid providers in any of the following categories:
 - a. Individual practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill Kentucky Medicaid.
 - b. Provider group: A group of more than one individually licensed practitioners who forms a business entity to render health services and bill Kentucky Medicaid.
 - c. Licensed organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render health services and bill Kentucky Medicaid.
 2. Providers must meet the following criteria:
 - a. Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
 - b. Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
 - c. Have the administrative capacity to provide quality of services in accordance with state and federal requirements;

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

- d. Use a financial management system that provides documentation of services and costs;
 - e. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements;
 - f. Demonstrate programmatic and administrative experience in providing comprehensive case management services; and
 - g. Demonstrate referral systems and linkages and referral ability with essential social and health services agencies.
3. Each case manager shall be required to meet the following minimum requirements:
- a. Master's degree in social work, family studies, clinical counseling, psychology, nursing or related human services field approved by the Department for Medicaid Services; and a minimum of two (2) years' experience providing service coordination or linking/referring for community based services for individuals with complex behavioral health needs and co-occurring physical or behavioral health disorders or multi-agency involvement; or
 - b. A Bachelor's degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services) and five (5) years' experience providing service coordination or linking/referring for community based services for individuals with complex behavioral health needs and co-occurring physical or behavioral health disorders or multi-agency involvement; and
 - c. Successful completion of case management training approved by the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KBHDID) within six (6) months of employment, and completion of recertification requirements approved by KBHDID every three (3) years; and
 - d. Bachelor's level staff shall be supervised by a behavioral health professional, who has completed case management training approved by KBHDID. Supervision shall occur at least three (3) times per month. At least two of these supervisory contacts shall be on an individual basis and face-to-face. Behavioral health professional is defined as:
 - (1) Individuals that are licensed and have autonomous functioning:
 - Advanced Practice Registered Nurse (APRN)
 - Licensed Clinical Social Worker (LCSW)
 - Licensed Marriage and Family Therapist (LMFT)
 - Licensed Professional Clinical Counselor
 - Licensed Psychological Practitioner
 - Licensed Psychologist
 - Licensed Professional Art Therapist
 - Physician
 - Psychiatrist
 - Certified Alcohol and Drug Counselor (CADC)

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

Or

- (2) Master's level Individuals listed below under supervision:
- Certified Psychologist
 - Licensed Psychological Associate
 - Licensed Marriage and Family Therapy Associate.
 - Certified Social Worker, Master Level
 - Licensed Professional Counselor Associate
 - Licensed Professional Art Therapist Associate
 - Registered nurse licensed by the Kentucky Board of Nursing

Or

- (3) Bachelor's level with the following requirements:
- Registered nurse licensed by the Kentucky Board of Nursing; OR
 - A Bachelor's degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services) AND
 - Five (5) years of documented full-time experience providing specialized case management within target population.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

F. Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

- Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

H. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

I. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues

J. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

K. Limitations:

1. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
2. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c)).
3. FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))
4. The individuals in the target groups may not be receiving case management services under an approved waiver program.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental IllnessTarget Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

- A. The target group adults and children individuals who:
1. Have a severe mental illness (SMI) diagnosed based on the criteria included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, with clinically significant symptoms which have persisted in the individual for a continuous period of at least two (2) years, or that the individual has been hospitalized for mental illness more than once in the last two (2) years, and that the individual is presently significantly impaired in his ability to function socially or occupationally or both [KRS 210.005(3)]; or
 2. Are age 20 or younger and have a severe emotional disability diagnosed based on the criteria included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, that presents substantial limitations that have persisted for at least one (1) year or are judged by a mental health professional to be at high risk of continuing for one (1) year without professional intervention in at least two (2) of the following five (5) areas:
 - a. self-care,
 - b. interpersonal relationships,
 - c. family life,
 - d. self-direction,
 - e. and education; or
 3. Has been removed from the child's home by the Department for Community-Based Services and has been unable to be maintained in a stable setting due to behavioral or emotional disturbance [KRS 200.503(2)]; and
 4. Are in the custody of the Department for Community-Based Services, or at risk of out-of-home placement; or are children or adults at risk of in-patient mental health treatment.
- Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 30 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)
- B. Areas of State in which services will be provided (§1915(g)(1) of the Act):
- Entire State
 Only in the following geographic areas:
- C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
- Services are provided in accordance with §1902(a)(10)(B) of the Act.
 Services are not comparable in amount duration and scope (§1915(g)(1)).

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental Illness

- D. Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:
1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - a. taking client history;
 - b. identifying the individual's needs and completing related documentation; and
 - c. gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - d. An assessment or reassessment must be completed at least annually, or more often if needed based on changes in the individual's condition.
 2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - a. specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - b. includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - c. identifies a course of action to respond to the assessed needs of the eligible individual.
 3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - a. activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
 4. Monitoring and follow-up activities:
 - a. activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - (1) services are being furnished in accordance with the individual's care plan;
 - (2) services in the care plan are adequate; and
 - (3) changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
 - (4) Monitoring shall occur no less than once every three (3) months and shall be face-to-face.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental Illness

- Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. Case management services for this target group may be provided by enrolled Kentucky Medicaid providers in any of the following categories:
 - a. Individual practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill Kentucky.
 - b. Provider group: A group of more than one individually licensed practitioners who forms a business entity to render health services and bill Kentucky Medicaid.
 - c. Licensed organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render health services and bill Kentucky Medicaid.
2. Providers must meet the following criteria:
 - a. Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
 - b. Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
 - c. Have the administrative capacity to provide quality of services in accordance with state and federal requirements;
 - d. Use a financial management system that provides documentation of services and costs;
 - e. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements;
 - f. Demonstrate programmatic and administrative experience in providing comprehensive case management services; and
 - g. Demonstrate referral systems and linkages and referral ability with essential social and health services agencies.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental Illness

3. Each case manager shall be required to meet the following minimum requirements:
- a. Bachelor of Arts or Sciences degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services); and
 - b. A minimum of one (1) year of full-time employment working directly with individuals with behavioral health needs after completion of educational requirements or a master's degree in a behavioral science, as defined above, may substitute for the one (1) year of experience;
 - c. Successful completion of case management training approved by the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KBHDID) within six (6) months of employment, and completion of recertification requirements approved by KBHDID every three (3) years; and
 - d. Supervision by a behavioral health professional, who has completed case management training approved by KBHDID, shall occur at least two (2) times per month. At least one of these supervisory contacts shall be on an individual basis and face-to-face. Behavioral health professional is defined as:
 - (1) Individuals that are licensed and have autonomous functioning:
 - Advanced Practice Registered Nurse (APRN)
 - Licensed Clinical Social Worker (LCSW)
 - Licensed Marriage and Family Therapist (LMFT)
 - Licensed Professional Clinical Counselor
 - Licensed Psychological Practitioner
 - Licensed Psychologist
 - Licensed Professional Art Therapist
 - Physician
 - Psychiatrist
 - Certified Alcohol and Drug Counselor (CADC)

Or

 - (2) Master's level Individuals listed below under supervision:
 - Certified Psychologist
 - Licensed Psychological Associate
 - Licensed Marriage and Family Therapy Associate.
 - Certified Social Worker, Master Level
 - Licensed Professional Counselor Associate
 - Licensed Professional Art Therapist Associate
 - Registered nurse licensed by the Kentucky Board of Nursing

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental Illness

Or

- (3) Bachelor's level with the following requirements:
- Registered nurse licensed by the Kentucky Board of Nursing; OR
 - A Bachelor's degree in a behavioral science (including psychology, sociology, social work, family studies, human services, counseling, nursing or another human service degree program approved by the Department for Medicaid Services) AND
 - Five (5) years of documented full-time experience providing specialized case management within target population.

F. Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

- Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

H. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

State Plan under Title XIX of the Social Security Act

TARGETED CASE MANAGEMENT SERVICES

Adults and Children with Severe Emotional Disability or Severe Mental Illness

I. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

J. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

K. Limitations:

1. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
2. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
3. FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))
4. The individuals in the target groups may not be receiving case management services under an approved waiver program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

Attachment 3.1-C
Page 9.1

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 74-1

Approval Date: 12-04-13

Effective Date: 01/01/2014

This page intentionally left blank

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-012

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-012

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-012

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-012

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-012

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-012

Approval Date: 12-04-13

Effective Date: 01/01/2014

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-012

Approval Date: 12-04-13

Effective Date: 01/01/2014

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

This page intentionally left blank

TN No. 13-024
Supersedes
TN. No. 06-010

Approval Date: 12-04-13

Effective Date: 01/01/2014

Transportation (For Categorically Needy and Medically Needy)

- A. The Department for Medicaid Services assures that medically necessary transportation OF recipients to and from providers of service will be provided. The methods that will be used are as follows:
1. Any appropriate means of transportation which can be secured without charge through volunteer organizations, public services such as fire department and public ambulances, or relatives will be used.
 2. If transportation is not available without charge, payment will be made for the least expensive means of transportation suitable to the recipient, whenever determined to be medically necessary through preauthorization, postauthorization, or through the patient's meeting certain specified criteria relating to destination, point of departure, and condition.
 3. When transportation is required on a predictable basis, an amount to cover the transportation is allowed as a spenddown by the medically needy.
 4. When medical transportation is required, a preauthorization system at the local level is used for nonemergency transportation.
 5. Payments for locally authorized medical transportation shall be made directly to participating providers by the Medicaid Program.
 6. All Medicaid participating medical transportation providers, including private automobile carriers, shall have a signed participation agreement with the Department for Medicaid Services prior to furnishing the medical transportation service.
 7. Locally authorized medical transportation shall be provided on an exceptional postauthorization basis for nonemergency, medically necessary transportation under the following conditions: the client can justify the need for medical transportation arose and was provided; was provided outside the normal working hours; payments for the transportation has not been made; client was traveling to or from a medical service covered under the state plan, except for pharmaceutical services; and service was determined medically necessary by the state agency.

-
- B. Ambulance service shall be reimbursable only when it is the least expensive and most appropriate for the recipient's medical needs and the following criteria shall be met.
1. Emergency ambulance services to the nearest appropriate medical facility are provided without preauthorization when the emergency treatment is specified and rendered.
 2. Nonemergency ambulance services to a hospital, clinic, physician's office, or other health facility to secure medically necessary Medicaid covered services for a "stretcher bound" Medicaid recipient. "Stretcher bound" denotes the inability to get up from bed without assistance, the inability to ambulate, and the inability to sit in a chair or wheelchair.
 3. Any determination of medical necessity of transportation, and provision of preauthorization and postauthorization, is made by the Department for Medicaid Services or by the Department's authorized representative. Transportation only within the medical service area is approved unless preauthorized by the agency (or postauthorized in certain instances), unless previously designated criteria for transportation not requiring authorization are met.

State/Territory: Kentucky

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

General Coverage Criteria. The following general coverage criteria shall be applicable with regard to organ transplants.

1. For an organ transplant to be covered under the Medicaid Program, it must be the opinion of the transplant surgeon that the transplant is medically necessary; the failure to perform the organ transplant would create a life-threatening situation; and the prognosis must be that there is a reasonable expectation the transplant will be successful and result in prolonged life of quality and dignity.
2. The hospital and physician performing the transplant must be recognized by the Medicaid Program as being competent to perform the transplant. A staff and functioning unit at the hospital designed for and/or accustomed to performing transplants of nature envisioned, recognized as competent by the medical community, will ordinarily be considered competent by the program.

Reimbursement for Organ Transplants. Hospital payments for organ transplants will be set at eighty (80) percent of actual usual and customary charges with total payments not to exceed \$75,000 per transplant without regard to usual program limits on hospital length-of-stay. An exception to the maximum payment limit can be made by the Commissioner, Department for Medicaid Services on a case by case basis when the maximum payment limit restricts medically appropriate care or prohibits the availability of the needed transplant procedure or service. Physician payments for organ transplants will be at the usual Medicaid Program rates.

Application of Organ Transplants Policy. It is the intent of the Department for Medicaid Services that the organ transplant policy be applied uniformly and consistently so that the similarly situated individuals will be treated alike. To accomplish this goal the Department will use the methodology specified in this section in receiving and processing requests for coverage and payments for organ transplants.

1. All requests for authorization for organ transplants must be sent to the Commissioner, Department for Medicaid Services.

State/Territory: Kentucky

2. The Commissioner will assign the request to appropriate staff for investigation, report and recommendation. The report must show whether the person requesting the transplant is Medicaid eligible (or approximately when the person will become eligible); the type of transplant requested; the name of the facility (and physician if considered necessary) where the transplant is to be performed; any fee arrangement that has been made with the facility and/or physician (or a statement as to whether there is a disagreement with regard to fees); the proposed date of the transplant; the prognosis; a finding as to whether the facility/physician is considered qualified for the transplant being considered; and a finding as to whether program criteria for coverage is met.
3. After consideration of the report and recommendation, the Commissioner will determine whether the general coverage criteria are met and payments for the transplant should be made. If the decision is to provide coverage, Medicaid Program staff will assist the recipient with necessary arrangements for the transplant. If the decision is negative, the recipient will be notified of the manner in which the request does not meet agency guidelines.

Scope of Coverage. This organ transplant policy is applicable with regard to the following types of transplant: heart, lung, bone marrow and liver. Other types of transplants will also be covered under this policy upon identification and request except when special treatment of the transplant services is not considered necessary (i.e., usual program coverage and reimbursement is considered adequate), or when the transplant is considered by the Department for Medicaid Services to be experimental in nature. The Medicaid Program will not cover experimental transplants, i.e., those which have not previously been proven effective in resolving the health problems for which the transplant is the proposed preferable treatment mode.

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Page Intentionally Left Blank

Citation	Condition or Requirement
----------	--------------------------

1932(a)(1)(A) AA Section 1932(a)(1)(A) of the Social Security Act.

The State of Kentucky enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

A recipient, who has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, will be restricted to one or more of the following:

- (1) *One (1) primary care provider who:*
 - a. *Shall be accessible to the recipient within normal time and distance standards for the community in which the recipient resides;*
 - b. *Shall provide services and manage the lock-in recipient’s necessary health care services;*
 - c. *If the lock-in recipient needs a specialty service that the designated primary care provider is unable to provide, the designated primary care provider shall refer the lock-in recipient to other providers as necessary so the recipient receives all medical necessary services.*
 - d. *Shall participate in the recipient’s periodic utilization review*
 - e. *If the designated primary care provider is a physician, he may also serve as the lock-in recipient’s designated controlled substance prescriber; or*
- (2) *One (1) prescriber for non emergency prescriptions for controlled substances. This provider shall serve as the sole prescriber and manager of controlled substances for the lock-in recipient.*

For B.1 and B.2, place a check mark on any or all that apply.

Citation	Condition or Requirement
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)	1. The State will contract with an ___ i. MCO <u>X</u> ii. PCCM (including capitated PCCMs that qualify as PAHPs) ___ iii. Both
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	2. The payment method to the contracting entity will be: ___ i. fee for service; ___ ii. capitation; <u>X</u> iii. a case management fee; ___ iv. a bonus/incentive payment; ___ v. a supplemental payment, or ___ vi. other. (Please provide a description below).
1905(i) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

Not applicable

If applicable to this state plan, place a check mark to affirm the state has met **all** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

- ___ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.
- ___ ii. Incentives will be based upon specific activities and targets.
- ___ iii. Incentives will be based upon a fixed period of time.
- ___ iv. Incentives will not be renewed automatically.
- ___ v. Incentives will be made available to both public and private PCCMs.
- ___ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

Citation	Condition or Requirement
	<p><u>X</u> vii. Not applicable to this 1932 state plan amendment.</p>
CFR 438.50(b)(4)	<p>4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. <i>(Example: public meeting, advisory groups.)</i></p> <p><i>In order to implement this program, the State had to file an Administrative Regulation with the Legislative Research Commission. As a result, a Public Hearing was conducted allowing the public to testify in support of or in opposition of this new program.</i></p> <p><i>The state also published Public Notices in the states three largest newspapers outlining this program.</i></p> <p><i>In addition, letters were sent to all providers and hospitals prior to implementation. The state also sent a letter to all current Lock-In participants explaining the new program.</i></p> <p><i>The state will continue to work with providers, legislators, advocates and recipients as this program is implemented through provider education meetings and letters.</i></p>
1932(a)(1)(A)	<p>5. The state plan program will ____/will not <u>X</u> implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory <u>X</u>/voluntary____ enrollment will be implemented in the following county/area(s):</p> <p><i>The Lock In program will be in all counties of the state except the current 16 counties covered through Passport. Passport (PHP) does their own Lock-In Program and oversees their locked in population/members for the 16 counties in the greater Louisville area</i></p> <p><i>Mandatory enrollment shall be initiated for a recipient if in any two (2) 180 calendar day periods within an eighteen (18) months' timeframe.</i></p> <ul style="list-style-type: none"><i>(a) Received services from at least five (5) different providers;</i><i>(b) Received at least ten (10) different prescription drugs; and received prescriptions from at least three (3) or more different pharmacies; or</i><i>(c) Had at least four (4) hospital emergency department visits for a condition that was not an emergency medical condition; or</i><i>(d) Received services from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition.</i>

Citation	Condition or Requirement
----------	--------------------------

- i. county/counties (mandatory) _____
- ii. county/counties (voluntary)_____
- iii. area/areas (mandatory)_____
- iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met

Exception would be freedom of choice as outlined in 42CFR 431.54.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)

4. The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as 1905(a)(4)(C) defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)

5. The state assures that all the applicable requirements 42CFR Part 38The state as for MCOs and PCCMs will be met.

Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. ___ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met. Not applicable – this is not an “at risk” contract.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. <u>X</u> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 74.40	8. <u>X</u> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. <u>Eligible groups</u>
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. <i>Eligible groups are as identified in Section B-5 of the pre-print as over utilizing Medicaid services. Any Medicaid recipient that is at least 19 years of age or not in the Passport service area that has been found to over utilize Medicaid services will be placed in the Lock-In program.</i>
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. <i>Not applicable – no voluntary enrollment</i>

Citation	Condition or Requirement
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ___ Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. (<i>Example: Recipients, who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.</i>)
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ___ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. ___ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ___ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ___ Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)	vi. ___ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ___ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.
E.	<u>Identification of Mandatory Exempt Groups</u> <i>Children, under the age of 19 years of age are exempt from the Lock-In Program</i>
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (<i>Examples: children receiving services at a specific clinic or enrolled in a particular program.</i>) <i>Children, under the age of 19 years of age are exempt from the Lock-In Program</i>

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	<p>2. Place a check mark to affirm if the state's definition of title V children is determined by:</p> <p><i>Not applicable because no one under the age of 19 will be enrolled into the Lock – In</i></p> <p><input type="checkbox"/> i. program participation, <input type="checkbox"/> ii. special health care needs, or <input type="checkbox"/> iii. both</p>
1932(a)(2) 42 CFR 438.50(d)	<p>3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.</p> <p><i>Not applicable because no one under the age of 19 will be enrolled into the Lock – In</i></p> <p><input type="checkbox"/> i. yes <input type="checkbox"/> ii. no</p>
1932(a)(2) 42 CFR 438.50 (d)	<p>4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (<i>Examples: eligibility database, self-identification</i>)</p> <p><i>Children, under the age of 19 years of age are exempt from the Lock-In Program. Children will be identified through age edits in the MMIS system. This response is applicable to item i. – iv. Below.</i></p> <p>i. Children under 19 years of age who are eligible for SSI under title XVI;</p> <p>ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;</p> <p>iii. Children under 19 years of age who are in foster care or other out-of-home placement;</p> <p>iv. Children under 19 years of age who are receiving foster care or adoption assistance.</p>

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	<p>5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. <i>(Example: self-identification)</i></p> <p><i>All children under 19 years of age are exempt from the Lock-In Program.</i></p>
1932(a)(2) 42 CFR 438.50(d)	<p>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: <i>(Examples: usage of aid codes in the eligibility system, self-identification)</i></p> <p>i. Recipients who are also eligible for Medicare.</p> <p><i>Medicare recipients are exempt from the Lock-In Program and will be identified through MMIS edits.</i></p> <p>ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</p> <p><i>Not applicable – Kentucky does not have Indian Tribes</i></p>
42 CFR 438.50	<p>F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</p> <p><i>Nursing facility patients that have been in the nursing home or long-term care facility for more than 30 days in a given calendar year are exempt</i></p>
42 CFR 438.50	<p>G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u></p> <p><i>Not applicable.</i></p>

Citation	Condition or Requirement
	H. <u>Enrollment process.</u>
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. <i>Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program.</i> Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i). <i>If the recipient's provider has agreed to be a Lock In provider, the recipient will be allowed to continue treatment with the existing provider.</i> ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). <i>If the recipient's provider has agreed to be a Lock In provider, the recipient will be allowed to continue treatment with the existing provider.</i> iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). (Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p>3. As part of the state's discussion on the default enrollment process, include the following information:</p> <ul style="list-style-type: none">i. The state will <u>X</u> /will not ____ use a lock-in for managed care managed care.ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. <i>(Example: state generated correspondence.)</i> <i>Lock-In recipients will receive a letter from the KY Department for Medicaid Services informing them that they are being placed in the Lock-In Program. The letter will outline the reason they are being placed in the Program, and allowing them 30 days to select their Primary Care Physician (PCP) or narcotic provider or one will be assigned for them. Medicaid recipients shall have a choice from at least two (2) participating providers in their area</i>iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. <i>(Examples: state generated correspondence, HMO enrollment packets etc.)</i> <i>Not applicable under authority of 42 CFR 431.54</i>v. Describe the default assignment algorithm used for auto-assignment. <i>(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</i> <i>Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program</i>

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p>vi. Describe how the state will monitor any changes in the rate of default assignment. (<i>Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker</i>)</p> <p><i>Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program</i></p> <p>I. <u>State assurances on the enrollment process</u></p> <p>Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.</p> <p><i>Not applicable for this program under authority of 42 CFR 431.54</i></p> <p>1. <input checked="" type="checkbox"/> The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.</p> <p>2. <input checked="" type="checkbox"/> The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).</p> <p><i>Except as outlined in 42 CFR 431.54</i></p> <p>3. <input checked="" type="checkbox"/> The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.</p> <p><input type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p> <p>4. <input type="checkbox"/> The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)</p> <p><input checked="" type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p>

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p>5. <u>X</u> The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.</p> <p><u> </u> This provision is not applicable to this 1932 State Plan Amendment.</p> <p>J. <u>Disenrollment</u></p> <p>1. The state will <u>X</u>/will not <u> </u> use lock-in for managed care.</p> <p>2. The lock-in will apply for <u>24</u> months (up to 24 months).</p> <p><i>We initially lock the member in for 24 months but at 12 months intervals, member utilization reviews are conducted. (Any subsequent lock in period is for 12 months at a time)</i></p> <p><i>Per authority of 42 CFR 431.54</i></p> <p>3. Place a check mark to affirm state compliance.</p> <p><u>X</u> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).</p> <p><i>The state does not allow disenrollment without cause.</i></p> <p>4. Describe any additional circumstances of "cause" for disenrollment (if any).</p> <p><i>Recipient or provider may request to disenroll from the Lock In program if:</i></p> <p>(a) <i>the designated provider submits to the department a written request for a release from serving as the recipient's designated provider. The provider shall continue to serve as the recipient's designated provider until a comparable designated provider is selected;</i></p> <p>(b) <i>The recipient relocates outside of the designated provider's geographic area;</i></p>

Citation	Condition or Requirement
	(c) The recipient submits a written request to the department which: 1. Requests a designated provider change; and 2. Includes information to support cause or a necessary reason for the change, including the recipient: (d) Was denied access to a needed medical service; (e) Received poor quality of care; or (f) Does not have access to a provider qualified to treat the recipient's health care needs; (g) The designated provider withdraws or is terminated from participation in the Medicaid Program; or (h) The department determines that it is in the best interest of the lock-in recipient to change the designated provider.
	<u>K. Information requirements for beneficiaries</u> Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	<u>X</u> The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	<u>L. List all services that are excluded for each model (MCO & PCCM)</u>

Citation	Condition or Requirement
1932 (a)(1)(A)(ii)	<p>M. <u>Selective contracting under a 1932 state plan option</u></p> <p>To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.</p> <p><i>Not applicable</i></p> <ol style="list-style-type: none">1. The state will____/will not <u>X</u> intentionally limit the number of entities it contracts under a 1932 state plan option.2. ____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (<i>Example: a limited number of providers and/or enrollees.</i>)4. <u>X</u> The selective contracting provision in not applicable to this state plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Kentucky

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

Yes No

2. Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

Yes No

3. All individuals eligible under the State's approved title XIX plan.

4. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. Eligible categorically needy individuals

3. Eligible medically needy individuals

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

Attachment 4.11-A
Page 14.1

STANDARDS FOR INSTITUTIONS

Standards to be utilized by state authorities for approval of institutions to participate in Title XIX of the Social Security Act are as follows:

1. Standards established for institutional certification by Title XVIII of the Social Security Act. The types and kinds of institutions in which medical care and services may be provided to eligible recipients are:
 - a. Hospitals certified to participate under Title XVIII of the Social Security Act or determined currently to meet the requirements for such participation.
 - b. State and private institutions for mental diseases which meet the requirements for a psychiatric hospital under Title XVIII, Section 1861 (f) of the Social Security Act.
 - c. State institutions for tuberculosis which meet the requirements for a tuberculosis hospital under Title XVIII, Section 1861 (g) of the Social Security Act.
 - d. Skilled nursing facilities certified to participate under Title XVIII of the Social Security Act or determined currently to meet the requirements for such participation.
2. Standards governing Title XIX requirements of participation for intermediate care facilities are described as follows:
 - a. Meet federal, state and local laws and hold a current license as an intermediate care facility.
 - b. Have an advisory physician or a medical advisory committee composed at least one licensed physician who shall be responsible for advising the administrator on the overall medical management of the patients in the facility.
 - c. Have an administrator responsible for the written program of medical services that indicates the scope of care to be provided, the policies relating to, and procedures for implementation of the services.
 - d. Assure that each patient is under the supervision of a licensed physician;
 - e. Have a Director of Nursing Services responsible for the supervision of the organized nursing staff and the nursing services that are provided in the facility, establishing minimum qualifications for nursing personnel and participating in the development of policies related to patient care.

- f. Have procedures for administration of pharmaceutical services in accordance with accepted medical practice.
- g. Establish and maintain adequate records which shall include a medical record for each patient, financial records of personal money for each patient, and a permanent chronological patient registry indicating date of admission, discharge, or death.
- h. Have a qualified Director of Food Service who is responsible for the provision of dietary services that will maintain adequate nutrition and contribute appreciably to the patients total well—being.
- i. Have social services available to assist all residents in dealing with related social problems.
- j. Maintain administrative records to reflect expenditures related to food purchase and personnel employed by the facility.
- k. Be in compliance with Title VI of the Civil Rights Act of 1964.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State Kentucky

Attachment 4.16-A
Page 18.1

Cooperative Arrangements with State Health and State Vocational
Rehabilitation Agencies

The following is a description of the cooperative arrangements with the State health and State vocational rehabilitation agencies by means of which the services administered or supervised by those agencies will be utilized to the maximum degree and will be coordinated with the medical care and services provided by State agency under the plan:

1. The agreement with the Bureau of Rehabilitation Service, Department of Education, the state vocational rehabilitation agency, provides for fulfillment of the requirements of 42 FR 431.615. A copy of this agreement is attached. (Attachment 4.16-A.1)
2. The provisions of the agreement between the former Departments of Health and Economic Security fulfill the requirements of 42 CFR 431.615 and continue to remain in force. A copy of this agreement is attached. (Attachment 4.16-A.2)
3. The intra-cabinet memorandum of agreement with the Department for Health Services provides for preventive and remedial health care services for eligible Medicaid recipients and fulfills the requirements of 42 CFR 431.615.
4. The intra-cabinet memorandum of agreement with the Department for Mental Health and Mental Retardation Services provides for prescreening, annual resident review, and other administrative functions relating to Preadmission Screening and Annual Resident Review (PASAPR) and fulfills the requirements of 42 CFR 431.620.
5. The state agency provides for the coordination of the operations under Title XIX with the states operations under the special supplemental food program for Women, Infants, and Children under Section 17 of the Child Nutrition Act of 1966 by notifying all Medicaid recipients of the availability of WIC benefits and referring such potential WIC eligible to the WIC Program.
6. The interagency memorandum of agreement with the Commission for Handicapped Children provides for Title V Grantee services and fulfills the requirements of 42 CFR 431.615.

TN No. 92-10
Supersedes
TN No. 90-29

Approval Date 5/12/92

Effective Date 4-1-1992

7. The intra-cabinet memorandum of agreement with the Department for Public Health, the Department for Community Based Services and the Department for Mental Health and Mental Retardation Services provides for targeted case management services for Medicaid eligible recipients including children in the custody of or at risk of being in the custody of the state, and children under the supervision of the state, and adults who may require protective services from the state, and fulfills the requirements of 42 CFR 431.615.

8. The intra-cabinet memorandum of agreement with the Department for Public Health, the Department for Community Based Services and the Department for Mental Health and Mental Retardation Services provides for rehabilitative services for children in the custody of or at risk of being in the custody of the state, and for children under the supervision of the state, and fulfills the requirements of 42 CFR 431 .615.

9. The interagency agreements with the Commission for Children with Special Health Care Needs and the Department for Public Health provide for targeted case management, and diagnostic, preventive, and rehabilitative early intervention services for Medicaid eligible recipients participating in the Kentucky Early Intervention Program for infants and toddlers, and fulfills the requirements of 42 CFR 431-615.
10. The Title V interagency agreement with the Department for Public Health provides for targeted case management to first time parenting pregnant women and their infants and toddlers up to three (3) years of age. Eligible recipients are those women and their infants that screen positive on the screening tool adopted for use in the Health Access Nurturing Development Services (HANDS) program.

A G R E E M E N T

This Agreement is for the purpose of clarifying the relationship between a program of rehabilitation services administered through the Bureau of Rehabilitation Services of the Kentucky Department of Education and a program of medical assistance administered by the Department of Economic Security, in cooperation with the State Department of Health, under Title XIX of the Social Security Act. The Agreement also serves to formalize procedures and practices that are presently in force between the Department and the Bureau. A cooperative relationship has long existed between the two Agencies in the matter of services to and referral of mutual clients.

The Department and Bureau agrees to use the facilities of each Agency for rehabilitating applicants and recipients of medical and financial assistance. This includes sharing of information between agencies on mutual clients and to respect the confidential nature of information made available by either Agency.

In recognition of the fact that a very large number of individuals who receive services from the Bureau will be eligible for medical care benefits administered by the Department, staff of the Bureau will be alert to referral to the Department of individuals who may qualify for such benefits. Staff of the Department will refer to the Bureau those recipients who are in need of rehabilitation services.

Title XIX funds will be used to pay for medical services, within the scope of the Department's program, which are a part of the plan of treatment and rehabilitation of individuals eligible under Title XIX. The Bureau will thus be enabled to broaden the benefits of its program to individuals in need of service who are not eligible for Title XIX benefits, or to provide additional supplementary benefits. Except, Bureau funds will be used in the event of necessity to maintain quality of care.

Policies of either Agency known to effect the cooperative work of the agencies will be jointly evaluated. Plans to effect policy changes needed to achieve joint goals will be joint efforts.

The Bureau and the Department hereby agree to direct all other of their activities toward using the resources of the two Agencies to the best advantage of clients served jointly.

/s/ Ben F. Coffman

Ben F. Coffman
Assistant Superintendent
Bureau of Rehabilitation Service
Department of Education

/s/ C. Leslie Dawson

Leslie Dawson
Commissioner
Department of Economic Security

6/14/66
Date

6/14/66
Date

CONTRACT

This agreement entered into this 27th day of December, 1960, between the Department of Economic Security, party of the first part, and the State Department of Health, party of the second part, is made pursuant and subject to the provisions of Sections 205.510 to 206.610, 205.991 and 211.106 of the Kentucky Revised Statutes:

WITNESSETH:

WHEREAS, the 1960 General Assembly of the commonwealth of Kentucky by the enactment of Sections 205.510 – 205.610, 205.991 and 211.106 of the Kentucky Revised Statutes, has recognized and declared that it is an essential function, duty and responsibility of the Commonwealth of Kentucky to provide medical care to its indigent citizenry; and

WHEREAS, the General Assembly has directed that the Department of Economic Security shall contract with the State Department of Health for the purpose of carrying out the medical aspects of the Medical Care Program for Indigent Persons in accordance with the intent of said Sections 205.510 – 206.610, 205.991 and 211.106 of the Kentucky Revised Statutes;

NOW, THEREFORE, in consideration of the covenants and premises hereinafter set out, the parties hereto, in order to implement, carry out and fulfill the duties and responsibilities placed upon the parties by the enactment into law of the Medical Care Program for Indigent Persons do agree as follows:

1. The party of the first part will provide funds to the party of the second part, within limitations to be hereafter agreed to from time to time by the parties, giving consideration to existing budgetary conditions for the actual, necessary expenses which second party incurs in carrying out the duties and responsibilities outline herein.
2. The party of the second part shall carry out the medical care aspects of the Program and in doing so will among other things:
 - a. Certify that services rendered are in accordance with quantity and quality standards as established;
 - b. Certify to the Department of Economic Security that medical services have been rendered by qualified vendors;
 - c. Develop and maintain manuals of policies, procedures, and instructions for the operation of the medical aspects of the Program;
 - d. Develop bases of payment for medical care and any alterations therein; and certify vendor billings for compliance with bases of payment as established;

- e. evaluate the medical aspects of the Program, and assist in the. evaluation of the total Program, and in preparing recommendations for alterations therein;
 - f. establish and maintain separately or jointly with first party statistical procedures and methods for the accumulation of accurate records on utilization of the Program; and for use as a control technique in the enforcement of quality and quantity standards; and for use in the evaluation of the Program and recommendations for alterations therein;
 - g. prepare periodic program reports and other reports and materials;
 - h. provide staff assistance to the Advisory Council for Medical Assistance;
 - i. work with the technical advisory committees and county medical review committees as they carry out their functions;
 - j. develop and recommend rules and regulations pertaining to quality and quantity standards for medical aspects of the Program;
 - k. jointly with the first party establish and maintain effective channels for the dissemination of information regarding the Program to professional organizations involved and to the public;
 - l. assist local health departments in working with community groups and organizations interested in the Medical Care Program;
 - m. perform all other duties required of said second party by law or regulations promulgated thereunder, and all other duties agreed to by the parties.
3. In the event the appropriate funds become insufficient to provide medical services on a uniform basis pursuant to this contract, the Department of Health shall consult with and advise the Department of Economic Security as to the best method of expenditure reduction and upon the manner and method of reduction of medical services for the duration of such insufficiency of funds. In like manner, in the event that, appropriated funds are over and above the amount necessary to provide medical services in accordance with established regulations, the Department of Health shall consult with and advise the Department of Economic Security as to the method of expanding services provided and upon the manner and method of expansion of medical services for the duration of such surplus of funds.

4. The parties hereto further agree that second party will maintain adequate records of administrative expenditures and should a Federal audit exception be taken to an administrative expenditure made by second party, and said exception later sustained, then second party shall refund to first party the amount of the excepted expenditure.

This Agreement shall continue in full force and effect until terminated in writing by both parties or cancelled by either party upon written notice to the other party given at least sixty (60) days prior to the designated termination date, at which time both parties shall enter into a new contract.

IN TESTIMONY WHEREOF, the party of the first part has caused this instrument to be executed by Jo M. Ferguson, its Commissioner, and the party of the second party by Russell E. Teague, M.D., its Commissioner, the day and date first above written.

Approved: /s/ William L. Brooks DEPARTMENT OF ECONOMIC SECURITY
Asst. Attorney General
Department of Finance
Party of the First Part

Approved: /s/ Maurice F. Carpenter By /s/ Jo M. Ferguson
Director of Purchases . Jo M. Ferguson
Commissioner

Approved: /s/ Robert Matthews, Jr. STATE DEPARTMENT OF HEALTH
Commissioner of Finance
Party of the Second Part

By /s/ Russell E. Teague, M.D.
Russell E. Teague, M. D.
Commissioner

Liens and Adjustments or Recoveries

- A. The Medicaid agency uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home as specified under regulations at 42 CFR 433.36(d):

Kentucky does not impose liens against property, therefore the specified determination is not applicable.

- B. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR 433.36(f):

Kentucky does not impose liens against property, therefore the specified criteria is not applicable.

- C. The Medicaid agency uses the following definitions:

Aged institutionalized individual - a recipient age fifty five (55) or older who received Nursing Facility (NF) services, Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (ICF/MRIDD) services, Home and Community Based Services (HCBS) or Supports for Community Living (SCL) services with payment for these services made, wholly or in part, by the Medicaid Program.

Estate - all real and personal property or other assets in which the deceased recipient had a legal title or interest, to the extent of his or her interest, as defined for purposes of state probate law. In addition, it shall include all other assets in which the deceased individual had legal title or interest at the time of death, to the extent of his or her interest. Examples include assets conveyed to a survivor, heir or assign of the deceased recipient through joint tenancy, tenancy in common survivorship, life estate, living trust or other arrangement.

Estate representative - the court appointed fiduciary or the fiduciary's attorney, the recipient family member or other interested party who represents to the Medicaid agency in writing that he or she is the representative for the deceased Medicaid recipient's estate.

Period of institutionalization - the period of time an aged institutionalized or permanently institutionalized individual received Medicaid services.

Liens and Adjustments or Recoveries (continued)

Permanently institutionalized — a Medicaid recipient residing in a nursing facility or intermediate care facility for the mentally retarded or developmentally disabled for six (6) months or more.

Recipient family member - the surviving spouse, child or sibling of a deceased Medicaid recipient.

Surviving child — a Medicaid recipient's living child under age 21, or a child who is blind or disabled as defined in 42 USC 1 382c.

Undue hardship - The Medicaid agency determines that an undue hardship exists when an asset subject to recovery is the sole income-producing asset, family farm or business, conveyed to the surviving recipient family member. A sole income-producing asset shall not include residential real property producing income through a lease or rental arrangement.

- D. The Medicaid agency uses the following procedure to provide general notice to the Medicaid recipient or the recipient's representative at the time of application or reapplication for institutionalized services:

The Medicaid agency provides a written general notice to the recipient or the recipient's representative that explains the provisions of the estate recovery program. The general notice contains information regarding when an estate is subject to recovery, the type of charges that will be included in an estate recovery claim, how the executor or estate representative will be notified, and information about exemptions and limitations to estate recovery.

- E. The Medicaid agency uses the following collection procedures:

1. Upon the death of an institutionalized recipient, the institutional provider is required to notify the eligibility office within ten (10) days of the death. The eligibility office then notifies the Medicaid agency of the death.
2. The Medicaid agency calculates the total estate recovery claim by totaling the claims paid on behalf of a deceased recipient for any period of institutionalization. The amount of the claim includes the following:
 - a. Where applicable, the expenditures for Nursing Facility (NF) services, Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (ICF/MRIDD) services; Home and Community Based Services (HCBS); or Supports for Community Living (SCL) services;
 - b. Costs of related prescription drugs, hospital services, related physician services, Medicare cost-sharing, or Medicare premiums; and

Liens and Adjustments or Recoveries (continued)

- c. Any capitation payment made by the Medicaid agency to a managed care organization on behalf of the deceased recipient.
 - 3. The amount recovered shall not exceed the amount paid by the Medicaid agency on behalf of the deceased recipient for services received during periods of institutionalization.
- F. The Medicaid agency uses the following procedure to file its claim and provide notice of intent to recovery to the estate representative, family member or heir of the deceased Medicaid recipient:
- 1. The agency provides written notice to the estate representative, family member or heir of the deceased Medicaid recipient if the agency has such information. If no estate representative exists, notice shall be provided to the family members or heirs if the recipient has provided the agency with this information through the eligibility application process. The estate representative is responsible for notifying individuals who are affected by the proposed recovery.
 - 2. The notice includes the action the agency intends to initiate, the reason for the action, the amount of Medicaid's claim, exemptions and limitations to estate recovery, the address to contact the Medicaid agency and advises the representative to contact the Medicaid agency if more information is needed regarding Medicaid's claim. The notice advises the representative to respond to Medicaid's claim within 60 days.
 - 3. Included with the written notice is the general notice, as provided at the time of eligibility or recertification, advising the representative of the exemptions and the conditions that are considered when requesting an undue hardship exemption. The notice also contains a listing of the documentation the Medicaid agency will accept in proof of the request for an exemption.
- G. Estate recovery may be waived if either of the following two criteria is met:
- 1. The administrative cost of recovering from the estate is more than the total date- of-death value of the estate subject to recovery.
 - a. The administrative cost shall be comprised of the estimated financial equivalent of agency staff time and resources required to recover the full claim in any individual case.

Liens and Adjustments or Recoveries (continued)

- b. This administrative cost shall be compared to actual date of death value, less any exemptions or limitations to recovery known at the time the estimate is made, including any payments made to contractors who may perform the recovery function. If the cost is equal or greater to the value subject to recovery, it shall be determined not cost effective to pursue recovery.
 - c. Based upon a review of historical data regarding the average value of cases, including extrapolated estimates of the expanded value of the estate under current rules, and the staff time and resources involved in securing recovery, the agency has determined that it is not cost effective to recover when the total date-of-death value of the estate is \$10,000 or less.
2. An undue hardship exists.
- a. The estate representative shall apply for an undue hardship exemption by making a written request to the Medicaid agency within 30 days of receipt of Medicaid's notice of the claim, and must also provide documentation to substantiate an undue hardship exists.
 - b. Medicaid will issue a decision on the exemption request within 30 days of receipt of the request and all supporting documentation. If a hardship exemption is denied, an estate representative's may request an appeal within 30 days of the denial, and an administrative hearing shall be conducted.
 - c. An undue hardship shall not exist if the deceased recipient created the hardship by resorting to estate planning methods under which the recipient illegally divested assets to avoid estate recovery.
- H. The Medicaid agency may grant an exemption of the recovery provisions on a case-by- case basis to the extent of the anticipated cost of continuing education or health care needs of an estate heir. The estate representative shall submit to the Medicaid agency a written request for an exemption and provide verification of the cost of such exemption to the satisfaction of the Medicaid agency.
- I. A deceased recipient's estate shall be subject to recovery of Medicaid expenditures if it is adjudicated through a final administrative appeal process or court action that the recipient qualified for Medicaid fraudulently. If the recipient qualified for Medicaid benefits fraudulently, the exemptions or limitations established by administrative regulation shall not apply.
- J. The Division of Program Integrity, Recovery Operations Branch or its designee is responsible for collecting the payments, considering requests for exemptions, processing hearing requests and depositing funds in the appropriate Medicaid account.



Medicaid Premiums and Cost Sharing

State Name: Kentucky

OMB Control Number: 0938-1148

Transmittal Number: KY - 14 - 0005

Expiration date: 10/31/2014

Cost Sharing Requirements

G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid.

Yes

- The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

- The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.
- No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).
- The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):
- The state includes an indicator in the Medicaid Management Information System (MMIS)
 - The state includes an indicator in the Eligibility and Enrollment System
 - The state includes an indicator in the Eligibility Verification System
 - The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
 - Other process
- Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department.

Yes

- The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:
- Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;
 - Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
 - Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;



Medicaid Premiums and Cost Sharing

- Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- Provide a referral to coordinate scheduling for treatment by the alternative provider.
- The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

Definition of non-emergency care is defined as any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is not required. Hospitals will operationalize this process by performing the required EMTALA screening on the patient and if they determine the condition non-emergent (determined by medical professional at the hospital), the ER staff (either a nurse, doctor or intake staff) will advise the recipient that it is not a condition that required emergency treatment, and that they (the hospital) will assist them in locating another facility (late night clinic, etc), call their primary care physician when they are open, or go to an urgent care clinic that may be available. If the individual still opts to be treated at the ER, they will be required to pay the \$8 co-pay.

Cost Sharing for Drugs

The state charges cost sharing for drugs.

Yes

The state has established differential cost sharing for preferred and non-preferred drugs.

Yes

- The state identifies which drugs are considered to be non-preferred.
- The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Beneficiary and Public Notice Requirements

- Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

Preventive Health Services, including "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines, preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program project; and additional preventive services for women recommended by the Institute of Medicine (IOM) shall not be subject to co-pays



Medicaid Premiums and Cost Sharing

PRA Disclosure Statement

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.

V 20140415



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: KY - 14 - 0005

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals **G2a**

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+	Preferred and non-preferred generic drug	1.00	\$	Prescription	Preferred and non-preferred generic drug or atypical anti-psychotic drug that does not have a generic equivalent	X
+	Preferred brand name drug that does not have a generic equivalent	4.00	\$	Prescription	Preferred brand name drugs that does not have a generic equivalent and is available under the supplemental rebate program	X
+	Non-preferred brand name drug	8.00	\$	Prescription		X
+	Chiropractor	3.00	\$	Visit		X
+	Dental	3.00	\$	Visit		X
+	Podiatry	3.00	\$	Visit		X
+	Optometry	3.00	\$	Visit		X
+	General Ophthalmological services	3.00	\$	Visit		X
+	Office visit for care by a physician	3.00	\$	Visit	Office visit for care by a physician, (CPT codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214) physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, or nurse midwife or any behavioral health professional	X
+	Physician Service	3.00	\$	Visit		X
+	Visit to a rural health clinic, primary care center, or federally qualified health center	3.00	\$	Visit		X
+	Outpatient hospital service	4.00	\$	Visit		X
+	Emergency Room visit for a non-emergency service	8.00	\$	Visit		X



Medicaid Premiums and Cost Sharing

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+	Inpatient hospital admission	50.00	\$	Entire Stay		X
+	Physical therapy, speech therapy, occupational therapy	3.00	\$	Visit	Physical Therapy, Speech Pathology Services, Speech/Hearing/Language Therapy Services and Occupational Therapy	X
+	Durable medical equipment	4.00	\$	Other	\$4.00 per date of service	X
+	Ambulatory surgical center	4.00	\$	Visit		X
+	Laboratory, diagnostic, or x-ray service	3.00	\$	Visit		X

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+							X

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.

Yes

The cost sharing charges for non-preferred drugs imposed on otherwise exempt individuals are the same as the charges imposed on non-exempt individuals.

Yes

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.

No



Medicaid Premiums and Cost Sharing

PRA Disclosure Statement

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.

V.20140415

TN No: 14-005
Kentucky

Approval Date: 018/10/15
G2a-3

Effective Date: 07/01/14



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: KY - 14 - 0005

Expiration date: 10/31/2014

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to <u>all</u> medically needy individuals.	<input type="checkbox"/> Yes
The cost sharing charged to medically needy individuals is the same as that charged to categorically needy individuals.	<input type="checkbox"/> Yes

PRA Disclosure Statement

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.

V 20140415

TN No: 14-005

Approval Date: 08/10/15

Effective Date: 07/01/14

Kentucky

G2b-1



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: 14 - - 0005

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting

G2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals.

PRA Disclosure Statement

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.

V 20140415

TN No: 14-005
Kentucky

Approval Date: 08/10/15
G2c-1

Effective Date: 07/01/14



Medicaid Premiums and Cost Sharing

State Name: Kentucky

OMB Control Number: 0938-1148

Transmittal Number: KY - 14 - 0005

Expiration date: 10/31/2014

Cost Sharing Limitations

G3

42 CFR 447.56
1916
1916A

- The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
 - 133% FPL; and
 - If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- Disabled or blind individuals under age 18 eligible for the following eligibility groups:
 - SSI Beneficiaries (42 CFR 435.120).
 - Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
 - Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- An individual receiving hospice care, as defined in section 1905(o) of the Act.
- Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

TN No: 14-005

Approval Date: 08/10/15

Effective Date: 07/01/14

Kentucky

G3-1



Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over.

Yes

Indicate below the age of the exemption:

- Under age 19
- Under age 20
- Under age 21
- Other reasonable category

Description:

Kentucky exempts all kids under the age of 19. In addition, recipients between the ages of 18-21 who are in state custody and are in foster care or residential treatment are exempted from co-pays.

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs.

No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specifically identified in the state plan as not being related to pregnancy.
- Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
 - The state accepts self-attestation



Medicaid Premiums and Cost Sharing

- The state runs periodic claims reviews
- The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
- The Eligibility and Enrollment and MMIS systems flag exempt recipients
- Other procedure

Additional description of procedures used is provided below (optional):

If an individual notifies us that they are an American Indian/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), and Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State, we will use the same "Y/N" indicators switch in the MMIS system, as described below, and set that individual to be exempt from cost-sharing. Additionally, DMS uses a single streamlined applications which asks the following:

Member of a federally recognized tribe, band, nation, community, etc?*

Received services from Indian Health Service, a tribal health program, urban indian health program or through a referral from one of these programs?*

Eligible to receive services from Indian Health Service, a tribal health program, urban indian health program or through a referral from one of these programs?*

Tribe name*

Tribe state*

Federally recognized Tribe Verification*

Federally Recognized Tribe Verification date

- To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

- The MMIS system flags recipients who are exempt
- The Eligibility and Enrollment System flags recipients who are exempt
- The Medicaid card indicates if beneficiary is exempt
- The Eligibility Verification System notifies providers when a beneficiary is exempt
- Other procedure

Additional description of procedures used is provided below (optional):

KY as a "Y/N" indicator switch in the MMIS system. At the time of enrollment and renewal, if the recipient is exempt from cost sharing the indicator switch is set to indicate that they are exempt from any cost sharing. MMIS has been programmed not to deduct co-payments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act. MMIS will identify the exempt recipients by age for children under age 18 (or 19 for optional groups), by aid category and recipient status for pregnant women and institutionalized individuals. Additionally, MMIS will identify the exempt demo kids up to age 21 in state custody, foster care or residential treatment. KY uses the same indicator for exempting foster children. Medicaid recipients covered under an approved Waiver program is subject to co-payments for all services except those provided under the waiver program.



Medicaid Premiums and Cost Sharing

Payments to Providers

- The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid.

Yes

- The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

- Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

The percentage of family income used for the aggregate limit is:

5%

4%

3%

2%

1%

Other: %

The state calculates family income for the purpose of the aggregate limit on the following basis:

Quarterly

Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation.

Yes

Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

- As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

Managed care organization(s) track each family's incurred cost sharing, as follows:

The Department for Medicaid Services passes co-pay indicators to the MCOs. The MMIS houses quarterly family income and passes this to the MCOs along with the co-pay indicator. In the event the family reaches the



Medicaid Premiums and Cost Sharing

quarterly out-of-pocket max, a co-pay indicator in MMIS is turned to "N" to indicate no co-pay

Other process:

- Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The maximum amount of total cost-sharing shall not exceed 5% of a family's total income for a quarter. Kentucky as a program called co-payment tracking within the MMIS system that will track the member's co-pays to ensure that they are not charged more than the 5% during a quarter. Information regarding the quarterly amount of household income for each case is stored in the MMIS and is updated on a quarterly basis. As claims are processed, the billed services evaluated to determine if a co-payment should have been assessed. If the service was subject to co-payment based on service and member category, the system calculates the amount of the co-payment and maintains that amount in the system. If 5% of the stored income is reached, the co-payment indicator for the member or household is turned off in the system and providers can see the copayment is no longer applicable. Additionally, members will be notified through mail when they have incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current quarterly cap period. Current methodology assumes that all copayments are paid by the member. This will be coordinated with the pharmacy benefit manager (PBM) as well.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period.

No

- Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

In the event a family believes they have incurred cost sharing over the aggregate limit, the family can call the Member Services toll free line to receive assistance regarding this issue. In the event cost sharing was incurred incorrectly, claims would be processed for the provider and the provider would be responsible for reimbursing the member.

- Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Members must report changes in income to the Department within 30 days of the change. Changes are recorded in the system immediately upon notification and cost sharing aggregate limits are changed as well.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5).

No

PRA Disclosure Statement

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.

V.20140415

TN No: 14-005
Kentucky

Approval Date: 08/10/15
G3-5

Effective Date: 07/01/14

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.

Revision: HCFA-PM-91 -.4 (BPD)
August 1991

Page 56d

State: Kentucky

RESERVED

TN No. 14-005
Supersedes
TN No. 02/05

Approval Date: 08/10/15

Effective Date: 07/01/2014

Revision: HCFA-PM-91 -4 (BPD)
August 1991

Page 56e

State: Kentucky

RESERVED

TN No. 14-005
Supersedes
TN No. 02-05

Approval Date: 08/10/15

Effective Date: 07/01/2014

Revision: HCFA-PM-91-4 (BPD)
August 1991

Page 56f

State: Kentucky

RESERVED

TN No. 14-005
Supersedes
TN No. 02-05

Approval Date: 08/10/15

Effective Date: 07/01/2014

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

- A. Cost Sharing Provisions Under the KyHealth Choices Benefit Plan: The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act. Cost sharing is being imposed under 1916 of the Social Security Act.

Service	Co-pay	Amount and Basis for Determination
Prescription Drugs	X	\$1 for each preferred and non-preferred generic drug or atypical antipsychotic drug that does not have a generic equivalent; \$4 for each preferred brand name drug that does not have a generic equivalent and is available under the supplemental rebate program; or \$8 for each non-preferred brand name drug. The Department for Medicaid Services (DMS) shall reduce a pharmacy provider's reimbursement by the applicable co-pay outlined above.
Audiology		\$0.00
Chiropractor	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Dental	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Hearing Aid Dealer		A co-payment will not be imposed on hearing aids.
Podiatry	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Optometry*	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
General ophthalmological services*	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Eyewear		A co-payment will not be imposed on eyewear.
Office visit for care by a physician,** physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, or nurse midwife or behavioral health professional	X	\$3.00 per each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Physician Service	X	\$3.00 per each service. DMS shall reduce a provider's reimbursement by \$3.00.

*CPT codes 92002, 92004, 92012, and 92014

**CPT codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214

- B. Preventive Health Services, including "A" and "B" services recommended by the United State Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program project; and additional preventive services for women recommended by the Institute of Medicine (IOM) shall not be subject to co-pays.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Cost Sharing Provisions Under the KyHealth Choices Benefit Plan, continued:

Service	Co-pay	Amount and Basis for Determination
Visit to a rural health clinic, primary care center, or federally qualified health center	X	\$3.00 per each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Outpatient hospital service	X	\$4.00 for each visit. DMS shall reduce a provider's reimbursement by \$4.00.
Emergency room visit for a non-emergency service	X	\$8 for each visit. DMS shall reduce a provider's reimbursement by \$8.
Inpatient hospital admission	X	\$50.00 per admission. DMS shall reduce a provider's reimbursement by \$50.00.
Physical Therapy, Speech Pathology Services, Speech/Hearing/Language Therapy Services and Occupational Therapy	X	\$3.00 per each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Durable Medical Equipment	X	\$4 per date of service. DMS shall reduce a provider's reimbursement by \$4.00.
Ambulatory Surgical Center	X	\$4.00 for each visit. DMS shall reduce a provider's reimbursement by \$4.00.
Laboratory, diagnostic, or x-ray service	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.

- C. The following shall not be subject to a copayment, with the exception of the \$8 co-pay for non-preferred brand drugs:
- (a) Individuals excluded in accordance 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act.
 - (b) A service provided to a recipient who has reached his or her 18th birthday.
 - (c) A service provided to a recipient in an optional group, such as foster care who remains on Medicaid, who has reached his or her 18th birthday but has not turned 19.
 - (d) Individuals who are pregnant.
 - (e) Individuals receiving hospice service.
- D. Services included and related to established age and periodicity screenings pursuant to Centers for Disease Control guidelines shall not be subject to co-pays.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

- E. The maximum amount of total cost-sharing shall not exceed 5% of a family's total income for a quarter. Kentucky has a program called copayment tracking within the MMIS system that will track the member's co-pays to ensure that they are not charged more than the 5% during a quarter. Information regarding the quarterly amount of household income for each case is stored in the MMIS and is updated on a quarterly basis. As claims are processed, the billed services evaluated to determine if a copayment should have been assessed. If the service was subject to co-payment based on service and member category, the system calculates the amount of the copayment and maintains that amount in the system. If 5% of the stored income is reached, the copayment indicator for the member or household is turned off in the system and providers can see the copayment is no longer applicable. Additionally, Members will be notified through mail when they have incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current quarterly cap period. Current methodology assumes that all copayments are paid by the member. This will be coordinated with the pharmacy benefit manager (PBM) as well.
- F. Definition of non-emergency care is defined as any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is **not** required. Hospitals will operationalize this process by performing the required EMTALA screening on the patient and if they determine the condition non-emergent (determined by medical professional at the hospital), the ER staff (either a nurse, doctor or intake staff) will advise the recipient that it is not a condition that requires emergency treatment, and that they (the hospital) will assist them in locating another facility (late night clinic, etc.), call their primary care physician when they are open, or go to urgent care clinic that may be available. If the individual still opts to be treated at the ER, they will be required to pay the \$8 co-pay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

This page intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

This page is intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

B. The method used to collect cost sharing charges for categorically needy individuals:

- Providers are responsible for collecting the cost sharing charges from individuals.
- The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Federal limits on the services for which copayment applies restrict the maximum copayment charges. The State's scope of services is broad and eligible recipients have low, if any, out-of-pocket medical expenses; therefore, the state believes that all recipients within the class that are subject to copayments should be able to pay the required copayment.

Should a recipient claim to be unable to pay the required copayment, the provider may not deny service, but may arrange for the recipient to pay the copayment at a later date. Any uncollected amount is considered a debt to providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.56(a) are described below:

KY has a "Y/N" indicator switch in the MMIS system. At the time of enrollment and renewal, if the recipient is exempt from cost sharing the indicator switch is set to indicate that they are exempt from any cost sharing. MMIS has been programmed not to deduct copayments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act. MMIS will identify the exempt recipients by age for children under age 18 (or 19 for optional groups), by aid category and recipient status for pregnant women and institutionalized individuals. Recipients outside the exempt status will have a copayment due and printed on the Medicaid cards they received each month. Providers will use the Medicaid card to identify those recipients who should pay a copayment.

If an individual notifies us that they are an American Indians/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State, we will use the same "Y/N" indicator switch in the MMIS system and set that individual to be exempt from cost-sharing.

KY imposes cost-sharing for non-preferred drugs to individuals otherwise exempt from cost-sharing.

- E. Cumulative maximums on charges:

- State policy does not provide for cumulative maximums.
 Cumulative maximums have been established as described below:

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

A. Cost Sharing Provisions Under the Ky Health Choices Benefit Plan: The following charges are imposed on the medically needy for services. Cost sharing is being imposed under 1916 of the Social Security Act.

Service	Type of Charge Co-pay	Amount and Basis for Determination
Prescription Drugs	X	\$1 for each preferred and non-preferred generic drug or atypical antipsychotic drug that does not have a generic equivalent; \$4 for each preferred brand name drug that does not have a generic equivalent and is available under the supplemental rebate program; or \$8 for each non-preferred brand name drug. The Department for Medicaid Services (DMS) shall reduce a pharmacy provider's reimbursement by the applicable co-pay/co-insurance outlined above.
Audiology		\$0.00
Chiropractor	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Dental	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Hearing Aid Dealer		A co-payment will not be imposed on hearing aids.
Podiatry	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Optometry*	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
General ophthalmological services*	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Eyewear		A co-payment will not be imposed on eyewear.
Office visit for care by a physician,** physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, or nurse midwife or behavioral health practitioner	X	\$3.00 per visit. DMS shall reduce a provider's reimbursement by \$3.00.

*CPT codes 92002, 92004, 92012, and 92014

**CPT codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. Cost Sharing Provisions Under the KyHealth Choices Benefit Plan, continued:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Co-pay	
Physician Service			X	\$3.00 per each service. DMS shall reduce a provider's reimbursement by \$3.00.
Visit to a rural health clinic, primary care center, or federally qualified health center			X	\$3.00 per visit. DMS shall reduce a provider's reimbursement by \$3.00.
Outpatient hospital service			X	\$4.00 for each visit. DMS shall reduce a provider's reimbursement by \$4.00.
Emergency room visit for a non-emergency service			X	\$8 for each visit. DMS shall reduce a provider's reimbursement by \$8.
Inpatient hospital admission			X	\$50.00 per admission. DMS shall reduce a provider's reimbursement by \$50.00.
Physical Therapy, Speech, hearing, language therapy and occupational therapy			X	\$3.00 per each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Durable Medical Equipment			X	\$4.00 per date of service. DMS shall reduce a provider's reimbursement by \$4.00.
Ambulatory Surgical Center			X	\$4.00 for each visit. DMS shall reduce a provider's reimbursement by \$4.00.
Laboratory, diagnostic, or x-ray service			X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.

- B. The following shall not be subject to a copayment with the exception of the \$8 co-pay for non-preferred drugs:
- (a) Individuals excluded in accordance 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act.
 - (b) A service provided to any recipient who has reached his or her 18th birthday.
 - (c) A service provided to a recipient in an optional group, such as foster care who remains on Medicaid, who has reached his or her 18th birthday but has not turned 19.
 - (d) Individuals who are pregnant.
 - (e) Individuals receiving hospice service.
- C. Services included and related to established age and periodicity screenings pursuant to Centers for Disease Control guidelines shall not be subject to co-pays.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

- D. The maximum amount of total cost sharing shall not exceed 5% of a family's total income for a quarter. Kentucky has a program called copayment tracking within the MMIS system that will track the member's co-pays to ensure that they are not charged more than the 5% during a quarter. Information regarding the quarterly amount of household income for each case is stored in the MMIS and is updated on a quarterly basis. As claims are processed, the billed services evaluated to determine if a copayment should have been assessed. If the service was subject to co-payment based on service and member category, the system calculates the amount of the copayment and maintains that amount in the system. If 5% of the stored income is reached, the copayment indicator for the member or household is turned off in the system and providers can see the copayment is no longer applicable. Additionally, Members will be notified through mail when they have incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current quarterly cap period. Current methodology assumes that all copayments are paid by the member. This will be coordinated with the PBM as well.
- F. Definition of non-emergency care is defined as any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is **not** required. Hospitals will operationalize this process by performing the required EMTALA screening on the patient and if they determine the condition non-emergent (determined by medical professional at the hospital), the ER staff (either a nurse, doctor or intake staff) will advise the recipient that it is not a condition that requires emergency treatment, and that they (the hospital) will assist them in locating another facility (late night clinic, etc.), call their primary care physician when they are open, or go to urgent care clinic that may be available. If the individual still opts to be treated at the ER, they will be required to pay the \$8 co-pay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

This page is intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

This page is intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

B. The method used to collect cost sharing charges for categorically needy individuals:

- Providers are responsible for collecting the cost sharing charges from individuals.
- The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Federal limits on the services for which copayment applies restrict the maximum copayment charges. The State's scope of services is broad and eligible recipients have low, if any, out-of-pocket medical expenses; therefore, the state believes that all recipients within the class that are subject to copayments should be able to pay the required copayment.

Should a recipient claim to be unable to pay the required copayment, the provider may not deny him service, but may arrange for the recipient to pay the copayment at a later date. Any uncollected amount is considered a debt to providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.56(a) are described below:

KY has a "Y/N" indicator switch in the MMIS system. At the time of enrollment and renewal, if the recipient is exempt from cost sharing the indicator switch is set to indicate that they are exempt from any cost sharing. MMIS has been programmed not to deduct copayments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act. MMIS will identify the exempt recipients by age for children under age 18 (or 19 for optional groups), by aid category and recipient status for pregnant women and institutionalized individuals. Recipients outside the exempt status will have a copayment due and printed on the Medicaid cards they received each month. Providers will use the Medicaid card to identify those recipients who should pay a copayment.

If an individual notifies us that they are an American Indians/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State, we will use the same "Y/N" indicator switch in the MMIS system and set that individual to be exempt from cost-sharing.

KY imposes cost-sharing for non-preferred drugs to individuals otherwise exempt from cost-sharing.

- E. Cumulative maximums on charges:

- State policy does not provide for cumulative maximums.
 Cumulative maximums have been established as described below:

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Premiums Imposed on Low Income Pregnant Women and Infants

- A The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

Not Applicable

- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

Not Applicable

*Description provided on attachment.

TN No. 92-01
Supersede:
TN No. None

Approval Date NOV 14 1994

Effective Date 1-1-92
HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

C. State or local funds under other programs are used to pay for premiums:

Yes No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

Not applicable

*Description provided on attachment.

TN No. 92-01
Supersedes
TN No. None

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

- A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

Not applicable

- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment:

Not applicable

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

C. State or local funds under other programs are used to pay for premiums:

Yes No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

Not applicable

*Description provided on attachment.

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14, 1994

Effective Date 1-1-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Premiums Imposed on Families Receiving Extended Benefits
During a Second Six-Month Period

- A. The following method is used to determine the premium imposed during each premium payment period on families receiving extended benefits (Transitional Medicaid or TMA) during the second six-month period under section 1902(a)(52) and section 1925 of the Act:

The premium amount for months seven through twelve is \$30 per family per month for families who remain eligible for TMA. We calculated this premium amount by taking three percent of the 100 percent federal poverty level (FPL) guideline for a family of two in 2003 and rounding down to the nearest whole dollar.

1. If a family pays the premium as a quarterly or semi-annual payment, they will get a ten percent discount.
2. The premium will never exceed three percent of the family's average gross monthly earnings, less the average monthly cost of child care that is necessary for the employment of the caretaker relative.
3. A family is exempt from the premium requirement if average gross monthly earnings less work-related child care is equal to or less than 100 percent FPL for the family size.

- B. A description of the billing method used is as follows (include due date for premium payment and notification of the consequences of nonpayment):

1. Bills are issued on the 7th working day before the end of each month, with payment due the fifth of the next month.
2. Payments must be made in advance, by the fifth of the month for the following month.
3. Families who do not pay by the fifth of the month are sent a reminder that premium payments are past due,
4. If the family fails to make the second monthly premium payment, medical coverage stops at the end of the second month for which the family has not paid the premium.

Premiums Imposed on Families Receiving Extended Benefits
During a Second Six-Month Period (continued)

5. All bills and reminder notices inform families that they will lose their health care benefits if premiums are not paid.
 6. The department will do the following before stopping benefits due to premium non-payment:
 - a. Give notice of the past due premiums;
 - b. Provide an opportunity to pay past due premiums; and
 - c. Give families an opportunity to prove that income has decreased and the family should be exempt from premium payment.
 7. If TMA is discontinued due to non-payment and the recipients are eligible for benefits in another Medicaid or SCHIP group, their coverage will be automatically continued in the appropriate category.
- A. The criteria for determining good cause for failure to pay such premium on a timely basis are described below.
- Reasons for good cause include:
1. An immediate family member living in the home was institutionalized or died during the payment month;
 2. The family was victim of a natural disaster including flood, storm, earthquake, or serious fire;
 3. The specified relative was out of town for the payment month; or
 4. The family moved and reported the move timely, but the move resulted in:
 - a. A delay in receiving the billing notice; or
 - b. Failure to receive the billing notice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Kentucky

It should be noted that States can select one or more options in imposing cost sharing (including co-payments, co-insurance, and deductibles) and premiums.

- A. For groups of individuals with family income above 100 percent but below 150 percent of the F1)1.4
1. Cost sharing
 - a. No cost sharing is imposed.
 - b. Cost sharing is imposed under section 1916A of the Act as follows (specify the amounts by group and services (see below)):
 - In Family Choices cost sharing amounts are placed on the KCHIP Medicaid Expansion Children (101-150 percent of the poverty line) under 1916A(a) and 1916A(b)(1)-(2) of the Act. The cost sharing amounts for Family Choices can be found on Attachment 3.1-C pages 10.17-10.20.
 - The methodology to determine family income does not differ from the methodology for determining eligibility. Net income is used to determine eligibility.
 - b. Limitations:

The total aggregate amount of cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent oldie family income of the family involved, as applied on a monthly and quarterly basis as specified by the State above. Under state regulation, there is a \$225 cost sharing limit for medical services and an additional cost sharing limit of \$225 for pharmacy services on an annual basis. The state will enforce the cap that is the least of each family's total income.

 - Cost sharing with respect to any item or service may not exceed 10 percent of the cost of such item or service.
 - c. No cost sharing will be imposed for the following services:
 - Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid and assistance is made available under part B of the title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
 - Preventive services (such as well baby and well child care and immunizations) provided to children
 - under 18 years of age, regardless of family income;
 - Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
 - Services furnished to a terminally individual who is receiving hospice care, (as defined in section I 905(o) of the Act);
 - Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
 - Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
 - Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
 - Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(11)(XVIII) and 1902(aa) of the Act.

- Services provided to individuals with income not exceeding 100 percent of the poverty line. Except for those that apply to prescription drugs and Hospital Non-emergency services as defined in 1916A(c) and 1916A(e).
- d. Enforcement
1. Pharmacist are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.
 2. Providers permitted to reduce or waive cost sharing on a case-by-case basis.
 3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.
 4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.
2. Premiums
No premiums may be imposed for individuals with family income above 100 percent but below 150 percent of the FPL.
- B. For groups of individuals with family income above 150 percent of the FPL: 1. Cost sharing amounts
- a. No cost sharing is imposed.
 - b. X / Cost sharing is imposed under section 1916A of the Act as follows (specify amounts by groups and services (see below)):\
- b. Limitations:
- The total aggregate amount of cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly and quarterly basis as specified by the State above.
 - Cost sharing with respect to any item or service may not exceed 20 percent of the cost of such item or service.
- c. No cost sharing will be imposed for the following services;
- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(1), and including services furnished to individuals with respect to whom aid and assistance is made available under parts of the title IV to children in foster care and individuals with respect to whom, adoption or foster care assistance is made available under part E of such title, without regard to age;
 - Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age, regardless of family income;
 - Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
 - Services furnished to a terminally individual who is receiving hospice care, (as defined in section 1905(o) of the Act);
 - Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
 - Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
 - Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
 - Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

- d. Enforcement
1. Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.
 2. Providers permitted to reduce or waive cost sharing on a case-by-case basis.
 3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing if noted as such in Attachment 3.I-C pages 10.17-10;24, Attachment 4.18-A pages I, 1(a), and Attachment 4.18-C pages 1, 1(a).
 4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.
2. Premiums
- a. No premiums are imposed.
 - b. Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.
- b. Limitations:
- The total aggregate amount of cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly and quarterly basis as specified by the State above.
- c. Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals furnished to individuals with respect to whom aid and assistance is made available under part B of the title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Pregnant women;
 - Any terminally ill-individual receiving hospice care, as defined in section 1905(o);
 - Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs; and
 - Women who are receiving Medicaid by virtue of the applications of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.
- d. Enforcement
1. Prepayment required for the following groups of individuals who are applying for Medicaid:
 2. Eligibility terminated after failure to pay for 60 days for the following groups of individuals who are receiving Medicaid:
 3. Payment will be waived on a case-by-case basis for undue hardship.
- C. Period of determining aggregate 5 percent cap
- Specify the period for which the 5 percent maximum would be applied.

- Quarterly
 Monthly

D. Method for tracking cost sharing amounts

Describe the State process used for tracking cost sharing and informing beneficiaries and providers of their beneficiary's liability and informing providers when an individual has reached his/her maximum so further costs are no longer charged.

The Department tracks cost-sharing based on claims submissions. All cost sharing outlined in the state plan and regulations is calculated on an individual member basis and aggregated by case.

Providers can determine if a member is subject to cost sharing one of two, ways:

1. Providers can access the member benefit plan and cost sharing obligations via a web-based program, KY Health Net; or
2. Providers can access member cost sharing obligations by calling the toll free voice response line.

Both options allow the provider to see/hear the poverty level indicator of the Member, out of pocket maximum amount, and an indicator that informs them if the out of pocket maximum amount of cost sharing has been met for the quarter.

Individual members have an out of pocket cost sharing amount of \$225 for pharmacy services and a \$225 maximum for medical services. Therefore, individual cost sharing cannot exceed \$450 per calendar year. However, aggregate cost sharing per case cannot exceed 5% of the family's income for the quarter. Once members reach the out-of-pocket maximum amount per quarter, their cost sharing indicator is changed to "N" and providers do not collect co-payments for the remainder of the quarter. Likewise, when the out of pocket maximum is reached per member, the cost sharing indicator is changed to "N" and providers do not collect co-payments for the remainder of the year.

Members can call the toll free line to check the amount of cost sharing they have paid per quarter and per year to determine if their out of pocket amount has been met

Also describe the State process for informing beneficiaries and providers of the allowable cost sharing amounts.

Cost sharing amounts are outlined in our Member Handbook. When enrolled, the beneficiaries are informed of the toll free Member Services number and that the Member handbook will be provided to them upon request.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: KENTUCKY

- A. In accordance with section 1916A of the Social Security Act (the Act), alternative cost sharing will be implemented for non-preferred drugs to encourage the use of less costly effective drugs. For individuals otherwise not subject to cost sharing as a result of section 1916A(b)(3)(B) of the Act the cost sharing charge for non-preferred drugs will not exceed a nominal amount as specified under section 1916. For individuals whose family income is at or below 150 percent of the Federal poverty level (FPL), cost sharing may not exceed a nominal amount as defined in section 1916. For individuals whose family income is above 150 percent of the FPL, cost sharing charges may not exceed 20 percent of the cost of the drug. Cost sharing for non-preferred drugs counts toward the 5 percent aggregate cap.
- B. In case of a drug that is not a preferred drug, the cost sharing amount for the preferred drug will be charged for a non-preferred drug if the prescribing physician determines that the preferred drug would be less effective or would have adverse effects for the individual or both. These overrides will meet the State criteria for prior authorization and will be approved through the State prior authorization process before the preferred drug cost sharing is applied to the non-preferred drug.
- C. States may exclude specified drugs or classes of drugs from the non-preferred or preferred drug class.
- D. Cost sharing is implemented for non-preferred drugs for the following groups of beneficiaries as indicated below:
- Members of Global Choices non-preferred drug copay is listed on Attachment 4.18-A, page 1 and Attachment 4.18-C, page 1, and eligibility (up to 250 percent of the federal poverty level) or population covered for Global Choices can be found on Attachment 4.18-A page 1(b)-1(d) and Attachment 4.18-C page 1(b)-1(d);
 - Members of Family Choices non-preferred drug copay is listed on Attachment 3.1-C, page 10.19. In Family Choices cost sharing amounts are placed on the KCHIP Medicaid Expansion Children (101-150 percent of the federal poverty level) under 1916A(a) and 1916A(b)(1)-(2) of the Act; and
 - Members of Comprehensive or Optimum Choices non-preferred drug copay is listed on Attachment 3.1-C page 10.23, and eligibility (up to 300 percent of the federal poverty level) or population covered for Comprehensive and Optimum Choices can be found on Attachment 3.1-C pages 10.1-10.2.
- E. Cost sharing for non-preferred drugs may be waived or reduced below nominal for the following populations or services:
- Individuals under 18 years of age with mandatory coverage and Title IV-B and Title IV-E children;
 - Preventive services;
 - Pregnant women;
 - Terminally ill individuals receiving hospice care;
 - Individuals who are inpatients in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
 - Emergency services;
 - Family planning services and supplies; and ,
 - Services under the breast and cervical cancer program.

Cost sharing will not be waived or reduced for any population except as provided in section F.

- F. Cost sharing for preferred drugs may not be charged for the following populations or services:

TN No: 06-012
Supersedes
TN No: None

Approval Date: 01/22/09

Effective Date: 7/01/2006

- Individuals under 18 years of age with mandatory coverage and Title IV-B and Title IV-E children;
- Preventive Services;
- Pregnant women;
- Terminally ill individuals receiving hospice care;
- Individuals who are inpatients in a hospital nursing facility, intermediated care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
- Emergency Services;
- Family Planning services and supplies; and,
- Services under the breast and cervical cancer program.

G. Cost sharing payment requirements:

- Providers are permitted to require, as a condition for the provision of prescriptions, the payment of cost sharing.

H. Availability of Information

- States must make available to the public and to beneficiaries the schedule of the cost sharing/premium amounts for specific items and the various eligibility groups.

1 General Overview

- A. Effective for discharges on or after October 1, 2015, the Department will pay for acute care inpatient hospital services provided to a Medicaid recipient who is not enrolled with a managed care organization under a diagnosis related group (DRG) based methodology using the CMS Medicare Severity Diagnosis Related Grouper (MS-DRG) grouper. The methodology will be the Medicare Inpatient Prospective Payment System as described in this State Plan. The revised system will utilize the hospital specific Medicare operating and capital base rates, and the Medicare-established relative weights. Hospital services not paid for using the DRG-based methodology will be paid for using per diem rates or as otherwise stated in this plan.

The following will be excluded from the DRG methodology:

- 1) Services provided in Critical access hospitals. Reimbursement procedures are described in section 4, beginning on page 22 of this document;
- 2) Services provided in Free-standing rehabilitation hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
- 3) Services provided in Long-term acute care hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
- 4) Psychiatric services, including substance abuse, in Acute care hospitals. Reimbursement procedures are described in section 2(Z), beginning on page 18 of this document;
- 5) Services provided in Free-standing psychiatric hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
- 6) Rehabilitation services in Acute care hospitals. Reimbursement procedures are described in section 2(Z), beginning on page 18 of this document; and

B. Appeals and Review Process.

- 1) Matters Subject to an Appeal. A hospital may appeal whether the Medicare data specific to the hospital that was extracted by the Department in establishing the hospital's reimbursement was the correct data.
- 2) Appeal Process.
 - a. An appeal shall comply with the requirements and provisions established in this section.
 - b. (1) A request for a review of an appealable issue shall be received by the department within sixty (60) calendar days of the date of receipt by the provider of the department's notice of rates set under Regulation 907 KAR 10:830, revised 9/4/2015.
 - (2) The request referenced in paragraph (1) of this subsection shall:
 - (a) Be sent to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, 6th Floor, Frankfort, Kentucky 40621-0002; and
 - (b) Contain the specific issues to be reviewed with all supporting documentation necessary for the departmental review.
 - c. (1) The department shall review the material referenced in subsection (b) of this section and notify the provider of the review results within 30 days of its receipt except as established in paragraph (2) of this subsection.

1 Overview (continued)

B. Appeals and Review Process (continued)

- (2) If the provider requests a review of a non-appealable issue under 907 KAR 10:830 (revised 9/4/2015), the department shall:
 - (a) Not review the request; and
 - (b) Notify the provider that the review is outside of the scope of 907 KAR 10:830 (revised 9/4/2015).
- d. (1) A provider may appeal the result of the department's review, except for a notification that the review is outside the scope of 907 KAR 10:830 (revised 9/4/2015), by sending a request for an administrative hearing to the Division for Administrative Hearings (DAH) within thirty (30) days of receipt of the department's notification of its review decision.
 - (2) A provider shall not appeal a notification that a review is outside of the scope of 907 KAR 10:830 (revised 9/4/2015).
- e. (1) An administrative hearing shall be conducted in accordance with KRS Chapter 13B.
 - (2) Pursuant to KRS 13B.030, the Secretary of the Cabinet for Health and Family Services delegates to the Cabinet for Health and Family Services, Division for Administrative Hearings (DAH) the authority to conduct administrative hearings under 907 KAR 10:830 (revised 9/4/2015).
 - (3) A notice of the administrative hearing shall comply with KRS 13B.050.
 - (4) The administrative hearing shall be held in Frankfort, Kentucky no later than ninety (90) calendar days from the date the request for the administrative hearing is received by the DAH.
 - (5) The administrative hearing date may be extended beyond the ninety (90) calendar days by:
 - (a) A mutual agreement by the provider and the department; or
 - (b) A continuance granted by the hearing officer.
 - (6) (a) If the prehearing conference is requested, it shall be held at least thirty (30) calendar days in advance of the hearing date.
 - (b) Conduct of the prehearing conference shall comply with KRS 13B.070.
 - (7) If a provider does not appear at the hearing on the scheduled date, the hearing officer may find the provider in default pursuant to KRS 13B.050(3)(h).
 - (8) A hearing request shall be withdrawn only under the following circumstances:
 - (a) The hearing officer receives a written statement from a provider stating that the request is withdrawn; or
 - (b) A provider makes a statement on the record at the hearing that the provider is withdrawing the request for the hearing.
 - (9) Documentary evidence to be used at the hearing shall be made available in accordance with KRS 13B.090.
 - (10) The hearing officer shall:
 - (a) Preside over the hearing; and
 - (b) Conduct the hearing in accordance with KRS 13B.080 and 13B.090.
 - (11) The provider shall have the burden of proof concerning the appealable issues under 907 KAR 10:830 (revised 9/4/2015).

1 Overview (continued)

B. Appeals and Review Process (continued)

- (12) (a) The hearing officer shall issue a recommended order in accordance with KRS 13B.110.
- (b) An extension of time for completing the recommended order shall comply with the requirements of KRS 13B.110 (2) and (3).
- (13) (a) A final order shall be entered in accordance with KRS 13B.120.
- (b) The cabinet shall maintain an official record of the hearing in compliance with KRS 13B.130.
- (c) In the correspondence transmitting the final order, clear reference shall be made to the availability of judicial review pursuant to KRS 13B.140, 13B.150, and KRS 13B.160.

C. Adjustment of rates.

- 1) Final rates are not adjusted except for correction of errors, to make changes resulting from the dispute resolution or appeals process, if the decision determines that rates were not established in accordance with the approved State Plan, Attachment 4.19-A, or to make changes resulting from Federal Court orders including to the extent necessary action to expand the effect of a Federal Court order to similarly situated facilities. .
- 2) New rates shall be set for each universal rate year, and at any point in the rate year when necessitated by a change in the applicable statute or regulation subject to a state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS), if applicable.

D. Use of a Universal Rate Year

- 1) A universal rate year shall be established for rates in this attachment as follows:
 - a. For DRG rates, excluding non-distinct part unit (non-DPU) psychiatric and rehabilitation hospital rates, the universal rate year shall be October 1 through September 30 of the following year.
 - b. For Psychiatric Residential Treatment Facility (PRTF) rates, the universal rate year shall be November 1 through October 31 of the following year.
 - c. For all other hospital rates referenced in this attachment, the universal rate year shall be July 1 through June 30 of the following year, or as specifically stated throughout this attachment.
- 2) A hospital shall not be required to change its fiscal year to conform with a universal rate year.

E. Cost Reporting Requirements.

- 1) The department follows the Medicare Principles of reimbursement found in 42 CFR 413 and the CMS Publication 15 to determine allowable cost. Additional cost report requirements are as follows:

1 Overview (continued)

E. Cost Reporting Requirements (continued)

- 2) An in-state hospital participating in the Medicaid program shall submit to the department a copy of a Medicare cost report form CMS 2552-10 it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1, the Supplemental Medicaid Schedule KMAP-4, and the Supplemental Medicaid Schedule KMAP-6 as follows:
 - a. A cost report shall be submitted:
 - (1) For the fiscal year used by the hospital; and
 - (2) Within five (5) months after the close of the hospital's fiscal year; and
 - b. Except as follows, the department shall not grant a cost report submittal extension:
 - (1) If an extension has been granted by Medicare, the cost report shall be submitted simultaneously with the submittal of the Medicare cost report; or
 - (2) If a catastrophic circumstance exists, for example flood, fire, or other equivalent occurrence, the department shall grant a thirty (30) day extension.
- 3) If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a complete cost report is received.
- 4) A cost report submitted by a hospital to the department shall be subject to audit and review.
- 5) An in-state hospital shall submit to the department a final Medicare-audited cost report upon completion by the Medicare intermediary along with an electronic cost report file (ECR).

F. Unallowable Costs

- 1) The following shall not be allowable cost for Medicaid reimbursement unless otherwise noted:
 - a. A cost associated with a political contribution;
 - b. The allowability of legal fees is determined in accordance with the following:
 - (1) A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet for Health and Family Services is not allowable;
 - (2) A legal fee relating to a lawsuit against the Cabinet for Health and Family Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and
 - c. Cost associated with travel and related expenses must take into consideration the following:

1 Overview (continued)

F. Unallowable Costs (continued)

- (1) A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity is not allowable.
- (2) A cost for a training or educational purpose outside the Commonwealth of Kentucky shall be allowable.
- (3) If a meeting is not solely educational, the cost, excluding transportation, shall be allowable if an educational or training component is included.

2) A hospital shall identify an unallowable cost on the Supplemental Medicaid Schedule KMAP-1.

3) The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report.

G. Trending of an In-state Hospital's Cost Report Used for Non-DRG Rate Setting Purposes.

1) An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the department, either audited or un-audited, shall be trended from the midpoint of the cost report year to the beginning of the universal rate year to update an in-state hospital's Medicaid cost. This methodology applies for all rate setting throughout this attachment.

2) The trending factor to be used shall be the inflation factor prepared by GII (Global Insight, Incorporated, a market basket data indexing and forecasting firm referred to as GII) for the period being trended.

H. Indexing for Inflation of an In-state Hospital's Cost Report Used for Rate Setting Purposes.

1) After an allowable Medicaid cost has been trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost to the midpoint in the universal rate year. This methodology applies for all rate setting throughout this attachment.

2) The department shall use the inflation factor prepared by GII (Global Insight, Incorporated) as the indexing factor for the universal rate year.

I. Cost Basis.

1) An allowable Medicaid cost shall:

- a. Be a cost allowed after a Medicaid or Medicare audit;
- b. Be in accordance with 42 C.F.R. Part 413;
- c. Include an in-state hospital's provider tax; and
- d. Not include a cost in the Unallowable Costs listed in Section (1)F of this attachment.

2) A prospective rate shall include both routine and ancillary costs.

1 Overview (continued)

I. Cost Basis. (continued)

- 3) A prospective rate shall not be subject to retroactive adjustment, except for:
 - a. A critical access hospital; or
 - b. A facility with a rate based on un-audited data.
- 4) An overpayment shall be recouped by the department as follows:
 - a. A provider owing an overpayment shall submit the amount of the overpayment to the department; or
 - b. The department shall withhold the overpayment amount from a future Medicaid payment due the provider.

J. Access to Subcontractor's Records. If a hospital has a contract with a subcontractor for services costing or valued at \$10,000 or more over a twelve (12) month period:

- 1) The contract shall contain a provision granting the department access:
 - a. To the subcontractor's financial information; and
 - b. In accordance with 907 KAR 1:672, published on January 4, 2008, Provider enrollment, disclosure, and documentation for Medicaid participation; and
- 2) Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

K. New Provider, Change of Owner or Merged Facility

- 1) The Department shall reimburse a new acute care hospital based on the Medicare IPPS Final Rule Data Files and Tables inputs in effect at the time of the hospital's enrollment with the Medicaid program as described in section (2) of this attachment. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
- 2) If no applicable rate information exists in the Medicare IPPS Final Rule Data Files and Tables for a given period for an in-state acute care hospital, the Department shall use, for the in-state acute care hospital, the average of all in-state acute care hospitals for the operating rate, capital rate, and outlier cost-to-charge ratio, excluding any adjustments made for sole community hospitals or Medicare dependent hospitals.
- 3) If a hospital undergoes a change of ownership, the new owner shall be reimbursed at the rate in place at the time of the ownership change.

1 Overview (continued)

K. New Provider, Change of Owner or Merged Facility (continued)

4) A merged facility of two or more entities.

a. The merger of two per diem facilities shall:

- (1) Merge the latest available data used for rate setting.
- (2) Combine bed utilization statistics, creating a new occupancy ratio.
- (3) Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs.
- (4) If one (1) of the entities merging has disproportionate status and the other does not, retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid.
- (5) Recognize an appeal of the merged per diem rate on Conditions of Medicaid provider participation, withholding overpayments, administrative appeal process, and sanctions.

5) Cost report submission

- a. Require each provider to submit a Medicaid cost report for the period ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end.
- b. A Medicaid cost report for the period starting with the day of the merger and ending on the fiscal year end for the merged entity shall also be filed with the department in accordance with this attachment.

L. Payment Not to Exceed Charges or the Upper Payment Limits.

- 1) The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges plus disproportionate share payments, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges, the state will recoup payments in excess of allowable charges plus disproportionate share payments.
- 2) The state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement. Medicare upper payment limits as required by 42 CFR 447.272 will be determined in advance of the fiscal year from cost report and other applicable data from the most recent rate setting as compared to reimbursement for the same period. Cost data and reimbursement shall be trended forward to reflect current year upper payment limits. See Exhibit A for detail description and formula for UPL demonstration.

M. Public Process for Determining Rates for Inpatient Hospitals. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

N. The Hospital Provider Tax is described in Kentucky Revised Statute 142.303, revised June 26, 2007.

1 Overview (continued)

- O. As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Department for Medicaid Services will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Beginning with the Medicaid State Plan year 2011 DSH audit, DSH payments made to hospitals may be adjusted based on the results of the federally-mandated DSH audits as follows:

- 1) DSH payments found in the DSH audit process for a given state fiscal year that exceed the hospital specific uncompensated care cost (UCC) DSH limits will be recouped from hospitals to reduce their payments to their limit. Any payments that are recouped from hospitals as a result of the DSH audit will be redistributed to hospitals that are shown to have been paid less than their hospital-specific DSH limits. Redistributions will occur proportionately to the original distribution of DSH funds not to exceed each hospital's specific UCC DSH limit. If DSH funds cannot be fully redistributed within the original distribution pool, due to the hospital specific limits, the excess funds will be redistributed to the other distribution pools in proportion to the original DSH payments made by the state.
- 2) If the Medicaid program's original DSH payments did not fully expend the federal DSH allotment for any state fiscal year, the remaining DSH allotment will be retroactively paid to hospitals that are under their hospital-specific DSH limit reflecting the potential redistributions in #1 above. These additional DSH payments will be made in proportion to the original DSH payments, and will be limited to each hospital's specific DSH limit.

-
2. Acute Care Hospital Services
- A. DRG-Based Methodology
- 1) An eligible in-state acute care hospital shall be paid for all covered inpatient acute care services on a fully-prospective per discharge basis.
- B. Effective for discharges on or after October 1, 2015, the department's reimbursement shall equal ninety-five (95) percent of a hospital's Medicare DRG payment excluding the following Medicare reimbursement components:
- 1) A Medicare low-volume hospital payment;
 - 2) A Medicare end stage renal disease payment;
 - 3) A Medicare new technology add-on payment;
 - 4) A Medicare routine pass-through payment;
 - 5) A Medicare ancillary pass-through payment;
 - 6) A Medicare value-based purchasing payment or penalty;
 - 7) A Medicare readmission penalty in accordance with Item "M" below;
 - 8) A Medicare hospital-acquired condition penalty in accordance with Item "M" below;
 - 9) Any type of Medicare payment implemented by Medicare after October 1, 2015; or
 - 10) Any type of Medicare payment not described below.
- C.
- 1) For covered inpatient acute care services, in an in-state acute care hospital, the total hospital-specific per discharge payment shall be the sum of:
 - a. A DRG base payment; and
 - b. If applicable, a cost outlier payment.
 - 2) The resulting payment shall be limited to ninety-five (95) percent of the calculated value.
 - 3) If applicable, a transplant acquisition fee payment shall be added pursuant to Item "L" below.
- D.
- 1) The department shall assign a DRG classification to each unique discharge billed by an acute care hospital.
 - 2)
 - a. The DRG assignment shall be based on the most recent Medicare Severity DRG (MS-DRG) grouping software released by the Centers for Medicare and Medicaid Services beginning with version 32 on October 1, 2015 unless CMS releases version 33 on October 1, 2015.
 - b. If CMS releases version 33 on October 1, 2015, the department shall make interim payments for dates of service beginning October 1, 2015 based on version 32 and then retroactively adjust claims for dates of service beginning October 1, 2015 using version 33.
 - c. The grouper version shall be updated in accordance with the Reimbursement Updating Procedures outlined below in Item R.

2. Acute Care Hospital Services

- 3) In assigning a DRG for a claim, the department shall exclude from consideration any secondary diagnosis code associated with a never event.

- E.
 - 1) A DRG base payment shall be the sum of the Medicare operating base payment and the capital base payment calculated as described in paragraphs 3) and 4) below.
 - 2) All calculations in this subsection shall be subject to special rate-setting provisions for sole community hospitals found in Item O and Medicare dependent hospitals found in Item P.
 - 3)
 - a. The Medicare operating base payment shall be determined by multiplying the hospital-specific operating rate by the DRG relative weight.
 - b. If applicable, the resulting product of subparagraph "a." of this paragraph shall be multiplied by the sum of one (1) and a hospital-specific operating indirect medical education (IME) factor determined in accordance with subparagraph "g." below.
 - c. Beginning October 1, 2015, the hospital-specific operating rate referenced in subparagraph "a." above shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS as described in subparagraphs "d." through "g." below. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
 - d. The Medicare IPPS standard amount established for operating labor costs from Table 1 shall be multiplied by the wage index from Table 3 associated with the final Core Based Statistical Area (CBSA) assigned to the hospital by Medicare, inclusive of any Section 505 adjustments applied by Medicare, as reported in the IPPS impact file.
 - e. The resulting product of subparagraph "d." shall be added to the Medicare IPPS standard amount for non-labor operating costs.
 - f. The operating rate shall be updated in accordance with Item "R" below.
 - g.
 - (1) Beginning October 1, 2015, the hospital-specific operating IME factor shall be taken from the Federal Fiscal Year 2016 Medicare Inpatient Prospective Payment System (IPPS) Final Rule Data Files and Tables published by CMS.
 - (2) The operating IME factor shall be updated in accordance with Item "R" below.
 - 4)
 - a. The capital base payment shall be determined by multiplying the hospital-specific capital rate by the DRG relative weight.
 - b. If applicable, the resulting product of subparagraph "a." above shall be multiplied by the sum of one (1) and a hospital-specific capital indirect medical education factor determined in accordance with subparagraph "g." below.
 - c. Beginning October 1, 2015, the hospital-specific capital rate referenced in subparagraph "a." above shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS as described in subparagraphs "d" through "g" below. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
 - d. The Medicare IPPS standard amount established for capital costs shall be multiplied by the geographic adjustment factor (GAF) associated with the final CBSA assigned to the hospital by Medicare.
 - e. The capital rate shall be updated in accordance with Item "R" below.

2. Acute Care Hospital Services

- f. Effective October 1, 2015, the hospital-specific capital IME factor shall be taken from the Medicare Inpatient Prospective Payment System (IPPS) Final Rule Data Files and Tables published by CMS.
- g. The capital IME factor shall be updated in accordance with Item "R." below.
- F.
 - 1) The department shall make a cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each DRG as established as follows.
 - 2) A cost outlier shall be subject to QIO review and approval.
 - 3) A discharge shall qualify for a cost outlier payment if its estimated cost, as calculated in Item "F" (4) below, exceeds the DRG's outlier threshold, as calculated in Item "F" (5) below.
 - 4)
 - a. The department shall calculate the estimated cost of a discharge:
 - (1) For purposes of comparing the discharge cost to the outlier threshold; and
 - (2) By multiplying the sum of the hospital-specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.
 - b.
 - (1) A Medicare operating and capital-related cost-to-charge ratio shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
 - (2) The Medicare operating and capital cost-to-charge ratios shall be updated in accordance with Item "R." below.
 - 5)
 - a. The department shall calculate an outlier threshold as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold.
 - b.
 - (1) Beginning October 1, 2015, the fixed loss cost threshold shall equal the Medicare fixed loss cost threshold established for Federal Fiscal Year 2016.
 - (2) The fixed loss cost threshold shall be updated in accordance with Item "R." below.
 - 6)
 - a. For specialized burn DRGs as established by Medicare, a cost outlier payment shall equal ninety (90) percent of the amount by which estimated costs exceed a discharge's outlier threshold.
 - b. For all other DRGs, a cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.
- G.
 - 1) The department shall establish DRG relative weights obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect under Item "D." above. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
 - 2) Relative weights shall be revised to match the grouping software version for updates in accordance with Item "R." below.
- H. The department shall separately reimburse for a mother's stay and a newborn's stay based on the DRGs assigned to the mother's stay and the newborn's stay.
- I.
 - 1) If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.
 - 2) For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

2. Acute Care Hospital Services

- 3) a. The department shall calculate an average daily discharge rate by dividing the DRG base payment by the Medicare geometric mean length-of-stay for a patient's DRG classification.
 - b. The Medicare geometric length-of-stay shall be obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect under subparagraph "c." below.
 - c. The geometric length-of-stay values shall be revised to match the grouping software version for updates in accordance with Item "R." below.
 - 4) Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five (95) percent of the amount calculated for each.
 - 5) For a hospital receiving a transferred patient, the department shall reimburse the standard DRG payment established in Item "D." above.
- J.
- 1) The department shall reimburse a transferring hospital for a transfer from an acute care hospital to a qualifying post-acute care facility for selected DRGs as a post-acute care transfer.
 - 2) The following shall qualify as a post-acute care setting:
 - a. A skilled nursing facility;
 - b. A cancer or children's hospital;
 - c. A home health agency;
 - d. A rehabilitation hospital or rehabilitation distinct part unit located within an acute care hospital;
 - e. A long-term acute care hospital; or
 - f. A psychiatric hospital or psychiatric distinct part unit located within an acute care hospital.
 - 3) A DRG eligible for a post-acute care transfer payment shall be in accordance with 42 U.S.C. 1395ww(d)(4)(J).
 - 4) a. The department shall pay each transferring hospital an average daily rate for each day of a stay.
 - b. A transfer-related payment shall not exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.
 - c. A DRG identified by CMS as being eligible for special transfer payment in the Medicare IPPS Final Rule Data Files and Tables, shall receive fifty (50) percent of the full DRG payment plus the average daily rate for the first day of the stay and fifty (50) percent of the average daily rate for the remaining days of the stay up to the full DRG base payment. The Medicare IPPS release is found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>. DRG special transfer payment indicators will be updated in accordance with Item "R" below.
 - d. A DRG that is referenced in paragraph 3) of this subsection and not referenced in subparagraph "c." above shall receive twice the average daily rate for the first day of the stay and the average daily rate for each following day of the stay prior to the transfer.
 - e. Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five (95) percent of the amount calculated for each.
 - 5) a. The average daily rate shall be the base DRG payment allowed divided by the Medicare geometric mean length-of-stay for a patient's DRG classification.
 - b. The Medicare geometric mean length-of-stay shall be determined and updated in accordance with Item "I(3)" above.

2. Acute Care Hospital Services

- K. The department shall reimburse a receiving hospital for a transfer to a rehabilitation or psychiatric distinct part unit the facility-specific distinct part unit per diem rate, in accordance with 907 KAR 10:815 (published 5/3/11), for each day the patient remains in the distinct part unit.
- L. 1) The department shall reimburse for an organ transplant on a prospective per discharge method according to the recipient's DRG classification.
- 2) a. The department's organ transplant reimbursement shall include an interim reimbursement followed by a final reimbursement.
- b. The final reimbursement shall:
- (1) Include a cost settlement process based on the Medicare 2552 cost report form; and
 - (2) Be designed to reimburse hospitals for ninety-five (95) percent of organ acquisition costs.
- c. 1) An interim organ acquisition payment shall be made using a fixed-rate add-on to the standard DRG payment using the rates below:
- (a) Kidney Acquisition - \$65,000;
 - (b) Liver Acquisition - \$55,000;
 - (c) Heart Acquisition - \$70,000;
 - (d) Lung Acquisition - \$65,000; or
 - (e) Pancreas Acquisition - \$40,000.
- 2) Upon receipt of a hospital's as-filed Medicare cost report, the department shall calculate a tentative settlement at ninety-five (95) percent of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified above.
- 3) Upon receipt of a hospital's finalized Medicare cost report, the department shall calculate a final reimbursement which shall be a cost settlement at ninety-five (95) percent of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified above.
- 4) The final cost settlement shall reflect any cost report adjustments made by CMS.

M. Payment Adjustment for Provider Preventable Conditions

Effective June 1, 2012, and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFR 434, 438 and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Never Events (NE), Other Provider Preventable Conditions (OPPCs) and Additional Other Provider Preventable Conditions (AOPPC).

Payments for Health Care Acquired Conditions (HCACs) shall be adjusted in the following manner:

For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC.

For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number of days associated with the diagnoses not present on admission for any HCAC. The number of reduced days shall be based on the average length of stay (ALOS) on the diagnosis tables published by the ICD vendor used by the Medicaid agency. For example, an inpatient claims with 45 covered days identified with an HCAC diagnosis having an ALOS of 3.4, shall be reduced to 42 covered days.

2. Acute Care Hospital Services

Also, consistent with the requirement of 42 CFR 447.26(c):

- (c)(2) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
- (c)(3) Reductions in provider payment may be limited to the extent that the following apply:
- i. The identified provider preventable conditions would otherwise result in an increase in payment.
 - ii. The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.
- (c)(5) Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

Health Care-Acquired Conditions

The state identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A:

- Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-A

- Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

N. Preadmission Services for an Inpatient Acute Care Service.

A preadmission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:

- 1) Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and
- 2) Exclude a service furnished by a home health agency, a skilled nursing facility, or hospice, unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.

2. Acute Care Hospital Services

O. Reimbursement for Sole Community Hospitals.

An operating rate for sole community hospitals shall be calculated as described below:

- 1) a. For each sole community hospital, the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
- b. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables, located at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>.
- c. Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with Item "R." below.
- 2) a. The department shall compare the rate referenced in paragraph 1) above with the operating rate calculated in Item "E(3)" above.
- b. The higher of the two rates compared in "2) a." above shall be utilized as the operating rate for sole community hospitals.

P. Reimbursement for Medicare Dependent Hospitals.

- 1) a. For a Medicare-dependent hospital, the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
- b. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
- c. Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with the reimbursement updating procedures in Item "R." below.
- 2) a. The department shall compare the Medicare-dependent hospital rate referenced in paragraph 1) above with the operating rate calculated in Item "E(3)" above.
- b. If the Item "E(3)" operating rate is higher, it shall be utilized as the hospital's operating rate for the period.
- 3) a. If the rate referenced in paragraph (1) is higher, the department shall calculate the arithmetic difference between the two (2) rates.
- b. The difference shall be multiplied by seventy-five (75) percent.
- c. The resulting product shall be added to the Item "E(3)" operating rate to determine the hospital's operating rate for the period.
- 4) If CMS terminates the Medicare-dependent hospital program, a hospital that is a Medicare-dependent hospital at the time that CMS terminates the program shall receive operating rates as calculated in Item "E(3)" above.

Q. Direct Graduate Medical Education Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs.

- 1) The department shall reimburse for the direct costs of a graduate medical education program approved by Medicare as established below.
 - a. A payment shall be made:
 - (1) Separately from the per discharge and per diem payment methodologies; and
 - (2) On an annual basis corresponding to the hospital's fiscal year.

2. Acute Care Hospital Services

- b. The department shall determine an annual payment amount for a hospital:
- (1) Total direct graduate medical education costs shall be obtained from a facility's as-filed CMS 2552 cost report, worksheet E-4, line 25.
 - (2)
 - (a) The facility's Medicaid utilization shall be calculated by dividing Medicaid fee-for-service covered days during the cost report period, as reported by the Medicaid Management Information System, by total inpatient hospital days, as reported on worksheet E-4, line 27 of the CMS 2552 cost report.
 - (b) The resulting Medicaid utilization factor shall be rounded to six (6) decimals.
 - (3) The total graduate medical education costs shall be multiplied by the Medicaid utilization factor to determine the total graduate medical education costs related to the fee-for-service Medicaid program.
 - (4) Medicaid program graduate medical education costs shall then be multiplied by ninety-five (95) percent to determine the annual payment amount.

R. Reimbursement Updating Procedures.

- 1)
 - a. The department shall annually update the Medicare grouper software to the most current version used by the Medicare program. The annual update shall be effective October 1 of each year, except as provided below.
 - b. If Medicare does not release a new grouper version effective October 1 of a given year
 - (1) The current grouper effective prior to October 1 shall remain in effect until a new grouper is released; and
 - (2) When the new grouper is released by Medicare, the department shall update the Medicare grouper software to the most current version used by the Medicare program.
 - c. The department shall not update the Medicare grouper software more than once per federal fiscal year which shall be October 1 through September 30 of the following year.
- 2) At the time of the grouper update, all DRG relative weights and geometric length-of-stay values shall be updated to match the most recent relative weights and geometric length-of-stay values effective for the Medicare program.
- 3)
 - a. Annually, on October 1, all values obtained from the Medicare IPPS Final Rule Data Files and Tables shall be updated to reflect the most current Medicare IPPS final rule in effect. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
 - b.
 - (1) Within thirty (30) days after the Centers for Medicare and Medicaid Services publishes the Medicare IPPS Final Rule Data Files and Tables for a given year, the department shall send a notice to each hospital containing the hospital's data from the Medicare IPPS Final Rule Data Files and Tables to be used by the department to establish diagnosis related group rates on October 1.

2. Acute Care Hospital Services

- (2) The notice referenced above shall request that the hospital:
 - (a) Review the information; and
 - (b) If the hospital discovers that the data in the notice sent by the department does not match the data published by the Centers for Medicare and Medicaid Services, notify the department of the discrepancy prior to October 1.

- 4) All Medicare IPPS final rule values utilized shall be updated to reflect any correction notices issued by CMS, if applicable.
- 5) Other than an adjustment resulting from an appeals decision requiring an amendment, the department shall make no other adjustment.

S. Readmissions.

- 1) An unplanned inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.
- 2) Reimbursement for an unplanned readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.

T. Reimbursement for Out-of-State Hospitals.

- 1) The department shall reimburse an acute care out-of-state hospital for inpatient care on a fully prospective per discharge basis except for the following hospitals:
 - a. A children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and a bordering state; and
 - b. Vanderbilt Medical Center.
- 2) For eligible inpatient acute care service in an out-of-state acute care hospital the total hospital-specific per discharge payment shall be calculated in the same manner as an in-state hospital with modifications to rates used as described below.
- 3) The DRG payment parameters listed below shall be modified for out-of-state hospitals not specifically excluded in paragraph 1).
 - a. The operating rate used in the calculation of the operating base payment described in Item "E(3)(a)" shall equal the average of all in-state acute care hospital operating rates calculated in accordance with Item "E(3)" multiplied by eighty (80) percent, excluding any adjustments made for:
 - (1) Sole community hospitals; or
 - (2) Medicare-dependent hospitals.
 - b. The capital rate used in the calculation of the capital base payment described in Item "E(4)(a)" shall equal the average of all in-state acute care hospital capital rates calculated in accordance with Item "E(4)" multiplied by eighty (80) percent.
 - c. The DRG relative weights used in the calculation of the operating base payment described in Item "E(3)(a)" and the calculation of the capital base payment described in Item "E(4)(a)" shall be reduced by twenty (20) percent.

2. Acute Care Hospital Services

- d. The following provisions shall not be applied:
 - (1) Medicare indirect medical education cost or reimbursement;
 - (2) Organ acquisition cost settlements;
 - (3) Disproportionate share hospital distributions; and
 - (4) Any adjustment mandated for in-state hospitals pursuant to KRS 205.638.
- e. The Medicare operating and capital cost-to-charge ratios used to estimate the cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, shall be determined by calculating the arithmetic mean of all in-state cost-to-charge ratios established in accordance with Item "F(4)" above.

- 4) The department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, and except for Vanderbilt Medical Center, the average operating rate and average capital rate paid to in-state children's hospitals.
- 5) The department shall reimburse for inpatient care provided by Vanderbilt Medical Center using the hospital-specific Medicare base rate extracted from the CMS IPPS Pricer Program in effect at the time that the care was provided multiplied by eighty-five (85) percent.
- 6) The out-of-state hospitals referenced in paragraphs 4) and 5) shall not be eligible to receive indirect medical education reimbursement, organ acquisition cost settlements, or disproportionate share hospital payments.
- 7)
 - a. The department shall reimburse a hospital referenced in subsection 4) or 5) of this section a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG.
 - b. A cost outlier shall be subject to quality improvement organization review and approval.
 - c. The department shall determine the cost outlier threshold for an out-of-state claim regarding a hospital using the same method used to determine the cost outlier threshold for an in-state claim as described in Item F above.

U. Certified Public Expenditures.

- 1)
 - a. The department shall reimburse an in-state public government-owned or operated hospital the full cost of a Medicaid fee-for-service inpatient service provided during a given state fiscal year via a certified public expenditure (CPE).
 - b. A payment shall be limited to the federal match portion of the hospital's uncompensated care cost for inpatient Medicaid fee-for-service recipients.
- 2) To determine the amount of costs eligible for a CPE, a hospital's allowed days shall be multiplied by routine cost per diems found on worksheet D-1 Part II, lines 38 and 42-47 of the CMS 2552-10 cost report. Allowed ancillary charges shall be multiplied by cost-center specific cost-to-charge ratios from the hospital's 2552-10 cost report found on worksheet C part I, column 9.
- 3) The department shall verify whether or not a given CPE is allowable as a Medicaid cost.

2. Acute Care Hospital Services

- 4) a. An interim CPE reconciliation settlement shall be processed upon receipt of a facility's as-filed 2552-10 cost report.
- b. Subsequent to a final cost report being submitted to the department, a final CPE settlement shall be reconciled with the actual costs reported to determine the final CPE for the period.
- c. If any difference between actual cost and submitted costs remains, the department shall reconcile any difference with the provider.

V. Intensity Operating Allowance Inpatient Supplement Payments.

- 1) A State owned or operated University Teaching Hospital, including a hospital operated by a related party organization as defined at 42 CFR 413.17, which is operated as part of an approved School of Medicine, shall be based on the upper payment limits as required by 42 CFR 447.272 and will be determined prospectively each year based on the difference between the total payments made by Medicaid, excluding DSH, and the estimated Medicare payments for the same services. The Medicare payments will be determined based on the Medicare Principles of Reimbursement in accordance with 42 CFR 412 and 413.
- 2) The detailed formula to determine the supplemental payments is described in Exhibit B incorporated as part of this attachment.
- 3) The prospective supplemental payments will be reconciled annually to the final cost report filed for the rate year or prospective payment period.
- 4) Any payments made under this section are subject to the payment limitations as specified in 42 CFR 447.271, whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.
- 5) Payments made under this section shall be prospectively determined quarterly amounts, subject to a year-end reconciliation.
- 6) In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by CMS, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.
- 7) Pediatric Teaching Hospital

A state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

- a. Calculated by determining the difference between Medicaid costs as stated on the audited Medicare 2552-10 cost report filed as of June 1 each year and payments received for the Medicaid recipients (i.e., Medicare, KMAP, TPL, and Medical Education); and including,
- b. An additional quarterly payment of \$250,000 (\$1 million annually).

(Medicaid recipients shall not include recipients receiving services reimbursed through a Medicaid managed care contract.)

W. Supplemental Payments for DRG Psychiatric Access Hospitals

- 1) For services provided on and after April 2, 2001 the Department shall provide supplemental payments to certain hospitals to assure access to psychiatric services for patients in rural areas of the Commonwealth. To qualify for psychiatric access payments a hospital must meet the following criteria:

2. Acute Care Hospital Services

- a. The hospital is not located in a Metropolitan Statistical Area (MSA);
 - b. The hospital provides at least 65,000 days of inpatient care as reflected in the Department's Hospital Rate data for Fiscal Year 1998-99;
 - c. The hospital provides at least 20% of inpatient care to Medicaid eligible recipients as reflected in the Department's Hospital Rate data for State Fiscal Year 1998-99; and
 - d. The hospital provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.
- 2) Each qualifying hospital will receive a psychiatric access payment amount based on its proportion of the hospital's Medicaid psychiatric days to the total Medicaid psychiatric days for all qualifying hospitals applied to the total funds for these payments. Payments will be made on a quarterly basis in according with the following:

$$\frac{\text{Medicaid patient days}}{\text{Total Medicaid patient days}} \times \text{Fund} = \text{Payment}$$

- 3) Total Medicaid payments to a hospital from all sources shall not exceed Medicaid charges plus disproportionate share payments. A hospital's disproportionate share payment shall not exceed the sum of the payment shortfall for Medicaid services and the costs of the uninsured. The fund shall be an amount not to exceed \$6 million annually.

X. Appalachian Regional Hospital System supplemental payments.

All DRG hospitals operating in the Commonwealth of Kentucky that belong to the Appalachian Regional Hospital System will receive an adjusted payment equal to the difference between what Medicaid pays for inpatient services and what Medicare would pay for those same services to Medicaid eligible individuals or its proportionate share of \$7.5 million, whichever is lower. The Upper Payment Limit as defined in 42 CFR 447.272 will be applied on a facility-specific basis as described in Exhibit A. These payments will be made on a quarterly basis within 30 days of the end of the quarter.

Y. Supplemental DRG Payments

- 1) The Department will pay no more in the aggregate for inpatient hospital services than the inpatient Upper Payment Limit, as set forth in 42 CFR 447.253(b)(2) and 42 CFR 447.272. The Department will determine the inpatient Upper Payment Limit by estimating what would be paid for inpatient hospital services under the Medicare principles of reimbursement. The methodology used by the Department to calculate the inpatient Upper Payment Limits can be found in Attachment 4.19-A Exhibit A.
- 2) An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility in accordance with applicable federal regulations.
 - a. For the purpose of this attachment, Medicaid patient days shall not include enrollee days which means a day of an inpatient hospital stay of a Medicaid recipient who is enrolled with a managed care organization.
 - b. A payment made under the Supplemental DRG payments shall not duplicate a payment made via Disproportionate share hospital distributions.

2. Acute Care Hospital Services

Z. Per Diem Methodology: Payment for Rehabilitation or Psychiatric or Substance Abuse Care in an In-State Acute Care Hospital.

1) Distinct Part Unit (DPU)

The department shall reimburse for rehabilitation or psychiatric care in an in-state acute care hospital that has a Medicare-designated rehabilitation or psychiatric distinct part unit on a per diem basis as follows:

- a. On a facility-specific per diem basis equivalent to the per diem cost reported for Medicare distinct part unit patients on the most recently received Medicare cost report prior to the rate year. Routine costs for the distinct part unit will be determined by multiplying allowed days by worksheet D-1 Part I, Title XIX - Subprovider, line 38. Ancillary costs will be determined by multiplying allowed charges by the cost center specific cost-to-charge ratio found on worksheet C part I, column 9 of the 2552-10 cost report.
- b. Reimbursement for an inpatient rehabilitation or psychiatric service shall be determined by multiplying a hospital's rehabilitation or psychiatric per diem rate by the number of allowed patient days.
- c. A rehabilitation or psychiatric per diem rate shall be the sum of a rehabilitation or psychiatric operating per diem rate and a rehabilitation or psychiatric capital per diem rate, as appropriate.
 - (1) The rehabilitation or psychiatric operating cost-per-day amounts used to determine the rehabilitation or psychiatric operating per diem rate shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric cost basis (as appropriate), excluding capital costs and medical education costs, by the number of Medicaid rehabilitation or psychiatric patient days in the base year.
 - (2) The Medicaid rehabilitation or psychiatric cost basis and patient days shall be based on Medicaid claims for patients with a rehabilitation or psychiatric diagnosis (as appropriate) with dates of service in the base year. The rehabilitation or psychiatric operating per diem rate shall be adjusted for inflation in accordance with Section (5)(A)(1) of this attachment.
- d. Computation of rates.
 - (1) A rehabilitation or psychiatric capital per diem rate shall be facility-specific and shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric capital cost basis by the number of Medicaid rehabilitation or psychiatric patient days (as appropriate) in the base year.
 - (2) The Medicaid rehabilitation or psychiatric capital cost basis and patient days shall be based on Medicaid claims for patients with rehabilitation or psychiatric diagnoses (as appropriate) with dates of service in the base year.
 - (3) The rehabilitation or psychiatric capital per diem rate shall not be adjusted for inflation.

2) Non Distinct Part Unit (Non-DPU)

The department shall reimburse for rehabilitation or psychiatric care provided in an in-state hospital that does not have a Medicare-designated distinct part unit:

-
- a. On a projected payment basis using:
- (1) A facility specific per diem basis equivalent to its aggregate projected payments for DRG services divided by its aggregate projected Medicaid paid days.
 - (2) Aggregate projected payments and projected Medicaid paid days shall be the sum of:
 - (a) Aggregate projected payments and aggregate projected Medicaid paid days for non-per diem DRG services as calculated by the model established in section (2)A;
 - (b) Actual prior year payments inflated by the inflation factor provided by GII; and
 - (c) Per diem DRG service Medicaid days; and
- b. In compliance with provisions for the use of a universal rate year and taking into consideration Medicaid policy with regard to unallowable costs as shown in (1)D and F of this attachment.
3. Payment for Long-term Acute Care Hospital Care, In-State Freestanding Psychiatric or Substance Abuse Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.
- A. The department shall reimburse for inpatient care provided to eligible Medicaid recipients in an in-state freestanding psychiatric hospital, in-state freestanding rehabilitation hospital, or LTAC hospital on a per diem basis including both psychiatric or substance abuse care where applicable.
- B. The department shall calculate a per diem rate by:
- 1) For rates effective July 1, 2015 through June 30, 2019, using a hospital's fiscal year 2014 Medicare cost report, allowable cost and paid days to calculate a base cost per day for the hospital. Routine costs will be determined by multiplying allowed days by worksheet D-1 Part I, Title XIX, line 38. Ancillary costs will be determined by multiplying allowed charges by the cost center specific cost-to-charge ratio found on worksheet C part I, column 9 of the 2552-10 cost report. Rates will be re-based every four years with adjustments for inflation in non-rebase years, in accordance with section 5 of this attachment. For future rebasing periods beginning July 1, 2019, using the most recently received hospital fiscal year Medicare cost report at the time of rate-setting;
 - 2) Trending and indexing a hospital's specific cost, excluding capital cost, per day to the current state fiscal year;
 - 3) Calculating an average base cost per day for hospitals within similar categories, for example rehabilitation hospitals, using the indexed and trended base cost per day;
 - 4) Assigning no hospital a base cost per day equaling less than ninety-five (95) percent of the weighted average trended and indexed base cost per day of hospitals within the corresponding category;

3. Payment for Long-term Acute Care Hospital Care, In-State Freestanding Psychiatric or Substance Abuse Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.
 - 5) Applying a parity factor equivalent to aggregate cost coverage established by the DRG reimbursement methodology described in the diagnostic related group hospital reimbursement portion of the state plan; and
 - 6) Applying available provider tax funds on a pro-rata basis to the pre-provider tax per diem calculated in paragraphs 1 through 5 of this subsection.
- C. In-State Hospital Minimum Occupancy Factor.
- 1) If an in-state hospital's minimum occupancy is not met, allowable Medicaid capital costs shall be reduced by:
 - a. Increasing the occupancy factor to the minimum factor; and
 - b. Calculating the capital costs using the calculated minimum occupancy factor.
 - 2) The following minimum occupancy factors shall apply:
 - a. A sixty (60) percent minimum occupancy factor shall apply to a hospital with 100 or fewer total licensed beds;
 - b. A seventy-five (75) percent minimum occupancy factor shall apply to a hospital with 101 or more total licensed beds; and
 - c. A newly-constructed in-state hospital shall be allowed one (1) full universal rate year before a minimum occupancy factor shall be applied.
- D. Reduced Depreciation Allowance. The allowable amount for depreciation on a hospital building and fixtures, excluding major movable equipment, shall be sixty-five (65) percent of the reported depreciation amount as shown in the hospital's cost reports.
- E. Payment to a Newly-participating In-State Freestanding Psychiatric Hospital, Freestanding Rehabilitation Hospital or a Long Term Acute Care Hospital.
- 1) The department shall reimburse a newly-participating in-state freestanding psychiatric hospital, freestanding rehabilitation hospital or long term acute care hospital the minimum per diem rate paid to hospitals in their category until the first fiscal year cost report is submitted by the hospital.
 - 2) Upon submission of the first fiscal year cost report for a facility, the department shall reimburse the facility a per diem rate in accordance with Section (3)B of this attachment.

4. Payment for Critical Access Hospital Care.
- A. The department shall pay a per diem rate to a critical access hospital equal to the hospital's Medicare rate.
 - B. A critical access hospital's final reimbursement for a fiscal year shall reflect any adjustment made by CMS.
 - C. Cost Report Requirements.
 - 1) A critical access hospital shall comply with the cost reporting requirements established in the In-State Hospital Cost Reporting Requirements section.
 - 2) A cost report submitted by a critical access hospital to the department shall be subject to audit and review.
 - D. An out-of-state critical access hospital shall be reimbursed under the same methodology as an in-state critical access hospital.
 - E. The department shall reimburse for care in a federally defined swing bed in a critical access hospital at the same rate as established by the Centers for Medicare and Medicaid Services for Medicare.
 - F. Reimbursement Limit. Total reimbursement to a hospital, other than to a critical access hospital, shall be subject to the limitation established in 42 C.F.R. 447.271.

5. In-State Psychiatric, Rehabilitation, and Long-term Acute Care Hospitals Reimbursement Updating Procedures including psychiatric or substance abuse care, where applicable.
- A. The department shall adjust an in-state hospital's per diem rate annually according to the following:
- 1) The Healthcare Cost Review, a publication prepared by IHS Global Insight (GI) is used to obtain to update trending and indexing factors. The most recently received first-quarter publication is used for rate-setting. For trending and indexing factors the Total %MOVAVG line from Table 6.1CY, Hospital Prospective Reimbursement Market Basket, is used. The second quarter column of the respective year being trended/indexed to is used.
 - 2) A capital per diem rate shall not be adjusted for inflation.
- B. The department shall, except for a critical access hospital, rebase an in-state psychiatric, rehabilitation, and long-term acute care hospital's per diem rate every four (4) years.
- C. Except for an adjustment resulting from an audited cost report, the department shall make no other adjustment, except for correction of error, as a result of a change resulting from a dispute resolution or appeal to the extent rates were not set in accordance with the State Plan or Federal Court decision; or as a result of a properly promulgated policy change and approved by CMS through a State Plan amendment.

6. Reimbursement for Out-of-state Hospitals for Critical Access Care, Long Term Acute Care, Rehabilitation Care and Psychiatric Care including psychiatric or substance abuse care, where applicable.
- A. For inpatient psychiatric or rehabilitation care provided by an acute out-of-state hospital, the department shall reimburse a per diem rate comprised of an operating per diem rate and a capital per diem rate.
- 1) The psychiatric or rehabilitation operating per diem rate shall be the median psychiatric or rehabilitation operating per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 - 2) The psychiatric or rehabilitation capital per diem rate shall be the median psychiatric or rehabilitation capital per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 - 3) An out-of-state hospital's per diem rate shall not include:
 - a. A provider tax adjustment; or
 - b. Graduate medical education costs.
- B. For care provided by an out-of-state freestanding long term acute care, critical access, or freestanding psychiatric hospital, the department shall reimburse a per diem rate comprised of an operating per diem rate and a capital per diem rate for each type of facility as appropriate.
- 1) The long term acute care or critical access operating per diem rate shall equal the median operating rate, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding hospitals of the same type. The psychiatric operating per diem rate shall equal seventy (70) percent of the median operating rate, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding psychiatric hospitals.
 - 2) The long term acute care or critical access capital per diem rate shall be the median capital per diem rate for all in-state freestanding hospitals of the same type. The psychiatric capital per diem rate shall equal seventy (70) percent of the median capital rate, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding psychiatric hospitals.
 - 3) An out-of-state hospital's per diem rate shall not include:
 - a. A provider tax adjustment; or
 - b. Graduate medical education costs.
- C. For care in an out-of-state rehabilitation hospital, the department shall reimburse a per diem rate equal to the median rehabilitation per diem rate for all in-state rehabilitation hospitals except that an out-of-state hospital's per diem rate shall not include:
- 1) A provider tax adjustment; or
 - 2) Graduate medical education costs.
- D. The department shall apply the requirements of 42 C.F.R. 447.271 to payments made pursuant to the plan provisions shown in this section of this attachment.

7. Supplemental Payments for a Free-standing In-state Rehabilitation Hospital:

A state designated rehabilitation teaching hospital that is not state-owned or operated shall receive an annual rehabilitation teaching supplement payment, determined on a per diem basis, in an amount calculated by determining the difference between Medicaid costs as stated on the most recently received cost report each year, and payments received for the Medicaid patients (i.e., Medicare, KMAP, TPL, and Medical Education.)

8. Disproportionate Share Hospital Provisions

A. Definition. A disproportionate share hospital or DSH means an in-state hospital that:

- 1) Has an inpatient Medicaid utilization rate of one (1) percent or higher; and
- 2) Meets the criteria established in 42 U.S.C. 1396r-4(d).
- 3) Has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.
- 4) Meets the requirements established in section 1923(d) of the Act.

B. Disproportionate Share Hospital Distribution General Provisions. A DSH distribution shall:

- 1) Be made to a qualified hospital;
- 2) Be based upon a hospital's proportion of inpatient and outpatient indigent care from the preceding state fiscal year, excluding university teaching hospitals;
- 3) Be a prospective amount. For example, a DSH distribution made to a hospital in October 2007 shall be applied to the reimbursement for the state fiscal year beginning July 1, 2007 and ending June 30, 2008;
- 4) Not be subject to settlement or revision based on a change in utilization during the year to which it applies;
- 5) Be made on an annual basis;
- 6) Be made from a hospital's share of the allocated pool or total disproportionate share funds with the following allocation into three (3) pools: forty-three and ninety-two hundredths percent (43.92%) allocated to acute care hospitals; thirty-seven percent (37%) allocated to university hospitals; and nineteen and eight hundredths percent (19.08%) allocated to private psychiatric hospitals and state mental hospitals, up to the maximum dollar cap from the annual federal allotment;
- 7) "Type I hospital" means an in-state disproportionate share hospital with 100 beds or less that participates in the Medicaid Program;
- 8) "Type II hospital" means an in-state disproportionate share hospital with 101 beds or more that participates in the Medicaid Program, except for a hospital that meets the criteria for a Type III or Type IV hospital;
- 9) "Type III hospital" means an in-state disproportionate share state university teaching hospital, owned or operated by either the University of Kentucky or the University of Louisville Medical School; and
- 10) "Type IV hospital" means an in-state disproportionate share hospital participating in the Medicaid Program that is a state-owned psychiatric hospital.

C. Disproportionate Share Hospital Distribution to a DRG-Reimbursed Acute Care Hospital. The department shall determine a DSH distribution to a DRG-reimbursed acute care hospital by:

- 1) For the Federal Fiscal Year ending September 30, 2015 and September 30, 2016 by multiplying the final SFY 2013-2014 indigent share factor by the total fund allocated to the acute care pool.
- 2) For the period beginning October 1, 2016 and subsequent state fiscal years, by:
 - a. Determining a hospital's average reimbursement per discharge;
 - b. Dividing the hospital's average reimbursement per discharge by Medicaid days per discharge;

8. Disproportionate Share Hospital Provisions

- c. Payment for Long-term Acute Care Hospital Care, In-State Freestanding Psychiatric or Substance Abuse Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.
- d. Multiplying the amount established in paragraph b by the hospital's total number of inpatient indigent care days for the most recently completed state fiscal year to establish the hospital's inpatient indigent care cost for purposes of this section;
- e. Determining an in-state hospital's outpatient indigent care cost for purposes of this section by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with 803 KAR 25:091 (Published 10/25/2011);
- f. Combining the inpatient indigent care cost established in paragraph (c) with the outpatient indigent care cost established in paragraph (d) to establish a hospital's indigent care cost total; and
- g. Comparing the total indigent care cost for each DRG-reimbursed hospital to the indigent care costs of all hospitals receiving DSH distributions under the acute care pool to establish a DSH distribution on a pro rata basis:
 - (1) Annual distribution to acute care hospitals shall be calculated for the period ending September 30, 2015 and ending September 30, 2016, by multiplying the final SFY 2013-2014 indigent care factor by the total fund allocated to the acute care pool.
 - (2) Annual distribution to acute care hospitals shall be calculated for the period beginning October 1, 2016 and subsequent state fiscal years, by multiplying the annual indigent care factor for each hospital by the total fund allocated to the acute care pool.

- D. Disproportionate Share Hospital Distribution to a Critical Access Hospital, Rehabilitation Hospital or Long Term Acute Care Hospital. The department shall determine a DSH distribution to a critical access hospital, rehabilitation hospital, or long term acute care hospital:

For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:

- 1) Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection (2) of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and
- 2) Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with 803 KAR 25:091;
- 3) Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and
- 4) Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to state statute establishing a hospital's DSH distribution on a pro rata basis.

8. Disproportionate Share Hospital Provisions

- E. Disproportionate Share Hospital Distribution to a Private Psychiatric Hospital. The department shall determine a DSH distribution to a private psychiatric hospital:

For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:

- 1) Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection 2 of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and
- 2) Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge by the Department of Labor in accordance with 803 KAR 25:091 (published 10/25/11) or by establishing an inpatient equivalency;
- 3) Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and
- 4) Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis.

- F. Disproportionate Share Hospital Distribution to a State Mental Hospital. The Department shall determine a DSH distribution to a state mental hospital by:

- 1) Comparing each state mental hospital's costs of services provided to individuals meeting the indigent eligibility criteria established in subsections H and I of this Section, minus any payment made by or on behalf of the individual to the hospital; and
- 2) Using the DSH funding allocated to state mental hospitals to establish a state mental hospital's DSH distribution on a pro rata basis.

- G. Disproportionate Share Hospital Distribution to a University Hospital. The department's DSH distribution to a university hospital shall be based on the hospital's historical proportion of the costs of services to Medicaid recipients, minus reimbursement paid related to Diagnostic related group (DRG) inpatient hospital reimbursement, or the nondiagnostic related group inpatient hospital reimbursement and supplemental or IOA payments, plus the costs of services to indigent and uninsured patients minus any distributions made on behalf of indigent and uninsured patients; and

- H. Indigent Care Eligibility.

- 1) Prior to billing a patient and prior to submitting the cost of a hospital service to the department as uncompensated, a hospital shall use the indigent care eligibility form, DSH-001, Application for Disproportionate Share Hospital Program, to assess a patient's financial situation to determine if:
 - a. Medicaid or Kentucky Children's Health Insurance Program (KCHIP) may cover hospital expenses; or
 - b. A patient meets the indigent care eligibility criteria.

8. Disproportionate Share Hospital Provisions

- 2) An individual referred to Medicaid or KCHIP by a hospital shall apply for the referred assistance, Medicaid or KCHIP, within thirty (30) days of completing the DSH-001, Application for Disproportionate Share Hospital Program, at the hospital.

I. Indigent Care Eligibility Criteria.

- 1) A hospital shall receive disproportionate share hospital funding for an inpatient or outpatient medical service provided to an indigent patient under the provisions of this attachment if the following apply:
 - a. The patient is a resident of Kentucky;
 - b. The patient is not eligible for Medicaid or KCHIP;
 - c. The patient is not covered by a third-party payor;
 - d. The patient is not in the custody of a unit of government that is responsible for coverage of the acute care needs of the individual;
 - e. The hospital shall consider all income and countable resources of the patient's family unit and the family unit shall include:
 - (1) The patient;
 - (2) The patient's spouse;
 - (3) The minor's parent or parents living in the home; and
 - (4) Any minor living in the home;
 - f. A household member who does not fall in one (1) of the groups listed in paragraph (e) of this subsection shall be considered a separate family unit;
 - g. Countable resources of a family unit shall not exceed:
 - (1) \$2,000 for an individual;
 - (2) \$4,000 for a family unit size of two (2); and
 - (3) Fifty (50) dollars for each additional family unit member;
 - h. Countable resources shall be reduced by unpaid medical expenses of the family unit to establish eligibility; and
 - i. The patient or family unit's gross income shall not exceed the federal poverty limits published annually in the Federal Register and in accordance with KRS 205.640.
- 2) Except as provided in subsection (3) of this section, total annual gross income shall be the lessor of:
 - a. Income received during the twelve (12) months preceding the month of receiving a service; or
 - b. The amount determined by multiplying the patient's or family unit's income, as applicable, for the three (3) months preceding the date the service was provided by four (4).
- 3) A work expense for a self-employed patient shall be deducted from gross income if:
 - a. The work expense is directly related to producing a good or service; and
 - b. Without it the good or service could not be produced.
- 4) A hospital shall notify the patient or responsible party of his eligibility for indigent care.

8. Disproportionate Share Hospital Provisions

- 5) If indigent care eligibility is established for a patient, the patient shall remain eligible for a period not to exceed six (6) months without another determination.

J. Indigent Care Eligibility Determination Fair Hearing Process.

- 1) If a hospital determines that a patient does not meet indigent care eligibility criteria as established in subsections H and I of this Section, the patient or responsible party may request a fair hearing regarding the determination within thirty (30) days of receiving the determination.
- 2) If a hospital receives a request for a fair hearing regarding an indigent care eligibility determination, impartial hospital staff not involved in the initial determination shall conduct the hearing within thirty (30) days of receiving the hearing request.
- 3) A fair hearing regarding a patient's indigent care eligibility determination shall allow the individual to:
 - a. Review evidence regarding the indigent care eligibility determination;
 - b. Cross-examine witnesses regarding the indigent care eligibility determination;
 - c. Present evidence regarding the indigent care eligibility determination; and
 - d. Be represented by counsel.
- 4) A hospital shall render a fair hearing decision within fourteen (14) days of the hearing and shall provide a copy of its decision to:
 - a. The patient or responsible party who requested the fair hearing; and
 - b. The department.
- 5) A fair hearing process shall be terminated if a hospital reverses its earlier decision and notifies, prior to the hearing, the patient or responsible party who requested the hearing.
- 6) A patient or responsible party may appeal a fair hearing decision to a court of competent jurisdiction in accordance with state statute on judicial review of final order.

K. Indigent Care Reporting Requirements.

- 1) On a quarterly basis, a hospital shall collect and report to the department indigent care patient and cost data.
- 2) If a patient meeting hospital indigent care eligibility criteria is later determined to be Medicaid or KCHIP eligible or has other third-party payor coverage, a hospital shall adjust its indigent care report previously submitted to the department in a future reporting period.

L. Merged Facility. If two (2) separate entities merge into one (1) organization and one (1) of the merging entities has disproportionate status and the other does not, the department shall retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid.

8. Disproportionate Share Hospital Provisions

M. Payment Limits: Limit on Amount of Disproportionate Share Payment to a Hospital.

- 1) Payments made under these provisions do not exceed the OBRA '93 limits described in 1923 (g) of the Social Security Act. This limit is the sum of the following two measurements that determine uncompensated costs: (a) Medicaid shortfall; and (b) costs of services to uninsured patients less any payments received. Medicaid shortfall is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the non-disproportionate share hospital payment method under this state plan. The cost of services to the uninsured includes inpatient and outpatient services. Costs shall be determined by multiplying a hospital's cost to charge ratio by its uncompensated charges. Uninsured patients are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.
- 2) The final hospital-specific DSH limit will be determined retrospectively through the annual DSH examination. For a given state fiscal year DSH examination, in the event DSH payments are found to exceed the limits described in subsection 1 above, funds may be redistributed in accordance with state plan, Attachment 4.19.A, Section (1)(O).
- 3) Limit on Amount of Disproportionate Share Payment to a Hospital
 - a. A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for Medicaid recipient services and the costs of uninsured patients. (Section 1923(g) of the Social Security Act.)
 - b. Payment Shortfall for Medicaid Recipient Services. The payment shortfall for Medicaid recipient services is the amount by which the costs of inpatient and outpatient services provided Medicaid recipients exceed the payments made to the hospital for those services excluding disproportionate share payments.
 - c. Unrecovered Cost of Uninsured/indigent Patients. The unrecovered cost of uninsured/indigent patients is the amount by which the costs of inpatient and outpatient services provided to uninsured/indigent patients exceed any cash payments made by or on behalf of them. An uninsured/indigent patient is an individual who has no health insurance and meets income standards established in state law.
- 4) The disproportionate share hospital payment shall be an amount that is reasonably related to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

9. Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

- A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A
- B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

Level I PRTF

To be reimbursable under the Medicaid Program, Level I PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level I PRTF services in accordance with Attachment 3.1-A, Section 16 – Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse for Level I PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of \$280.09; or the usual and customary charge
- 2 The per diem rate shall be increased each biennium by 2.22 percent.
- 3 The per diem or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:
 - (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be covered and reimbursed under Kentucky's pharmacy program in accordance 907 KAR 1:018 (published 3/2/2012).

Level II PRTF

To be reimbursable under the Medicaid program, Level II PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level II PRTF services in accordance with Attachment 3.1-A, Section 16 – Inpatient Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse a per diem rate as follows for Level II PRTF services and costs for a recipient not enrolled in a managed care organization:
 - (a) \$345 for Level II PRTF services to a recipient who meets the rate group one (1) criteria described below;
 - (b) \$365 for Level II PRTF services to a recipient who meets the rate group two (2) criteria described below;
 - (c) \$385 for Level II PRTF services to a recipient who meets the rate group three (3) criteria described below; or
 - (d) \$405 for Level II PRTF services to a recipient who meets the rate group four (4) criteria described below.

2 Rate Groups

- (a) Rate group one (1) criteria shall be for a recipient who:
1. Is twelve (12) years of age or younger;
 2. Is male or female; and
 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (b) Rate group two (2) criteria shall be for a recipient who:
1. Is twelve (12) years of age or younger;
 2. Is male or female; and
 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (c) Rate group three (3) criteria shall be for a recipient who:
1. Is thirteen (13) years of age or older;
 2. Is male or female; and
 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (d) Rate group four (4) criteria shall be for a recipient who:
1. Is thirteen (13) years of age or older;
 2. Is male or female; and
 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (e) Rate group four (4) criteria also includes the following for a recipient who:
1. Is under twenty-two (22) years of age;
 2. Is male or female; and
 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Has an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient lower than seventy (70).

C. The per diem rates referenced above, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:

- (a) Including all care and treatment costs;
- (b) Including costs for all ancillary services;
- (c) Including capital costs;
- (d) Including room and board costs; and
- (e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program

- D. The department shall annually evaluate each per diem rate for Level II PRTF services and costs by reviewing the most recent, reliable claims data and cost report data to analyze treatment patterns, technology, and other factors that may alter the cost of efficiently providing Level II PRTF services.
- E. The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.
- F. (1) The department's reimbursement for a bed reserve day which qualifies as a bed reserve day for a recipient not enrolled in a managed care organization shall be:
- (a) Seventy-five (75) percent of the rate established if the Level I or II PRTF's occupancy percent is at least eighty-five (85) percent; or
 - (b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is less than eighty-five (85) percent.
 - (c) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - i. Is in Medicaid payment status in a Level I or II PRTF;
 - ii. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - iii. Is reasonably expected to return requiring Level I or II PRTF care; and
 - iv. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital
- (2) The department's reimbursement for a therapeutic pass day which qualifies as a therapeutic pass day for a recipient not enrolled in a managed care organization shall be:
- (a) 100 percent of the rate established if the Level I or II PRTF's occupancy percent is at least fifty (50) percent; or
 - (b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is below fifty (50) percent.
 - (c) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - i. Is in Medicaid payment status in a Level I or II PRTF;
 - ii. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - iii. Is reasonably expected to return requiring Level I or II PRTF care; and
 - iv. Has not exceeded the therapeutic pass day limit established; or
 - v. Received an exception to the limit.
 - vi. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - vii. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.
- (3) (a) A Level I or II PRTF's occupancy percent shall be based on a midnight census.
- (b) An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.
- (c) An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.

(10) Reimbursement for Out-of-state Hospitals.

- A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.
1. The all-inclusive DRG payment amount:
 - a. Shall be based on the patients diagnostic category; and
 - b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
 2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

This describes the methodology for calculating the Commonwealth of Kentucky's ("Commonwealth") inpatient hospital upper payment limits ("UPLs"). The Department's UPL methodology is in accordance with UPL guidance set forth by the Centers for Medicare and Medicaid Services ("CMS").

Overview of the Upper Payment Limit Methodology

The Commonwealth estimated the inpatient UPLs for the most recent state fiscal year by calculating a reasonable estimate of what would have been paid for Medicaid services using Medicare payment principles, by provider class. If the Medicaid payments for those services were equal to or less than the reasonable estimate of what would have been paid using Medicare payment principles, the Commonwealth met the UPL test.

For the inpatient hospital UPL analysis, the Commonwealth used various approaches to estimate what hospitals would have been paid using Medicare payment principles. These approaches are summarized as follows:

- *Private and non-state governmental owned acute hospitals:* Estimated payments under the Medicare Inpatient Prospective Payment System ("IPPS") payment methodology for the Federal Fiscal Year ("FFY") that most closely matches the UPL time period
- *Privately-owned psychiatric and rehabilitation distinct part units ("DPU"), and freestanding psychiatric, rehabilitation, and long-term acute care hospitals:* Estimated costs using the Medicare TEFRA approach (same approach as the outpatient analysis)
- *State-owned or operated university teaching hospitals:* Comparison of case-mix adjusted payment per discharge between Medicare and Medicaid for the UPL time period. These calculations have been made separately and are not included in this narrative.

Overview of Data Used for Analysis

The following data sources were used in the UPL calculations:

- Fee-for-service ("FFS") inpatient Medicaid claims data from the Medicaid Management Information System ("MMIS") for with dates of service that are within the UPL time period
- Most recently available Form CMS 2552 ("Medicare cost report") data extracted from the Healthcare Cost Report Information System ("HCRIS") dataset
- Supplemental Medicaid payment data from the Commonwealth as calculated in accordance with sections found in Attachment 4.19-A.

Development of UPL Analysis

The following summarizes the steps involved in the development of the UPL amounts for inpatient hospital services.

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- Step 1: Assigned Providers Into Provider Classes
Step 2: Calculated Reasonable Estimate of What Would Have Been Paid Under Medicare Payment Principles
Step 3: Determined Total Payments for Medicaid Services
Step 4: Compared Medicare Payments to Medicaid Payments for Each Provider Class

Each step is described in detail below.

Step 1: Assigned Providers Into Provider Classes

Per Federal UPL regulations, hospitals were placed into three provider classes:

- State-owned or operated
- Non-state government-owned or operated
- Privately-owned or operated

These provider class designations were determined via correspondence with staff from the Kentucky Office of the Inspector General, Division of Health Care Facilities and Services.

Step 2: Calculated Reasonable Estimate of What Would Have Been Paid Under Medicare Payment Principles

Inpatient UPL analysis

There are several approaches to estimating Medicare payments for inpatient services, depending on the type of facility. These approaches are described as follows.

A. *Non-state governmental and Privately-Owned Acute Hospitals*

Kentucky Medicaid reimburses FFS acute inpatient hospital claims on a prospective basis using the Medicare Diagnosis Related Group ("DRG") Groupers. As such, it was reasonable to estimate what

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

payments would have been under the Medicare Inpatient Prospective Payment System ("IPPS") methodology for the same services paid by Medicaid during the UPL time period. The steps to estimating the Medicare IPPS payments are described as follows:

- 1) Medicare Rate Data: Medicare IPPS rate components were extracted from following sources (shown in Table 1):

Table 1: Medicare IPPS Rate Components

Medicare IPPS Rate Component	Source
<ul style="list-style-type: none"> • National Adjusted Operating Standardized Amounts, broken out by Labor and Non-Labor Components • Capital Standard Federal Payment Rates • Diagnosis Related ("DRG") Classifications, Relative Weights and Geometric Mean Average Length of Stay ("GLOS") • Post Acute Transfer DRGs 	"Final Rule" Federal Register
<ul style="list-style-type: none"> • Wage indices • Geographic Adjustment Factors ("GAF") • Operating IME Adjustment Factors • Capital IME Adjustment Factors • Other Hospital ("HSP") Factors • Medicare Hospital Aggregate Operating and Capital CCRs 	CMS IPPS Final Rule Data Files and Tables
<ul style="list-style-type: none"> • Quarterly Price Index Levels 	CMS PPS Hospital Input Price Index Levels, published by GLOBAL INSIGHT

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- 2) Medicare IPPS Rates: Medicare payment rates were determined as follows:
- a) Acute Base Rates: Operating and capital acute base rates were calculated for each hospital. For operating, the labor portion of the National Adjusted Operating Standardized Amount was adjusted by facility wage index. For capital, the full Capital Standard Federal Payment Rate was adjusted by facility GAF.
 - b) Indirect Medical Education ("IME") Factors: operating and capital IME factors were obtained from the Medicare IPPS Final Rule public use file. .
 - c) Disproportionate Share Hospital ("DSH") Payment per Discharge Factors: DSH factors were determined for each hospital using Medicare DSH payments amounts and discharge information reported on the Medicare cost report.
 - d) Hospital-Specific ("HSP") Factor: Operating HSP factors were extracted from the IPPS Final Rule public use file for qualifying Sole Community Hospitals and Medicare Dependent Hospitals.
- 3) Development of Inpatient Paid Claims Database: Payments under the annual FFY IPPS methodology were calculated using Medicaid inpatient claims. Payments were calculated based on the assigned DRG classification, discharge status, submitted charges and length of stay from the claims data.
- a) Non-transfer claims: For claims where the patient was not discharged to another hospital, DRG payments were estimated by multiplying the DRG relative weight by the operating and capital base rates. For qualifying hospitals, IME, DSH and HSP payments were estimated by multiplying the respective factors by the operating and capital DRG payments.
 - b) Normal Transfer Claims: For claims where the patient was discharged to another hospital and the DRG was not designated as special post-acute transfer, payments were estimated based on the transfer adjustment.
 - i. The transfer adjustment was calculated as follows:
$$(\text{Length of stay} + 1) / (\text{DRG GLOS})$$

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- ii. If the transfer adjustment was less than 1.0, payments were estimated by multiplying the total payment under the non-transfer claim methodology by the transfer adjustment
 - iii. If the transfer adjustment was greater than or equal to 1.0, payments were estimated using the non-transfer claim methodology
- c) Special Post-Acute Transfer Claims: For claims where the patient was discharged to another hospital and the DRG was designated as a special post-acute transfer, payments were estimated based on the special transfer adjustment:
- i. The special transfer adjustment was calculated as follows: $0.5 + \frac{((\text{Length of stay} + 1) * 0.5)}{(\text{DRG GLOS})}$
 - ii. If the special transfer adjustment was less than 1.0, payments were estimated by multiplying the total payment under the non-transfer claim methodology by the special transfer adjustment
 - iii. If the special transfer adjustment was greater than or equal to 1.0, payments were estimated using the non-transfer claim methodology
- d) Outlier Claims: A claim qualified for an outlier payment if the total costs, estimated by multiplying Medicare hospital aggregate CCRs by submitted charges, exceeded the total outlier threshold. The total outlier threshold equaled the sum of the Medicare IPPS fixed loss amount and the full DRG payment, including IME and DSH payments. For transfer claims, the outlier threshold was multiplied by the transfer adjustment.

If a claim qualified for an outlier payment, outlier payments were calculated as follows:

- i. Outlier payment:
$$[(\text{Claim Cost}) - (\text{Outlier Threshold})] * (\text{Marginal Cost Factor})$$
 - ii. Marginal cost factor: 90% for DRGs with an MDC of 22 (Burn) and 80% for all other DRGs
- e) Medicare payments were determined for every inpatient claim, resulting in an inpatient paid claims database

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- f) Using the inpatient paid claims database, Medicare payments by provider were determined.
- 4) Medicare IPPS Direct GME payments: Medicare reimburses teaching hospitals for the Direct GME costs related to the Medicare program. Medicare direct GME payments were estimated by determining the direct GME cost related to the Medicaid program. Direct GME payments were calculated as follows:
- a) Total provider direct medical education costs were estimated using Medicare GME payments and discharge information reported on the Medicare cost report. Medicare GME payments were divided by reported discharges to determine a per discharge GME cost. b) The Medicaid portion of the direct GME costs was estimated by multiplying Medicaid days times the GME payment per discharge determined in paragraph a.
- 5) Other Medicare IPPS Payments: Additional Medicare payments were added to the UPL demonstration for various payment programs from E part A of the cost report, including:
- o High Percentage ESRD Beneficiary Discharges (Acuity Adjusted)
 - o New Technology Add-ons (Acuity Adjusted)
 - o Credits Received from Manufacturers for Replacement Devices (Acuity Adjusted)
 - o Organ Acquisition Costs
 - o Cost of Teaching Physicians
 - o Routine Service Pass-Throughs
 - o Ancillary Services Pass-Throughs
- Acuity adjusted payments were divided by the ratio of Medicaid case mix index (CMI) to Medicare CMI to account for differences in patient acuity between the two demographics. Payments were then divided by total discharges reported on the Medicare cost report and multiplied by Medicaid discharges to estimate the Medicaid portion of the costs.

B. Psychiatric and Rehabilitation DPUs, Freestanding Psychiatric, Rehabilitation, and Long-term Acute Care Hospitals

Kentucky Medicaid reimburses all claims from psychiatric and rehabilitation DPUs and freestanding psychiatric, rehabilitation, and long-term acute care hospitals on a per diem payment basis. As such, it was not reasonable to estimate payments under Medicare's Inpatient Psychiatric Facility Prospective Payment System ("IPF PPS") or Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS") Methodologies. In lieu of replicating Medicare's payment methodologies, the Commonwealth used estimated TEFRA costs as a reasonable proxy for Medicare payments for hospital DPU and freestanding hospital claims.

Inpatient services include both routine and ancillary costs. Routine costs were estimated by applying cost per diems from the appropriate subprovider line on D-1 part II of the Medicare cost report to Medicaid patient days reported by the MMIS, while ancillary costs were estimated by applying cost-to-charge ratios from C part I, column 9 of the Medicare cost report to Medicaid claim ancillary charges reported by the MMIS. MMIS charges were allocated to Medicare cost centers utilizing hospital-specific groupings on subprovider worksheet D-3, Title XIX of the Medicare cost report.

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- 1) Inflation Factors: After routine and ancillary costs were calculated for each hospital DPU, inflation factors were developed to inflate costs to the UPL time period.
 - a) Price index levels were extracted from the CMS Prospective Payment System Hospital Input Price Index
 - b) The midpoint of each hospital Medicare cost report fiscal year was determined
 - c) Inflation factors were calculated based on the percentage change in Price Index Levels from the midpoint of each hospital's Medicare cost report to the midpoint of the UPL time period

Step 3: Determined Total Payments for Medicaid Services

For the inpatient hospital analyses, Medicaid FFS payments for each hospital were determined based on amounts reported in the MMIS for each claim in the FFS claims data. Other supplemental Medicaid payments amounts received from the Commonwealth were included in the inpatient UPL analysis. The Medicaid payments included in the UPL analysis are described detail below:

- A. FFS Medicaid Payments: Using the inpatient paid claims databases from the MMIS, total FFS Medicaid inpatient payments were calculated by summing all applicable Medicaid payment fields for each hospital.
- B. Other Supplemental Inpatient Medicaid Payments:
 - 1) Direct GME Payments: Based on Medicaid direct graduate medical education payments.
 - 2) Intensity Operating Allowance ("IOA") Payments: Based on Medicaid IOA payments to teaching hospitals.
 - 3) Level II Neonatal Payment: Based on Medicaid Level II Neonatal payments to Central Baptist (if applicable)
 - 4) All other payments that may be made determined on a year by year basis.

Step 4: Compared Medicare Payments to Medicaid Payments for Each Provider Class

After calculating Medicaid payments and a reasonable estimate of Medicare payments for each hospital, subtotals were calculated for each provider class. The remaining limit for each provider class was determined by subtracting total Medicaid payments from total estimated Medicare payments. If the difference was positive, there was remaining limit, and the provider class passed the UPL test. If the difference was negative, there was no remaining limit, and the provider class did not pass the UPL test.

University of Louisville Hospital and University of Kentucky Hospital
Upper Payment Limits Demonstration Calculations
FYE (Providers Fiscal Year End)

Step 1: Find Medicare per case rate with case mix removed

- | | | | |
|----|---|----|---------|
| 1. | Portions of Medicare Payments for (Fiscal Year End) Subject to Case Mix Index | | |
| a. | Other than Outlier payments (MCR Wksht E part A Line 1) | | |
| b. | IME Adjustment (MCR Wksht E Part A Line 29) | | |
| c. | DSH Adjustment (MCR Wksht E Part A Line 34) | | |
| d. | Capital Adjustment (MCR Wksht. E Part A Lines 50 and 51) | | |
| e. | Credits received from manufacturers for replaced devices (Wksht E Part A Line 68) | \$ | |
| f. | Total Medicare Payments Subject to Case Mix Index (total lines 1a through 1d, less line 1e) | | |
| 2. | Adjustment for Case Mix Index | | |
| a. | Medicare Case Mix Index-From Medicare annual PS&R Reports | | |
| b. | Case Mix Adjusted Total Payments (In 1f/In 2a) | | #DIV/o! |
| 3. | Medicare Payments for (Fiscal Year End) not subject to case mix index | | |
| a. | Outlier Adjustment (MCR Wksht E Part A Line 2.) | | |
| b. | GME adjustment (MCR Wksht E Part A Line 52) – Excluding Medicare Part B | | |
| c. | PPS Exempt Psych Unit (MCR Wksht E-3 Part 1 Ln 4) | \$ | |
| d. | New Technology & Organ Acquisition pass-thru (MCR Wksht E Part A Lines 54 and 55) | \$ | |
| e. | Routine service pass-thru (Wksht E Part A Line 57) | | |
| f. | Other ancillary other pass-thru (Wksht E Part A Lines 53 and 58 and E Part B Ln 9)Total Medicare | | |
| g. | Payments Not Subject to Case Mix Index (total lines 3a through 3f) | \$ | |
| 4. | Total Medicare Payment | | #DIV/0! |
| 5. | Medicare Discharges (MCR Wksht. S-3 Part 1 Line 12)-Reconciled to Medicare annual PS&R Reports | | |

Step 2: Find Medicaid per case rate with case mix removed

- | | | | |
|----|--|--|---------|
| 6. | Medicaid Payments for (Fiscal Year End) Subject to Case Mix Index | | |
| a. | Medicaid Inpatient Payments subject to CMI-Reconciled to the annual Medicaid Paid Claims Listing | | |
| 7. | Adjustment for Case Mix | | |
| a. | Medicaid Case Mix Index Using Medicare Weights (Internal Report)-Reconciled to the Medicaid MMIS. | | |
| b. | Case Mix Adjusted Total Payments (In 6a/In7a) | | *DIV/0! |
| 8. | Medicaid Payments not subject to case mix index-Reconciled to the annual Medicaid paid claims listing. | | |

TN # 15-006

Supersedes

TN # 07-010Approval Date May 04 2016Effective Date: October 1, 2015

a.	Outlier adjustment		
b.	GME adjustment (Annual Payment)		
c.	PPS Exempt Psych Unit Payments		
d.	Transplants (Internal Reports Match to Medicaid Remittance)-reconciled to the Medicaid MMIS		
e.	Total Medicaid Payments Not Subject to Case Mix Index (total lines 8a thru 8d)	\$	
9.	Total Medicaid payment with case mix removed (Ln 7b + Ln 8e)		#DIV/0!
10.	Calculate Per Case Payment		
a.	Medicaid Discharges-Reconciled to the Medicaid MMIS.		
b.	Per case Medicaid rate with case mix removed (Ln 9/Ln 10a)		#DIV/0!

Step 3: Calculate UPL Gap

11.	Per Case Differential from Medicare payments subject to case mix (Ln 2b/Ln 5) – (Ln 7b/Ln 10a)		#DIV/0!
12.	Per Case Differential adjusted for Medicaid case mix using Medicare weights (Ln 11 x Ln 7a)		#DIV/0!
13.	Available Gap Under Case Mix Portion of UPL for UPL Payment (Ln 12 x Ln 10a)		#DIV/0!
13.1	Per Case Differential from Medicare Payments, Not Subject to Case Mix (Ln 3g/Ln 5a) – (Ln 8e/Ln10a)		#DIV/0!
13.2	Available Gap Under Non-case Mix Portion of UPL for UPL Payment (Ln 13.1 X Ln 10a)		#DIV/0!
13.3	Available UPL Gap for U PL Payment (Ln 13 + Ln 13.2)		#DIV/0!

Step 4: Inpatient Charges

14.	Total Medicaid Inpatient Charges-Reconciled to the Medicaid MMIS.	\$	
15.	Medicaid Inpatient Payments-Reconciled to the Medicaid MMIS.		
16.	Medicaid Charge Gap (Ln 14 – Ln 15)	\$	

Step 5: UPL Gap Available

17.	Less of Charge Gap (Ln 16) or UPL Gap (Ln 13.3)		#DIV/0!
Step 6: Calculate Federal Payment Available			
18.	Federal Matching Percentage	\$	
19.	Federal Incremental Payment (Ln 17 x Ln 18)		#DIV/0!
20.	State Match (Line 17 – Ln 19)		#DIV/0!

NOTE:

TN # 15-006

Supersedes

TN # 07-010Approval Date May 04 2016Effective Date: October 1, 2015

1. This worksheet shall include all Medicare & Medicaid payments EXCEPT Medicaid DSH
2. All MCR reference are to the CMS 2552-10 cost report forms. In the event the cost report report forms are revised all data will be from the applicable forms of the new cost report.
3. Medicaid discharges shall include 0 paid discharges.
4. Medicaid Management Information System

OS Notification

State/Title/Plan Number: KY 07-010
Type of Action: SPA Approval
Required Date for State Notification:
Fiscal Impact: FY 2008 \$ 14,020,000 Federal Share
FY 2009 \$ 14,020,000 Federal Share

Number of Services Provided by Enhanced Coverage, Benefits or Retained
Enrollment: 0
Number of Potential Newly Eligible People: 0
Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0 Reduces Benefits: No

Detail:

Effective October 15, 2007 this amendment modifies the State's reimbursement methodology for setting payment rates for inpatient hospital services. Specifically, the amendment provides for a rebasing of the diagnosis-related groups base rates and relative weight, adds a high volume per diem payment methodology based on Medicaid utilization and deletes obsolete language.

Other Considerations: This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

We do not recommend the Secretary contact the governor.

CMS Contact: Stanley Fields, NIRT 502-223-5332
Venesa Day, NIRT 410-786-8281

Certified Public Expenditures incurred in providing services to Medicaid and individuals with no source of third party insurance.

The Kentucky Medicaid Agency uses the CMS Form 2552 cost report for its Medicaid program and all acute care hospitals must submit this report each year. The Agency will utilize Worksheet Series S, B, C and D to determine the cost of services provided to Medicaid recipients and services to individuals with no source of third party insurance to be certified as public expenditures (CPE) from the CMS Form 2552 for inpatient services provided by hospitals. The Agency will use the protocol as described below.

Interim Payment

Interim payments will be made through the state Medicaid Management Information System (MMIS) and paid based on the approved Diagnosis Related Grouper (DRG) payment, per diem payments, fee schedule payments and/or dedicated on-demand payments through the state eMARS system.

Cost of Medicaid

1. **Interim Reconciliation of Interim Medicaid Inpatient Hospital Payment rate Post Reporting Year:** Upon completion of the State fiscal year, each hospital's interim payments and supplemental payments will be reconciled to its CMS Form 2552 cost report as filed to the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period. For hospitals that have a cost reporting period that differs from the State fiscal year end date of June 30th, the cost reports that overlap the State fiscal year will be used for the calculation. The reconciliation will occur upon receipt of the electronic CMS Form 2552 cost report that includes the June 30th fiscal year end of the State.

The State will apply the cost per diems calculated on the Medicare Worksheet D-1 Part II lines 38 and 42-47 to the respective routine days from Worksheet S-3, Part 1, Medicaid column, to determine Medicaid routine service cost for acute services. The cost per diem calculated on Medicare Worksheet D-1, Part II, line 38 for each subprovider will be applied to the respective days on worksheet S-3, Part 1, Medicaid column. Cost to charge ratios calculated on the Medicare Worksheet D-4 or D-3 will be applied to the Medicaid inpatient ancillary charges related to CMS ancillary service cost centers to determine Medicaid inpatient ancillary service cost. A calculation will be made to add back the cost of graduate medical education to the cost per diems and cost to charge ratios, if removed as a step-down adjustment on Worksheet B, Part I columns 22 and 23. The Medicaid days and charges are reconciled to MMIS paid claims data.

In addition to the cost calculated through application of cost per diems to routine service days and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures.

The Worksheet D-6 or D-4 series with the inclusion of medical education cost as stated above for each organ will be used to determine organ acquisition cost. The total amount of Medicaid organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 or D-4 Part III Line 53 or 61 divided by Total usable organs per Worksheet D-6 or 0-4 Part III Line 54 or 62 times number of Medicaid organs (fee for service) transplanted during the year.

Total Medicaid inpatient cost therefore will be the sum of routine service cost, ancillary service cost, graduate medical education cost, and organ acquisition cost. Any Medicaid payments (other than the interim payments provided in this protocol) and third party and client responsibility payments are deducted from the total Medicaid inpatient cost to determine the certifiable amount. The State will compare the interim payments made to the interim Medicaid cost computed here for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

2. Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate Post Reporting Year: Upon issuance of a Notice of Program Reimbursement for CMS Form 2552 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period(s). For hospitals that have a cost reporting period that differs from the State fiscal year end date of June 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

The State will apply the cost per diems calculated on the Medicare Worksheet D-1 Part II lines 38 and 42-47 to the respective routine days from Worksheet S-3, Part 1, Medicaid column to determine Medicaid routine service cost for acute services. The cost per diem calculated on Medicare Worksheet D-1, Part II, line 38 for each subprovider will be applied to the respective days on Worksheet S-3, Part 1, Medicaid column. Cost to charge ratios calculated on the Medicare Worksheet 0-4 or D-3 will be applied to the Medicaid inpatient ancillary charges related to CMS ancillary service cost centers to determine Medicaid inpatient ancillary service cost. A calculation will be made to add back the cost of graduate medical education to the cost per diems and cost to charge ratios, if removed as a step-down adjustment on Worksheet B, Part I columns 22 and 23. The Medicaid days and charges are reconciled to MMIS paid claims data.

In addition to the cost calculated through application of cost per diems to routine service and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures. The Worksheet D-6 or D-4 series with the inclusion of medical education cost as stated above for each organ will be used to determine organ acquisition cost. The total amount of Medicaid organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 or D-4 Part III Line 53 or 61 divided by Total usable

organs per Worksheet D-6 or D-4 Part 111 Line 54 or 62 times the number of Medicaid organs (fee for service) transplanted during the year.

Total Medicaid inpatient cost therefore will be the sum of routine service cost, ancillary service cost, graduate medical education cost, and organ acquisition cost. Any Medicaid payments other than the interim payments provided in this protocol and third party and client responsibility payments are deducted from the total Medicaid inpatient cost to determine the certifiable amount. The State will compare the final reconciliation to the interim reconciliation for each hospital. Any difference to the Medicaid cost will be recorded as an adjustment on the CMS 64 report.

Methods and Standards for Establishing Payment Rates — Other Types of Care

I. Drugs

A. Reimbursement

1. Participating pharmacies are reimbursed for the cost of the drug plus a dispensing fee. Payments shall not exceed the federal upper limits specified in 42 CFR 447.331 through 447.334.
2. Participating dispensing physicians are reimbursed for the cost of the drug only.
3. Providers will be reimbursed only for drugs supplied from pharmaceutical manufacturers who have signed a rebate agreement with CMS.

B. Payment Limits — Payment for the cost of drugs shall be the lesser of:

1. The Federal Upper Limit (FUL) means the maximum federal financial participation available toward reimbursement for a given drug dispensed to a Medicaid recipient.
2. The State Maximum Allowable Cost (SMAC). A SMAC may be established for any drug for which two or more A-rated therapeutically equivalent, multi-source, non-innovator drugs with a significant cost difference exist. The SMAC will be determined taking into account drug price status (non-rebatable, rebatable), marketplace status (obsolete, regional availability), equivalency rating (A-rated), and relative comparable pricing. Other factors considered are clinical indications of generic substitution, utilization and availability in the marketplace. The source of comparable drug prices will be nationally recognized comprehensive data files maintained by a vendor under contract with the Department for Medicaid Services. Resources accessed to determine SMAC include Wholesale Acquisition Cost (WAC), and Direct Price (to retail pharmacies) with weights applied based on the distribution of the volume purchased.
 - a. Multiple drug pricing resources are utilized to determine the estimated acquisition cost for the generic drugs. These resources include pharmacy providers, wholesalers, drug file vendors, and pharmaceutical manufacturers;

-
- b. The Estimated Acquisition Cost (EAC) for each product is maintained in a WAC pricing file database;
 - c. Products are then sorted into drug groups by Generic Code Number (GCN), which denotes the same generic name, strength, and dosage form;
 - d. A filter is applied to remove all drug products that are obsolete, are not therapeutically equivalent, or are not available in the marketplace;
 - e. The acquisition cost for the remaining drug products are analyzed to produce the estimated acquisition cost for the drug group giving due consideration (which consists of utilization and availability in the marketplace) to the lower cost products;
 - f. The resulting estimated acquisition cost is used to produce a SMAC rate. The resulting SMAC is always greater than the pharmacy provider actual acquisition cost and is designed to provide the pharmacy with an appropriate profit margin;
 - g. The SMAC rate will then be applied to all brand and generic drug products in that specific GCN;
 - h. The SMAC file is updated monthly. Kentucky's MAC list may be downloaded from the following website: <http://www.chfs.ky.gov/dms>.
 - i. A pharmacy provider may appeal a SMAC price;
3. Effective October 1, 2011, the Estimated Acquisition Cost (EAC) for a generic drug shall equal the Wholesale Acquisition Cost (WAC) plus 3.2% and for a brand drug shall equal the WAC plus 2%; or
 4. If WAC pricing is not available, the provider will be required to contact the manufacturer for WAC or produce an invoice price or
 5. The provider's Usual and Customary charge (U&C).

Methods and Standards for Establishing Payment Rates — Other Types of Care

I. Drugs

B. Payment Limits — Payment for the cost of drugs shall be the lesser of:

6. The department shall reimburse for drugs at the lesser of:

- Branded Drugs: WAC + 2% (plus dispensing fee) OR
- Generic Drugs: WAC + 3.2 % (plus dispensing fee) OR
- FUL + dispense fee OR
- MAC + dispense fee OR
- Usual & Customary (U & C)

7. For nursing facility residents meeting Medicaid patient status, an incentive of two (2) cents per unit dose shall be paid to long term care, personal care, and supports for community living pharmacists for repackaging a non-unit dose drug in unit dose form.

8. Injectable Drugs administered in a physician's office

A physician injectable drug product that is administered by a physician or their authorized agent during an in office procedure, and is federally rebateable pursuant to manufacturer agreement, and is identified on the Kentucky Physician Injectable Drug List (posted on the Kentucky Medicaid website and periodically updated) shall be reimbursed at the lesser of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent.

Methods and Standards for Establishing Payment Rates - Other Types of Care

C. Dispensing Fee

1. Effective February 23, 2005, the dispensing fee for a generic drug prescription is \$5.00 and for a brand name drug prescription is \$4.50. The dispensing fee is applied to any drug reimbursed through the pharmacy benefit program at the point of sale.

II. Physician Services**A. Definitions**

- (1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.
- (2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.
- (3) "Medical School Faculty Physician" is a physician who is employed by a state-supported school of medicine (for teaching and clinical responsibilities), receives their earnings statement (W-2) from the state-supported school of medicine for their teaching and clinical responsibilities, and they are part of a university health care system that includes:
 - (a) a teaching hospital; and
 - (b) a state-owned pediatric teaching hospital; or
 - (c) an affiliation agreement with a pediatric teaching hospital.
- (4) Reimbursement for an anesthesia service shall include:
 - (a) Preoperative and postoperative visits;
 - (b) Administration of the anesthetic;
 - (c) Administration of fluids and blood incidental to the anesthesia or surgery;
 - (d) Postoperative pain management;
 - (e) Preoperative, intraoperative, and postoperative monitoring services; and
 - (f) Insertion of arterial and venous catheters.

B. Reimbursement

- (1) Payment for covered physician services shall be based on the lesser of the physicians' usual and customary actual billed charges or the Medicaid Physician Fee Schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physician Services. The agency's fee schedule rate was set as of January 1, 2014 and is effective for services provided on or after that date and are updated annually on January 1st or thirty (30) days following the release of the revised CPT Codes from the American Medical Association, whichever is earlier. All rates are published on the agency's website at <http://www.chfs.ky.gov/dms/fee.htm>.
- (2) If there is not an established fee in the Medicaid Physician Fee Schedule, the reimbursement shall be forty-five (45) percent of the billed charge. After the first quarter, Medicaid will establish a reimbursement rate based on the average payments for each procedure code during that quarter. The rate for that code will then be added to our Medicaid Physician Fee Schedule. If Medicare develops RBRVS Units for a procedure code, Kentucky will revise our Fee Schedule using the Medicare RBRVS Units

- (3) The flat rate for a service shall be established by multiplying the dollar conversion factor by the sum of the RVU units plus the number of units spent on that specified procedure. RBRVS units shall be multiplied by a dollar conversion factor to arrive at the fixed upper limit. The dollar conversion factors are as follows:

<u>Types of Service</u>	<u>Kentucky Conversion Factor</u>
Deliveries	Not applicable
Non-delivery Related Anesthesia	\$15.20
Non-anesthesia Related Services	\$29.67

C. Reimbursement Exceptions

- (1) Physicians, who are enrolled in the Vaccines for Children (VFC) Program, will only be reimbursed for the administration of specified immunizations obtained free from the Department for Public Health through the VFC Program to provide immunizations for Medicaid recipients under the age of nineteen (19). Vaccine costs for any VFC specified immunization will not be reimbursed for the physicians who are enrolled in the VFC Program. For additional information on vaccine administration, please see Att. 4.19-B, Page 20.5(4).

- (2) Payments for obstetrical delivery services provided on or after September 15, 1995 shall be reimbursed the lesser of the actual billed charge or at the standard fixed fee paid by type of procedure. The obstetrical services and fixed fees are:

Delivery only	\$870.00
Vaginal delivery including postpartum care	\$900.00
Cesarean delivery only	\$870.00
Cesarean delivery including postpartum care	\$900.00

- (3) For delivery-related anesthesia services provided on or after July 1, 2006, a physician shall be reimbursed the lesser of the actual billed charge or a standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Vaginal delivery	\$215.00
Cesarean section	\$335.00
Neuroxial labor anesthesia for a vaginal delivery or cesarean section	\$350.00
Additional anesthesia for cesarean delivery following neuroxial labor anesthesia for Vaginal delivery	\$25.00
Additional anesthesia for cesarean hysterectomy following neuroxial labor Anesthesia	\$25.00

- (4) Payment for individuals eligible for coverage under Medicare part B is made, in accordance with Sections A and B and items (1) through

-
- (5) Procedures which are specified by Medicare and published annually in the Federal Register, which are commonly performed in the physician's office, will be reimbursed adjusted rates to take into account the change in usual site of service (facility vs. non-facility based on Medicare Site of Service designation) and are subject to the outpatient upper payment limit.
 - (6) Payments for the injection procedure for chemonucleolysis of intervertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or \$793.50.
 - (7) Specified family planning procedures in the physician office setting shall be reimbursed at the lesser of the actual billed charges or the Medicaid Physician Fee Schedule plus actual cost of the supply minus ten percent.
 - (8) For information relating to physician injectable drug products that are administered by a physician or their authorized agent during an in office procedure see Attachment 4.19-B, Page 20.1(b).
 - (9) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).
 - (10) For practice related services provided by a physician assistant, the participating physician shall be reimbursed at the lesser of the usual and customary charges actual billed charges or 75 percent of the Medicaid Physician Fee Schedule per procedure
 - (11) Any physician participating in the lock-in program will be paid a \$10.00 per month lock-in fee for provision of patient management services for each recipient locked in to that physician.
 - (12) Supplemental payments will be made for services provided by medical school faculty physicians either directly or as supervisors of residents. These payments are in addition to payments otherwise provided under the state plan to physicians that qualify for such payments under the criteria outlined below in Part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in Parts (b) and (c) of this section.
 - a. To qualify for a supplemental payment under this section, physicians must meet the following criteria:
 1. Be Kentucky licensed physicians;
 2. Be enrolled as Kentucky Medicaid providers; and
 3. Be Medical School Faculty Physicians as defined in Att 4.19-B, page 20.3, with an agreement to assign their payments to the state-owned academic medical center in accordance with 42 CFR 447.10.

-
- b. For physicians qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between payments otherwise made to these physicians and the average rate paid for the services by commercial insurers. The payment amounts are determined by:
1. Annually calculating an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the providers' contracted rates with commercial insurers for each procedure code from an actual year's data, beginning with CY 2006;
 2. Multiplying the total number of Medicaid claims paid per procedure code by the average commercial payment rate for each procedure code to establish the estimated commercial payments to be made for these services; and
 3. Subtracting the initial fee-for-service Medicaid payments, all Medicare payments, and all Third Party Liability payments already made for these services to establish the supplemental payment amount. Effective January 1, 2007 all claims, where Medicare is the primary provider, will be excluded from the supplemental payment methodology.
 4. The supplemental payments will be calculated annually after the end of each CY using actual data from the most recent completed CY. Claims data will only be used for physicians meeting the criteria in Part (a) above. If a physician did not meet the criteria for the whole calendar year, then only the claims data that coincides with their dates of eligibility will be used in the calculation. The supplemental payments will not be increased with any trending or inflationary indexes.
- c. Initial fee-for-service payments under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made as four (4) equal quarterly payments.
- (13) A second anesthesia service provided by a provider to a recipient on the same date of service shall be reimbursed at the Medicaid Physician Fee Schedule amount
- (14) If more than one procedure is performed at the same time, the provider shall be reimbursed one hundred (100) percent of the Medicaid Physician Fee Schedule for the first procedure and fifty (50) percent of the Medicaid Physician Fee Schedule for each additional procedure.
- (15) A fixed rate of twenty-five (25) dollars for anesthesia add-on services provided to a recipient under age one (1) or over age seventy (70).

-
- (16) Physicians, who are not enrolled in the VFC Program, will be reimbursed for the administration of immunizations, to include the influenza vaccine, as well as the vaccine cost, as defined in the Center for Disease Control (CDC) Vaccine Price List published as of January 1, 2014 to a Medicaid recipient of any age.
- (17) After Hours Services - CPT 99050 is reported when services are provided in the office at times other than regularly scheduled office hours or days when the office is normally closed. DMS refers to this time as "After Hours," and defines "After Hours" as services rendered between 5:00 p.m. and 8:00 a.m. on weekdays, and anytime on weekends and holidays when the office is usually closed. For example – if normal office hours are scheduled from 9:00 – 5:00 and service is provided at 7:00, the provider would bill CPT 99050. However, if normal office hours are scheduled from 9:00 am – 7:00 pm and the service is performed at 6:00, the provider would NOT bill for CPT code 99050.

CPT code 99050 is eligible for separate payment, in addition to the basic covered service, if the basic service provided meets all of the criteria described below:

- It is reported with an office setting place of service;
- It is rendered after hours; and
- The basic service time is based on arrival time, not actual time services commence.

CPT code 99050 is not eligible for separate payment when it is reported with a preventive diagnosis and/or a preventive service.

Effective for services provided on or after January 1, 2015, payment for CPT Code 99050 will be \$25.00

- (18) Deep sedation of general anesthesia relating to oral surgery performed by an oral surgeon shall have a fixed rate of \$150.
- (19) For an evaluation and management service with a corresponding CPT of 99214 or 99215 exceeding the limit outlined in Att. 3.1-A p. 7.2.1 & Att. 3.1-B p. 21, DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.
- (20) The evaluation and management services with a corresponding CPT of 99201-99205 and 99211-99215 will be reimbursed at eighty-seven and one half (87.5) percent of Medicare Fee Schedule in effect as of January 1, 2006.

(23) For an evaluation and assessment service with a corresponding CPT of 99407 for tobacco cessation, the Department will pay a fixed fee of \$52.03 for a physician. For the same services performed by a physician assistant or an APRN, the Department will pay 75% of the physician fee.

D. Assurances. The State hereby assures that payment for physician services are consistent with efficiency, economy, and quality of care and payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances.

Physician Services - Wellness Incentive

Method of Payment

- The state has adjusted its fee schedule to make payment at the higher rate for each CPT Code the State has included in the Enhanced Wellness Fee Schedule.

Primary Care Services Affected by this Payment Methodology

- This payment applies to all billing codes listed below. Multiple services performed on the same day by the same provider will be processed using Modifier 1 and Modifier 2. Multiple enhanced payments may be paid for same day/same provider up to the Medicare Allowed Amount for the CPT Code listed. The State has included quantity limits that apply to the number of enhanced payments a provider will receive per year for each CPT code listed.

Providers Eligible for Enhanced Wellness Methodology

Provider Type 64 and 65, including all specialties and subspecialties and Provider Type 78 (APRN) and 95 (Physician Assistant) are eligible for the enhanced Wellness reimbursement.

TN #: 14-009
Supersedes
TN #: 13-003

Approval Date: 05-18-15

Effective Date: January 1, 2015

Physician Services - Wellness Incentive (cont.)

Primary Care Services Affected by this Payment Methodology

The Wellness Enhanced Rate is the lesser of the modified rate and the 2014 Medicare Rate.

Modifier Descriptions	
33/U5 identifies vaccine administration	33/UA identifies well child visits first 15 months of life
33/U7 identifies screenings	33/UB identifies BMI/Weight Counseling
33/U8 identifies after hours	33/UD identifies controlling BP

Bonus Fee Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description
90460	33	U5	\$0.00	\$3.30	\$12.00	\$15.30	\$15.30	Modified Rate
90471	33	U5	\$0.00	\$3.30	\$12.00	\$15.30	\$15.30	Modified Rate
90472	33	U5	\$0.00	\$3.30	\$10.00	\$13.30	\$13.30	Modified Rate
90473	33	U5	\$0.00	\$3.30	\$12.00	\$15.30	\$15.30	Modified Rate
90474	33	U5	\$0.00	\$3.30	\$10.00	\$13.30	\$13.30	Modified Rate
83655	33	U7	\$0.00	\$17.13	\$16.00	\$33.13	\$33.13	Modified Rate
99381	33	UA	\$103.36	\$78.58	\$16.00	\$94.58	\$94.58	Modified Rate
99382	33	UA	\$107.92	\$89.90	\$16.00	\$105.90	\$105.90	Modified Rate
99391	33	UA	\$93.12	\$67.57	\$16.00	\$83.57	\$83.57	Modified Rate
99392	33	UA	\$99.61	\$78.58	\$16.00	\$94.58	\$94.58	Modified Rate
99461	33	UA	\$91.40	\$75.36	\$16.00	\$91.36	\$91.36	Modified Rate
99201	33	UA	\$39.86	\$29.66	\$16.00	\$45.66	\$39.86	Medicare Rate
99202	33	UA	\$68.99	\$53.00	\$16.00	\$69.00	\$68.99	Medicare Rate
99203	33	UA	\$100.39	\$79.04	\$16.00	\$95.04	\$95.04	Modified Rate
99204	33	UA	\$155.31	\$112.27	\$16.00	\$128.27	\$128.27	Modified Rate
99205	33	UA	\$194.18	\$143.29	\$16.00	\$159.29	\$159.29	Modified Rate
99211	33	UA	\$18.28	\$16.98	\$16.00	\$32.98	\$18.28	Medicare Rate
99212	33	UA	\$40.17	\$31.08	\$16.00	\$47.08	\$40.17	Medicare Rate
99213	33	UA	\$67.93	\$42.63	\$16.00	\$58.63	\$58.63	Modified Rate
99214	33	UA	\$100.55	\$67.10	\$16.00	\$83.10	\$83.10	Modified Rate
99215	33	UA	\$135.11	\$98.39	\$16.00	\$114.39	\$114.39	Modified Rate
77055	33	U7	\$81.75	\$56.43	\$17.00	\$73.43	\$73.43	Modified Rate
77056	33	U7	\$104.99	\$70.46	\$17.00	\$87.46	\$87.46	Modified Rate
77057	33	U7	\$75.19	\$58.97	\$17.00	\$75.97	\$75.19	Medicare Rate

TN #: 14-009
Supersedes
TN #: 13-003

Approval Date: 05-18-15

Effective Date: January 1, 2015

Physician Services - Wellness Incentive (cont.)

Bonus Fee Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description
G0202	33	U7	\$120.80	\$91.56	\$17.00	\$108.56	\$108.56	Modified Rate
G0204	33	U7	\$147.47	\$99.65	\$17.00	\$116.65	\$116.65	Modified Rate
G0206	33	U7	\$116.11	\$80.34	\$17.00	\$97.34	\$97.34	Modified Rate
88141	33	U7	\$29.62	\$18.02	\$13.00	\$31.02	\$29.62	Medicare Rate
88142	33	U7	\$0.00	\$27.64	\$13.00	\$40.64	\$40.64	Modified Rate
88143	33	U7	\$0.00	\$27.64	\$13.00	\$40.64	\$40.64	Modified Rate
88147	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate
88148	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate
88150	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate
88160	33	U7	\$58.45	\$36.56	\$13.00	\$49.56	\$49.56	Modified Rate
88161	33	U7	\$53.45	\$36.81	\$13.00	\$49.81	\$49.81	Modified Rate
88162	33	U7	\$87.37	\$45.06	\$13.00	\$58.06	\$58.06	Modified Rate
G0123	33	U7	\$0.00	\$27.64	\$13.00	\$40.64	\$40.64	Modified Rate
G0144	33	U7	\$0.00	\$29.15	\$13.00	\$42.15	\$42.15	Modified Rate
G0145	33	U7	\$0.00	\$35.04	\$13.00	\$48.04	\$48.04	Modified Rate
P3000	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate
Q0091	33	U7	\$40.64	\$33.66	\$13.00	\$46.66	\$40.64	Medicare Rate
44388	33	U7	\$322.86	\$191.73	\$15.00	\$206.73	\$206.73	Modified Rate
44389	33	U7	\$362.87	\$210.07	\$15.00	\$225.07	\$225.07	Modified Rate
44391	33	U7	\$457.41	\$280.73	\$15.00	\$295.73	\$295.73	Modified Rate
44392	33	U7	\$404.58	\$267.50	\$15.00	\$282.50	\$282.50	Modified Rate
44394	33	U7	\$457.15	\$285.40	\$15.00	\$300.40	\$300.40	Modified Rate
45330	33	U7	\$124.52	\$64.08	\$15.00	\$79.08	\$79.08	Modified Rate
45331	33	U7	\$148.99	\$83.80	\$15.00	\$98.80	\$98.80	Modified Rate
45332	33	U7	\$265.56	\$108.61	\$15.00	\$123.61	\$123.61	Modified Rate
45341	33	U7	\$150.29	\$148.42	\$15.00	\$163.42	\$150.29	Medicare Rate
45342	33	U7	\$228.98	\$171.39	\$15.00	\$186.39	\$186.39	Modified Rate
45345	33	U7	\$167.48	\$142.59	\$15.00	\$157.59	\$157.59	Modified Rate
45355	33	U7	\$198.12	\$137.10	\$15.00	\$152.10	\$152.10	Modified Rate
45378	33	U7	\$359.50	\$228.82	\$15.00	\$243.82	\$243.82	Modified Rate
45379	33	U7	\$461.67	\$292.40	\$15.00	\$307.40	\$307.40	Modified Rate
45380	33	U7	\$428.21	\$255.86	\$15.00	\$270.86	\$270.86	Modified Rate
45381	33	U7	\$428.82	\$284.36	\$15.00	\$299.36	\$299.36	Modified Rate
45382	33	U7	\$556.15	\$335.55	\$15.00	\$350.55	\$350.55	Modified Rate

TN #: 14-009
Supersedes
TN #: 13-003

Approval Date: 05-18-15

Effective Date: January 1, 2015

Physician Services - Wellness Incentive (cont.)

Bonus Fee Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description
45383	33	U7	\$522.37	\$343.18	\$15.00	\$358.18	\$358.18	Modified Rate
45386	33	U7	\$607.98	\$530.14	\$15.00	\$545.14	\$545.14	Modified Rate
45387	33	U7	\$332.42	\$232.95	\$15.00	\$247.95	\$247.95	Modified Rate
45391	33	U7	\$283.59	\$212.17	\$15.00	\$227.17	\$227.17	Modified Rate
45392	33	U7	\$364.54	\$268.20	\$15.00	\$283.20	\$283.20	Modified Rate
82270	33	U7	\$0.00	\$4.44	\$15.00	\$19.44	\$19.44	Modified Rate
82274	33	U7	\$0.00	\$21.70	\$15.00	\$36.70	\$36.70	Modified Rate
G0105	33	U7	\$359.50	\$255.86	\$15.00	\$270.86	\$270.86	Modified Rate
G0121	33	U7	\$359.50	\$297.76	\$15.00	\$312.76	\$312.76	Modified Rate
G0328	33	U7	\$0.00	\$21.70	\$15.00	\$36.70	\$36.70	Modified Rate
99050	33	U8	\$0.00	\$10.00	\$15.00	\$25.00	\$25.00	Modified Rate
94010	33	U7	\$32.26	\$24.44	\$12.00	\$36.44	\$32.26	Medicare Rate
94014	33	U7	\$47.92	\$12.62	\$12.00	\$24.62	\$24.62	Modified Rate
94016	33	U7	\$24.53	\$4.89	\$12.00	\$16.89	\$16.89	Modified Rate
94060	33	U7	\$54.27	\$45.35	\$12.00	\$57.35	\$54.27	Medicare Rate
94375	33	U7	\$35.71	\$28.04	\$12.00	\$40.04	\$35.71	Medicare Rate
99201	33	UB	\$39.86	\$29.66	\$10.00	\$39.66	\$39.66	Modified Rate
99202	33	UB	\$68.99	\$53.00	\$10.00	\$63.00	\$63.00	Modified Rate
99203	33	UB	\$100.39	\$79.04	\$10.00	\$89.04	\$89.04	Modified Rate
99204	33	UB	\$155.31	\$112.27	\$10.00	\$122.27	\$122.27	Modified Rate
99211	33	UB	\$18.28	\$16.98	\$10.00	\$26.98	\$18.28	Medicare Rate
99212	33	UB	\$40.17	\$31.08	\$10.00	\$41.08	\$40.17	Medicare Rate
99213	33	UB	\$67.93	\$42.63	\$10.00	\$52.63	\$52.63	Modified Rate
99214	33	UB	\$100.55	\$67.10	\$10.00	\$77.10	\$77.10	Modified Rate
99215	33	UB	\$135.11	\$98.39	\$10.00	\$108.39	\$108.39	Modified Rate
99382	33	UB	\$107.92	\$89.90	\$10.00	\$99.90	\$99.90	Modified Rate
99383	33	UB	\$112.71	\$89.90	\$10.00	\$99.90	\$99.90	Modified Rate
99384	33	UB	\$127.76	\$101.22	\$10.00	\$111.22	\$111.22	Modified Rate
99385	33	UB	\$123.96	\$95.21	\$10.00	\$105.21	\$105.21	Modified Rate
99386	33	UB	\$143.58	\$116.70	\$10.00	\$126.70	\$126.70	Modified Rate
99387	33	UB	\$155.84	\$127.40	\$10.00	\$137.40	\$137.40	Modified Rate
99392	33	UB	\$99.61	\$78.58	\$10.00	\$88.58	\$88.58	Modified Rate
99393	33	UB	\$99.30	\$78.58	\$10.00	\$88.58	\$88.58	Modified Rate

TN #: 14-009
Supersedes
TN #: 13-003

Approval Date: 05-18-15

Effective Date: January 1, 2015

Physician Services - Wellness Incentive (cont.)

Bonus Fee Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description
99394	33	UB	\$108.97	\$89.90	\$10.00	\$99.90	\$99.90	Modified Rate
99395	33	UB	\$111.38	\$84.80	\$10.00	\$94.80	\$94.80	Modified Rate
99396	33	UB	\$118.91	\$100.83	\$10.00	\$110.83	\$110.83	Modified Rate
99397	33	UB	\$127.76	\$106.26	\$10.00	\$116.26	\$116.26	Modified Rate
99201	33	UD	\$39.86	\$29.66	\$16.00	\$45.66	\$39.86	Medicare Rate
99202	33	UD	\$68.99	\$53.00	\$16.00	\$69.00	\$68.99	Medicare Rate
99203	33	UD	\$100.39	\$79.04	\$16.00	\$95.04	\$95.04	Modified Rate
99204	33	UD	\$155.31	\$112.27	\$16.00	\$128.27	\$128.27	Modified Rate
99205	33	UD	\$194.18	\$143.29	\$16.00	\$159.29	\$159.29	Modified Rate
99211	33	UD	\$18.28	\$16.98	\$16.00	\$32.98	\$18.28	Medicare Rate
99212	33	UD	\$40.17	\$31.08	\$16.00	\$47.08	\$40.17	Medicare Rate
99213	33	UD	\$67.93	\$42.63	\$16.00	\$58.63	\$58.63	Modified Rate
99214	33	UD	\$100.55	\$67.10	\$16.00	\$83.10	\$83.10	Modified Rate
99215	33	UD	\$135.11	\$98.39	\$16.00	\$114.39	\$114.39	Modified Rate
99241	33	UD	\$45.48	\$36.55	\$16.00	\$52.55	\$45.48	Medicare Rate
99242	33	UD	\$85.97	\$67.83	\$16.00	\$83.83	\$83.83	Modified Rate
99243	33	UD	\$117.67	\$90.43	\$16.00	\$106.43	\$106.43	Modified Rate
99245	33	UD	\$214.66	\$166.18	\$16.00	\$182.18	\$182.18	Modified Rate
99386	33	UD	\$143.58	\$116.70	\$16.00	\$132.70	\$132.70	Modified Rate
99387	33	UD	\$155.84	\$127.40	\$16.00	\$143.40	\$143.40	Modified Rate
99394	33	UD	\$108.97	\$89.90	\$16.00	\$105.90	\$105.90	Modified Rate
99395	33	UD	\$111.38	\$84.80	\$16.00	\$100.80	\$100.80	Modified Rate
99396	33	UD	\$118.91	\$100.83	\$16.00	\$116.83	\$116.83	Modified Rate
99397	33	UD	\$127.76	\$106.26	\$16.00	\$122.26	\$122.26	Modified Rate

TN #: 14-009
Supersedes
TN #: 13-003

Approval Date: 05-18-15

Effective Date: January 1, 2015

Physician Services - Wellness Incentive (cont.)

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2015, ending on June 30, 2016. All rates are published at <http://chfs.ky.gov/dms/fee.htm>.

TN #: 14-009
Supersedes
TN #: New

Approval Date: 05-18-15

Effective Date: January 1, 2015

III. Dental Services

A. Definitions.

For purposes of determination of payment usual and customary actual billed charge refers to the uniform amount the individual dentist charges in the majority of cases for a specific dental procedure or service.

“Dental School Faculty Dentist” is a dentist who is employed by a state-supported school of dentistry.

B. Reimbursement for Outpatient and Inpatient Services.

- (1) The department shall reimburse participating dentists for covered services provided to eligible Medicaid recipients at the dentist’s actual billed charge not to exceed the fixed upper limit per procedure established by the department.
- (2) With the exceptions specified in section (3), (4), (5), and (8) the upper payment limit per procedure shall be established by increasing the limit in effect on 9/30/00 by 32.78%, rounded to the nearest dollar. This rate of increase is based upon an allocation of funds by the 2000 Kentucky General Assembly and a comparison to rates of other states based upon a survey of Dental Fees by the American Dental Association. The DMS fee schedule rate was set as of October 31, 2008 and is effective for services provided on or after that date. All rates are published on the DMS website <http://www.chfs.ky.gov/dms/fee.htm>.
- (3) If an upper payment limit is not established for a covered dental service in accordance with (2) above, the department shall establish an upper limit by the following:
 - a. The state will obtain no less than three (3) rates from other sources such as Medicare, Workmen’s Compensation, private insurers or three (3) high volume Medicaid providers:
 - b. An average limit based upon these rates will be calculated; and
 - c. The calculated limit will be compared to rates for similar procedures to assure consistency with reimbursement for comparable services.
- (4) The following reimbursement shall apply:
 - a. Orthodontic Consultation, \$112.00, except that a fixed fee of \$56.00 shall be paid if:
 1. The provider is referring a recipient to a medical specialist;
 2. The prior authorization for orthodontic services is not approved; or
 3. A request for prior authorization for orthodontic services is not made.
 - b. Prior authorized early phase orthodontic services for moderately severe disabling malocclusions, \$1,367 for orthodontists and \$1,234 for general dentists..
 - c. Prior authorized orthodontic services for moderately severe disabling malocclusions, \$1,825 for orthodontists and \$1,649 for general dentists.

-
- d. Prior authorized orthodontic services for severe disabling malocclusions, \$2,754 for orthodontists and \$2,455 for general dentists.
 - e. Prior authorized services for Temporomandibular Joint (TMJ) therapy, an assessed rate per service not to exceed \$424.
- (5) This reimbursement methodology does not apply to oral surgeons' services that are included within the scope of their licenses. Those services are reimbursed in accordance with the reimbursement methodology for physician services.
- (6) Medicaid reimbursement shall be made for medically necessary dental services provided in an inpatient or outpatient setting if:
- a. The recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if provided in a dentist's office; and
 - b. In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in an inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.
- (7) Supplemental payments will be made in addition to payments otherwise provided under the state plan to practice plans whose dentists qualify for such payments under the criteria outlined below in Part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in Parts (b) and (c) of this section.
- a. To qualify for a supplemental payment under this section, dentists in the practice plan must meet the following criteria:
 - i. Be Kentucky licensed dentists;
 - ii. Be enrolled as Kentucky Medicaid providers; and
 - iii. Be members of a practice plan under contract to provide professional services at a state-owned academic medical center as determined by the Department.
 - b. For practice plans qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between Medicaid payments otherwise made to these practice plans and the average rate paid for the services by commercial insurers. The average commercial rates are determined by:
 - i. Calculating a commercial payment to charge ratio for all services paid to the eligible providers by commercial insurers using the providers' claims-specific data from the most currently available fiscal year;
 - ii. Multiplying the Medicaid charges by the commercial payment to charge ratio to establish the estimated commercial payments to be made for these services; and
 - iii. Subtracting the interim Medicaid payments already made for these services to establish the supplemental payment amount.
 - c. Practice plans eligible under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made on a quarterly basis or as determined by the Department.
- (8) The upper payment limit per procedure for a recipient under age twenty-one (21) shall be established by increasing the limit in effect on 9/30/07 by 30%, rounded to the nearest dollar. The 30% limit increase applied to all dental procedure codes, except dental procedure codes D2951, D0150, D0140, D0330, D1520, D1525, shall not be adjusted from the limit in effect on 9/30/07. The DMS fee schedule rate was set as of October 31, 2008 and is effective for services provided on or after that date. All rates are published on the DMS website <http://www.chfs.ky.gov/dms/fee.htm>

IV. Vision Care Services**A. Definitions.**

For purposes of determination of payment, "usual and customary actually billed charge" refers to the uniform amount the individual optometrist or ophthalmic dispenser charges in the majority of cases for a specific procedure or service.

B. Reimbursement for Covered Procedures and Materials for Optometrists.

- (1) Reimbursement for covered services, within the optometrist's scope of licensure, except materials and laboratory services shall be based on the lesser of the optometrists' usual and customary actual billed charges or the fixed upper limit per procedure established by the department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS) with a conversion factor of \$29.67.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Optometry. The agency's fee schedule rate was set as of January 1, 2011 and is effective for services provided on or after that date. The agency's fee schedules are reviewed annually and updated as necessary. All rates are published on the Department for Medicaid Services web site at <http://chfs.ky.gov/dms/fee.htm>.

- (2) With the exception of rates paid for dispensing services, fixed upper limits for vision services shall be calculated using the same RBRVS units as those used in the physicians services program, with the units multiplied by the "all other services" conversion factor to arrive at the fixed upper limit for each procedure.
- (3) Reimbursement for materials (eyeglasses or part of eyeglasses) shall be made at the lesser of the optical laboratory cost of the materials or the upper limits for materials as set by the department. An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient's medical records for post-payment review. The agency upper limits for materials are set based on the agency's best estimate or reasonable and economical rates at which the materials are widely and

consistently available, taking into consideration statewide billing practices, amounts paid by Medicaid programs in selected comparable states, and consultation with the optometry Technical Advisory Committee of the Medical Assistance Advisory Council as to the reasonableness of the proposed upper limits.

- (4) Laboratory services shall be reimbursed at the lesser of the actual billed amount or the Medicare allowable reimbursement rates. If there is no established Medicare allowable reimbursement rate, the payment shall be sixty-five (65) percent of usual and customary actual billed charges.

C. Maximum Reimbursement for Covered Procedures and Materials for Ophthalmic Dispensers

Reimbursement for a covered service within the ophthalmic dispenser's scope of licensure shall be as described in Section B (above).

D Effect of Third Party Liability

When payment for a covered service is due and payable from a third party source, such as private insurance, or some other third party with a legal obligation to pay, the amount payable by the department shall be reduced by the amount of the third party payment.

- F. Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

V. Hearing Services

- A. The State Agency shall reimburse a participating audiologist at usual and customary actual billed charges up to the fixed upper limit per procedure established by the Kentucky Medicaid Fee Schedule with a conversion factor of \$29.67.

Audiologists shall be entitled to the same dispensing fee for hearing aids as shown in Section B.

B. Hearing Aid Dealers.

1. If a manufacturer's invoice price is submitted for a hearing instrument billed to the department, the department shall reimburse the lesser of:
 - a) The manufacturer's invoice price plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date: or
 - b) The actual hearing instrument specialist's cost plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date: or
 - c) The suggested retail price submitted by the manufacturer for the hearing instrument.
2. If the manufacturer's invoice price of a hearing instrument billed to the department does not match the manufacturer's submitted price schedule which includes the manufacturer's invoice price for the hearing instrument, the department shall reimburse the participating specialist in hearing instruments at the less of:
 - a) The lowest price submitted for a comparable hearing instrument plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date: or
 - b) The actual specialist in hearing instruments' cost plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date: or
 - c) The lowest suggested retail price submitted by the manufacturer for a comparable instrument.

- C. Replacement Cord Reimbursement. The department shall reimburse for a replacement cord at the hearing instrument specialist's cost plus a professional fee set at \$21.50.

- D. Hearing Instrument Repair Reimbursement. The department shall reimburse a hearing instrument specialist in hearing instruments for a hearing instrument repair:
1. On the basis of the manufacturer's charge for repair or replacement of parts;
 2. Plus the hearing instrument specialist's cost for postage and insurance relative to the repair
 3. Plus a professional fee of \$21.50; and
 4. Not to exceed the price of a new hearing instrument.

State: Kentucky

2. If the manufacturer of the hearing aid billed to the program has not submitted a dealer price schedule which includes that hearing aid, the State Agency shall reimburse that participating hearing aid dealer at the lessers of:
 - a) The lowest dealer price submitted for a comparable hearing aid plus a professional fee of seventy-five (75) dollars or at the actual dealer cost plus a professional fee of seventy-five (75) dollars or twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date;
 - b) The actual dealer cost plus a professional fee of seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date; or
 - c) The lowest suggested retail price submitted for a comparable aid. A comparable aid is defined as an aid falling within the general classification of fitting type, i.e., body, behind-the-ear, in-the-ear, eyeglasses.
- C. Cords. The State Agency shall make payment for a replacement cord at the dealer's cost, plus professional fee set at the fixed upper limit.
- D. Hearing Aid Repairs. The State Agency shall reimburse a hearing aid dealer for a hearing aid repair on the basis of the manufacturer's charge for repair or replacement of parts, plus the dealer's cost for postage and insurance relative to the repair, plus a professional fee set at the fixed upper limit.

VI. Screening Services

- A. The state agency shall reimburse providers for screening services in accordance with their usual payment procedures outlined in this state plan.
- B. The state agency shall reimburse screening clinics or agencies with the lesser of the payment procedure for physician's services described in Attachment 4.19-B, page 20.3, or the usual and customary charge of the provider for the service.

VI-A. Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

- (1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services) the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:
 - (a) 1905(a)(1), inpatient hospital services;
 - (b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
 - (c) 1905(a)(3), other laboratory and X-ray services;
 - (d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
 - (e) 1905(a)(5)(A), physicians services; 1905(a)(5)(B), medical and surgical services furnished by a dentist;
 - (f) 1905(a)(6), medical care by other licensed practitioners;
 - (g) 1905(a)(7), home health care services;
 - (h) 1905(a)(9), clinic services;
 - (i) 1905(a)(10), dental services;
 - (j) 1905(a)(11), physical therapy and related services;
 - (k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
 - (l) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
 - (m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
 - (n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
 - (o) 1905(a)(17), nurse—midwife services;
 - (p) 1906(a)(18), hospice care;
 - (q) 1905(a)(19), case management services; and
 - (r) 1905(a)(22), other medical and remedial care specified by the Secretary.
- (2) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21 the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100% of usual and customary charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:

- (a) Any service described in 1, above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
- (b) 1905(a)(8), private duty nursing services;
- (c) 1905(a)(20), respiratory care services;
- (d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under 1905(a)(6); and
- (e) 1905(a)(24), other medical or remedial care recognized by the Secretary but which are not covered in the plan including services of Christian Science nurses, care and services provided in Christian Science sanitoriums, and personal care services in a recipient's home.

VII: Transportation Services**A. Ambulance Services**

- (1) The department shall reimburse an ambulance service at the lesser of the provider's usual and customary charge or an upper limit established by the department for the service. Payment for an ambulance service shall be contingent upon a statement of medical necessity.
- (2) The upper limit for air ambulance transportation shall be set at \$3,500 per one (1) way trip.
- (3) The upper limit for an ambulance service (other than air ambulance transportation) shall be calculated by adding a base rate, mileage allowance, and flat rate fee as follows:
 - (a) The base rate for Advanced Life Support (ALS) emergency ambulance transportation to the emergency room of a hospital shall be set at \$110 per one (1) way trip; the mileage allowance for trips shall be four (4) dollars per mile for mileage from mile one (1); a flat rate of twenty-five (25) dollars shall be set for each additional recipient with no additional allowance for mileage.
 - (b) The base rate for Basic Life Support (BLS) emergency ambulance transportation to the emergency room of a hospital shall be set at eighty-two dollars and fifty cents (82.50) per one (1) way trip; the mileage allowance for trips shall be three (3) dollars per mile for mileage from mile one (1); a flat rate of twenty (20) dollars shall be set for each additional recipient with no additional allowance for mileage.
 - (c) The base rate for any ALS or BLS providing emergency ambulance transportation to an appropriate medical facility or provider other than the emergency room of a hospital shall be set at sixty (60) dollars per one (1) way trip; the mileage allowance for trips shall be two (2) dollars and fifty (50) cents per mile for mileage from mile one (1); a flat rate of fifteen (15) dollars shall be set for each additional recipient with no additional rate for mileage.
 - (d) The base rate for BLS emergency ambulance transportation to the emergency room of a hospital during which the services of an ALS Medical First Response provider is required to stabilize the patient shall be \$110; the mileage allowance shall be four (4) dollars per mile from mile one (1); a flat rate of twenty-five (25) dollars shall be set for each additional recipient with no additional rate for mileage.

-
- (e) The base rate for BLS emergency ambulance transportation to a medical facility or provider other than the emergency room of a hospital during which the services of an ALS Medical First Response provider are required shall be sixty (60) dollars; the mileage allowance shall be two (2) dollars and fifty (50) cents per mile from mile one (1); a flat rate of fifteen (15) dollars shall be set for each additional recipient with no additional rate for mileage.
 - (f) The base rate for non-emergency ambulance transportation during which the recipient requires no medical care during transport shall be fifty-five (55) dollars and the mileage allowance shall be two (2) dollars per mile from mile one (1).
 - (g) The cost of other itemized supplies for ALS or BLS emergency transportation services shall be the actual cost as reflected on the transportation provider's invoice which shall be maintained in the provider's files and shall be produced upon request by the department. Each quarter, the department shall review a random sample of invoices to verify reported costs.
- (4) In addition to the rates described in paragraph (3) above, administration of oxygen during an ambulance transportation service (other than air ambulance transportation) shall be reimbursed at a flat rate of ten (10) dollars per one (1) way trip when medically necessary.
 - (5) Reimbursement for an ambulance service shall not be made if a recipient receives transportation free as the result of a local subscription fee or tax.

B. Commercial Transportation Carriers

When a broker has been terminated, the department shall reimburse participating commercial transportation carriers at usual commercial rates on an interim basis (pending selection of a new broker) with limitations as follows:

- (1) For taxi services provided in regulated areas the provider shall be reimbursed the normal passenger rate charged to the general public for a one (1) way trip regardless of the number of Medicaid eligible recipients transported when the trip is within the medical service area. The taxi shall be paid the single passenger rate regardless of the number of additional passengers.
- (2) For taxi services in those areas of the state where taxi rates are not regulated by the appropriate local rate setting authority, and for taxi services in regulated areas when they go outside the medical service area, the provider shall be reimbursed the normal passenger rate charged the general public for a single passenger (without payment for additional passengers, if any) up to the upper limit; reimbursement for transport of a parent or attendant shall be considered included within the upper limit allowed for the trip. The upper limit for a taxi transporting a recipient shall be:

-
- (a) The usual and customary charge up to a maximum of six (6) dollars for trips of five (5) miles or less, one (1) way, loaded miles.
 - (b) The usual and customary charge up to a maximum of twelve (12) dollars for trips of six (6) to ten (10) miles, one (1) way, loaded miles.
 - (c) The usual and customary charge up to a maximum of twenty (20) dollars for trips of eleven (11) to twenty-five (25) miles, one (1) way, loaded miles.
 - (d) The usual and customary charge up to a maximum of thirty (30) dollars for trips of twenty-six (26) miles to fifty (50) miles, one (1) way, loaded miles.
 - (e) For trips of fifty-one (51) miles or above shall be the lesser of the usual and customary charge or an amount derived by multiplying one (1) dollar by the actual number of miles, not to exceed a maximum of seventy-five (75) dollars per trip, one (1) way, loaded miles.

C. Private Automobile Carriers.

- (1) The department shall reimburse private automobile carriers at the basic rate of twenty-two (22) cents per mile plus a flat fee of four (4) dollars per recipient if waiting time is required. For round trips of less than five (5) miles the rate shall be computed on the basis of a maximum allowable fee of six (6) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. Private automobile carriers shall have a signed participation agreement with the Department for Medicaid Services prior to furnishing reimbursable medical transportation services.
- (2) For round trips of five (5) to twenty-five (25) miles the rate for private automobile carriers shall be computed on the basis of maximum allowable fee of ten (10) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. The maximum allowable fee rates shall not be utilized in situations where mileage is paid.

-
- (3) Even though the maximum allowable fee rate when computed on the basis of twenty- two (22) cents per mile plus four (4) dollars for waiting time would not equal the six (6) dollars or ten (10) dollars allowable amounts, the higher amount is paid to encourage private automobile carriers to provide necessary medical transportation. Additionally, nothing in this section requires the department to pay the amounts specified if the private automobile carrier expresses a preference for reimbursement in a lesser amount, then the lesser amount shall be paid. Toll charges shall be reimbursable when presented with a receipt.
 - (4) Waiting time shall be a reimbursable component of the private automobile carrier transportation fee only if waiting time occurs. If waiting time occurs due to admittance of the recipient into the medical institution, the private automobile carrier may be reimbursed for the return trip to the point of recipient pick-up as though the recipient were in the vehicle; that is, the total reimbursable amount shall be computed on the basis of the maximum allowable fee or mileage rate plus waiting time. Waiting time shall not be paid for the attendant or caretaker relative (e.g., mother, father) who is accompanying the recipient and not personally being transported for Medicaid covered service.
 - (5) If a private automobile carrier is transporting more than one (1) recipient, only one (1) mileage payment shall be allowed. Mileage shall be computed on the basis of the distance between the most remote recipient and the most remote medical service utilized; and will include any necessary additional mileage to pickup and discharge the additional recipients.

D. Non-Commercial Group Carriers.

- (1) The department shall reimburse participating non-commercial group carriers based on actual reasonable, allowable cost to the provider based on cost data submitted to the department by the provider.
- (2) The minimum rate shall be twenty (20) cents per recipient per mile transported and the rate upper limit shall be fifty (50) cents per recipient per mile transported.
- (3) Payment for a parent or other attendant shall be at the usual recipient rate.

E. Specialty Carriers.

- (1) Participating specialty carriers shall be reimbursed at the lesser of the following rates:

-
- (a) The actual charge for the service; or
 - (b) The usual and customary charge for that service by the carrier, as shown in the schedule of usual and customary charges submitted by the carrier to the department or
 - (c) The program maximum established for the service.
- (2) Program maximums shall be:
- (a) For nonambulatory recipients who require the use of a wheelchair, the upper limit shall be twenty-five (25) dollars for the first recipient plus four (4) dollars for each additional nonambulatory recipient transported on the same trip, for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollar and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and certified; mileage charges shall not be allowed for additional recipients.
 - (b) For ambulatory recipients who are disoriented, the upper limit shall be twelve (12) dollars and fifty (50) cents for the first recipient plus four (4) dollars for each additional disoriented recipient transported on the same trip for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollars and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and verified; mileage charges shall not be allowed for additional recipients.
 - (c) For both paragraphs (a) and (b) of this section, empty vehicle miles shall not be included when computing allowable reimbursement for mileage.
- (3) Reimbursement shall be made at specialty carrier rates for the following types of recipients only:
- (a) Nonambulatory recipients who need to be transported by wheelchair, but shall not include recipients who need to be transported as stretcher patients; and
 - (b) Ambulatory recipients who are disoriented.

(4) The specialty carrier shall obtain a statement from the recipient's physician (or, if the recipient is in a nursing facility, from the director of nursing, charge nurse, or medical director in lieu of physician) to verify that transportation by the specialty carrier is medically necessary due to the recipient's nonambulatory or disoriented condition. Claims for payment which are submitted without the required statement of verification shall not be paid.

F. Specially authorized transportation services authorized in unforeseen circumstances may be paid for at a rate adequate to secure the necessary service; the amount allowed shall not exceed the usual and customary charge of the provider. The Department for Medicaid Services shall review and approve or disapprove requests for specially authorized transportation services based on medical necessity.

G. Use of flat rates.

Transportation payment shall not exceed the lesser of six (6) dollars per trip, one (1) way (or twelve (12) dollars for a round trip), or the usual fee for the participating transportation provider computed in the usual manner if:

- (1) The recipient chooses to use a medical provider outside the medical service area; and
- (2) The medical service is available in the recipient's medical service area; and
- (3) The recipient has not been appropriately referred by the medical provider within his medical service area.

H. Meals and Lodging.

The flat rate for meals and lodgings for recipients and attendants when preauthorized (or post-authorized if appropriate) by the department shall be as follows:

- (1) Standard Area:
 - (a) Meals: breakfast-\$4 per day; lunch-\$5 per day; dinner-\$11 per day; and
 - (b) Lodgings: \$40 per day
- (2) High Rate Area:
 - (a) Meals: breakfast-\$5 per day; lunch-\$6 per day; dinner-\$15 per day; and
 - (b) Lodgings: \$55 per day.

I. Limitations.

- (1) Any reimbursement for medical transportation shall be contingent upon the recipient receiving the appropriate preauthorization or postauthorization for medical transportation as required by the Department for Medicaid Services.
- (2)
 - (a) Authorization shall not be granted for recipients transported for purposes other than to take the recipient to or from covered Medicaid services being provided to that recipient, except in the instance of one (1) parent accompanying a child to or from covered medical services being provided to the child or if one (1) attendant is authorized for a recipient traveling to or from covered medical services based on medical condition of the recipient.
 - (b) Reimbursement shall be limited to transportation services and shall not include the services, salary or time of the attendant or parent.
- (3) An individual who owns a taxi company and who uses the taxi as his personal vehicle shall be reimbursed at the private auto rate when transporting household family members.
- (4) Mileage for reimbursement purposes shall be computed by the most direct accessible route from point of pickup to point of delivery.

VIII. Outpatient Hospital Services

A. In-State Outpatient Hospital Service Reimbursement.

1.
 - a. Except for critical access hospital services, and an individual in the Lock-In program, the department shall reimburse on an interim basis for in-state outpatient hospital services at a facility specific outpatient cost-to-charge ratio based on the facility's most recently filed Medicaid cost report.
 - b. An outpatient cost-to-charge ratio shall be expressed as a percent of the hospital's charges.
2. A facility specific outpatient cost-to-charge ratio paid during the course of a hospital's fiscal year shall be designed to result in reimbursement, at the hospital's fiscal year end, equaling ninety-five (95) percent of a facility's total allowable Medicaid outpatient costs incurred during the hospital's fiscal year.
3. Except as established in item 4. of the In-State Outpatient Hospital Services section:
 - a. Upon reviewing an in-state outpatient hospital's as submitted Medicaid cost report for the hospital's fiscal year, the department shall preliminarily settle reimbursement to the facility equal to ninety-five (95) percent of the facility's allowable Medicaid outpatient costs incurred in the corresponding fiscal year; and
 - b. Upon receiving and reviewing an in-state outpatient hospital's finalized Medicaid cost report for the hospital's fiscal year, the department shall settle final reimbursement to the facility equal to ninety-five (95) percent of the facility's total allowable Medicaid outpatient costs incurred in the corresponding fiscal year.
4.
 - a. Under no circumstances shall the department's total reimbursement for outpatient hospital services exceed the aggregate limit established in 42 C.F.R. 447.321.
 - b. If projections indicate for a given state fiscal year that reimbursing for outpatient hospital services at ninety-five (95) percent of allowable Medicaid costs would result in the department's total outpatient hospital service reimbursement exceeding the aggregate limit established in 42 CFR 447.321, the department shall proportionately reduce final outpatient hospital service reimbursement for each hospital to equal a percent of costs which shall result in total outpatient hospital reimbursement equaling the aggregate limit established in 42 CFR 447.321.
5. A service in a hospital emergency room that is determined to be non-emergency for a Lock-In recipient shall be reimbursed at \$25.00.
6. In accordance with 42 USC 1396r-8(a)(7), a hospital shall include the corresponding National Drug Code (NDC) when billing a physician administered drug in the outpatient hospital setting.
7. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 6 will be bundled with the fixed rate payment and not reimbursed separately.

-
6. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 5 will be bundled with the fixed rate payment and not reimbursed separately.
- B. Out-of-State Outpatient Hospital Service Reimbursement. Excluding services provided in a critical access hospital and laboratory services, reimbursement for an outpatient hospital service provided by an out-of-state hospital shall be ninety-five (95) percent of the average in-state outpatient hospital cost-to-charge ratio times the Medicaid covered charges billed by the out-of-state hospital.
- C. Critical Access Hospital Outpatient Service Reimbursement.
1. The department shall reimburse for outpatient hospital services in a critical access hospital as established in 42 CFR 413.70(b) through (d).
 2. A critical access hospital shall comply with the cost reporting requirements established in subsection E of the Outpatient Reimbursement section of the state plan.
 3. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 5 will be bundled with the fixed rate payment and not reimbursed separately.
- D. Outpatient Hospital Laboratory Service Reimbursement.
1. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 5 will be bundled with the fixed rate payment and not reimbursed separately.
 2. Laboratory service reimbursement, in accordance with item 1 in the Outpatient Hospital Laboratory Service Reimbursement section, shall be:
 - a. Final; and
 - b. Not settled to cost.
 3. An outpatient hospital laboratory service shall be reimbursed in accordance with item D.2 of the Outpatient reimbursement section of the state plan regardless of whether the service is performed in an emergency room setting or in a non-emergency room setting.

E. Cost Reporting Requirements.

1. Claims for services provided prior to January 5, 2009, will be reimbursed per State Plan Amendment 03-015 pages 20.12(f)-20.12(f)(3) effective August 1, 2003.
2. To assure that the Upper Payment Limit is not exceeded in SFY 2008-2009 (July 1, 2008 through June 30, 2009), two analyses will be performed :
 - a. An analysis of the cost of providing outpatient services and the reimbursement projected for the rate year (using both payment methodologies during partial years) beginning July 1, 2008 and ending June 30, 2009.
 - b. An analysis of the cost of providing outpatient services (based on the relative charges applied) for the period of January 5, 2009 and June 30, 2009; and the reimbursement projected based on the payment methodology in effect during this period.
3. As of January 5, 2009, an in-state outpatient hospital participating in the Medicaid program shall submit to the department a copy of the Medicare cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1, the Supplemental Medicaid Schedule KMAP-4 and the Supplemental Medicaid Schedule KMAP-6 as follows:
 - a. A cost report shall be submitted:
 - (1) For the fiscal year used by the hospital; and
 - (2) Within five (5) months after the close of the hospital's fiscal year; and
 - b. Except as follows, the department shall not grant a cost report submittal extension:
 - (1) The department shall grant an extension if an extension has been granted by Medicare. If an extension has been granted by Medicare, when the facility submits its cost report to Medicare it shall simultaneously submit a copy of the cost report to the department; or
 - (2) If a catastrophic circumstance exists, as determined by the department (for example flood, fire, or other equivalent occurrence), the department shall grant a thirty (30) day extension.
4. If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a completed cost report is received.
5. If a cost report indicates payment is due by a hospital to the department, the hospital shall submit the amount due or submit a payment plan request with the cost report.
6. If a cost report indicates a payment is due by a hospital to the department and the hospital fails to remit the amount due or request a payment plan, the department shall suspend future payment to the hospital until the hospital remits the payment or submits a request for a payment plan.

- 7 An estimated payment shall not be considered payment-in-full until a final determination of cost has been made by the department.
- 8 A cost report submitted by a hospital to the department shall be subject to departmental audit and review.
- 9 Within seventy (70) days of receipt from the Medicare intermediary, a hospital shall submit to the department a printed copy of the final Medicare-audited cost report including adjustments.
- 10
 - a. If it is determined that an additional payment is due by a hospital after a final determination of cost has been made by the department, the additional payment shall be due to the department within sixty (60) days after notification.
 - b. If a hospital does not submit the additional payment within sixty (60) days, the department shall withhold future payment to the hospital until the department has collected in full the amount owed by the hospital to the department.

F. Supplemental Payments to Non-state Government-owned or Operated Hospitals.

1. The Department provides quarterly supplemental payments to non-state government-owned or operated hospitals for outpatient services provided to Medicaid recipients. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321.
2. To qualify for a supplemental payment, a hospital must be a non-state government-owned or operated hospital that has entered into an Intergovernmental Transfer Agreement with the Commonwealth. The payment amount for a qualifying hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's payments for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all qualifying hospitals for the same fiscal year.

G. Emergency Room Services

1. Effective for services provided on and after September 1, 2002, the Department will reimburse for emergency room services at a flat rate per visit based upon the level of service provided. In addition, diagnostic and radiological procedures will be paid at specific rates.
2. There shall be rates for three (3) levels of service and an assessment fee:
 - Level I shall be those services billed using CPT codes 99281 and 99282, reimbursed at \$82.00.
 - Level II shall be those services billed using CPT codes 99283 and 99284, reimbursed at \$164.00.
 - Level III shall be those services billed using CPT codes 99285, reimbursed at \$264.00
 - An assessment, or triage, shall be payable at \$20.00

Included in the flat rate are pharmacy (except for thrombolytic agents), medical supplies, radiology (except as described in 4 below), laboratory, physical and respiratory therapy, electrocardiogram, and electroencephalogram.
3. The flat rates per visit were calculated in accordance with the following:

The Level II rate was calculated by multiplying the average costs for Level II services in state fiscal years 2000 and 2001 (adjusted by the moving average of Data Resources, Inc. for the Hospital Market Basket) by .75.

The Level I rate is established at 50% of the Level II rate.
The Level III rate is established at \$100 higher than the Level II rate.
4. Separate rates were established for the following:

The rates for treatment procedures including cardiac catheterization and lithotripsy are calculated at 150% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

The rates for diagnostic procedures including CT scans, ultra sounds, and magnetic reasoning imaging are calculated at 100% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

The rate for observation are calculated at 100% of the average adjusted costs for state fiscal years 2000 and 2001.
5. Thrombolytic agents shall be reimbursed at acquisition costs.

X. Home Health Agency Services

- (1) The following home health services are paid in accordance with a fee schedule established by the state Medicaid agency, not to exceed billed charges:

Skilled Nursing
Home Health Aide
Medical Social Service
Physical, Occupational and Speech Therapy

- (2) Enteral nutritional products and disposable medical supplies shall be reimbursed based on costs as submitted on an annual cost report. Providers shall be paid an interim rate determined by multiplying a provider's facility-specific cost to charge ratio by its billed charges. Interim payments shall not exceed submitted charges and will be settled back to actual cost at the end of the home health agency's fiscal year, subject to lower of costs or charges. Interim payments will be settled back to allowable cost within 18 months following the end of the agency's fiscal year. Allowable costs will be based on audited or desk reviewed cost reports and determined in accordance with Medicare reimbursement principles. Cost reports for each of the home health agencies described in sections (3), (4), and (5) must be received by the Department within five (5) months of the close of the agency's fiscal year (May 31).

Public providers will not be subject to the lower of cost or charges and will be reimbursed their total allowable cost for enteral nutritional and disposable medical supplies.

- (3) Payment to a new home health agency for the services described in (1) will be in accordance with the methodology described in (1). New home health agencies will be paid for enteral nutritional products and disposable medical supplies on an interim basis by multiplying their billed charges for these products by seventy (70) percent. A new home health agency will be held to the seventy (70) percent threshold until a cost report is received by the state Medicaid agency. A home health agency that did not participate under the current ownership or a previous ownership in the prior year will be considered a new home health agency. A new home health agency will be reimbursed as described above until a cost report is received by the department, no later than May 31 prior to the rate year beginning July 1.
- (4) Payment to an out of state home health agency for the services described in (1) will be in accordance with the methodology described in (1). Out of state agencies will be paid for enteral nutritional products and disposable medical supplies by multiplying billed charges by eighty (80) percent.

- (5) For home health services provided by licensed county health department home health agencies, a supplemental payment which represents the difference between the estimated costs of home health services for the eight month period beginning November 1, 2002 and ending June 30, 2003 and the amount of payments made by the Department for these services under the flat fee reimbursement as describe in (1) will be made.

Using cost reports filed with the Department, the Department will calculate the unit cost for a service listed under (1) and compare the unit cost to the rate per unit as described in (1). The supplemental payment will equal the difference between the cost per unit of service multiplied by the number of units of service provided during the period. In this way, the Department shall assure public providers reimbursement for their total allowable costs.

If a provider's costs as estimated from the annual cost report are less than the estimated payments, the Department will recoup any excess payments.

- (6) Services provided by County Health Department Home Health Agencies. For the fiscal period beginning July 1, 2003 and for subsequent periods beginning July 1, supplemental payments will be made on a quarterly basis. The supplemental payments will be compared to the provider's annual cost report and adjustments made as described in (5) above.

8. Private Duty Nursing Services

DMS will reimburse for private duty nursing services at a rate of nine dollars per fifteen minutes. DMS will not reimburse for more than ninety-six units per recipient per twenty-four hour period or 8,000 units per twelve-consecutive month period per recipient.

XI. Laboratory Services

Eff. The state agency will reimburse participating independent laboratories, outpatient surgical clinics, renal dialysis centers, and outpatient hospital clinics 62% of the current Medicare Clinical Laboratory Fee Schedule.

XII For services provided on or after July 1, 1990, physician (clinical diagnostic) laboratory services shall be reimbursed 60% of the current Medicare Clinical Laboratory Fee Schedule. For laboratory services with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges.

XIII Family Planning Clinics

Effective 7/1/87, the State Agency will reimburse participating family planning agencies for covered services in accordance with 42 CFR 447.32. Payments to physicians and Advanced Registered Nurse Practitioners (ARNP) for individual services shall be reimbursed the lesser of the actual billed amount or the below listed amounts:

	Physicians	ARNP
Initial Clinic Visit	\$50.00	\$37.75
Annual Clinic Visit	\$60.00	\$45.00
Follow-up Visit with Pelvic Examination	\$25.00	\$18.75
Follow-up Visit without Pelvic Examination	\$20.00	\$15.00
Counseling Visit	\$13.00	\$13.00
Counseling Visit w/3 months contraceptive supply	\$17.00	\$17.00
Counseling Visit w/6 months contraceptive supply	\$20.00	\$20.00
Supply Only Visit – Actual acquisition cost of contraceptive supplies dispensed		

XIV. Durable Medical Equipment, Supp. Prosthetics and Orthotics

1. General DME Items

For DME items that have an HCPC code (except for customized items) reimbursement shall be based on the Medicaid fee schedule, not to exceed the supplier's usual and customary charge.

2. Manual Pricing of DME Items

- a. Customized items with a miscellaneous HCPC code of K0108 will require prior-authorization and will be reimbursed at invoice minus twenty- two (22) percent, not to exceed the supplier's usual and customary charge.
- b. Customized components that do not have a HCPC code, and all other miscellaneous codes will require prior-authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary change.
- c. DME items that do not have HCPC codes and have been determined by the department to be covered will require prior authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary charge.
- d. Specialized wheelchair bases with codes of K0009 and K0014 will require prior authorization and will be reimbursed at manufacturers suggested retail price minus fifteen (1 5) percent, not to exceed the supplier's usual and customary charge.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Other diagnostic, screening, preventive and rehabilitative services provided by licensed community mental health centers, and other mental health and substance use providers shall be reimbursed as outlined below:

1. Community Mental Health Centers (CMHCs) are paid CMHC-specific cost-based rates per service based on the type of practitioner rendering the service. For the period beginning January 1, 2014, the rates are those in existence for the practitioners in CY 2013. Separate rates are set for the following practitioners:
 - Licensed Psychologist (LP)
 - Licensed Psychological Practitioner (LPP)
 - Licensed Clinical Social Worker (LCSW)
 - A psychiatric social worker with a master's degree from an accredited school
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Professional Art Therapist (LPAT)
 - Licensed Marriage and Family Therapist (LMFT)
 - Licensed Behavior Analyst (LBA)
 - Psychiatrist
 - Physician
 - A psychiatric nurse licensed in the state of Kentucky with one of the following combination of education and experience:
 - i. Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.
 - ii. Bachelor of Science in Nursing and one (1) year of experience in a mental health setting.
 - iii. A graduate of a three-year educational program with two (2) years of experience in a mental health setting.
 - iv. A graduate of a two-year educational program (Associate degree) with three (3) years of experience in a mental health setting.
 - Licensed Alcohol and Drug Counselor (LADC)
 - Licensed Alcohol and Drug Counselor Associate*(LADCA)
 - A professional equivalent, through education in a behavioral health field and experience in a behavioral health setting, qualified to provide behavioral health services.
 - The following professionals under the appropriate supervision:
 - i. A mental health associate with a minimum of a Bachelor's degree in psychology, sociology, social work, or human services under supervision of one of the above professionals;
 - ii. A licensed psychological associate;
 - iii. A licensed professional counselor associate;
 - iv. A licensed professional art therapist associate;

XVI. Other diagnostic, screening, preventive and rehabilitative services.

- ix. Peer Support Specialist working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, or a LPATA ;
- x. A certified alcohol and drug counselor (CADC) working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a LPAT, or a LPATA; and
- xi. A community support associate who is working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, a LPATA, a LBA, or a LABA.

The current reimbursement methodology, as outlined above, for services provided in CMHCs will end on June 30, 2016.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. All other mental health and substance use providers

The reimbursement described below is applicable to the following mental health and substance use disorder services.

- Screening
- Assessment
- Psychological Testing
- Crisis Intervention
- Residential Crisis Stabilization
- Day Treatment
- Peer Support
- Parent/Family Peer Support
- Individual Outpatient Therapy
- Group Outpatient Therapy
- Family Outpatient Therapy
- Collateral Outpatient Therapy
- Partial Hospitalization
- Service Planning
- SBIRT – Screening, Brief Intervention and Referral to Treatment (Substance use only)
- Medication Assisted Treatment (Substance use only)
- Comprehensive Community Support Services (Mental health & Co-occurring only)
- Therapeutic Rehabilitation Program (TRP) (Mental health only)

Reimbursement for the services listed above are based on the Kentucky specific Medicaid fee schedule, which can be found at <http://chfs.ky.gov/dms/fee.htm> and is effective beginning on January 1, 2014. The Medicaid fee schedule is based on the following methodology:

1. Physician Base Fee is calculated based on the following (in descending order of applicability):
 - (a) If a current Kentucky-specific Medicare rate exists for the service, physicians will be reimbursed at 75% of the current Kentucky-specific Medicare rate, as published by CMS on an annual basis, using 15 minute increments. This is calculated using the following methodology:
 - i The Mental Health and Substance Abuse rates start with the current standard Kentucky specific Non-Facility Medicare rate for a 60 minute service.
 - ii The 60 minute elapsed time rate is converted to a 15 minute rate to correspond to the Kentucky Medicaid reimbursement methodology of 15 minute units for traditional Medicaid and Mental Health providers.
 - iii The Kentucky Medicaid rate for physicians/psychiatrists is 75% of the current Kentucky-specific Medicare rate.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. All other mental health and substance use providers

- (b) If a current Kentucky-specific Medicare rate does not exist, physicians will be reimbursed for the service based on the state's payment rates for similar services in other Kentucky Medicaid reimbursement programs (with similar degrees of complexity). Kentucky has developed, based on Resource Based Relative Value Scale weighting where possible, and absent RBRVS metrics, a weighted average based comparison of charges, so that a service that Medicare has not priced generates a Medicaid rate to a physician that is "similar" to a rate for either a similar RVRBS metric or a similar percent of charges metric.
- (c) If a current Kentucky-specific Medicare rate does not exist and the service is not similar to other Kentucky Medicaid reimbursed services, physicians will be reimbursed for the service based on the state's payment rates for similar services in other Kentucky programs that are not Medicaid reimbursed (i.e., funded only through State General Funds).

XVI. Other diagnostic, screening, preventive and rehabilitative services.

- B. Other practitioners providing the service (listed in 1, 2, 3, 4, and 5 below) will be reimbursed based on a step down methodology calculated as a percentage of the physician rate (75% of the current Kentucky-specific Medicare rate, or the established Medicaid rate if a current Kentucky-specific Medicare rate does not exist). The step down includes:
- (1) 85% - Advanced Practice Registered Nurse (APRN), Licensed Psychologist (LP)
 - (2) 80% - Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Psychological Practitioner (LPP), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Art Therapist (LPAT), Licensed Behavior Analyst (LBA), Licensed Alcohol and Drug Counselor (LADC), Certified Alcohol and Drug Counselor (CADC).
 - (3) 70% - Licensed Psychological Associate (LPA), Licensed Marriage and Family Therapist Associate (LMFTA), Licensed Professional Counselor Associate (LPCA), Certified Social Worker, Masters Level (CSW), Physician Assistant (PA) working under the supervision of a physician, Licensed Professional Art Therapist Associate (LPATA), Licensed Assistant Behavior Analyst (LABA), Licensed Alcohol and Drug Counselor Associate (LADCA). The billing provider is either the supervisor, a provider group, or licensed organization.
 - (4) 50% - Bachelors-level providers
 - (5) 40% - Other non-bachelors-level providers

Partial hospitalization will be reimbursed a rate of \$194.10 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate is posted at <http://chfs.ky.gov/dms/fee.htm>.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.
2. The partial hospitalization rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

3. Per 42 CFR 431.107, each provider or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

Residential Services for Substance Use Disorders will be reimbursed a rate of \$230 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year. This per diem was calculated by using Kentucky's EPSDT rate for similar facility services.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.
2. The residential services for substance use disorders rate is based on rates currently set for state plan services - Kentucky's EPSDT rate for similar services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.
3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Residential Services for Substance Use Disorders will be reimbursed a rate of \$230 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year. This per diem was calculated by using Kentucky's EPSDT rate for similar facility services.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.
2. The residential services for substance use disorders rate is based on rates currently set for state plan services - Kentucky's EPSDT rate for similar facility services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.
3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Intensive outpatient program will be reimbursed on a per diem basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Intensive Outpatient Therapy. The agency's fee schedule rate was set as of December 2, 2015 and is effective for services provided on or after that date. All rates are published <http://chfs.ky.gov/dms/fee.htm>. This per diem was calculated by using Kentucky's existing rate for rehabilitative children in the custody of or at risk of being in the custody of the state or for children under the supervision of the state and converting it to a per diem for the same service.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.
2. The intensive outpatient program rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.
3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Assertive Community Treatment will be reimbursed a rate of \$750 per month for a four (4) person team, and \$1,000 per month for a ten (10) person team. In order to be reimbursed this rate, at least one service must be provided during the period. These rates will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.
2. The ACT rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.
3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

- B. Effective for services provided on and after July 2, 2001, primary care centers will be reimbursed in accordance with the prospective payment system described in Attachment 4.19-B, page 20.16 for FQHCs and RHCs.

For drugs for specified immunizations provided free from the Health Department to primary care centers for immunizations for Medicaid recipients, the cost of the drugs are paid to the Health Department. The specified immunizations are: diphtheria and tetanus toxoids and pertuisis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any type) (OPV); and hemophilus B conjugate vaccine (HBCV).

Effective January 1, 1989, the cost for these immunizations will not be allowed as a part of the primary care center cost base so long as these drugs are available free from the Health Department.

TN No.: 89-30
Supersedes
TN No.: None

Approval
Date: Oct 16, 1989

Effective
Date: 7-1-1989

For the period 10/01/02 through 6/30/04, adjusted payments will be made to Community Mental Health Centers to recognize and support their continued commitment to the provision of mental health services. These payments will be made on a quarterly basis and will reflect the difference in the costs used to determine current rates and Medicaid Costs determined as follows:

1. Using audited cost reports ending June 30, 2000, costs for the covered mental health rehabilitation services described in Attachment 3.1- A, page 7.6.1(a) and Attachment 3.1-B, page 31.5(a) will be allocated to the following cost centers: therapeutic rehabilitation, outpatient individual, outpatient group, outpatient psychiatry, outpatient/personal care home, outpatient/in-home setting, and hospital psychiatric (professional services provided in an inpatient setting).
2. The Medicaid percentage for each cost center will be determined by dividing Medicaid units of service by total units of service by cost center.
3. Medicaid costs per cost center will be determined by multiplying costs by the Medicaid percentage per cost center.
4. Medicaid costs per cost center will be inflated to the mid-point of the rate year using the Home Health Market Basket Index.
5. The increased Medicaid capital will be determined by multiplying any capital increase from the base year to the rate year by the aggregate Medicaid percentage. The aggregate Medicaid percentage is determined by dividing total Medicaid costs by total costs.
6. The difference between the base year Medicaid costs and the inflated Medicaid costs will be added to the increased Medicaid capital.
7. Costs shall be determined in accordance with cost principles outlined in the Provider Manual. Only Medicaid recognized costs will be included in the calculation.
8. These adjusted payments will expire on July 1, 2004.

Payment methodology for rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and that are provided through an agreement with the State Health or Title V agency.

A. Rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rates for rehabilitative services are negotiated rates between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of each service.

The payment rate for rehabilitative services that are authorized after June 30, 2002, are uniform rates, determined by 98% of the weighted median of claims for each service for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

B. Rehabilitative services for children under the supervision of the state and that are provided through an agreement with the State Health or Title V agency.

Payments for rehabilitative services covered in Attachment 3.1-A, page 7.6.1 and Attachment 3.1B, page 31.5 for the target populations are per service. They are based upon one or more documented rehabilitative services provided to each client. The rates for the rehabilitative services are based upon the actual direct and indirect costs to the providers. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing rehabilitative services based on financial information submitted by the provider.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: identification, by recipient and worker, of each individual service provided, a showing of all direct costs for rehabilitative services; and a showing of all indirect costs for rehabilitative services appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principle if necessary.

Rehabilitative service providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

XVII. FQHC/RHC Services

Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) shall be made in accordance with section 1902 of the Social Security Act as amended by section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA).

For the period of January 1, 2001 through June 30, 2001, the state will implement an alternative reimbursement methodology that is agreed to by the state and the individual center/clinic and results in a payment rate to the center/clinic that is at least equal to the Medicaid PPS rate. The alternative methodology shall be in accordance with the state plan in effect on December 31, 2000.

All FQHCs and RHCs are reimbursed on a prospective payment system beginning with State Fiscal Year 2002 with respect to services furnished on or after July 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the clinic/centers reasonable cost for the clinic/center's fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during the clinic/center's fiscal year 2001 and increased by an appropriate medical index. These costs are divided by the number of visits/encounters for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for state fiscal year 2002. For each state fiscal year thereafter, each clinic/center will be paid the amount (on a per visit basis) equal to the amount paid in the previous state fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic during that state fiscal year. The clinic/center must supply a budgeted cost report of the change in service to justify scope of service adjustments.

For newly qualified FQHCs/RHCs after State Fiscal Year 2001, initial payments are established by cost reporting methods. A newly qualified clinic/center shall submit a budgeted cost report from which an interim rate shall be established. After completion of a clinic/center fiscal year, a final PPS rate will be established. After the initial year, payment is set using the MEI methods used by other clinics/centers, with adjustments for increases or decreases in the scope of service furnished by the clinic/center during that fiscal year.

In the case of a FQHC or RHC that contracts with a Medicaid managed care organization, supplemental payments will be made quarterly to the center or clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the center or clinic is entitled under the PPS.

Until a prospective payment methodology is established, the state will reimburse FQHCs/RHCs based on the rate in effect on June 30, 2001. This rate is based on the State Plan in effect on June 30, 2001. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.

XVIII. Outpatient Surgical Centers

The Department shall utilize the 1996 Medicare ambulatory surgical center group rates for the federal Cincinnati, Ohio-Kentucky region to reimburse for an outpatient surgical center service. Following is a chart which states the reimbursement rate for each corresponding surgical group:

ASC Group	Reimbursement Rate
Group 1	\$307.38
Group 2	\$412.79
Group 3	\$471.90
Group 4	\$582.25
Group 5	\$664.02
Group 6	\$775.59
Group 7	\$921.15
Group 8	\$911.55

Procedures that are not included in one (1) of the eight (8) Medicare surgical groups, reimbursement shall be on the basis of forty-five (45) percent of the center's usual and customary charge for the procedure performed. Payment rates shall not exceed the provider's usual and customary charge to the general public. Hospital based outpatient surgical centers shall be reimbursed in the same manner as hospital outpatient services.

XIX Nurse-Midwife Services

Participating nurse-midwife providers shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of the nurse-midwife.

For services provided on or after July 1, 1990, payments to nurse-midwives shall be at usual and customary actual billed charges on a procedure-by-procedure basis, with reimbursement for each procedure to be the lesser of the actual billed charge or at seventy—five (75) percent of the fixed upper limit per procedure for physicians.

XX Nurse Anesthetist services

Reimbursement will be made at the rate of seventy—five (75) percent of the anesthesiologist's allowable charge for the same procedure under the same conditions, or at actual billed charges if less.

Exception:

For inpatient delivery—related anesthesia services provided on or after December 1, 1988, a nurse anesthetist will be reimbursed the lesser of the actual billed charge or the standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Normal Delivery	\$150.00
Low Cervical C-Section	\$202.50
Classic C-Section	\$240.00
Epidural Single	\$236.25
Epidural Continuous	\$251.25
C-Section with Hysterectomy, subtotal	\$240.00
C-Section with Hysterectomy, total	\$240.00
Extra peritoneal C-Section	\$240.00

XXI. Podiatry Services

The cabinet shall reimburse licensed, participating podiatrists for covered podiatry services rendered to eligible Medical Assistance recipients at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the cabinet at 65 percent of the median billed charge for outpatient services and 50 percent of the median billed charge for inpatient services using 1989 calendar year billed charges. If there is no median available for a procedure, or the cabinet determines that available data relating to the median for a procedure is unreliable, the cabinet shall set a reasonable fixed upper limit for the procedure consistent with the general array of upper limits for the type of service. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

XXII. Hospice Care**A. General Reimbursement**

Reimbursement for hospice care will be made at one of four predetermined rates for each day in which a recipient is under the care of the hospice. The daily rate is applicable to the type and intensity of services furnished to the recipient for that day. There are four levels of care into which each day of care is classified:

1. Routine Homecare
2. Continuous Homecare
3. Inpatient Respite Care
4. General Inpatient Care

The Medicaid hospice rates are set prospectively by Centers for Medicare and Medicaid Services, based on the methodology used in setting Medicare hospice rates and adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register.

B. Reimbursement for Room and Board

Hospice is reimbursed a per diem amount to cover room and board, for those recipients who reside in a nursing facility. The state shall reimburse ninety five percent (95%) of the nursing facility's Medicaid per diem to the hospice provider, to cover the expenses of the room and board provided to the hospice patient who occupies a Medicaid certified bed in a nursing facility.

The hospice provider shall have a contract with the nursing facility stipulating that:

1. Room and board shall be provided by the nursing facility for the hospice resident;
2. The rate the nursing facility will charge the hospice provider for room and board furnished to the Medicaid hospice resident; and
3. The hospice is fully responsible for the professional management of the Medicaid hospice patient's care.

C. Limitation on Payments for Inpatient Care

1. The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicaid patients not exceed twenty percent (20%) of the total days for which these patients have elected hospice.
2. At the end of the cap period, Medicaid will calculate a limitation on payment for inpatient care (general or respite) to ensure payment is not made in excess of twenty percent (20%) of the total number of days of hospice care furnished to Medicaid patients.
3. If the number of days of inpatient care furnished to Medicaid patients is equal to or less than twenty percent (20%) of the total days of hospice care to Medicaid patients, no adjustment is necessary. Overall payments to a hospice are subject to the cap amount.

D. Monitoring of Reimbursement

The Department for Medicaid Services will perform a desk audit on each hospice provider once a year following the end of the cap period in order to compute and apply the cap amount and audit payments made for inpatient services.

XXIII. Case Management Services

A. Targeted case management services for adults and children with Substance Use Disorders.Monthly Rate:

Targeted case management for adults and children with substance use disorders will be reimbursed at a monthly rate of \$334. This rate was established using a reasonable estimate for the salary and fringe benefits of a Bachelors-level practitioner, consistent with the minimum case manager qualifications for this service, to derive the 15 minute unit base rate of \$10.76. This base rate was increased by 12% to account for overhead costs, which creates the 15 minute unit rate of \$12.05. Assuming 25 cases per month, the amount of working time per month is estimated to be 6.93 hours per each case. That working time, multiplied by four 15 minute units of the Bachelors-level base rate of \$12.05, equals \$334 per month. These rates are effective 7/1/2014.

A unit of service shall:

- (a) Be one (1) month; and
- (b) Consist of a minimum of four (4) service contacts including:
 1. At least two (2) face-to-face contacts with the recipient; and
 2. Two (2) additional contacts which may be by telephone or face-to-face with, or on behalf of, the recipient.

B. Targeted case management services for adults and children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues.Monthly Rate:

Targeted case management for adults and children with co-occurring mental health or substance use disorders and chronic or complex physical health issues will be reimbursed at a monthly rate of \$541. This rate was established using a reasonable estimate for the salary and fringe benefits of a Bachelors-level practitioner to derive the 15 minute unit base rate of \$10.76. After accounting for the additional education of a Masters-level practitioner (33%) and overhead costs (12%), the 15 minute unit rate is \$15.60. Assuming 20 cases per month, the amount of working time per month is estimated to be 8.66 hours per each case. That working time, multiplied by four 15 minute units of \$15.60, equals \$541 per month. This rate is effective 7/1/2014.

A unit of service shall:

- (a) Be one (1) month; and
- (b) Consist of a minimum of five (5) service contacts including:
 1. At least three (3) face-to-face contacts with the recipient (may include parent/legal guardian for individuals under age 21); and
 2. Two (2) additional contacts which may be by telephone or face-to-face with, or on behalf of, the recipient.

XXIII. Case Management Services

C. Targeted case management services for adults and children with Severe Emotional Disability or Severe Mental Illness

Monthly Rate:

Targeted case management for adults and children with severe emotional disability or severe mental illness will be reimbursed at a monthly rate of \$334. This rate was established using a reasonable estimate for the salary and fringe benefits of a Bachelors-level practitioner, consistent with the minimum case manager qualifications for this service, to derive the 15 minute unit base rate of \$10.76. This base rate was increased by 12% to account for overhead costs, which creates the 15 minute unit rate of \$12.05. Assuming 25 cases per month, the amount of working time per month is estimated to be 6.93 hours per each case. That working time, multiplied by four 15 minute units of the Bachelors-level base rate of \$12.05, equals \$334 per month. These rates are effective 7/1/2014.

A unit of service shall:

- (a) Be one (1) month; and
- (b) Consist of a minimum of four (4) service contacts including:
 - 1. At least two (2) face-to-face contacts with the recipient; and
 - 2. Two (2) additional contacts which may be by telephone or face-to-face with, or on behalf of, the recipient.

XXV. Advanced Registered Nurse Practitioner Services**(1) Reimbursement**

- a. Participating licensed advanced registered nurse practitioners (ARNP) shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of a licensed ARNP.
- b. Except as specified in subsection c of this section or Section 2 below, reimbursement for a procedure provided by an ARNP shall be at the lesser of the following:
 1. The ARNP's actual billed charge for the service; or
 2. Seventy-five (75) percent of the amount reimbursable to a Medicaid participating physician for the same service.
- c. An ARNP employed by a primary care center, federally qualified health center, hospital, or comprehensive care center shall not be reimbursed directly for services provide in that setting while operating as an employee.

(2) Reimbursement Limitations.

- a. The fee for administration of a vaccine to a Medicaid recipient under the age of twenty-one (21) by an ARNP shall be three (3) dollars and thirty (30) cents up to three (3) administrations per ARNP, per recipient, per date of service.
- b. The cost of a vaccine provided to a physician or other provider enrolled in the Vaccines for Children (VFC) Program and available free through the Vaccines for Children Program shall not be reimbursed.
- c. For information relating to physician injectable drug products that are administered by a physician or their authorized agent during an in office procedure see Attachment 4.19-B, Page 20.1(b).

-
- d. Reimbursement for an anesthesia service provided during a procedure shall be inclusive of the following elements:
1. Preoperative and post-operative visits;
 2. Administration of the anesthetic;
 3. Administration of intravenous fluids and blood or blood products incidental to the anesthesia or surgery;
 4. Post-operative pain management; and
 5. Monitoring services.
- e. Reimbursement of a psychiatric service provided by an ARNP shall be limited to four (4) psychiatric services per ARNP, per recipient, per twelve (12) months.
- f. Reimbursement for a laboratory service provided in an office setting shall be inclusive of:
1. The fee for collecting and analyzing the specimen; and
 2. Should the test require an arterial puncture or venipuncture, the fee for the puncture.
- g. Reimbursement shall be limited to one (1) of the following evaluation and management services performed by an ARNP per recipient, per date of service:
1. A consultation service;
 2. A critical care service;
 3. An emergency department evaluation and management service;
 4. A home evaluation and management service;
 5. A hospital inpatient evaluation and management service;
 6. A nursing facility service;
 7. An office or other outpatient evaluation and management service;
 8. A preventive medicine service; or
 9. A psychiatric or other psychotherapy service.

XXVI: Federally Qualified Health Center Services

Enrolled Federally Qualified Health Center providers shall be paid full reasonable cost determined in the same manner as for primary care centers except that cost shall not include an incentive payment.

XXVIII. Services Provided by Local Health Departments.

1. Services that are provided by local health departments shall be reimbursed 100% of the Medicare Physician Fee Schedule rate that is in effect as of January 1, 2014 and updated annually on January 1st. The Fee Schedule is located at <http://www.chfs.ky.gov/NR/rdonlyres/AAF5A26B-D321-4D41-9AB0-8A49CF4BE3AB/0/Preventive2012FeeSchedule6WEB.pdf>. Any codes on the aforementioned Fee Schedule that is not on the Medicare Fee Schedule will be reimbursed at the Medicaid developed Physician Fee Schedule, last updated on January 1, 2013, or Dental Fee Schedule, last updated on January 1, 2009, both of which are located at <http://www.chfs.ky.gov/dms/fee.htm>
2. Covered services shall be provided by a:
 - a. Physician;
 - b. Dentist;
 - c. Physician Assistant;
 - d. Public Health Dental Hygienist;
 - e. Advanced Registered Nurse Practitioner; or
 - f. Registered Nurse. A “registered nurse” is defined by state law as a person who is licensed in accordance with state law to engage in registered nursing practice. State law defines “registered nursing practice” as the performance of acts requiring substantial specialized knowledge, judgment, and nursing skill based upon the principles of psychological, biological, physical, and social sciences in the application of the nursing process in:
 - (1) The care, counsel, and health teaching of the ill, injured, or infirm;
 - (2) The maintenance of health or prevention of illness of others;
 - (3) The administration of medication and treatment as prescribed by a physician, physician assistant, dentist, or advanced registered nurse practitioner and as further authorized or limited by the Kentucky Board of Nursing, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses. Components of medication administration include but are not limited to:
 - (a) Preparing and giving medications in the prescribed dosage, route, and frequency, including dispensing medications;
 - (b) Observing, recording, and reporting desired effects, untoward reactions, and side effects of drug therapy;
 - (c) Intervening when emergency care is required as a result of drug therapy;
 - (d) Recognizing accepted prescribing limits and reporting deviations to the prescribing individual;
 - (e) Recognizing drug incompatibilities and reporting interactions or potential interactions to the prescribing individual; and
 - (f) Instructing an individual regarding medications;

-
- (4) The supervision, teaching of, and delegation to other personnel in the performance of activities relating to nursing care; and
 - (5) The performance of other nursing acts which are authorized or limited by the Kentucky Board of Nursing, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses.
3. This methodology applies to the following services:
- a. Early and periodic screening, diagnosis, and treatment (EPSDT) services which are described in Attachment 3.1-A, pages 7.1.2 – 7.1.4, 7.1.7, 7.1.8 and Attachment 3.1-B, pages 16-18, 20.1 and 20.2.
 - b. Pediatric services which include the following:
 - (1) Diagnostic and nursing evaluation and management services;
 - (2) Provision of all childhood immunizations as described by Attachment 3.1-A, page 9a included in the Vaccines for Children (VFC) program. Providers will only be reimbursed the administration fee for vaccines provided under the VFC program. Provision of other immunizations to children as recommended by the CDC;
 - (3) Medications and other treatment procedures; and
 - (4) Follow-up nursing care.
 - c. Prenatal and related services – Services provided or arranged in accordance with the standards developed for the prenatal program include the following:
 - (1) Pregnancy testing/confirmation;
 - (2) Contact visit counseling;
 - (3) Initial examination;
 - (4) Subsequent monitoring visits;
 - (5) Laboratory tests, as necessary;
 - (6) Individual counseling;
 - (7) Hands voluntary home visitation program;
 - (8) Initial infant assessment;
 - (9) Postpartum visit; and
 - (10) Family planning visit.
 - d. Services for individuals with chronic diseases such as:
 - (1) Diagnostic evaluation and management services;
 - (2) Laboratory tests, as necessary;
 - (3) Medications and other treatment procedures;
 - (4) Individual counseling; and
 - (5) Adult immunizations as recommended by the CDC.

- e. Chronic disease services which are provided for the following:
- (1) Diabetes;
 - (2) Heart disease and stroke program;
 - (3) Women's Cancer Screening program;
 - (4) Substance abuse prevention program;
 - (5) Tobacco prevention and cessation;
 - (6) Obesity;
 - (7) Arthritis/osteoarthritis;
 - (8) Depression;
 - (9) Oncology;
 - (10) Hemophilia;
 - (11) Sickle Cell;
 - (12) Organ transplants; and
 - (13) Rare disease.
- f. Family planning services are described in Attachment 3.1-A, page 7.1.9 and Attachment 3.1-B, page 20.3. These services include the following:
- (1) Complete medical history;
 - (2) Physical examination;
 - (3) Laboratory and clinical test supplies; and
 - (4) Counseling and prescribed birth control methods to best suit the patient's needs.

XXIX Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

- (1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services), the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:
 - (a) 1905(a)(1), inpatient hospital services;
 - (b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
 - (c) 1905(a)(3), other laboratory and X-ray services;
 - (d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
 - (e) 1905(a)(5)(A), physicians services; 1905(a)(5)(B), medical and surgical services furnished by a dentist;
 - (f) 1905(a)(6), medical care by other licensed practitioners;
 - (g) 1905(a)(7), home health care services;
 - (h) 1905(a)(9), clinic services;
 - (i) 1905(a)(10), dental services;
 - (j) 1905(a)(11), physical therapy and related services;
 - (k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
 - (l) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
 - (m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
 - (n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
 - (o) 1905(a)(17), nurse-midwife services;
 - (p) 1905(a)(18), hospice care;
 - (q) 1905(a)(19), case management services; and
 - (r) 1905(a)(28), other medical and remedial care specified by the Secretary.
- (2) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21, the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100 percent of usual and customary charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:
 - (a) Any service described in one (1), above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
 - (b) 1905(a)(8), private duty nursing services;
 - (c) 1905(a)(20), respiratory care services;
 - (d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under 1905(a)(6); and

- 3) For medically-necessary evaluative, diagnostic, preventive, and treatment services listed in Section 1905(a) of the Social Security Act, the state shall pay in accordance with items (1) or (3), as applicable, except that for governmental providers the payment shall be a fee-for-service system designed to approximate cost in the aggregate with settlement to reconciled cost. The following describes the methodology utilized in arriving at the rates.
- (a) Medicaid providers are paid according to the Kentucky Medicaid Fee Schedule and its modifiers which are maintained by the department and paid through the fee-for-service system. "Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of covered services. The agency's current fee schedule rate was set as of January, 2010 and is effective for services provided on or after that date. All rates are published on the KY Medicaid web site at <http://chfs.ky.gov/dms/fee.htm>.
 - (b) Fee for new services are established based on the fees for similar existing services. If there are no similar services the fee is established at 75% of estimated average charge.
 - (c) Fees for particular services can be increased based on administrative review if it is determined that the service is essential to the health needs of Medicaid recipients, that no alternative treatment is available, and that a fee adjustment is necessary to maintain physician participation at a level adequate to meet the needs of Medicaid recipients. A fee may also be decreased based on administrative review if it is determined that the fee may exceed the Medicare allowable amount for the same or similar services, or if the fee is higher than Medicaid fees for similar services, or if the fee is too high in relation to the skills, time and other resources required to provide the particular service.
 - (d) Medicaid Services Provided in Schools are services that are medically necessary and provided in schools to Medicaid recipients in accordance with an Individualized Education Program, (IEP) or an Individual Family Service Plan (IFSP). Covered services include the following as described in Attachment 3.1-A pages 7.1.7(b)-7.1.7(e):
 - 1. Audiology
 - 2. Occupational Therapy
 - 3. Physical Therapy
 - 4. Behavioral Health Services
 - 5. Speech
 - 6. Nursing Services
 - 7. Respiratory Therapy
 - 8. Transportation

The interim payment to the Local Education Agencies for services (Paragraph (d) 1-7) listed above are based on the physician fee schedule methodology as outlined in Kentucky Medicaid Fee Schedule.

- (e) Direct Medical Services Payment Methodology
Beginning with cost reporting period August 1, 2008, the Department for Medicaid Services (DMS) will begin using a cost based methodology for all Local Education Agencies (LEAs). This methodology will consist of a cost report, time study and reconciliation. If payments exceed Medicaid-allowable costs, the excess will be recouped.

Once the first year's cost reports are received, and each subsequent year, the Department will examine the cost data for all direct medical services to determine if an interim rate change is justified.

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-eligible clients in the LEA, the following steps are performed:

1. Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services personnel listed in the descriptions of the covered Medicaid services delivered by school districts in Attachment 3.1-A pages 7.1.7(b) - 7.1.7(e).

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, direct materials, supplies and equipment.

Medical devices and equipment are only allowable for the provision of direct medical services. For items not previously approved, the LEA must use a pre-approval process to determine suitability, coverage, and reimbursement of medical supplies, material, and equipment. The following process must be followed by the schools at a minimum:

- 1) The medical device must be approved and effective (i.e., not experimental) and within the scope of the school based services shown as covered in the Medicaid state plan;
- 2) The use of the device must be determined suitable for the individual; and
- 3) The service or device must be approved by one of the covered medical professionals and reviewed by the Kentucky Department for Medicaid Services.

These direct costs are accumulated on the annual cost report, resulting in total direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

2. The net direct costs for each service is calculated by applying the direct medical services percentage from the CMS-approved time study to the direct cost in 1 above.

A time study which incorporates a CMS-approved methodology is used to determine the percentage of time medical service personnel spend on IEP-related medical services, and general and administrative time. This time study will assure that there is no duplicate claiming relative to claiming for administrative costs

3. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. Kentucky public school districts use predetermined fixed rates for indirect costs. The Department of Education (KDE) is the cognizant agency for the school districts, and approves unrestricted indirect cost rates for school districts for the US Department of Education (USDE). Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.
4. Net direct costs and indirect costs are combined.

-
5. Medicaid's portion of total net costs is calculated by multiplying the results from Item 4 by the ratio of the total number of students with Medicaid Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP) receiving services to the total number of students with an IEP or an IFSP.

(f) Transportation Services Payment Methodology

Effective dates of services on or after August 1, 2008, providers will be paid on a interim cost basis. Providers will be reimbursed interim rates for School Based Health Services (SBHS) Specialized Transportation services at the lesser of the provider's billed charges or the interim rate. The interim rate will be a per mile amount determined by the Department of Education Division of School Finance based on data collected from school districts. This interim rate will be an average of each school district's actual cost per mile. On an annual basis, a cost reconciliation and cost settlement will be processed for all over and under payments.

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1. Special transportation is specifically listed in the IEP as a required service;
2. A medical service is provided on the day that specialized transportation is provided; and
3. The service billed only represents a one-way trip.

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education. The cost identified on the cost report includes the following:

1. Bus Drivers
2. Mechanics
3. Substitute Drivers
4. Fuel
5. Repairs & Maintenance
6. Rentals
7. Contract Use Cost
8. Vehicle Depreciation

The source of these costs will be audited Chart of Accounts data kept at the school district and the Department of Education level. The Chart of Accounts is uniform throughout the State of Kentucky. Costs will be reported on an accrual basis.

1. A rate will be established and applied to the total transportation cost of the school district or the Department of Education. This rate will be based on the *Total IEP Special Education Department (SPED) Students in District Receiving Specialized Transportation* divided by the *Total Students in District Receiving Transportation*. The result of this rate (%) multiplied by the *Total District or Department of Education Transportation Cost* for each of the categories listed above will be include on the cost report. It is important to note that this cost will be further discounted by the ratio of *Medicaid Eligible SPED IEP One Way Trips* divided by the total number of *SPED IEP One Way Trips*. This data will be provided from transportation logs. The process will ensure that only one way trips for Medicaid eligible Special Education children with IEP's are billed and reimbursed for.

2. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. Kentucky public school districts use predetermined fixed rates for indirect costs. The Department of Education (KDE) is the cognizant agency for the school districts, and approves unrestricted indirect cost rates for school districts for the US Department of Education (USDE). Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.
3. Net direct costs and indirect costs are combined.

(g) Certification of Funds Process

On an annual basis, each provider will certify through its cost report its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

(h) Annual Cost Report Process

For Medicaid services listed in Paragraph (d) 1-8 provided in schools during the state fiscal year, each LEA provider must complete an annual cost report. The cost report is due on or before April 1 following the reporting period.

The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology.
2. Reconcile annual interim payments to its total CMS-approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual SBHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SBHS Cost Reports are subject to desk review by Department for Medicaid Services (DMS) or its designee.

(i) The Cost Reconciliation Process

The cost reconciliation process must be completed by DMS within twenty-four months of the end of the reporting period covered by the annual SBHS Cost Report. The total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the LEA provider's Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

(j) The Cost Settlement Process

EXAMPLE: For services delivered for the period covering August 1, 2007, through July 31, 2008, the annual SBHS Cost Report is due on or before April 1, 2009, with the cost reconciliation and settlement processes completed no later than July 31, 2010.

If a provider's interim payments exceed the actual, certified costs for Medicaid services provided in schools to Medicaid clients, the provider will remit the federal share of the overpayment at the time the cost report is submitted. DMS will submit the federal share of the overpayment to CMS within 60 days of identification.

If the actual, certified costs of a LEA provider exceed the interim payments, DMS will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

The Department for Medicaid Services (DMS), Kentucky Department of Education (KDE) and individual schools wish to share in the responsibility for promoting access to health care for students in the public school system, preventing costly or long term health care problems for at risk students, and coordinating students' health care needs with other providers. Many of these activities, when performed by school staff, meet the criteria for Medicaid school-based administrative claiming and may be reimbursable. For this purpose we have produced the Kentucky School Based Time Study document to set out the method for these reimbursements.

TN No. 08-010
Supersedes
TN No. None

Approval Date: 06-04-10

Effective Date: 9/15/08

State: Kentucky

XXX. Radiological (X-ray) Services

Payments for radiological services covered pursuant to the mandate contained in 42 CFR 440.30 shall be at usual and customary charges up to sixty (60) percent of the allowable physician fee for the same procedures where the physician is performing both the professional and technical portions of the service.

TN # 92-25
Supersedes
TN # None

Approved Date: Jan 13, 1993

Effective Date: 12-1-92

XXXI. Payment methodology for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and for adults in need of protective services.

A. Targeted case management services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rate for targeted case management is a negotiated rate between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of the service.

The payment rate for a targeted case management service that is authorized after June 30, 2002, is a uniform rate, determined by 98% of the weighted median of claims for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

The billable unit of service is one month

B. Targeted case management services for children under the supervision of the state and for adults in need of protective services.

Payments for targeted case management services for the target populations are monthly. They are based upon one or more documented targeted case management services provided to each client during that month. The monthly rate for the targeted case management services is based on the total average cost per client served by the provider. The monthly rate is established on a prospective basis based upon actual case management costs for the previous year. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing case management services based on financial information submitted by the provider.

Case management providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: directly coded worker time; identification, by recipient and worker, of each individual service provided, a showing of all direct costs for case management activities; and a showing of all indirect costs for case management activities appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principles if necessary.

XXII. Specialized Children's Services Clinics

Clinic services provided by Specialized Children's Services Clinics will be reimbursed initially at a statewide uniform all-inclusive rate per visit (encounter rate) of \$538. This rate is estimated to approximate the average statewide costs of all clinics providing the service. This rate includes the costs of professional services (physician and mental health professional), related costs of providing a sexual abuse exam, and facility costs (overhead). This rate is based on the projected cost of providing the service as submitted to the department by the providers and a consideration of rates paid to providers for similar services.

Providers will submit cost reports annually. Upon receipt of completed cost reports from all clinics, the department will establish a rate within 90 days using updated cost data.

Payments made under this provision shall not exceed the upper limit of payment as specified in 42 CFR 447.325.

XXIII. Targeted Case Management and Diagnostic, Preventive and Rehabilitative Early Intervention Services for children eligible for the Early Intervention program provided through a Title V agreement.

This payment system is for all providers, including those providing services under the Title V agreement described in Supplement 1 to Attachment 4.16-A, Item #10.

All costs shall be determined based on the methodology outlined in OMB Circular A-87. Payments for case management, diagnostic, rehabilitative, and preventive early intervention services shall be made in accordance with a fee schedule established by the Title V agency. Interim payments shall be based on the direct cost of providing the service. Payments for overhead and administrative costs associated with providing the service shall be determined with a settlement to cost at the end of the fiscal year. Providers will submit cost reports no later than 180 days after the end of the state fiscal year.

This page Intentionally Left Blank

XXXV Chiropractic Services

A. Definitions

- (1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.
- (2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.
- (3) "Covered chiropractic services" shall include the following:
 - (a) An evaluation and management service;
 - (b) Chiropractic manipulative treatment;
 - (c) Diagnostic X-rays;
 - (d) Application of a hot or cold pack to one (1) or more areas;
 - (e) Application of mechanical traction to one (1) or more areas;
 - (f) Application of electrical stimulation to one (1) or more areas; and
 - (g) Application of ultrasound to one (1) or more areas.

B. Reimbursement

- (1) Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Chiropractic Services. The agency's fee schedule rate was set as of January 1, 2014, and is effective for services provided on or after that date. All rates are published on DMS's website at <http://www.chfs.ky.gov/dms/fee.htm>.
- (2) If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein. RBRVS units shall be multiplied by the Non-anesthesia Related Services dollar conversion factor of \$29.67 to arrive at the fixed upper limit.

C. Reimbursement Exceptions.

- (1) Payment for individuals eligible for coverage under Medicare Part B is made, in accordance with Sections A and B and items (1) through (4) and (6) of this section within the individual's Medicare deductible and coinsurance liability.

(2) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the chiropractor's office are subject to outpatient limits if provided at alternative sites and shall be paid adjusted rates to take into account the change in usual site of services.

D. Assurances. The state hereby assures that (1) payment for chiropractor services are consistent with efficiency, economy, and quality of care (42 CFR 447.200); and (2) payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances (42 CFR 447.325).

Targeted case management services for at risk parents during the prenatal period and until the child's third birthday

This payment system is for all providers, including those providing services under the Title V agreement described in Attachment 4.16-A, Item #10.

Payments shall be based on cost. Interim rates based on projected cost shall be used with a settlement to cost at the end of the state fiscal year. Case management providers who are public state agencies shall have on file an approved cost allocation plan.

Interim rates shall be established in the following manner:

- 1) The rate for the assessment shall be based on the projected cost of providing the service consistent with methodology in OMB Circular A-87. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.
- 2) The rate for the professional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.
- 3) The rate for the family service worker/paraprofessional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

Cost will be accounted for as follows:

- 1) Case management staff directly related to the targeted case management program will code all direct time using categories designated for case management functions in 15 minute increments.
- 2) Any contract costs (i.e., for contracted services) will be based on the actual cost of acquisition of the service.
- 3) Any indirect costs of any public state agency will be determined using the appropriate cost allocation plan.

Providers will submit cost reports no later than 180 days after the end of the state fiscal year. Interim payments will be adjusted to actual cost based upon review and acceptance of these cost reports in accordance with usual agency procedures.

Reimbursement for Physical, Occupational and Speech Therapy - Outpatient

Reimbursement for physical, occupational, and speech therapy services are based on the Kentucky specific Medicaid fee schedule, which can be found at <http://chfs.ky.gov/dms/fee.htm>. The Medicaid fee schedule is based on the following methodology:

- Physician Base Fee is calculated based on 75% of the Medicare rate, as published by CMS on an annual basis.
- Other practitioners will be reimbursed based on a step down methodology calculated as a percentage of the physician rate of 75% of the Medicare rate. The step down includes:
 - 85% - Physical Therapist, Occupational Therapist, Speech Language Pathologist
 - 50% - Physical Therapy Assistant working under the supervision of a Physical Therapist if the Physical Therapist is the billing provider for the service, Occupational Therapy Assistant working under the supervision of an Occupational Therapist if the Occupational Therapist is the billing provider,

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT
State: Kentucky

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Payment of Medicare Part A & Part B Deductible/Coinsurance

- A. Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:
1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a specified rate or method is set out on Page 3 in item B of this attachment (see 3.below).
 2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".
 3. Payments are up to the amount of a special rate, or according to a special method, described on page 3 in item of this attachment, for those groups and payments listed below and designated with the letters "NR".
 4. Any exceptions to the general methods used for a particular group or payment are specified on page 3 in item B of this attachment (See 3. Above)

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT
State: Kentucky

Payment of Medicare Part A and Part B Deductible/Coinsurance (cont.)

QMBs:	Part A:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance
	Part B:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance

Other Medicaid Recipients	Part A:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance
	Part B:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance

Dual Eligible (QMB Plus)	Part A:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance
	Part B:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT
State: Kentucky

Payment of Medicare Part A and Part B Deductible/Coinsurance (cont.)

- B. Medicaid payment for specified Medicare crossover claims will be the lower of the allowed Medicaid payment rates or the Medicare coinsurance and deductibles.
1. The specified Medicare Part A crossover claims are defined as: Inpatient Hospital and Nursing Facilities (effective 9/01/02).
 2. The specified Medicare Part B claims are defined as:
 - a. Physician services, Community Mental Health Center services, Advanced registered nurse practitioner services, podiatry services, chiropractic services, dental services, hearing and vision services, and laboratory and x-ray services (effective 2/01/03);
 - b. Durable Medical Equipment and Pharmacy (effective 4/01/03);
 - c. Emergency ambulance services (effective 6/01/03); and
 - d. Ancillary Services/Nursing Facilities (effective 11/01/03).

In the event that Medicaid does not have a price for codes included on a crossover claim the Medicare coinsurance and deductible will be paid.

PAYMENTS FOR RESERVED BEDS

Payment is made for a reserved bed in Intermediate Care Facilities for the Mentally Retarded in accordance with the following:

A. Payment for the bed reservation shall not exceed the following number of days:

A maximum of fifteen (15) days for a hospital stay for treatment of an acute condition(s), and a total of forth-five (45) days for leave(s) of absence in any given quarter (except that not more than thirty (30) days of such leave may be consecutive days).

B. Payment may ordinarily be made when the following conditions exist:

1. The individual is an eligible recipient and is authorized for Program benefits in the level of care in which he is currently residing.
2. The individual is expected to return to the same level of care, barring complications:
3. There is a likelihood that the bed would be occupied by some other patient if not reserved (facilities with a vacancy history would not be reimbursed for reserving a bed);
4. In the case of a leave of absence, the physician orders and the patient's plan of care provides for such an absence.

PAYMENTS FOR RESERVED BEDS

Payment is made for a reserved bed for price-based nursing facilities in accordance with the following:

The program will cover reserved bed days in accordance with the following specified upper limits and criteria.

- (1) Reserved bed days will be covered for a maximum of fourteen (14) days per calendar year due to hospitalization.
- (2) Reserved bed days will be covered for a maximum of ten (10) days during the calendar years for leaves of absence other than for hospitalization.
- (3) Reserved bed days will be reimbursed at seventy-five (75) percent of a facility's rate if the facility's occupancy percent is ninety-five (95) percent.
- (4) Reserved bed days will be reimbursed at fifty (50) percent of a facility's rate if the facility's occupancy percent is less than ninety-five (95) percent.
- (5) Coverage during a recipient's absence for hospitalization or leave of absence is contingent on the following conditions being met:
 - (a) The person is in Title XIX payment status in the level of care he/she is authorized to receive and has been a resident of the facility at least overnight. Persons for whom Title XIX is making Title XVIII co-insurance payments are not considered to be in Title XIX payment status for purposes of this policy;
 - (b) The person can be reasonably expected to return to the same level of care;
 - (c) Due to demand at the facility for beds at that level, there is a likelihood that the bed would be occupied by some other patient where it not reserved;
 - (d) The hospitalization is for treatment of an acute condition, and not for testing, brace-fitting, etc.: and
 - (e) In the case of leaves of absence other than for hospitalization, the patient's physician orders and plan of care provide for such leaves. Leaves of absence include visits with relatives and friends, and leaves to participate in state-approved therapeutic or rehabilitative programs.

TN No. 05-005

Supersedes

TN No. 84-14

Approval Date: Dec 20, 2005

Effective Date: 07/01/05

FACILITY REIMBURSEMENT – METHODS AND PROCEDURES
FOR JANUARY 1, 2000 AND THEREAFTER

The following sections summarize the cost-based and price-based reimbursement methodologies for facilities in Kentucky.

Participation Requirements

To participate in the Medicaid Program, the facilities are required to be licensed as nursing facilities or as an intermediate care facility for individuals with an intellectual disability. Hospitals provide swing-bed hospital nursing facility care shall not be required to have the hospital beds licensed as NF beds. All nursing facilities (NFs) must participate in Medicare in order to participate in Medicaid, except for those NFs with waivers of the nursing requirements (who are prohibited by statute from participation in Medicare).

Audits

The state agency reviews all cost reports for compliance with administrative thresholds. Costs will be limited to those cost found reasonable. Overpayments found in audits under this paragraph will be accounted for in accordance with federal regulations.

Cost-Based Facilities

The following facilities shall be included in the cost-based facility methodology:

- a. A nursing facility with a certified brain injury unit;
- b. A nursing facility with a distinct part ventilator unit;
- c. A nursing facility designed as an institution for mental disease;
- d. A dually-licensed pediatric nursing facility;
- e. An intermediate care facility for individuals with an intellectual disability;
- f. Veteran's Affairs (VA) state operated and controlled nursing facility.

Cost Reports for Cost-Based Facilities

With the exception of the VA nursing homes, facilities shall use a uniform cost reporting form for submission at the facility's fiscal year end. The single state agency shall set a uniform rate year for cost-based NF's and ICF-IIDs (July 1-June 30) by taking the latest available cost data which is available as of May 16 of each year and trending the facility costs to July 1 of the rate year. For the VA facilities, the Medicare 2540-10 will be the cost report version used.

1. If the latest available cost report period has not been audited or desk reviewed prior to rate setting, the prospective rates shall be based on cost reports which are not audited or desk reviewed subject to adjustment when the audit or desk review is completed. If desk reviews or audits are completed after May 16, but prior to universal rate setting for the next rate year, the desk review or audited data shall be used.
2. Partial year or budgeted cost data may be used if a full year's data is unavailable. Unaudited reports shall be subject to adjustment to the audited amount.
3. Facilities paid on the basis of partial year or budgeted cost reports shall have their reimbursement settled back to allowable cost.

Allowable Cost

Allowable costs are cost found necessary and reasonable by the single state agency using Medicare Title XVIII-A principles except as otherwise stated in the approved state plan. Bad debts, charity and courtesy allowances for non-Title XIX patients are not included in allowable costs. A return on equity is not allowed.

Methods and standards for Determining Reasonable Cost-Related Payments

The methods and standards for the determination of reimbursement rates to non-Veteran's Affairs nursing facilities and intermediate care facilities for individuals with intellectual disabilities is as described in the Nursing Facility Reimbursement manual which is Attachment 4.19-D, Exhibit B. For VA facilities, the interim rates will be based on a pro-forma cost report until their first full year Medicare cost report is submitted. Thereafter, interim rates will be based on the per diem cost substantiated by the most recently available cost report data.

Payments Rates resulting from Methods and Standards

1. Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.
2. The rates take into account economic trends and conditions since costs are trended to the beginning of the rate year (July 1) and then indexed for inflation for the rate year using Global Insight inflation index.
3. Interim rates are established on July 1 of each year. Interim rates will be adjusted to include the cost of staffing ratio increases, level of service increases, to accommodate changes of circumstances affecting resident patient care, to correct errors in the rates (whether due to action or inaction of the state or the facilities), or to address displacement of residents. Rates shall be adjusted to an audited cost base if an unaudited cost report has been used due to new construction or other specified reasons which requires using an unaudited cost report.
4. The Medicare Upper Payment Limit (UPL) described in Exhibit B, Section 705 of this attachment is subject to increase to take into account any costs incurred to comply with Federal requirements or a combination of Federal and State requirements that were not in effect during the Medicare UPL base year. These requirements are actions that increase costs as a result of staffing ratio increases, level of service increases, to accommodate changes of circumstances affecting patient care, or to address displacement of residents. The increase will be equal to the average per diem cost of complying with such requirements times the total number of Medicaid patient days in the Medicare UPL current year as defined in Exhibit B, Section 705.

-
- a. NF/Brain Injury Units means units recognized by the Medicaid agency as specially designated and identified NF units dedicated to, and capable of, provide care to individuals with severe head injury. Facilities providing preauthorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae means a facility appropriately accredited by a nationally recognized accrediting agency or organization. To participate in Kentucky Medicaid the facility or unit must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

The all-inclusive rate for brain injury unit is \$360 per diem, excluding drugs and physician cost. These claims are to be submitted through the pharmacy and physician's programs. For those residents with brain injury and neurobehavioral sequelae, the per diem is a negotiated rate not to exceed usual and customary charges. This rate excludes drugs and physician costs. These claims shall be submitted through the pharmacy and physician's programs.

- b. Certified distinct part ventilator nursing facility unit means a preauthorized distinct part unit of not less than twenty (20) beds with a requirement that the facility have a ventilator patient census of at least fifteen (15) patients. The patient census shall be based upon the quarter preceding the beginning of the rate year, or upon the quarter precedent the quarter for which certification is requested if the facility did not qualify for participation as a ventilator care unit at the beginning of the rate year. The unit must have a ventilator machine owned by the facility for each certified bed with an additional backup ventilator machine required for every ten (10) beds. The facility must have an appropriate program for discharge planning and weaning from the ventilator. The fixed rate for hospital based facilities is \$460.00 per day, and the fixed rate for freestanding facilities is \$250.00 per day. The rates are to be increased based on the Data Resources Incorporated inflation index for the nursing facility services for each rate year beginning with the July 1, 1997 rate year.

5. The following special classes of nursing facilities are addressed in the Medicaid cost-based methodology regulation and are reimbursed at full reasonable and allowable cost in accordance with methodology described in Attachment 4.19 D, Exhibit B:
 - a. NF/institutions for Mental Diseases (IMD) means facilities identified by the Medicaid agency as providing nursing facility care primarily to the mentally ill.
 - b. NF/Dually licensed pediatric nursing facilities means facilities identified by the Medicaid agency as providing nursing facility care to residents under the age of twenty-one (21).
 - c. ICF-IID-Intermediate Care Facilities for individuals with an intellectual disability means facilities identified by the Medicaid agency as providing care primarily to the mentally retarded and developmentally disabled.
 - d. Veteran's Affairs nursing facilities.
6. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment.
7. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program. A sufficient number of providers assures eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

8. Participation in the program is limited to providers of service who accept, as payments in full, the amounts paid in accordance with the State Plan.
9. Payments will be made by Medicaid for Medicare Part A and Part B coinsurance in accordance with Attachment 4.19 B, Supplement 1.

Price-Based Nursing Facilities

The following facilities are reimbursed by the price-based nursing facility methodology:

- a. A free-standing nursing facility;
- b. A hospital-based nursing facility;
- c. A nursing facility with waiver;
- d. A nursing facility with mental retardation specialty; and
- e. A hospital providing swing bed nursing facility care.

Costs Reports for Price-Based Nursing Facilities

Price-based nursing facilities must submit the latest Medicare cost report and the Medicaid supplement schedules attached to Attachment 4.19-0 Exhibit-B. The Medicaid Supplement Schedules are utilized for statistical data. The Medicare Supplemental Cost Schedules are utilized for historical data.

The Medicare cost report and Medicaid supplement schedules shall be submitted to the Department pursuant to time frames established in HCFA Provider Reimbursement Manual-Part 2 (PUB. 15-11) Section 102, 102.1, 102.3 and 104.

Methods and Standards for Determining Price-based Nursing Facility Payments

The methods and standards for the determination of reimbursement rates to price-based nursing facilities is described in the Nursing Facility Reimbursement manual which is ATTACHMENT 4.19-D, Exhibit B.

Payment Rates Resulting from Methods and Standards

1. Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.
2. The standard price is market-based using historical data, salary surveys and staffing ratios. The standard price accounts for the higher wage rates for the urban area and the slightly lower rates for wages in the rural area.
3. The rate also takes into account a facility specific capital cost component based on an appraisal of each facility and the department shall appraise a price-based Nursing Facility to determine the facility specific capital component again in 2009.
4. The standard price is re-based in 2008 and consists of two components: the "case-mix" adjustable portion and the "non-casemix" adjustable portion.
 - (1) The "case-mix" adjustable portion consists of wages for direct care personnel, cost associated with direct care, and non-personnel operation cost (supplies, etc.).

-
- (2) The "non-case mix" adjustment portion consists of all other facility cost except capital cost.
6. Case-mix is based on data extracted from the Minimum Data Set 2.0 submitted to the state survey agency as required by CMS and the individual facility case-mix is calculated using the Resource Utilization Group (RUG) III version 5.12.
 7. Rates are established prospectively on July 1 of each year and adjusted for "case-mix at the beginning of each quarter during the rate year (January, April, July, and October). A "case-mix" adjustment is the only adjustment made to the rates by the Department.
 8. Other adjustments will not be made to the rates except for errors identified by the Department when computing the rate.
 9. Facilities protection period shall be in effect until June 30, 2002. No price-based nursing facility will receive a rate under the new methodology that is less than their rate that was set on July 1, 1999, adjustment for the facility's "resident acuity". However, nursing facilities may receive increase in rates as a result of the new methodology as the Medicaid budget allows.
 10. Effective January 1, 2003, county owned hospital-based nursing facilities shall not receive a rate that is less than the rate that was in effect on June 30, 2002.
 11. Payments under this methodology must not exceed \$260,997,283 for the period of January 1, 2000 to June 30, 2000.
 12. The Department remains at risk for increases in total nursing facility payments that result from higher utilization of beds by Medicaid recipients. The Department reserves the right to adjust rates, to remain within budgeted amount.

13. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program. A sufficient number of providers assures eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.
14. The Department shall require the submission of the most recent Medicare cost report and the Medicaid Supplemental Schedules included in the manual to be used for historical data.
15. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.
16. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment.
17. Payments will be made by Medicaid for Medicare Part A and Part B coinsurance in accordance with Attachment 4.19-B, Supplement 1.

PUBLIC PROCESS FOR DETERMINING RATES FOR LONG-TERM CARE
FACILITIES

The State has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Beginning April 2, 2001 and ending June 30, 2005, subject to the availability of funds, the Department will make supplemental payments to qualifying nursing facilities on a quarterly basis. The Department will use the following methodology to determine these payments:

- 1) For each state fiscal year, the Department will calculate the maximum addition payments that it can make to non-state government-owned or operated nursing facilities as set forth at 42 CFR Section 447.272 (a)(2) and 42 CFR Section 447.272 (b).
- 2) The Department will use the latest cost report data on file with the Department as of December 31, 2000 to identify the nursing facilities eligible for supplemental payments. To be eligible for supplemental payments the nursing facility must:
 - a) Be a nursing facility owned or operated by a local unit of government;
 - b) Have at least 140 or more Medicaid certified beds; and
 - c) Have Medicaid occupancy at or above 75%.

A qualifying nursing facility is an eligible facility that is owned or operated by a local unit of government that has entered into an Intergovernmental Transfer Agreement with the Commonwealth.

- 3) The Department will determine the amount of supplemental payments it will make to qualifying nursing facilities in a manner not to exceed the upper limit amount as calculated in 1 above.
- 4) Using the cost report data on file as of December 31, 2000, the Department will identify the total Medicaid days reported by the qualifying nursing facilities as identified in 2 above.
- 5) The Department will divide the total Medicaid days for each qualifying county-owned or operated nursing facility as determined in 2 above by the total Medicaid days for all qualifying facilities to determine the payment supplementation factor.
- 6) The Department will apply each qualifying county-owned or operated nursing facility's payment supplementation factor determined in 5 above to the total supplemental payment amount identified in 3 above to determine the payment to be made to each qualifying nursing facility.

Effective for services provided on and after September 1, 2001, the Department will make pediatric supplemental payments on a quarterly basis to qualifying nursing facilities. The Department will use the following methodology to determine these payments:

1. For the period of 9/01/01 through 6/30/02 and annually thereafter (7/01 through 6/30), the Department shall establish a pool of \$550,000 to be distributed to qualified facilities based upon their pro rata share of Medicaid patient days.
2. A nursing facility qualifies for a pediatric supplemental payment if it meets the following criteria:
 - a. Is located within the Commonwealth of Kentucky;
 - b. Has a Medicaid occupancy at or above 85%;
 - c. Provides services only to children under age twenty-one (21); and
 - d. Has forty (40) or more licensed beds.

Reimbursement for SFY 2002- 2003

- A. Excluding nursing facilities with brain injury units, intermediate care facilities for the mentally retarded and developmentally disabled, and state-owned nursing facilities, rates for cost-based nursing facilities will be the rates in effect on June 30, 2002.
- B. Rates for price-based nursing facilities will be established in accordance with the methodology described in Attachment 4.19-D, Exhibit A.

KENTUCKY CASE MIX ASSESSMENT AND REIMBURSEMENT SYSTEM

RESIDENT ASSESSMENT

INTRODUCTION

The Kentucky Department for Medicaid Services is implementing a new reimbursement system for price-based nursing facilities participating in the Medicaid program. These facilities include:

1. A free-standing nursing facility;
2. A hospital-based nursing facility;
3. A nursing facility with waiver;
4. A nursing facility with mental retardation specialty; and
5. A hospital providing swing bed nursing facility care.

The new price-based reimbursement methodology will consist of a reasonable standard price set for a day of service for rural and urban facilities. This should provide an incentive to providers to manage costs efficiently and economically.

The standard price includes:

1. Standardized wage rates;
2. Staffing *ratios*;
3. Benefits and absenteeism factors; and
4. "Other cost" percentages.

The new price-based reimbursement methodology is dependent on the specific care needs of each Medicaid and dually eligible Medicare resident in a nursing facility. The new methodology will base the resident acuity using the Minimum Data Set (MDS) 2.0 as the assessment tool. The Resource Utilization Group (RUGs) is the classification tool to place resident into different case-mix groups necessary to calculate the "casemix score". This methodology is based on a snapshot of facility's acuity on a particular point in time.

This methodology entails a re-determination of a facility's mix of residents each quarter in order to establish a new facility specific nursing rate on a quarterly basis.

One of the objectives of the new case-mix system is to mirror the resident assessment process used by Medicare and therefore not require the facilities to use two case-mix assessment tools to determine resident acuity. The second objective for using the MDS 2.0 and RUGS III is to improve reimbursement for facilities providing services for residents with higher care needs in order to improve access to care for those recipients.

1. There will be two major categories for the standard price:
 - a. Case-mix adjustable portion includes wages for personnel that provide or are associated with direct care and non- personnel operation costs (supplies, etc). The case-mix adjustable portion will be separated into urban and rural designations based on Metropolitan Statistical Area definitions; and
 - b. Non case-mix adjustable portion of the standard price includes an allowance to offset provider assessment, food, non-capital facility related cost, professional supports and consultation, and administration. These costs are reflected on a per diem basis and will be based on Metropolitan Statistical Area definitions.

Effective July 1, 2004, rates are increased \$7.60 per day.
2. Each July 1 the rate will be increased by an inflation allowance using the appropriate Data Resource Incorporated (DRI) Index for inflation. The DRI will not be applied to the capital cost component.

4. Capital Cost Add-on:

Each nursing facility will be appraised by November 30, 1999 and the department shall appraise a price-based NF to determine the facility specific capital component again in 2009. The appraisal contractor will use the E. H. Boeckh Co. Evaluation System for facility depreciated replacement cost. The capital cost component add-on will consist of the following limits:

- a. Forty thousand dollars per licensed bed;
- b. Two thousand dollars per bed for equipment;
- c. Ten percent of depreciated replacement cost for land value;
- d. A rate of return will be applied, equal to the 20 year Treasury bond plus a 2% risk factor, subject to a 9% floor and 12% ceiling; and
- e. In order to determine the facility-specific per diem capital reimbursement, the department shall use the greater of actual bed days or bed days at 90%.

5. Renovations to nursing facilities in non-appraisal years:

- a. For facilities that have 60 or fewer beds, re-appraisals shall be conducted if the total renovation cost is \$75,000 or more.
- b. For facilities that have more than 60 beds, re-appraisal shall be conducted if the total renovation cost is \$150,000.

6. Facilities Protection Period:

- a. Rate Protection — Until July 1, 2002, no NF shall receive a rate under the new methodology that is less than their rate that was set in July 1, 1999 unless a facility's resident acuity changes. However, NFs may receive increases in rates as a result of the new methodology as the Medicaid budget allows.
- b. Case Mix — Until July 1, 2000, no facility will receive an average case-mix weight lower than the case-mix weight used for the January 1, 1999 rate setting. After July 1, 2000 the facility shall receive the case-mix weight as calculated by RUGs III from data extracted from MDS 2.0 information.
- c. Effective January 1, 2003, county owned hospital-based nursing facilities shall not receive a rate that is less than the rate that was in effect on June 30, 2002.

7. Case-mix Rate Adjustments. Rates will be recomputed quarterly based on revisions in the case mix assessment classification that affects the Nursing Services components.

8. Case-mix rate adjustment will be recomputed should a provider or the department find an error.

TABLE OF CONTENTS

SECTION 100.	INTRODUCTION TO PRICE-BASED REIMBURSEMENT SYSTEM	Page 6
SECTION 110.	PARTICIPATION REQUIREMENTS	Page 7
SECTION 120.	PAYMENTS FOR SERVICES TO MEDICARE! MEDICAID RESIDENTS	Page 8
SECTION 130.	PRICE-BASED NF REIMBURSEMENT METHODOLOGY	Page 8
SECTION 140.	PRICE-BASED NF REIMBURSEMENT CALCULATION	Page 12
SECTION 150.	ON-SITE REVIEWS AND VALIDATION	Page 14
SECTION 160.	LIMITATION ON CHARGES TO RESIDENTS	Page 14
SECTION 170.	REIMBURSEMENT FOR REQUIRED SERVICES UNDER THE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR)	Page 15
SECTION 180.	NF PROTECTION PERIOD AND BUDGET CONSTRAINTS	Page 15
SECTION 190.	ANCILLARY SERVICES	Page 16
SECTION 200.	REIMBURSEMENT REVIEW AND APPEAL	Page 16
SECTION 210.	COST REPORT INSTRUCTIONS FOR PRICE-BASED	Page 17
SECTION 1.	SCHEDULE NF-1 - PROVIDER INFORMATION	Page 17
SECTION 2.	SCHEDULE NF-2 - WAGE AND SALARY INFORMATION	Page 17
SECTION 3.	SCHEDULE NF-3 - STAFF INFORMATION	Page 18
SECTION 4.	SCHEDULE NF-7 - ALLOCATION STATISTICS	Page 20
SECTION 5.	SCHEDULE NF-8 - MISCELLANEOUS INFORMATION	Page 21

SECTION 220.	INTRODUCTION TO COST-BASED REIMBURSEMENT SYSTEM	Page 22
SECTION 230.	PARTICIPATION REQUIREMENT	Page 23
SECTION 240.	REIMBURSEMENT FOR REQUIRED SERVICES UNDER THE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR) FOR VENTILATOR UNITS, BRAIN INJURY UNITS, IMD'S, AND PEDIATRIC FACILITIES	Page 23
SECTION 250.	LIMITATION ON CHARGES TO RESIDENTS	Page 23
SECTION 260.	ROUTINE COST	Page 24
SECTION 270.	ANCILLARY SERVICES	Page 26
SECTION 280.	INFLATION FACTOR	Page 27
SECTION 290.	PROSPECTIVE RATE COMPUTATION	Page 28
SECTION 300.	ADJUSTMENT TO PROSPECTIVE RATE	Page 28
SECTION 310.	RATE ADJUSTMENT FOR PROVIDER TAX	Page 30
SECTION 320.	OTHER OBRA NURSING HOME REFORM COST	Page 30
SECTION 330.	PAYMENT OF SPECIAL PROGRAMS CLASSES	Page 31
SECTION 340.	PAYMENT FOR ANCILLARY SERVICES	Page 32
SECTION 350.	RETROACTIVE ADJUSTMENT FOR ROUTINE SERVICES	Page 33
SECTION 360.	RETROACTIVE ADJUSTMENT FOR ANCILLARY SERVICES	Page 34
SECTION 370.	PAYMENTS FOR SERVICES TO MEDICARE! MEDICAID RESIDENTS	Page 36
SECTION 380.	RETURN ON EQUITY OF PROPRIETARY PROVIDERS	Page 36
SECTION 390.	DESK REVIEW AND FIELD AUDIT FUNCTION	Page 36
SECTION 400.	REIMBURSEMENT REVIEW AND APPEAL	Page 37
SECTION 410.	INTRODUCTION TO PROVIDER COST THAT ARE REIMBURSABLE	Page 37
SECTION 420.	ADEQUATE COST DATA	Page 38
SECTION 430.	APPORTIONMENT OF ALLOWABLE COST	Page 40
SECTION 440.	COST REPORTING	Page 40

SECTION 450.	BASIS OF ASSETS	Page 41
SECTION 460.	DEPRECIATION EXPENSE	Page 42
SECTION 470.	INTEREST EXPENSE	Page 43
SECTION 480.	FACILITY LEASE OR RENT ARRANGEMENTS	Page 47
SECTION 490.	CAPITAL LEASE	Page 48
SECTION 500.	AMORTIZATION OF ORGANIZATION AND START-UP COSTS	Page 48
SECTION 510.	ACCELERATED DEPRECIATION TO ENCOURAGE REFINANCING	Page 48
SECTION 520.	BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES	Page 49
SECTION 530.	COST OF EDUCATIONAL ACTIVITIES	Page 50
SECTION 540.	RESEARCH COSTS	Page 51
SECTION 550.	GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS	Page 51
SECTION 560.	VALUE OF SERVICES OF NON PAID WORKERS	Page 51
SECTION 570.	PURCHASE DISCOUNTS AND ALLOWANCE AND REFUNDS OF EXPENSES	Page 53
SECTION 580.	COST TO RELATED ORGANIZATIONS	Page 53
SECTION 590.	DETERMINATION OF ALLOWABLE COST OF SERVICES, SUPPLIES, AND EQUIPMENT	Page 55
SECTION 600.	COST RELATED TO RESIDENT CARE	Page 56
SECTION 610.	REIMBURSEMENT FOR SERVICES OF PHYSICIANS	Page 56
SECTION 620.	MOTOR VEHICLES	Page 56
SECTION 630.	COMPENSATION OF OWNERS	Page 57
SECTION 640.	OTHER COSTS	Page 61
SECTION 650.	ANCILLARY COST	Page 62
SECTION 660.	UNALLOWABLE COSTS	Page 63
SECTION 670.	SCHEDULE OF IMPLEMENTATION	Page 64
SECTION 680.	INTRODUCTION TO THE COST-BASED PAYMENT SYSTEM	Page 64

SECTION 690.	OCCUPANCY LIMITATION EXCEPTIONS	Page 65
SECTION 700.	DEFINITION OF ROUTINE AND ANCILLARY SERVICES	Page 65
SECTION 710.	LEASE OR RENT ARRANGEMENTS	Page 65
SECTION 720.	ALLOWABLE COST BASIS ON PURCHASE OF FACILITY AS AN ONGOING OPERATION	Page 65
SECTION 730.	INTEREST EXPENSE - EXCEPTION TO BORROWER LENDER RELATIONSHIP	Page 65
SECTION 740.	REIMBURSEMENT FOR SERVICES OR PHYSICIANS, DENTISTS, AND HOSPITALS	Page 66
SECTION 750.	EDUCATIONAL COST	Page 66
SECTION 760.	PURCHASE AND DISPOSAL OF SPECIALIZED MEDICAL EQUIPMENT	Page 67
SECTION 770.	INTRODUCTION TO INSTITUTE FOR MENTAL DISEASE	Page 67
SECTION 780.	DEFINITION	Page 68
SECTION 790.	INTRODUCTION TO DUAL LICENSE PEDIATRIC FACILITY	Page 68
SECTION 800.	DEFINITION	Page 68
SECTION 810.	INTRODUCTION TO THE COST-BASED NURSING FACILITY COST REPORT	Page 69
SECTION 1.	SCHEDULE A - CERTIFICATION AND OTHER DATA	Page 69
SECTION 2	SCHEDULE B - STATEMENT OF INCOME AND EXPENSE	Page 70
SECTION 3.	SCHEDULE C - BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL	Page 71
SECTION 4.	SCHEDULE C 1 ADJUSTMENT TO EQUITY CAPITAL	Page 73
SECTION 5.	OVERVIEW OF THE ALLOCATION PROCESS - SCHEDULE D-1 THROUGH D-5	Page 73
SECTION 6.	SCHEDULE D-1 - NURSING SERVICES COST	Page 75
SECTION 7.	SCHEDULE D-2 - OTHER CARE RELATED COSTS	Page 76

SECTION 8.	SCHEDULE D-3 - OTHER OPERATING COST	Page 78
SECTION 9.	SCHEDULE D-4 - CAPITAL COST	Page 79
SECTION 10.	SCHEDULE D-5 - ANCILLARY COSTS	Page 80
SECTION 11.	SCHEDULE D-6 - RECLASSIFICATION OF EXPENSES	Page 81
SECTION 12.	SCHEDULE D-7 -ADJUSTMENT TO EXPENSES	Page 81
SECTION 13.	SCHEDULE E - ANCILLARY SERVICES	Page 82
SECTION 14.	SCHEDULE F - ALLOCATION STATISTICS	Page 82

SECTION 100. INTRODUCTION TO PRICE- BASED REIMBURSEMENT SYSTEM

- A. January 1, 2000, a price-based reimbursement system will be implemented to reimburse a nursing facility (NF), a nursing facility with waiver (NF-W), a hospital based nursing facility (NF-HB) and a nursing facility with a mental retardation specialty (N F-MRS Beginning).
- B. The price-based system is a reimbursement methodology based on a standard price set for a day of service as opposed to reimbursing facilities based on the latest submitted cost report. The standard price is based on reasonable, standardized wage rates, staffing ratios, benefits and absenteeism factors and 'other cost' percentages.
- C. A rate model was developed which resolves issues inherent in the current system reflects current reimbursement methodology trends and satisfies the needs of the Department and the Provider community. The goal of the price-based methodology was to develop a uniform, acuity adjustment rate structure that would pay a nursing facility the same reimbursement for the same type of resident served. This rate structure accounts for resource utilization and allows rates to increase annually by an appropriate inflationary factor. The rate model is market based and accounts for the higher wage rates urban facilities must pay their employees; therefore the urban average rate is slightly higher than the rural. The rate does not distinguish between hospital based and freestanding facilities.
- D. This payment method is designed to achieve three major objectives:
 - 1. To assure that needed nursing facility care is available for all eligible recipients including those with higher care needs; and,
 - 2. To provide an equitable basis for both urban and rural facilities to participate in the Program; and,
 - 3. To assure Program control and cost containment consistent with the public interest and the required level of care.
- E. The system is designed to provide a reasonable reimbursement for providers serving the same type of residents in the nursing facility and to provide for a reasonable rate of return on the provider's investment.

-
- F. The price-based model reimbursement methodology provides for a facility specific capital cost add-on calculated using the E.H. Boeckh System, a commercial valuation system that estimates the depreciated and non-depreciated replacement cost of a facility.
 - G. The Office of Inspector General has required the submission of the Minimum Data Set (MDS) since 1992 and DMS sought to use a tool familiar to the nursing facility industry in order to calculate case-mix. The case-mix portion of the rate will utilize the MDS 2.0 and the Resource Utilization Group (RUG) III to calculate the individual facility's average case-mix.
 - H. The case-mix portion of the rate will be adjusted quarterly to reflect the facility's most recent case-mix assessment and to adjust the direct care and non-personnel operation costs (supplies, etc.) portion of the standard price for the current quarter.

SECTION 110. PARTICIPATION REQUIREMENTS

- A. The facilities referenced in Section one hundred (100) shall be reimbursed using the methodology described in 907 KAR 1:065. These facilities shall be licensed by the state survey agency (Office of Inspector General) for the Commonwealth of Kentucky and certified for Medicaid participation by the Department for Medicaid Services.
- B. A nursing facility, except a nursing facility with waiver, choosing to participate in the Medicaid Program will be required to have twenty (20) percent of its Medicaid certified beds participate in the Medicare program or ten (10) of its Medicaid beds participating in the Medicare program whichever is greater. If the NF has less than ten (10) beds all of its beds shall participate in the Medicare Program.
- C. The Medicaid Program shall reimburse all Medicaid beds in a nursing facility at the same rate. The Medicaid rate established for a facility is the average rate for all Medicaid participating beds in that individual facility.

SECTION 120. PAYMENTS FOR SERVICES TO MEDICARE/MEDICAID RESIDENTS

- A. Dually eligible residents and residents eligible for both Medicare and Medicaid (non-QMB) shall be required to Exhaust any applicable benefits under Title XVIII (Part A and Part B) prior to coverage under the Medicaid Program.
- B. APPLICATION. Services received by a resident that are reimbursable by Medicare shall be billed first to the Medicare Program. Any appropriate co-insurance or deductible payment due from the Medicaid Program shall be paid outside the Cost-based facility Cost-Related Payment System in a manner prescribed by the Department for Medicaid Services. Coinsurance and deductible payments shall be based on rates set by the Medicaid Program. A day of service covered in this manner shall be considered a Medicare resident day and shall not be included as a Medicaid resident day in the facility cost report.

SECTION 130. PRICE-BASED NF REIMBURSEMENT METHODOLOGY

- A. The price-based nursing facility reimbursement methodology reflects the differential in wages, property values and cost of doing business in rural and urban designated areas This results in two standard rates, a standard rate reflecting the lower wages for the rural facilities and a slightly higher rate for the urban facilities.
- B. The rural and urban designated areas are based on the "Metropolitan Statistical Area (MSA) designating the urban population centers based on the national census and updated on a yearly basis, as published by the Federal Office of Management and Budget.
- C. In order to determine the standard rates for urban and rural facilities, the department utilized an analysis of fair-market pricing and historical cost for staffing ratios, wage rates, cost of administration, food, professional support, consultation, and non-personnel operating expenses as a percentage of total cost.
- D. The standard price is comprised of the following components and percentages of the total rate:
 - 1. Personnel 65%

-
2. Non-personnel operating 6%;
 3. Administration 13%;
 4. Food 4%;
 5. Professional supports & consultation 2%;
 6. Non-capital facility related cost 3%; and
 7. Capital rate 7%.
- E. The standard price shall be re-based in 2008 and adjusted for inflation every July 1.
- F. A portion of the standard price for both urban and rural facilities Will be adjusted each calendar quarter for "case-mix". The "case-mix" adjusted portion shall include the following:
1. The personnel cost of a:
 - (a) DON-Director of Nursing;
 - (b) RN-Registered Nurse;
 - (c) LPN-Licensed Practical Nurse;
 - (d) Nurse Aide;
 - (e) Activities worker; and
 - (f) Medical records director.
 2. The non-personnel operating cost including:
 - (a) Medical supplies; and
 - (b) Activity supplies.
- G. The "non-case-mix" portion of the standard price shall not be adjusted for case mix and includes:
1. Administration;
 2. Non-direct care personnel;
 3. Food;
 4. Non-capital related costs;
 5. Professional support;
 6. Consultation;
 7. Capital cost component; and
 8. An allowance to offset a provider assessment.

-
- H. The capital cost component shall be an “add-on” to the non case-mix” adjusted portion of the rate.
- I. Ancillaries are services for which a separate charge is submitted and include:
1. Speech Therapy;
 2. Occupational Therapy;
 3. Physical Therapy;
 4. Oxygen Services;
 5. Laboratory; and
 6. X-ray.
- J. Ancillary therapy services are reimbursed pursuant to 907 KAR 1:023.
- K. Oxygen concentrator limitations. Effective October 1, 1991, the allowable cost of oxygen concentrator rentals shall be limited as follows:
1. A facility may assign a separate concentrator to any resident who has needed oxygen during the prior or current month and for whom there is a doctor’s standing order for oxygen. For the charge by an outside supplier to be considered as an allowable cost, the charge shall be based upon actual usage. A minimum charge by an outside supplier is allowable if this charge does not exceed twenty-five (25) percent of the Medicare Part B maximum. The minimum charge is allowable if the concentrator is used less than an average of two (2) hours per day during the entire month (for example, less than 60 hours during a thirty (30) day month). The maximum allowable charge by the outside supplier shall not exceed one hundred (100) percent of the Medicare Part B maximum. For the maximum charge to a facility to be considered as the allowable cost, the concentrator shall have been used on average for a period of at least eight (8) hours per day for the entire month (for example, 240 hours during a thirty (30) day month). In those cases where the usage exceeds that necessary for the minimum charge and is less than the usage required for the maximum charge, the reimbursement shall be computed by dividing the hours of usage by

240 and then multiplying the result of this division by the Medicare Part B maximum charge. For example, if a concentrator is used less than 220 hours during a thirty (30) day month and the maximum Part B allowable charge is \$250.00; then the allowable charge is computed by dividing the 220 hours by 240 hours and then multiplying the product of this division by \$250.00 to obtain the allowable charge of \$229.17. Allowable oxygen costs outlined in this paragraph shall be considered to be ancillary costs.

2. A facility shall be limited to one (1) standby oxygen concentrator for each nurses' station. The Medicaid Services Program may grant waivers of this limit. This expense shall be considered as a routine nursing expense for any month in which there is no actual use of the equipment. The allowable cost for standby oxygen concentrators shall be limited to twenty-five (25) percent of the maximum allowable payment under Medicare Part B for in home use.

NOTE: Drugs for residents in nursing facilities shall be reimbursed through the pharmacy program.

L. The department shall adjust the Standard Price if:

1. A government entity imposes a mandatory minimum wage or staffing ratio increase and the increase was not included in the DRI; or
2. A new licensure requirement or new interpretation of an existing requirement by the state survey agency that results in changes that affect all facilities within the class. The provider shall document

that a cost increase occurred as a result of licensure requirement or policy interpretation.

3. The provider- shall submit any documentation required by the department.

SECTION 140. PRICE- BASED NF REIMBURSEMENT CALCULATION

- A. For each calendar quarter, based on the classification of urban and rural, the department shall calculate an individual NF's price-based rate to be the sum of:
 1. The case-mix adjustable portion of a NF Standard Price, adjusted by the individual NF's current average case-mix index. Except that until June 30, 2000 the average case-mix index shall be the greater of the current average case-mix index or the case-mix average calculated as a ratio of the facility's case-mix index to the statewide average case-mix index that would have been used for January 1, 2000 rate setting. After July 1, 2000 the individual NF's actual average case-mix shall be used in the rate calculation; and
 2. The non-case-mix adjustable portion of the assigned total Standard Price and the capital cost component.
- B. A capital cost component shall be calculated on an individual facility basis based on the facility appraisal completed in November 1999. Reappraisal shall be conducted and utilized to determine the facility specific capital component. The department shall appraise a price- based NF to determine the facility specific capital component again in 2009. The Department shall contract with a certified appraisal company to perform the appraisal using the E.H. Boeckh Valuation System. The appraisal is based on the depreciated replacement value of the individual facility. The same Appraisal Company shall perform any re-appraisal that may be requested by a facility within that five-year period.
- C. A facility may request a re-appraisal within five years should renovations or additions have a minimum total cost of \$150,000 for facilities with more than sixty (60) licensed beds. For facilities having sixty (60) or less licensed beds, the total renovation or addition must be a

minimum total cost of \$75,000. The individual NF shall submit written proof of construction cost to the department in order to request a reappraisal. The individual NF shall reimburse the department's contracted appraisal company for the cost of the appraisal. The department shall reimburse the facility the cost of the appraisal or re-appraisal upon receipt of a valid copy of the paid invoice from the Appraisal Company.

- D. A capital cost component shall be calculated on an individual facility basis. A capital cost component based on the results of the appraisal shall be the total of the average licensed bed value and ten (10) percent of the licensed bed value for land on which the NF is built. To this sum, add two thousand dollars per licensed bed for equipment. To determine the rate of return for capital cost, multiply the sum of the preceding paragraph by the yield on a twenty (20) year Treasury bond plus a risk factor of two (2) percent. The rate of return shall be no less than nine (9) percent or greater than twelve (12) percent per state fiscal year. The final calculation to determine the individual NF's capital cost component shall be the product of the rate of return calculation divided by the total number of NF bed days as calculated in paragraph F of this section.
- E. To determine the average licensed bed value, the depreciated replacement cost of the NF shall be divided by the total number of licensed beds in the NF with the following limitations:
1. The average bed value shall not exceed \$40,000; and
 2. Shall exclude:
 - (a) Equipment; and
 - (b) Land,
- F. NF bed days used in the capital cost rate calculation shall be based on actual bed occupancy, except that the occupancy rate shall not be less than ninety (90) percent of certified bed days.
- G. The department shall utilize a rate of return for capital costs that shall be equal to the yield on a twenty (20) year Treasury bond as of the first business day on or after May 31 of each year. Should a change of ownership occur pursuant to 42 CFR 447.253 (2)(d), the new owner shall continue to receive the capital

cost rate of the previous owner unless the NF is eligible for re-appraisal pursuant to section IV B of this manual.

SECTION 150. ON-SITE REVIEWS AND VALIDATION

- A. On a quarterly basis, beginning January 1, 2000 the department shall perform an on-site review of the NF. The review will consist of a minimum of ten (10) percent of the MDS assessments completed by the NF. The department shall validate the MDS assessments by using the Long Term Care Facility Resident Assessment Instrument User's Manual.
- B. Should the department invalidate a NF's MDS, the NF may appeal the findings of the department within seven (7) business days. The department shall receive a written request by the NF that the department reconsider the invalidation. The department shall conduct the second validation with seven (7) business days of receipt of the request and notify the provider in writing of the decision. A provider may appeal the second validation per 907 KAR 1:671, Sections 8 and 9.

SECTION 160. LIMITATION ON CHARGES TO RESIDENTS.

- A. Except for applicable deductible and coinsurance amounts, a NF that receives reimbursement for a Medicaid resident shall not charge a resident or his representative for the cost of routine or ancillary services.
- B. A NF may charge a resident or his representative for an item if the resident requests the item and the NF informs the resident in writing that there will be a charge. A NF shall not charge a resident for an item or service if Medicare or Medicaid pays for the item pursuant to 42 CFR 483.1 0(c)(8)(ii).
- C. A NF shall not require a resident or an interested party to request any item or services as a condition of admission or continued stay. A NF shall inform the resident or an interested party requesting an item or service that a charge will be made in writing that there will be a charge and the amount of the charge.
- D. A NF may charge a resident for the cost of reserving a bed if requested by resident or interested party after the fourteenth (14th) day of a temporary absence from the facility pursuant to 907 KAR 1:022.

-
- E. Durable medical equipment (DME) and supplies shall be furnished by the NF and not be billed to the department under separate DME claim pursuant to 907 KAR 1:479.

SECTION 170. REIMBURSEMENT FOR REQUIRED SERVICES UNDER TEE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR).

- A. Prior to admission of an individual, a price-based NF shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.
- B. The department shall reimburse a NF for services delivered to an individual if the NF complies with the requirements of 907 KAR 1:755.
- C. Failure to comply with 907 KAR 1:755 may be grounds for termination of the NF's participation in the Medicaid Program.

SECTION 180. NF PROTECTION PERIOD AND BUDGET CONSTRAINTS

- A. For the period of January 1, 2000 through June 30, 2002, a NF shall not receive a rate that is less than the rate that s set for the NF pursuant to 907 KAR 1:025E on July 1, 1999, including any capital cost and extenuating circumstances add-ons.
- B. The department shall monitor payments on a monthly basis to ensure that aggregate payments made to NF's do not exceed the appropriated funds in fiscal years 2000 through 2002.
- C. In order to monitor the payments, the department shall on a monthly basis notify the industry's representatives in writing the total payment amount for the preceding month.
- D. The department shall also place on the Medicaid Internet site the amount of payment in aggregate to the NF's for the preceding month and the cumulative amount paid for the current state fiscal year.

SECTION 190. ANCILLARY SERVICES

- A. The department shall reimburse for an ancillary service that meets the criteria established in 907 KAR 1:023 utilizing the corresponding outpatient procedure code rate listed in the Medicaid Physicians Resource Based Relative Value Scale fee schedule.
- B. The department shall reimburse for an oxygen therapy utilizing the durable medical equipment fee schedule.
- C. Respiratory therapy and respiratory therapy supplies shall be considered in the routine services per diem rate.
- D. The department shall calculate an add-on amount in accordance with 907 KAR 1:065, Section 12, to be in effect from November 1, 2003 through June 30, 2004, to a nursing facility's routine services per diem rate if the nursing facility incurred cost providing respiratory therapy or respiratory therapy supplies for the period July 1, 2003 through September 30, 2003.
- E. A nursing facility shall submit documentation requested by the department in order to apply for a routine services per diem add-on in accordance with 907 KAR 1:065, Section 12.

SECTION 200. REIMBURSEMENT REVIEW AND APPEAL

A NF may Appeal department decisions as to the application of this regulation as it impacts the NF's price-based reimbursement rate in accordance with 907 KAR 1:671, Section 8 and 9.

SECTION 210. COST REPORT INSTRUCTIONS FOR PRICE-BASED

All Medicaid Supplemental Schedules must be accompanied by a working trial balance and audited financial statements (if applicable).

SECTION 1. SCHEDULE NF-1 - PROVIDER INFORMATION

Enter in the appropriate information. Choose whether the cost report is in a leap year or a regular 365 day year. Note that the cost report must have an original signature by an officer or administrator of the facility.

SECTION 2. SCHEDULE NF-2 -- WAGE AND SALARY INFORMATION

This schedule records a facility's labor costs.

- A. The pay period starting date should be the first day of the first payroll period in the provider's fiscal year. Likewise, the end date shall be the final day of the last payroll period in the fiscal year.
- B. Under wage information, the hours paid includes vacation pay, sick leave, bereavement, shift differential and holidays in *addition to* time engaged in for regular business activity. Hours worked, in contrast, are only those hours that the employee spent at the facility in normal work duties. Wages paid should include all compensation paid to the employee, including time worked, time in training, vacation, and sick time.
- C. Expenses incurred with outside businesses for temporary-nursing staff should be placed under contracted services. For each nursing category, enter the hours worked by the contract employees and the amount charged by the contracting business for wages paid. Hours paid and hours worked will differ only if the contract staff engaged in training while being employed at the facility.
- D. Benefits paid by the facility for *all employees* (nursing staff, administrative, etc.) should be included under Section C: the facility's contribution for health insurance, life insurance, etc. would be listed under these categories.

SECTION 3. SCHEDULE NF- 3- STAFF INFORMATION

On an annual basis the Department for Medicaid Services shall select a seven-day period in which the facility records information regarding their staffing levels and patient days.

- A. Record the number of residents in your facility in the Resident Census section. This includes only those full-time residents in the certified nursing facility section.
- B. For each of the staff categories, record the number of staff on duty. Contract staff should be included in this category.
- C. Continue this throughout the seven-day survey period.

SECTION 4. SCHEDULE NF- 7— ALLOCATION STATISTICS

A. Section A - Ancillary Charges

1. Column 1. Enter the total charges for each type of ancillary service on Line I through 6. The sum of lines 1 through 6 are totaled on line 7.
2. Column 2. Enter the total charges for each type of ancillary service provided to KMAP patients in certified beds on lines 1 through 6. Lines 1 through 6 a summed and totaled on line 7.
3. Column 3. The Medicaid percentage in column 3 is calculated by dividing KMAP charges in column 2 by total charges in column 1. Percentages shall be carried to four decimal places (i.e., XX.XXXX%).

B. Section B - Occupancy Statistics.

Certified Nursing Facility. Use the Bed Days Available worksheet on Box C to complete lines 1, 2, and 3. For line 4, enter in the Total Patient Days provided to all certified nursing facility residents. On line 6, enter in the KMAP Patient Days.

C. Non-Certified and Other Long-Term Care

1. Lines 1 and 2. Enter the number of licensed beds at the beginning and end of the fiscal year. Temporary changes due to alterations, painting, etc., do not affect bed capacity.
2. Line 3. Total licensed bed days available shall be determined by multiplying the number of beds in the period by the number of days in the period. Take into account increases and decreases in the number of licensed beds and the number of days elapsed since the changes. If actual bed days are greater than licensed bed days available, use actual bed days.
3. Line 4. Total patient days should be entered in.

SECTION 5. SCHEDULE NF- 8- MISCELLANEOUS INFORMATION

All providers must complete section A and B.

- A. A NF shall submit a Medicare cost report and Medicaid supplement schedule pursuant to HCFA Provider Reimbursement Manual - Part 2 (Pub. 15-11) Section 102, 102.1, 102.3 and 104 included in this manual.
- B. A copy of a NF's Medicare cost report for the most recent fiscal year end.
- C. A completed copy of the Medicaid supplemental schedules included in this manual shall also be submitted with the NE's Medicare cost report.
- D. A cost reports financial data related to routine services shall be used for statistical purposes.

SCHEDULE NF-1
PROVIDER INFORMATION

PROVIDER NAME:

PROVIDER NUMBER:

Period from: _____ to _____

Leap Year 365
 366

Street
Address

P. O. Box

City

State

Zip Code

Phone

Fax

Officer of Facility

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medicaid Cost Report for the period ended 01/01/2000 and to the best of my knowledge and belief, they are true and accurate statements prepared from the books and records of _____ in accordance with applicable program directives, except as noted.

(Print) _____
 Officer or Administrator of Facility

(Signed) _____
 Officer or Administrator of Facility

 Title

SCHEDULE NF-2
 WAGE AND SALARY INFORMATION

PROVIDER NAME:
 PROVIDER NUMBER:

FYE: 01/01/2000

Pay period start date: _____ End date: _____

A. Wage Information			
Cost Category	Hours Paid	Hours Worked	Wages Paid
A. RN	0	0	\$0
B. LPN	0	0	\$0
C. Aides	0	0	\$0
D. Director of Nursing	0	0	\$0
E. Activities	0	0	\$0
F. Medical Records	0	0	\$0
G. Dietary	0	0	\$0
H. Housekeeping/Laundry	0	0	\$0
I. Social Services	0	0	\$0
J. Maintenance	0	0	\$0
Total	0	0	\$0

B. Contracted Services			
Cost Category	Hours Paid	Hours Worked	Wages Paid
A. RN	0	0	\$0
B. LPN	0	0	\$0
C. Aides	0	0	\$0
Total	0	0	\$0

C. Benefits Paid for by Nursing Facility	
Totals taken from FYE 01/01/2000	
Health Insurance	\$0
Life Insurance	\$0
Retirement	\$0
Workers Compensation	\$0
FICA	\$0

SCHEDULE NF-3
STAFF INFORMATION

FYE: 01/01/2000

PROVIDER NAME:
PROVIDER NUMBER

Effective Date 1-1-00

Approved Date Aug 10, 2001

TN No. 00-04
Supersedes
TN No. 96-10

Patient Census	Number of Patient Days						
	09/13/99	09/14/99	09/15/99	09/16/99	09/17/99	09/18/99	09/19/99
	0	0	0	0	0	0	0
Number of Staff on Payroll							
Staff Category	09/13/99	09/14/99	09/15/99	09/16/99	09/17/99	09/18/99	09/19/99
RN							
RN Staffing – Day	0	0	0	0	0	0	0
RN Staffing – Evening	0	0	0	0	0	0	0
RN Staffing – Overnight	0	0	0	0	0	0	0
LPN							
LPN Staffing - Day	0	0	0	0	0	0	0
LPN Staffing – Evening	0	0	0	0	0	0	0
LPN Staffing–Overnight	0	0	0	0	0	0	0
Aides							
Aide Staffing – Day	0	0	0	0	0	0	0
Aide Staffing – Evening	0	0	0	0	0	0	0
Aide Staffing - Overnight	0	0	0	0	0	0	0
Food Service							
Food Service Workers – Day	0	0	0	0	0	0	0
Food Service Workers – Evening	0	0	0	0	0	0	0
Support Personnel							
Housekeeping/Laundry Service Workers	0	0	0	0	0	0	0
Social Services Worker	0	0	0	0	0	0	0
Activities Worker	0	0	0	0	0	0	0
Medical Records Worker	0	0	0	0	0	0	0
Maintenance Worker							
Director of Nursing							

SCHEDULE NF-7
 ALLOCATION STATISTICS

PROVIDER NAME:
 PROVIDER NUMBER:

FYE: 01/01/2000

Ancillary Charges	(1) TOTAL	(2) MEDICAID	(3) MEDICAID %
PHYSICAL THERAPY	\$0	\$0	0.0000%
X-RAY	\$0	\$0	0.0000%
LABORATORY	\$0	\$0	0.0000%
OXYGEN/RESP. THERAPY	\$0	\$0	0.0000%
SPEECH	\$0	\$0	0.0000%
OCCUPATIONAL THERAPY	\$0	\$0	0.0000%
TOTAL	\$0	\$0	

OCCUPANCY STATISTICS	(1)	(2)	(3)
LICENSED BEDS AT BEGINNING OF PERIOD	0	0	0
LICENSED BEDS AT END OF PERIOD	0	0	0
????? OCCUPANCY	0	0	0
????? PATIENT DAYS	0		
???? KMAP OCCUPANCY	0		

BED DAYS AVAILABLE – CERTIFIED NURSING FACILITY ONLY

Beginning Date	Ending Date	Days		Beds	=	Bed Days Available
		0	X	0	=	
		0	X	0	=	
		0	X	0	=	
		0	X	0	=	
		0	X	0	=	
		0	X	0	=	
		0	X	0	=	
				TOTAL BED DAYS AVAILABLE		0

TN # 00-04
 Supersedes
 TN 96-10

Approved Date Aug 10, 2001

Eff. Date 01-1-00

SCHEDULE NF-8
MISCELLANEOUS INFORMATION

PROVIDER NAME:
PROVIDER NUMBER:

TFY: 07/01/2000

Current Ownership

List the current owners and the percent owned. If the facility is corporately owned, list the officers of the company and their respective title.

Name	Percent Owned
------	---------------

Has the facility had a change of ownership in the past fiscal year? Change of ownership is defined as the transfer of the assets of a facility. The sale of stock in a facility does not constitute a change in ownership.

Yes No

If yes, indicate the new owners and the percent owned. If the facility is corporately owned, list the officers of the company and their respective title.

Name	Percent Owned
------	---------------

TN # 00-04
Supersedes
TN # 96-10

Approved Date: Aug 10, 2001

Eff. Date: 1-1-00

SECTION 220. INTRODUCTION TO COST-BASED REIMBURSEMENT SYSTEM

- A. The Department for Medicaid Services has established a prospective reimbursement system for costs-based facilities. Cost based facilities include the following:
1. Institutions for Mental Diseases (IMD's);
 2. Pediatric Nursing Facilities; and
 3. Intermediate Care facilities for individuals with an intellectual disability (ICF-IID).
 4. Veteran's Affairs (VA) state operated and controlled nursing facility.

The reimbursement methodology for the facilities listed is outlined here. Also included in this section are the facilities that are reimbursed by all-inclusive rates. The payment method is designed to achieve two major objectives: 1). To assure that needed facility care is available for all eligible recipients including those with higher care needs and, 2). To assure Department for Medicaid Services control and cost containment consistent with the public interest and the required level of care.

- B.
1. This cost-based system is designed to provide a reasonable return in relation to cost but also contains factors to encourage cost containment. Under this system, payment shall be made to state owned or operated, non-state but government owned or operated, and non-governmental ICF-IIDs on a prospectively determined basis for routine cost of care with no year-end adjustment required other than adjustments which result from either desk reviews or field audits.
 2. Effective with the eight month period ending June 30, 2006, and continuing annually thereafter on a state fiscal year basis, a year-end cost settlement will be required for state owned or operated ICF-IID. Total reimbursement to state owned or operated ICF-IID in aggregate shall be limited to the lesser of actual costs or the amount the state reasonably estimates would have been paid under Medicare Payment Principles. The determination will be in conformance with the standards and methods as expressed in 42 CFR 447.257 and 447.272. Cost associated with prescription drugs should be removed from the routine cost. Central Office Overhead costs for facilities that are state owned, but not state operated should be adjusted to remove costs that are determined in accordance with Medicare reimbursement principles to duplicate costs incurred by the operating entity.
 3. Effective with the period ending June 30, 2014, and continuing annually thereafter on a state fiscal year basis, a year-end cost settlement will be required for state owned or operated VA facilities. Total reimbursement to VA's in aggregate shall be limited to the lesser of actual costs or the amount the state reasonably estimates would have been paid under Medicare Payment Principles. The determination will be in conformance with the standards and methods as expressed in 42 CFR 447.257 and 447.272. Effective for dates of service on or after August 1, 2014, cost associated with prescription drugs will be included as an ancillary cost. Both routine and ancillary cost shall be determined in accordance with Medicare reimbursement principles. Central Office Overhead costs for facilities that are state owned, but not state operated should be adjusted to remove costs that are determined in accordance with Medicare reimbursement principles to duplicate costs incurred by the operating entity. An interim per diem inclusive of routine, capital, and ancillary costs will be established based on the most recently submitted Medicare cost report for the July 1 rate-setting period. Costs, excluding capital, will be trended and indexed utilizing Global Insight inflation

TN No. 14-007

Supersedes

TN No. 13-025Approval Date: Feb 10, 2015Effective Date: 8/1/2014

factors. A pro-forma cost report will be used for the initial rate-setting period if the Medicare cost report is not available. Once a desk review has been completed to review for allowable costs, and allow for Medicaid claims to process and paid through the MMIS for the period, a final cost settlement will be completed.

- C. Ancillary services as defined, shall be reimbursed on a cost basis with a year-end retroactive settlement. As with routine cost, ancillary services are subject to both desk reviews and field audits that may result in retroactive adjustments.
- D. The basis of the prospective payment for cost is the most recent annual cost report data (available as of May 16) trended to the beginning of the rate year and indexed to the mid-point of the prospective rate year. The routine cost is divided into two major categories: Nursing Services Cost and All Other Cost.

SECTION 230. PARTICIPATION REQUIREMENTS

PARTICIPATION REQUIREMENTS. Except for ICF-IID's and VA's, cost-based facilities participating in the Department for Medicaid program shall be required to have at least ten (10) of its Medicaid certified beds participating in the Medicare Program or twenty (20) percent of its beds if greater, but not less than ten (10) beds; for a facility with less than ten (10) beds, all beds participate in the Medicare Program.

SECTION 240. REIMBURSEMENT FOR REQUIRED SERVICES UNDER THE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR) FOR VENTILATOR UNITS, BRAIN INJURY UNITS, IMDS, AND PEDIATRIC FACILITIES.

- A. Prior to admission of an individual, a nursing facility shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.
- B. The department shall reimburse a nursing facility for services delivered to an individual if the facility complies with the requirements of 907 KAR 1:755
- C. Failure to comply with 907 KAR 1:755 may be grounds for termination of nursing the facility participation in the Medicaid Program.

SECTION 250. LIMITATION ON CHARGES TO RESIDENTS.

- F. Except for applicable deductible and coinsurance amounts, a NF that receives reimbursement for a Medicaid resident shall not charge a resident or his representative for the cost of routine or ancillary services.
- G. A NF may charge a resident or his representative for an item if the resident requests the item, the NF informs the resident in writing that there will be a charge. A NF shall not charge a resident for an item or service if Medicare or Medicaid pays for the item pursuant to 42 CFR 483.10(c)(8)(ii).
- H. A NF shall not require a resident or an interested party to request any item or services as a condition of admission or continued stay. A NF shall inform the resident or an interested party requesting an item or service that a charge will be made in writing that there will be a charge and the amount of the charge.

-
- I. A NF may charge a resident for the cost of reserving a bed if requested by resident or interested party after the fourteenth (14th) day of a temporary absence from the facility pursuant to 907 KAR 1:022.
 - J. Durable medical equipment (DME) and supplies shall be furnished by the NF and not be billed to the department under separate DME claim pursuant to 907 KAR 1474.

SECTION 260. ROUTINE COST

- A. Routine costs are broken down into two major categories: Nursing Service costs and All Other costs. Routine Cost includes all items and services routinely furnished to all residents.
- B. NURSING SERVICES COSTS. The direct costs associated with nursing services shall be included in the nursing service cost category. These costs include:
 - 1. Costs of equipment and supplies that are used to complement the services in the nursing services cost category;
 - 2. Costs for education or training including the cost of lodging and meals of nursing service personnel. Educational costs are limited to either meeting the requirements of laws or rules or keeping an employee's salary, status, or position or for maintaining or updating skills needed in performing the employee's present duties;
 - 3. The salaries, wages, and benefits of persons performing nursing services including salaries of the director of nursing and assistant director of nursing, supervising nurses, medical records personnel, registered professional nurses, licensed practical nurses, nurse aides, orderlies, and attendants;
 - 4. The salaries or fees of medical directors, physicians, or other Professionals performing consulting services on medical care which are not reimbursed separately; and
 - 5. The costs of travel necessary for training programs for nursing personnel required to maintain licensure, certification or professional standards.
 - 6. Nurse aide training costs billable to the program as an administrative cost are to be adjusted out of allowable cost.

- B. ALL OTHER COSTS. Costs reported in the All OTHER COST category includes three major cost centers as reported on the annual cost report:

Other Care-Related Cost, Other Operating Costs, Indirect Ancillary Costs, and Capital Costs.

1. Other Care-Related Costs. These costs shall be reported in the other care-related services cost category:
 - a. Raw food costs, not including preparation;
 - b. Direct costs of other care-related services; such as social services and resident activities;
 - c. The salaries, wages, and benefits of activities' directors and aides, social workers and aides, and other care-related personnel including salaries or fees of professionals performing consultation services in these areas which are not reimbursed separately under the Medicaid program;
 - d. The costs of training including the costs of lodging and meals to meet the requirements of laws or rules for keeping an employee's salary, status or position, or to maintain or update skills needed in performing the employee's present duties.
2. Other Operating Costs. The costs in this category shall include the supplies, purchased services, salaries, wages and benefits for:
 - a. Dietary Services
 - b. Laundry services including the laundering of personal clothing which is the normal wearing apparel in the facility. The cost of dry cleaning personal clothing, even though it is the normal wearing apparel in the facility, is excluded as an allowable cost. Providers shall launder institutional gowns, robes and personal clothing which is the normal wearing apparel in the facility without charge to recipients. The recipient or responsible party may at their discretion makes other arrangements for the laundering of personal clothing.
 - c. Housekeeping
 - d. Plant Operation and Maintenance
 - e. General and Administrative Services
3. Capital Costs. The costs in this category shall include:

- a. Depreciation on building and fixtures
 - b. Depreciation on equipment
 - c. Capital related interest expense
 - d. Rent
4. Indirect Ancillary Costs. Indirect ancillary costs are those costs associated with ancillary departments (including fringe benefits).

SECTION 270. ANCILLARY SERVICES

A. Ancillaries are services for which a separate charge is submitted and include:

1. Respiratory Therapy
2. Speech Therapy
3. Occupational Therapy
4. Physical Therapy
5. Oxygen Service
6. Laboratory
7. X-ray

B. Ancillary therapy services are reimbursed pursuant to 907 KAR 1:023.

C. Psychological and psychiatric services shall be billed as an ancillary service by an ICF- MR/DD.

NOTE: Effective October 1, 1990 drugs for residents in Cost-Based Facilities shall be reimbursed through the pharmacy program.

D. Oxygen concentrator limitations. Effective October 1, 1991, the allowable cost of oxygen concentrator rentals shall be limited as follows:

1. A facility may assign a separate concentrator to any resident whom has needed oxygen during the prior or current month and for whom there is a doctor's standing order for oxygen. For the charge by an outside supplier to be considered as an allowable cost, the charge shall be based upon actual usage. A minimum charge by an outside supplier is allowable if this charge does not exceed twenty-five (25) percent of the Medicare Part B maximum. The minimum

charge is allowable if the concentrator is used less than an average of two (2) hours per day during the entire month (for example, less than 60 hours during a thirty (30) day month). The maximum allowable charge by the outside supplier shall not exceed one hundred (100) percent of the Medicare Part B maximum. For the maximum charge to a facility to be considered as the allowable cost, the concentrator shall have been used on average for a period of at least eight (8) hours per day for the entire month (for example, 240 hours during a thirty (30) day month). In those cases where the usage exceeds that necessary for the minimum charge and is less than the usage required for the maximum charge, the reimbursable shall be computed by dividing the hours of usage by 240 and then multiplying the result of this division by the Medicare Part B maximum charge (for example, if a concentrator is used less than 220 hours during a thirty (30) day month and the maximum Part B allowable charge is \$250.00; then the allowable charge is computed by dividing the 220 hours by 240 hours and then multiplying the product of this division by \$250.00 to obtain the allowable charge of \$229.17). Allowable oxygen costs outlined in this paragraph shall be considered to be ancillary costs.

3. A facility shall be limited to one (1) standby oxygen concentrator for each nurses' station. The Medicaid Services Program may grant waivers of this limit. This expense shall be considered as a routine nursing expense for any month in which there is no actual use of the equipment. The allowable cost for standby oxygen concentrators shall be limited to twenty-five (25) percent of the maximum allowable payment under Medicare Part B for in home use.

SECTION 280. INFLATION FACTOR

The inflation factor index shall be used in the determination of the prospective rate shall be established by the Department for Medicaid Services. The index shall be based on Data Resources, Inc. The index represents an average inflation rate for the year and shall have general applicability to all facilities.

The inflation factor shall be applied to nursing services costs and all other costs excluding capital costs.

SECTION 290. PROSPECTIVE RATE COMPUTATION

- A. Prospective rates are established annually for a universal rate year, July 1 through June 30. Rate setting shall be based on the most recent cost reports available by May 16. If a desk review or audit of the most recent cost report is complete after May 16 but prior to universal rate setting for the rate year, the desk reviewed or audited data shall be utilized for rate setting. If a facility's rate is based upon a report that has not been audited or desk reviewed, the facility's rate is subject to revision after the cost report has been audited or desk reviewed.
- B. Allowable routine Cost-Based Facility cost is divided into two components: Nursing Services Cost and All Other Cost.
- C. Allowable cost for the Nursing Services Cost component shall be trended to the beginning of the universal rate year and indexed for the period covering the rate year based on an inflation factor obtained from the Data Resources, Incorporated (DRI) forecast table for Skilled Nursing Facilities.
- D. Allowable cost for the All Other Cost center, with the exception of the Capital Cost sub-component shall be trended and indexed in the same manner as Nursing Services costs.
- E. The total Cost-Based Facility Cost for each category, after trending and indexing, shall be divided by total Certified Cost- Based Facility days in order to compute a per diem. A minimum occupancy limit of ninety (90) percent of certified bed days available, (except for state government-owned facilities shall be seventy (70) percent of certified bed days), or actual bed days used if greater, and a maximum occupancy limit of ninety-eight (98) percent computed in the same manner, shall be used in computing the per diem.

SECTION 300. ADJUSTMENT TO PROSPECTIVE RATE

- A. Upon request by participating facility, an increase in the prospective rate shall be considered if the cost increase is attributed to one (1) of the following reasons:
 - 1. Governmentally imposed minimum wage increases, unless the minimum wage increase was taken into account and reflected in the setting of the trending and index factor.
 - 2. Direct effect of newly published licensure requirements or new interpretations of existing requirements by the appropriate

governmental agency as issued in regulation or written policy material which affects all facilities within the class. The provider shall demonstrate through proper documentation that a cost increase is the result of a new policy interpretation; or

3. Other direct governmental actions that result in an unforeseen cost increase.

- B. To receive a rate increase (except for Federal or State minimum wage increases), it shall be demonstrated by the facility that the amount of cost increase resulting directly from the governmental action exceeds on an annualized basis, the inflation factor allowance included in the prospective rate for the general cost area in which the increase occurs. For purposes of this determination, costs shall be classified into two (2) general categories, Nursing Service and all other.

Other Cost. Within each of these two (2) categories, costs are to be further broken down into "salaries and wages" and "other costs." Those costs directly related to salaries and fringe benefits shall be considered as "salaries and wages" when determining classifications.

- C. Other unavoidable cost increases of a substantial nature, which can be attributed to a single unique causal factor, shall be evaluated with respect to allowing an interim rate change. Ordinarily budget items such as food, utilities, and interest where cost increases may occur in a generalized manner shall be excluded from this special consideration. Secondary or indirect effects of governmentally imposed cost increases shall not be considered as "other unavoidable cost increases."
- D. The increase in the prospective rate shall be limited to the amount of the increase directly attributable to the governmental action to the extent that the increase on an annualized basis exceeds the inflation factor allowance included in the prospective rate for the cost center in question. In regard to minimum wage increases, the direct effect shall be defined as the time worked by total facility employees times the dollar amount of change in the minimum wage law. However, the amount allowed shall not exceed the actual salary and wage increase incurred by the facility in the month the minimum wage increase is effective. An exception to this shall be considered when there is an unusual occurrence that causes a decrease in the normal staff attendance in the months the minimum wage increase is effective.

-
- E. The effective date of a prospective rate adjustment shall be the first day of the calendar month in which the direct governmental action occurred. To be allowable, a request for an adjustment to the prospective rate shall be received by the Department for Medicaid Services within sixty (60) days of the direct governmental action, except where the costs are to be accumulated.
- F. If two (2) or more allowable reasons for a rate change occur in the same facility fiscal year, the costs may be accumulated and submitted at one (1) time. Each cost shall be documented. A rate adjustment, if allowed, shall be effective the first day of the calendar month in which the latest direct governmental action occurred if the request is made within the required sixty (60) days.

SECTION 310. RATE ADJUSTMENT FOR PROVIDER TAX

After January 1, 1994, provider tax forms shall be submitted to the Revenue Cabinet with the required supporting Revenue Cabinet schedules. Schedule J-Tax forms shall be submitted by providers by the end of the month in which corresponding filing with the Revenue Cabinet is made.

SECTION 320. OTHER OBRA NURSING HOME REFORM COSTS

Effective October 1, 1990 and thereafter, facilities shall be required to request preauthorization for costs that must be incurred to meet OBRA 87 Nursing Home Reform costs in order to be reimbursed for such costs. The preauthorization shall show the specific reform action that is involved and appropriate documentation of necessity and reasonableness of cost. Upon authorization by the Department for Medicaid Services, the cost may be incurred. A request for a payment rate adjustment may then be submitted to the Department for Medicaid Services with documentation of actual cost incurred. The allowable additional amount shall be added on to the facility's rate (effective with the date the additional cost was incurred) without regard to upper limits or the Cost Savings Incentive factor (i.e., the authorized Nursing Home Reform cost shall be passed through at 100 percent of reasonable and allowable costs) through June 30, 1991. For purposes of the July 1, 1991 rate setting, amounts associated with OBRA rate adjustments received prior to May 15, 1991 shall be folded into the applicable category of routine cost (subject to upper limits). Preauthorization shall not be required for

nursing home reform costs incurred during the period July 1, 1990, through September 30, 1990; however, the actual costs incurred shall be subject to tests of reasonableness and necessity and shall be fully documented at the time of the request for rate adjustment. Facilities may request multiple preauthorizations and rate adjustments (add-ons) as necessary for implementation of nursing home reform. Facility costs incurred prior to July 1, 1990, shall not (except for the costs previously recognized in a special manner, i.e., the universal precautions add-on and the nurse aid training add-on) be recognized as being nursing home reform costs. The special nursing home reform rate adjustments shall be requested using forms and methods specified by the Department for Medicaid Services a nursing home rate adjustment shall be included within the cost base for the facility in the rate year following the rate year for which the adjustment was allowed. Interim rate adjustments for nursing home reforms shall not be allowed for period after June 30, 1993. For purposes of the July 1, 1992 and July 1, 1993 rate setting, all amounts associated with OBRA rate adjustments for the preceding rate year shall be folded into the applicable category of routine cost. All nursing home reform rate adjustment requests shall be submitted by September 30, 1993.

SECTION 330. PAYMENT OF SPECIAL PROGRAM CLASSES

A. BRAIN INJURY UNIT

1. A nursing facility with a Medicaid certified brain injury unit providing pre-authorized specialized rehabilitation services for persons with brain injuries shall be paid at an all-inclusive (excluding drugs which shall be reimbursed through the pharmacy program) fixed rate which shall be set at \$475 per diem for services provided in the brain injury unit. The rates shall be increased or decreased based on the Global Insight Healthcare Cost Review, 1st Quarter Edition Index from the CMS Nursing Home without Capital Market Basket, Moving Average using the second quarter in the rate year.
2. A facility providing pre-authorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae shall be paid an all inclusive (excluding drugs) negotiated. The negotiated rate shall be a minimum of the approved rate for a Medicaid certified brain injury unit or a maximum of the lesser of the average rate paid by all payers for this service or the facilities usual and customary charges.
3. In order to participate in the Medicaid program as a Brain Injury Provider, the facility shall:
 - (a) Be Medicare and Medicaid certified;
 - (b) Designate at least ten (10) certified beds that are physically contiguous and identifiable; and,
 - (c) Be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)

- (d) Include administration and operations policies
- (e) Governing authority
- (f) Quality assurance and program evaluation.

B. VENTILATOR FACILITIES

A nursing facility recognized as providing distinct part ventilator dependent care shall be paid at an all-inclusive (excluding drugs which shall be reimbursed through the pharmacy program) fixed rate for services provided in the distinct part ventilator unit.

A distinct part ventilator unit shall:

1. Have a minimum of twenty (20) beds; and
2. Maintain a census of fifteen (15) patients.

The patient census shall be based upon the quarter preceding the beginning of the rate year, or the quarter preceding the quarter for which certification is requested if the facility did not qualify for participation as a distinct part ventilator care unit at the beginning of the rate year.

The fixed rate for hospital-based facilities shall be \$460 per day. The fixed rate for freestanding facilities shall be \$250 per day. The rates shall be increased or decreased based on the Data Resources, Inc. inflation factor for the rate year beginning July 1, 1997.

C. FEDERALLY DEFINED SWING BEDS

A federally defined swing bed shall meet the requirements pursuant to 42 CFR 482.66.

A federally defined swing bed shall be reimbursed pursuant to 42 CFR 447.280. -

SECTION 340. PAYMENT FOR ANCILLARY SERVICES

The reasonable, allowable, direct cost of ancillary services as defined provided as a part of total care shall be compensated through the Department for Medicaid Services on a reimbursable cost basis as an addition to the prospective rate. Ancillary services shall be subject to a year-end audit, retroactive adjustment and final settlement.

Each provider shall request a percentage factor tailored to its own individual cost and charge ratios for ancillary services. These ratios shall be limited to one hundred (100) percent and the Department shall analyze each request for

Medicaid Services staff to determine appropriateness of the requested percentage factor. Reimbursable ancillary costs shall be determined based on the ratio of Medicaid Program charges to total charges applied to direct departmental costs.

A retroactive settlement between actual direct allowable costs and actual payment made by the Department for Medicaid Services shall be made at the end of the accounting period based on the facility's annual Cost Report. Indirect ancillary costs shall be included in routine cost and reimbursed through the prospective rate.

The reasonable, allowable, direct cost of ancillary services as defined and provided as a part of total care shall be compensated through the Department for Medicaid Services on a reimbursable cost basis as an addition to the prospective rate. Ancillary services shall be subject to a year-end audit, retroactive adjustment and final settlement.

Each provider shall request a percentage factor tailored to its own individual cost and charge ratios for ancillary services. These ratios shall be limited to one hundred (100) percent and each request shall be analyzed by Department for Medicaid Services staff to determine appropriateness of the requested percentage factor. Reimbursable ancillary costs shall be determined based on the ratio of Medicaid Program charges to total charges applied to direct departmental costs. A retroactive settlement between actual direct allowable costs and actual payment made by the Department for Medicaid Services shall be made at the end of the accounting period based on the facility's annual Cost Report. Indirect ancillary costs shall be included in routine cost and reimbursed through the prospective rate.

SECTION 350. RETROACTIVE ADJUSTMENT FOR ROUTINE SERVICES

- A. A retroactive adjustment may be made for routine services in the following circumstances:
1. If incorrect payments have been made due to computational errors, i.e., mathematical errors, discovered in the cost basis or establishment of the prospective rate. Omission of cost data does not constitute a computational error.
 2. If a determination is made by the Department for Medicaid Services of misrepresentation on the part of the provider.

3. If a facility is sold and the funded depreciation account is not transferred to the purchaser.
4. If the prospective rate has been set based on an unaudited cost report and the prospective rate is adjusted based on a desk review
5. or field audit. The appropriate cost settlement shall be made to adjust the unaudited prospective payment amounts to the correct audited prospective payment amounts.
6. If adjustments are necessary, any amounts owed the provider shall be paid by the Department for Medicaid Services. Any amounts owed the Department for Medicaid Services shall be paid in cash or recouped through the MMIS payment system

B. **BANKRUPTCY OR INSOLVENCY OF PROVIDER.** If, on the basis of reliable evidence, the Department for Medicaid Services has a reasonable cause for believing that, with respect to a provider, proceedings have been or may shortly be instituted in a State or Federal court for purposes of determining whether the facility is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider shall be adjusted by the Department for Medicaid Services notwithstanding any other reimbursement principle or Department for Medicaid Services instruction regarding the timing or manner of adjustments, to a level necessary to insure that no overpayment to the provider is made. This section shall be applicable only to ancillary services.

SECTION 360. RETROACTIVE ADJUSTMENT FOR ANCILLARY SERVICES

- A. Actual cost reimbursable to a provider shall not be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment shall be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the ancillary services rendered to the Department for Medicaid Services recipients during that period.
- A. In order to reimburse the provider as quickly as possible, a partial retroactive adjustment may be made when the cost report is received. For this purpose, the costs shall be accepted as reported unless there are obvious errors or inconsistencies subject to later audit. When an audit is made and the final liability of the Department for Medicaid Services is determined, a final adjustment shall be made.

-
- C. To determine the retroactive adjustment, the amount of the provider's total allowable ancillary cost apportioned to the Department for Medicaid Services for the reporting year is computed. This is the total amount of the reimbursement the provider is due to receive from the Department for Medicaid Services for covered ancillary services rendered during the reporting period. The total of the interim payments made by the Medicaid Program in the reporting year is computed. The difference between the reimbursement due and the payments made shall be the amount of retroactive adjustment.
- D. **ANCILLARY SERVICES.** Upon receipt of the facility's cost report, the Department for Medicaid Services shall as expeditiously as possible analyze the report and commence any necessary audit of the report. Following receipt and analysis of any audit findings pertaining to the report, the Department for Medicaid Services shall furnish the facility a written notice of amount of Medicaid reimbursement. The notice shall (1) explain the Department for Medicaid Service's determination of total Medicaid reimbursement due the facility for the reporting period covered by the cost report or amended cost report; (2) relate this determination to the facility's claimed total reimbursable costs for this period; and (3) explain the amount(s) and the reason(s) for the determination through appropriate reference to the Department for Medicaid Services policy and procedures and the principles of reimbursement. This determination may differ from the facility's claim.
- The Department for Medicaid Services' determination as contained in a notice of amount of Medicaid reimbursement shall constitute the basis for making the retroactive adjustment to any Medicaid payments for ancillary services made to the facility during the period to which the determination applies, including the suspending of further payments to the facility in order to recover, or to aid in the recovery of, any overpayment determined to have been made to the facility.
- E. **ROUTINE SERVICES.** When a retroactive adjustment is made to the routine rate, the Fiscal Agent shall adjust all routine payments made based on the rate that was adjusted.

SECTION 370. PAYMENTS FOR SERVICES TO MEDICARE/MEDICAID RESIDENTS

- A. Dually eligible residents and residents eligible for both Medicare and Medicaid (non-QMB) shall be required to Exhaust any applicable benefits under Title XVIII (Part A and Part B) prior to coverage under the Medicaid Program.
- B. APPLICATION. Services received by a resident that are reimbursable by Medicare shall be billed first to the Medicare Program. Any appropriate co-insurance or deductible payment due from the Medicaid Program shall be paid outside the Cost-based facility Cost-Related Payment System in a manner prescribed by the Department for Medicaid Services. Coinsurance and deductible payments shall be based on rates set by the Medicaid Program. A day of service covered in this manner shall be considered a Medicare resident day and shall not be included as a Medicaid resident day in the facility cost report.

SECTION 380. RETURN ON EQUITY OF PROPRIETARY PROVIDERS

An allowance for a return on equity capital invested and used in the provision of resident care shall not be allowed.

SECTION 390. DESK REVIEW AND FIELD AUDIT FUNCTION

After the facility has submitted the annual cost report, the Division of Long Term Care shall perform an initial desk review's of the report. During the desk review process, Medicaid staff shall subject the submitted Cost Report to various tests for clerical accuracy and reasonableness. If the Medicaid Program detects clerical error, the Department for Medicaid Services shall return the submitted Cost Report to the providers for correction. If Medicaid staff suspect possible errors rather than simple clerical errors, the Medicaid staff shall require the provider to submit supporting documentation to clarify any areas brought into question during the desk review. The desk review shall not be deemed to be completed until all clerical errors have been rectified and all questions asked of the provider during the desk review process have been answered fully.

Additionally, results of this desk review shall be used to determine whether a field audit, if any, is to be performed. The desk review and field audits shall be conducted for purposes of verifying prior year cost to be used in setting prospective rates which have been set based on unaudited data. Ancillary service cost shall be subject to the same.

desk review and field audit procedure to settle prior year costs. The field audit procedures shall include an audit of Resident Fund Accounts to insure the Medicaid Program that the providers are in compliance with appropriate federal and state regulations.

SECTION 400. REIMBURSEMENT REVIEW AND APPEAL

A NF may appeal department decisions as to the application of this regulation as it impacts the NF's cost-based reimbursement rate in accordance with 907 KAR 1:671, Section 10.

SECTION 410. INTRODUCTION TO PROVIDER COST THAT ARE REIMBURSABLE

- A. The material in this pall deals with provider costs that are reimbursable by the Department for Medicaid Services. In general, these costs are reimbursed on the basis of a provider's actual costs, providing these costs are reasonable and related to resident care. These costs are termed allowable costs. That portion of a provider's total allowable costs allocable to services provided to Medicaid Program recipients shall be reimbursable under the Medicaid Program.
- B. Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the facility's operating costs include amount not related to resident care, specifically not reimbursable under the Medicaid Program or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts shall not be allowable.
- C. It is not possible to include the treatment of all items in this manual. If a provider presents a question concerning the treatment of cost not specifically covered, or desires clarification of information in this manual, the provider may make a request for determination. The request shall include all pertinent data in order to receive a binding response. Upon receipt of the request, the Department for Medicaid Services shall issue a binding response within sixty (60) days.

SECTION 420. ADEQUATE COST DATA

- A. To receive reimbursement for services provided Medicaid Program recipients, providers shall maintain financial records and statistical data sufficient to allow proper determination of costs payable under the Medicaid Program. This cost data shall be of sufficient detail to allow verification by qualified auditors using General Accounting Office and American Institute of Certified Public Accountants guidelines. The cost data shall be based on Generally Accepted Accounting Principles.
- B. Use of the accrual basis of accounting is required. Governmental institutions that operate on a cash basis of accounting may submit cost data on the cash basis subject to appropriate treatment of capital expenditures.

Under the accrual basis of accounting, revenue is reported in the period in which it is earned regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid. To allow comparability, financial and statistical records shall be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to effect such change.

- C. Providers, when requested, shall furnish the Department for Medicaid Services copies of resident service charge schedules and changes as they are put into effect. The Department for Medicaid Services shall evaluate charge schedules to determine the extent to which they may be used for determining Medicaid payment.
- D. Where the provider has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for service costing or valued at \$10,000 or more over a twelve (12)-month period, the contract shall contain a clause giving the Cabinet for Health Services access to the subcontractor's books. Access shall also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor. The contract shall contain a provision allowing access until four (4) years have expired after the services have been furnished.

-
- E. If the Department for Medicaid Services determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost, payments to the provider shall be suspended until the Department for Medicaid Services is assured that adequate records are maintained.
- F. A newly participating provider of services shall, upon request, make available to the Department for Medicaid Services for examination its fiscal and other records for the purpose of determining the provider's ongoing record keeping capability.
- G. Records shall be retained by the facility for three (3) years from the date the settled-without-audit or the audited cost report is received from the Department for Medicaid Services.

The financial records and statistical data that shall be kept shall include the following:

1. Records and documents relating to facility ownership, organization, and operation;
2. All invoices and purchase orders;
3. All billing forms or charge slips;
4. All agreements pertaining to asset acquisition, lease, sale or other action;
5. Documents pertaining to franchise or management arrangements including costs of parent or "home office" operations;
6. Resident service charge schedules;
7. Contracts pertaining to the purchase of goods or services;
8. All accounting books or original entry kept in sufficient detail to show source and reason for all expenditures and payments;
9. All other accounting books;
10. Federal and State income tax returns;
11. Federal withholding and State Unemployment returns; and,
12. All financial statements regardless whether prepared by the facility or by an outside firm;
13. Any documentation required by the Department shall be made available for examination; and,
14. All of these records shall be made available for examination at the facility, or at some other location within the Commonwealth, when requested by the Cabinet for Health Services.
Reasonable time

shall be given to out- of-state home offices to make the records available within the Commonwealth.

SECTION 430. APPORTIONMENT OF ALLOWABLE COST

- A. Consistent with prevailing practices where third party organizations pay for health care on a cost basis, reimbursement under the Medicaid Program involves a determination of(1) each provider's allowable costs of producing services, and (2) an apportionment of these costs between the Medicaid Program and other payors.

Cost apportionment is the process of recasting the data derived from the accounts ordinarily kept by a provider to identify costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and pro-ration of indirect costs.

- B. The objective of this apportionment is to ensure, to the extent reasonably possible, that the Medicaid Program's share of a provider's total allowable costs is equal to the Medicaid Program's share of the provider's total services, subject to Medicaid Program limitations on payments so as not to pay for inefficiencies and to provide a financial incentive for providers to achieve cost efficiencies.

SECTION 440. COST REPORTING

- A. The Medicaid Program requires each Cost-Based Facility o submit an annual report of its operations. The report shall be filed for the fiscal year used by the provider unless otherwise approved by the Medicaid Program.
- B. Amended cost reports (to revise cost report information that has been previously submitted by a provider) may be permitted or required as determined by the Medicaid Program.
- C. The cost report shall be due within sixty (60) days after the provider's fiscal year ends for non-VA facilities. The VA cost report shall be due within 5 months after the provider's fiscal year end, unless an extension has been approved by the Department.
- D. Providers may request in writing a thirty (30) day extension. The request shall explain in detail why the extension is necessary. There shall be no automatic extension of time for the filing of the cost report. After the extension period has elapsed, the Medicaid Program shall suspend all payments to the provider until an acceptable cost report is received.

-
- E. Newly participating providers not having a cost report on file containing twelve (12) months of actual data in the fiscal year shall submit a partial year cost report. Upon entry into the Medicaid Program, the provider shall inform the Department of Medicaid Services of the period ending date for the initial cost reporting period.
- F. A provider that voluntarily or involuntarily ceases to participate in the Medicaid Program or experiences a change of ownership shall file a cost report for that period under the Medicaid Program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement. The report shall be due within forty-five (45) days of the effective date of termination of the provider agreement. If a new owner's fiscal year end is less than six (6) months from the date of the change of ownership, Schedules A, D-5 and E as well as the ancillary portion of Schedule F shall be required to be filed at the end of the fiscal year. The rate paid to the new owner shall be the old owner's rate and shall remain in effect until a rate is again determined for a new universal rate year.

SECTION 450. BASIS OF ASSETS

- A. **PRINCIPLE.** Unless otherwise stated in this manual, the basis of an asset shall be the purchase price of that asset paid by the current owner.
- B. **REVALUATION UPON CHANGES IN OWNERSHIP.** If there is a change in ownership, the Medicaid Program shall treat the gain or loss on the sale of an asset in accordance with one (1) of the following methods (dependent on the date of the transaction) for purposes of determining a purchaser's allowable basis in relation to depreciation and interest costs.
1. For changes of ownership occurring prior to July 18, 1984, or if an enforceable agreement for a change of ownership was entered into prior to July 18, 1984, the following methodology applies:
 - a. The actual gain on the sale of the facility shall be determined. Gain shall be defined as any amount in excess of the seller's depreciated basis at the time of the sale as computed under the Medicaid Program policies. The value of Goodwill included in the purchase price shall not be

-
- considered part of the gain for purposes of determining the purchaser's cost basis.
- b. Two-thirds (2/3) of one (j) percent of the gain for each month of ownership since the date of acquisition of the facility by the seller shall be added to the seller's appreciated basis to determine the purchaser's allowable basis. This method recognizes a graduated proportion of the gain on the sale of a facility that shall be added to the seller's depreciated basis for computation of the purchaser's allowable basis. This allows full consideration of the gain by the end of twelve and one-half (12 1/2) years.
2. For changes of ownership occurring on or after July 18, 1984, the allowable basis for depreciation for the purchaser shall be the lesser of: 1) the allowable basis of the seller, at the time of the purchase by the seller, less any depreciation allowed to the seller in prior periods; plus the cost of any improvement made by seller, less the depreciation allowed to the seller on those improvements, at the time of closing, or 2) the actual purchase price.
- C. If a provider wishes to change its fiscal year, approval shall be secured in advance from the Department for Medicaid Services prior to the start of the fourth quarter of the original reporting period. If a provider has changed its fiscal year and does not have twelve (12) months in its most recent fiscal year, the provider shall file a cost report for its new fiscal year and include twelve (12) months of data, i.e., the provider should use all months included in their new fiscal year plus additional months from the prior fiscal year to construct a twelve (12) month report.

SECTION 460. DEPRECIATION EXPENSE

- A. **PRINCIPLE.** An appropriate allowance for depreciation expense on buildings and equipment shall be an allowable expense. The depreciation shall be:
1. Identifiable and in the facility's accounting records
 2. Based on the allowable basis;
 3. Prorated over the useful life of the asset; and,
 4. Goodwill and other intangible assets shall not be depreciated

-
- B. METHOD OF DEPRECIATION. Assets shall be depreciated using the straight-line method, unless Medicare has authorized another method for the facility; in which case, the facility may elect to utilize the method authorized for Medicare purposes.
 - C. USEFUL LIVES. In selecting a proper useful life, the 1988 Edition of the American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets" shall be used with respect to assets acquired in 1989 or later years. For assets acquired from 1983 through 1988, the 1983 Edition of the AHA's guidelines shall be used. For assets acquired before 1982, the 1973 Edition of the AHA's "Chart of Accounts for Hospitals" shall be used, or for assets acquired before 1981, guidelines published by the Internal Revenue Service, with the exception of those offered by the Asset Depreciation Range System, shall be used.

SECTION 470. INTEREST EXPENSE

- A. PRINCIPAL. Unless otherwise stated in this manual, interest expense shall be an allowable cost pursuant to 42 CFR 4 13.153 and it is both necessary and proper in accordance with the provisions of this manual.
- B. DEFINITIONS.
 - 1. "Interest" means interest is the cost incurred for the use of borrowed funds.
 - 2. "Necessary" means necessary requires that interest:
 - a. Be incurred on a loan made to satisfy a financial need of the provider that is related to resident care. Loans that result in excess funds or investments shall not be considered necessary.
 - b. Be incurred on a loan made for the following purposes:
 - c. Represent interest on a long-term debt existing at the time the provider enters the Medicaid Program plus interest on any new long-term debt, the proceeds of which are used to purchase fixed assets relating to the provision of the appropriate level of care not to exceed the allowable basis of the assets. If the debt is subject to variable interest rates found in "balloon"

type financing, renegotiated interest rates subject to tests of reasonableness should be allowable. The form of indebtedness may include mortgages, bonds, notes, and debentures when the principal is to be repaid over a period in excess of one year.

- (1) Other interest for working capital and operating needs that directly relate to providing resident care is an allowable cost. Working capital interest shall be limited to the interest expense that would have been incurred on two months of Medicaid Receivables. The amount of which this limitation is to be based is computed for cost reporting purposes by determining the monthly average Medicaid payments (both routine and ancillary) for the Cost Reporting period and multiplying the amount by two (2). Once the allowable amount of borrowing has been determined, it is multiplied by the provider's average working capital borrowing rate in order to determine the maximum allowable working capital interest. It should be emphasized that the two-month limit is a maximum. Working capital interest shall not be allowable simply because it does not exceed the two month limitation. Working capital interest that meets the two-month test shall meet all other tests of necessary and proper in order for it to be considered allowable.
- (2) Be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds, or have been separated, if necessary. When investment income is derived from combined or pooled funds, only that portion of investment income

resulting from the facility's assets after segregation shall be considered in the reduction of interest cost. Income from funded depreciation, a provider's qualified pension fund, or a formal deferred compensation plan shall not be used to reduce interest expense so long as these funds are used only for those purposes for which they were created.

3. Proper Interest Rate

- a. Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.
- b. Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans that meet one of the related party exemptions.

C. BORROWER-LENDER RELATIONSHIP.

1. To be allowable, interest expense shall be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans shall be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. Thus, interest paid by the facility to partners, stockholder, or related organizations of the facility shall not be allowable.
2. Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to those facilities classified as Intermediate Care Facilities prior to October 1, 1990, by partners, stockholders, or related organizations made prior to July 1, 1985 shall be allowable as cost, as determined under these principles, provided that the terms and conditions of payment of such loans

have been maintained in effect without subsequent modification subsequent to July 1, 1975. For facilities classified as Skilled

3. Facilities prior to October 1, 1990, the same policy applies for this type loan made prior to and maintained without modification subsequent to December 1, 1979. If the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment shall be accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a facility operated by members of a religious order borrows from the order, interest paid to the order shall be an allowable cost.
4. If funded depreciation is used for purposes other than improvements, replacement, or expansion of facilities or equipment related to resident care, allowable interest expense shall be reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment shall be accorded deposits in the provider's qualified pension fund where such deposits are used for other than the purposes for which the fund was established. If a facility is sold and the funded depreciation account is not transferred to the purchaser, the earnings of the funded depreciation account shall be treated as an investment income. Any investment income that had been earned by the funded depreciation account and had not been utilized to reduce interest expense, shall be considered an overpayment by the Medicaid Program and a retroactive cost settlement shall be computed at the time of the sale. If the funded depreciation account is transferred to the purchaser and the purchaser eliminates the account, any investment income earned in prior years by the account shall be offset against interest expense of the purchaser.

D. INTEREST NOT REASONABLY RELATED TO RESIDENT CARE

Interest expense is not reasonably related to resident care if:

1. It is paid on borrowings in excess of the allowable basis of the asset.
2. It is made to defer principle payments.
3. It is used to purchase goodwill or other intangible asset.
4. It is in the form of penalty payments.

- E. INTEREST EXPENSE ON PURCHASES OF FACILITIES ON OR AFTER JULY 18, 1984. For facilities purchased on or after July 18, 1984, but before October 1, 1985, the amount of interest expense allowed purchaser shall be limited to the amount that was allowable to the seller at the time of the sale. For facilities purchased on or after October 1, 1985, the amount of interest expense allowed to the purchaser shall be limited to the interest on the allowable basis of the asset reduced by the amount necessary (if applicable) to ensure that the increase in depreciation and interest paid to facilities purchased on or after October 1, 1985 does not exceed \$3,000,000 annually. Any reduction of allowable interest based on the \$3,000,000() limit shall be prorated proportionately among the affected facilities (i.e., the percentage reduction shall be applied equally.)

SECTION 480. FACILITY LEASE OR RENT ARRANGEMENTS

- A. For cost-based nursing facilities previously classified as Intermediate Care Facilities, the allowable cost of all lease or rent arrangements occurring after 4/20/76 shall be limited to the owner's allowable historical costs of ownership. The effective date of this limitation for nursing facilities previously classified as Skilled Nursing Facilities is 12/1/79. Historical costs of ownership can include the owner's interest expense, depreciation expense, and other costs such as taxes, insurance, maintenance, etc. In the event of the sale or leaseback arrangement, only the original owner's allowable basis shall be recognized. The owner's allowable historical cost shall be subject to the basis limitations as applied to property owned by providers. Additionally, allowable depreciation and interest shall not exceed that which would have been allowed had the provider owned the assets. In order to have the allowable cost determined and approved, all data pertaining to the lease or rent arrangement, including the name of previous owners, shall be submitted by the provider. In regard to lease or rent arrangements occurring prior to 4/20/76 for basic Intermediate Care and 12/1/79 for Skilled Nursing, the Medicaid Program shall determine the allowable Costs of such arrangements based on the general reasonableness of costs.
- B. Lease or Rent arrangements for land only shall be considered an allowable cost if the lease agreement does not contain an option to purchase at less than market value. if the lease amount is a set amount each year, the lease amount should be reclassified to the Depreciation Expense cost center. If

the lease amount varies from one (1) year to the next, the lease amount shall be reclassified to the Operation and Maintenance of Plant cost center.

SECTION 490. CAPITAL LEASES

Leases determined to be Capital Leases under Generally Accepted Accounting Principles (GAAP) shall be accounted for under the provisions of GAAP.

However, all basis limitations applicable to the depreciation and interest expense of purchased assets shall apply to Capital Leases.

SECTION 500. AMORTIZATION OF ORGANIZATION AND START-UP COSTS

Organization and start-up costs as defined in Health Insurance Manual 15 shall be amortized in accordance with the provisions of Health Insurance Manual 15.

SECTION 510. ACCELERATED DEPRECIATION TO ENCOURAGE REFINANCING

- A. To encourage facilities to refinance loans for long term debt in existence on December 1, 1992 at lower interest rates and for shorter duration than their current financing, the Kentucky Medicaid Program shall allow an increase in depreciation expense equal to the increased principal payments (principal payments on the allowable portion of the loan under the new financing minus the principal payments under the old financing on the allowable portion of the loan). However, this increase in allowable depreciation expense shall not exceed the reduction in allowable interest expense that results from the refinancing. Interest savings for any period shall be computed as follows: allowable interest expense which would have been incurred under the previous loan, plus allowable amortization of financing costs which would have been incurred under the previous financing arrangement, minus allowable interest expense under the new financing arrangement, minus allowable amortization of loan costs under the new loan (including any unamortized loan expense from the previous loan.) Total depreciation allowed (including the additional depreciation) shall reduce the allowable depreciable basis of the building. Total depreciation expense allowed over the lives of the assets that make up the facility shall not exceed the allowable undepreciated basis of the building. The additional depreciation allowed by the

provision shall first be applied against the allowable basis of the longest lived asset which has any remaining allowable undepreciated basis. The remaining allowable undepreciated basis of the facility at the end of the refinanced loan, shall be depreciated over the remaining useful lives of the assets utilizing straight line depreciation. If subsequent to the refinancing and claiming of accelerated depreciation, the facility is sold (either the operating entity holding the nursing facility licensure or the building on which the accelerated depreciation is claimed) or the facility voluntarily discontinues participation in the Medicaid Program, the following recapture provisions shall be applied:

1. The owner who claimed the accelerated depreciation shall pay the Medicaid Program an amount equal to the difference in depreciation claimed for the certified nursing facility with and without the accelerated depreciation times the average Medicaid percentage of total occupancy in the certified nursing facility.
2. If the facility remains in the Medicaid Program, the allowable depreciable basis for the new owner shall be the allowable depreciable basis had the prior owner never utilized accelerated depreciation for Medicaid reimbursement.

SECTION 520. BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES

- A. PRINCIPLE. Bad debts, charity, and courtesy allowances are deductions from revenue and shall not be included in allowable cost.
- B. DEFINITIONS.
 1. "Bad Debts" means a debt considered to be uncollectible from "accounts receivable" and "notes receivable" that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.
 2. "Charity allowances" means an allowance or reduction in charges made by the provider of services because of the indigence or medical indigence of the resident.
 3. "Courtesy Allowances" means an allowance that indicates a reduction in charges in the form of an allowance to physicians,

clergy, members of religious orders, and others as approved by the governing body of the facility, for services received from the facility. Employee fringe benefits, such as hospitalization and personnel health program, shall not be considered to be courtesy allowances.

- C. NORMAL ACCOUNTING TREATMENT - REDUCTION IN REVENUE. Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the services. These costs have already been incurred in the production of the services.
- D. CHARITY ALLOWANCES. Charity allowances have no relationship to recipients of the Medicaid Program and shall not be allowable costs.

SECTION 530. COST OF EDUCATIONAL ACTIVITIES

- A. PRINCIPLE. An appropriate part of the net cost of approved educational activities shall be an allowable cost.
- B. DEFINITIONS.
1. "Approved Educational Activity" means an educational activity formally organized or planned program of study usually engaged in by providers in order to enhance the quality of resident care in a facility. These activities shall be licensed where required by state law. If license is not required, the facility shall receive approval from the recognized national professional organization for the particular activity.
 2. "Net Cost" means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursements from grants, tuition, and specific donations.
 3. "Appropriate Part" means the net cost of the activity apportioned in accordance with the methods set forth in these principles.
- C. ORIENTATION AND ON-THE-JOB TRAINING. The costs of "orientation" and "on the job training" shall not be within the scope of this principle but shall be recognized as normal operating costs.

SECTION 540. RESEARCH COSTS

- A. PRINCIPLE. Costs incurred for research purposes, over and above usual resident care, shall not be included as allowable costs.
- B. APPLICATION. If research is conducted in conjunction with and as part of the care of residents, the costs of usual resident care shall be allowable to the extent that costs are not met by funds provided for the research. Under this principle, studies, analyses, surveys, and related activities to serve the facilities administrative and program needs shall not be excluded as allowable costs.

SECTION 550. GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

- A. PRINCIPLE. Unrestricted grants, gifts, and income from endowments shall not be deducted from operating costs in computing reimbursable cost. Grants, gifts, or endowment income designated by a donor for paying specific operating costs shall be deducted from the particular operating cost or group of costs.
- B. DEFINITIONS.
 - 1. "Unrestricted Grants, Gifts and Income from Endowments" means grants, gifts, and income from endowments, funds, cash or otherwise, given to a facility without restriction by the donor as to their use.
 - 2. "Designated or Restricted Grants, Gifts, and Income from Endowments" means grants, gifts, and income from endowments, funds, cash or otherwise, which shall be used only for the specific purpose designated by the donor. This does not refer to unrestricted grants, gifts, or income from endowments that have been restricted for a specific purpose by the facility.

SECTION 560. VALUE OF SERVICES OF NONPAID WORKERS

- A. PRINCIPLE. The value of services performed on a regularly scheduled basis by persons (in positions customarily held by full-time employees) as non-paid workers under arrangements without direct remuneration from the provider shall be allowed as an operating expense for the determination of allowable cost subject to limitations contained in paragraph (B) of this section. The amounts allowed shall not exceed those

paid others for similar work. Amounts shall be identifiable in the records of the facilities as a legal obligation for operating expense. Non-paid workers hired under arrangements with a Cabinet for Health Services authorized work experience program shall qualify for the purposes of the principles in this section.

- B. **LIMITATIONS - SERVICES OF NON-PAID WORKERS.** The service shall be performed on a regular, scheduled basis in positions customarily held by full-time employees and necessary to enable the provider to carry out the functions of normal resident care and operation of the facility. The value of services of a type for which facilities generally do not remunerate individuals performing those services shall not be allowed as a reimbursable cost under the Medicaid Program. For example, donated services of individuals in distributing books and magazines to residents, or in serving in a facility canteen or cafeteria or in a facility gift shop shall not be reimbursed.
- C. **APPLICATION.** The following illustrates how a facility shall determine an amount to be allowed under this principle: The prevailing salary for a lay nurse is \$5,000 for the year. The lay nurse receives no maintenance or special perquisites. A nun working as a nurse engaged in the same activities in the same facility receives maintenance and special perquisites which cost the facility \$2,000 and are included in the facility's allowable operating costs. The facility may then include in its records and additional \$3,000 to bring the value of the services rendered to \$5,000. The amount of \$3,000 shall be allowed if the facility assumes obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by the facility for the services.
- D. **APPLICATION**
- 1 Unrestricted funds, cash or otherwise, are generally the property of the provider to be used in any manner its management deems appropriate and shall not be deducted from operating costs. It would be inequitable to require providers to use the unrestricted funds to reduce the payments for care. The use of these funds is generally a means of recovering costs that are not otherwise recoverable. However, any interest earned on these funds shall be subject to the interest offset provisions of this manual.

2. Donor-restricted funds that are designated for paying certain operating expenses shall apply and serve to reduce these costs or groups of costs and benefit all residents who use the services covered by the donation. If costs are not reduced, the facility would secure reimbursement for the same expense twice; it would be reimbursed through the donor-restricted contributions as well as from residents and the Medicaid Program.

SECTION 570. PURCHASE DISCOUNTS AND ALLOWANCES AND REFUNDS OF EXPENSES

- A. PRINCIPLE. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.
- B. DEFINITIONS.
 1. "Discounts" means general reductions granted for the settlement of debts.
 2. "Allowances" means deductions granted for damage, delay shortage, imperfection, or other causes, excluding discounts and returns.
 3. "Refunds" means an amount paid back or credits allowed because of over collection.
- C. NORMAL ACCOUNTING TREATMENT - REDUCTION OF COSTS.

All discounts allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they shall be used to reduce the purchases or expenses of that period. However, if they are received in a Later accounting period, they shall be used to reduce the comparable purchases or expenses in the period in which they are received.

SECTION 580. COST TO RELATED ORGANIZATIONS

- A. PRINCIPLE. Cost applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are included in the allowable cost of the provider and is the cost of the related organization. However, the cost shall not exceed

the price of comparable services, facilities, or supplies that could be purchased elsewhere.

B. DEFINITIONS.

1. "Related to Provider" means that the provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by the organization furnishing the services, facilities, or supplies.
2. "Common ownership" means a relationship shall be considered to exist when an individual, including husband, wife, father, mother, brothers, sisters, sons, daughters, aunts, uncles, and in-laws, possesses five (5) percent or more of ownership or equity in the facility and the supplying business. A relationship shall also be considered to exist when it can be demonstrated that an individual or individual's control or influence management decisions or operations of the facility and the supplying business.
3. "Control" means if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

C. APPLICATION. If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is deemed to be a related organization, in effect the items are obtained from itself. Reimbursable cost shall include the cost for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider shall not exceed the market price. An example would be a corporation building a nursing home and then leasing it to another corporation controlled by the owner.

D. EXCEPTION. An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the Department for Medicaid Services that the supplying organization is a bona fide separate organization; that fifty-one (51) percent of the supplier's business activity of the type carried on with the facility is transacted with persons and organizations other than the facility and its related organizations and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by facilities such as the provider from other organizations and are not

a basic element of resident care ordinarily furnished directly to residents by facilities; and that the charge to the provider is in line with the charge for services, facilities, or supplies in the open market and not more than the charge made under comparable circumstances to others by the organization for services, facilities, or supplies. In these cases, the charge by the supplier to the facility for services, facilities, or supplies shall be allowable as cost.

SECTION 590. DETERMINATION OF ALLOWABLE COST OF SERVICES, SUPPLIES, AND EQUIPMENT

- A. PRINCIPLE. Reimbursement to providers for services, supplies and equipment shall be based on reasonable allowable cost as defined in this section.
- B. DETERMINING ALLOWABLE COST. The allowable cost of services, supplies and equipment shall exceed the lowest of:
 - 1. The acquisition of cost the provider;
 - 2. The provider's usual and customary charge to the public;
 - 3. The prevailing charge in the locality as determined by Medicare or the Department for Medicaid Services as applicable; or
 - 4. If the item or service is identified in the Federal Register as one that does not vary significantly in quality from one supplier to another, the lowest charge level as defined in 42 CFR 450.30.

SECTION 600. COST RELATED TO RESIDENT CARE

- A. PRINCIPLE. All payments to facilities shall be based on the reasonable cost of covered services and related to the care of recipients. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost. However, payments to facilities shall be based on the lesser of the reasonable cost of covered services furnished to Medicaid Program recipients or the customary charges to the general public for such services.

Reasonable cost of any services shall be determined in accordance with the principles of reimbursement establishing the method or methods to be used, and the items to be included. These principles take into account both direct and indirect costs of facilities. The objective is that under the

methods of determining cost, the costs with respect to individuals covered by the Medicaid Program shall not be borne by individuals not so covered, and the costs with respect to individuals not so covered shall not be borne by the Medicaid Program.

SECTION 610. REIMBURSEMENT FOR SERVICES OF PHYSICIANS

- A. PRINCIPLE. If the physician bills the Medicaid Program for services provided to the resident directly, such amount is to be approved and paid in accordance with the established practices relating to the physician element of the Medicaid Program. If the physician does not bill the Medicaid Program for services provided to the resident, costs to the facility are recognized as indicated in paragraph (C) of this section.
- B. REASONABLE COST. For the purposes of determining reasonable costs of services performed by physicians employed full time or regular part-time, reasonable cost of the services shall not exceed what a prudent and cost-conscious buyer would pay for comparable services by comparable providers.
- C. APPLICATION. If the physician is compensated by the facility for medical consultations, etc., on a part-time basis, the amounts paid to the physician, if reasonable, shall be recognized by the Medicaid Program as an allowable cost. Physician services by a part-time facility employee for medically necessary direct resident services shall be paid the physician directly through the physician's element of the Medicaid Program. If the physician is a full-time employee of a nursing facility all reasonable costs including direct resident services, shall be recognized as routine facility costs and shall not be billed to the Medicaid Program directly by the physician.

SECTION 620. MOTOR VEHICLES

- A. Costs associated with motor vehicles that are not owned by the facility, including motor vehicles that are registered or owned by the facility but used primarily by the owner, or family members thereof, shall be excluded as allowable costs.

-
- B. In 1986 Kentucky state law established allowable motor vehicle costs to be \$15,000 per vehicle, up to three (3) vehicles, if the vehicle is used for facility business. The allowable amount is adjusted annually for inflation according to the increase in the consumer price index for the most recent twelve-month period. Medically equipped motor vehicles shall be exempt from the limit. The Department may approve costs exceeding the limit on a facility by facility basis upon demonstration by the facility that additional costs are necessary for the operation of the facility.

SECTION 630. COMPENSATION OF OWNERS

- A. PRINCIPLE. A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed and are a necessary function.
- B. DEFINITIONS
1. "Reasonableness" requires the compensation allowance:
 - a. Be an amount as would ordinarily be paid for comparable services by comparable facilities;
 - b. Depend upon the facts and circumstances of each case; and,
 - b. Be pertinent to the operation and sound conduct of the facility.
 2. "Necessary" requires had the owner not rendered the services, the facility would have had to employ another person to perform the services.
 3. "Owner" means as any person or related family member (as specified below) with a cumulative ownership interest of five (5) percent or more. Members of the immediate family' of an owner, include husband, wife, father, mother, brothers, sisters, sons, daughters, aunts, uncles, and in-laws and shall be treated as owners for the purpose of compensation.
 4. "Compensation" means the total benefit received by the owner, including but not limited to: salary amounts paid for managerial, administrative, professional and other services; amounts paid by

the facility for the personal benefit of the owner; the cost of assets and services received from the facility and deferred compensation.

- C. APPLICATION. The cost of full-time owner-employees may be included as an allowable cost if the compensation is reasonably comparable to compensation for similar positions in the industry but shall not exceed the applicable compensation limit for owner-administrator. The compensation of part-time owner-employees performing managerial type functions shall be allowable to the extent that the compensation does not exceed the percent of time worked times eighty (80) percent of the applicable compensation limits for an owner-administrator.

Full-time owner-administrators and full-time owner-employees who perform non-managerial functions in facilities other than the facility that they are primarily associated shall, for Medicaid purposes, be limited to reasonable compensation of not more than fourteen (14) hours per week in addition to the salary in the facility with which they are primarily associated. To be considered reasonable compensation, the owner shall prove performance of a necessary function and be able to document the time claimed for compensation. If managerial functions are performed in a non-primary facility by the full-time owner-administrator or full-time owner-employee of another facility, the cost of the services shall not be allowed for purposes of the Medicaid Program.

Compensation for services requiring a licensed or certified professional performed on an intermittent basis shall not be considered a part of compensation, nor shall it be limited to the application of the owner-administrator compensation schedule, if the professional services (e.g. legal services) would have necessitated the procurement of another person to perform the services.

- D. COMPENSATION LIMITATION. Compensation for an owner-administrator shall be limited based on the total licensed beds of the facility in accordance with the following schedule:

LICENSED BEDS COMPENSATION	MAXIMUM
0-50	\$33,500

51-99	\$38,500
100-149	\$43,000
150-199	\$51,300
200+	\$52,600

This schedule shall be in effect for the period from July 1, 1991 through June 30, 1992. The compensation maximum shall be increased on July of each year by the Inflation Factor Index for wages and salaries Data Resources, Inc.). The Department for Medicaid Services shall utilize the moving average for the coming July 1 - June 30 fiscal year based on the latest inflation data available. The adjusted amounts shall be published annually in a reimbursement letter to all cost-based facility providers. Perquisites routinely provided to all employees and board of director's fees shall not be considered in applying owner's compensation limits

E. OTHER REQUIREMENTS

1. SOLE PROPRIETORSHIPS AND PARTNERSHIPS

The allowance of compensation for services of sole proprietors and partners shall be the amount determined to be the reasonable value of the services rendered (not to exceed the amount claimed for these services on the annual cost reports submitted by the facility. The allowance shall be an allowable cost regardless of whether there is any actual distribution of profits or other payments to the owner. The operating profit (or loss) of the facility shall not affect the allowance of compensation for the owners services.

2. CORPORATIONS.

To be included in allowable costs, compensation for services rendered as an employee, officer, or director by a person owning stock in a corporate provider shall be paid (by cash, negotiable instrument, or in-kind) during the cost reporting period in which the compensation is earned or within seventy-five (75) days thereafter. If payment is not made during this time period, the unpaid compensation shall not be included in allowable costs, either in the period earned or in the period when actually paid. For this purpose, an instrument to be negotiable shall be in writing and signed, shall contain an unconditional promise or other to pay a certain sum of money on demand or at a fixed and determinable future time and shall be payable to order or to bearer.

3. ACCRUED EXPENSES PAYABLE.

To be included in allowable costs, an accrued expense payable to an officer, director, stockholder, organization or other party or parties having control shall be paid (by cash, negotiable instrument, or in-kind) during the cost reporting period in which it has been incurred or within seventy-five (75) days thereafter. If payment is not made during this time period, the unpaid expense shall not be included in allowable costs, either in the period incurred or in the period when actually paid.

4. DEFINITIONS

- a. "Control" shall exist if an individual or an organization has the ability, directly or indirectly, to influence, manage or direct the actions or policies of the provider regardless of ownership interest.
- b. "Negotiable Instrument" means the negotiable instrument shall be in writing and signed, shall contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and shall be payable to order or to bearer.

SECTION 640. OTHER COSTS

- A. The cost of maintaining a chapel within the facility shall be allowable providing the cost is reasonable.
- B. The cost associated with facility license fees shall be allowed if proper documentation proves that the payment is a fee and not a tax.
- C. The costs associated with political contributions and legal fees for unsuccessful lawsuits filed by the provider shall be excluded from allowable cost. Legal fees relating to lawsuits against the Cabinet for Health Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or when otherwise agreed to by the parties involved or ordered by the court.

- D. The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities that shall not be allowable costs. However, costs (excluding transportation costs) for training or educational purposes outside the Commonwealth of Kentucky (except for owners or administrators) shall be allowable costs. Meetings per se shall not be considered educational; however, if educational or training components are included, the cost, exclusive of transportation shall be allowable. However, travel and associated expenses outside the Commonwealth of Kentucky shall not be allowable for owners and administrators for any reason.
- E. The cost of corporate income tax preparation shall be an allowable cost.
- F. Stockholder maintenance or servicing costs, such as preparation of an annual report, fees for filings required by the SEC etc., shall be allowable costs.
- G. The cost of the Board of Directors' fees shall be allowable, but shall be limited to five (5) meetings annually for single facility organizations and twelve (12) meetings annually for multiple facility organizations and shall meet a test of reasonableness. Other cost associated with Board of Directors' meetings

in excess of the above limitations on the number of meetings shall also be considered to be unallowable costs.

- H. Profits or revenues of the parent organization which are from sources not related to the provision of Cost-Based Facility care shall not be considered as reductions in the cost to the Medicaid Program if the investment funds that generated these profits or revenues were not co-mingled with investment funds of the facility, or have been unco-mingled, if necessary, and the source of the funds can be identified according to generally accepted accounting procedures.
- I. Employee leave time, if vested, shall be generally an allowable cost. For leave pay to be vested there shall be no contingencies on the employee's right to demand cash payment for unused leave upon termination of employment. Facilities continue to have the option of accounting for leave on an accrual or cash basis. If a facility wishes to switch its accounting method to the accrual accounting basis, the accumulated carryover from the prior year(s) may be expensed as utilized, in accordance with the facility's personnel rules concerning the taking of leave. Concurrent with the expensing of the carryover, current vacation earned shall be accrued
- J. Costs resulting from anti-union activity shall be disallowed. Costs associated with union activity, unless prohibited by the National Labor Relations Act or unless the costs are unreasonable or unnecessary, shall be allowed.
- K. In accordance with KRS 216.560(4), payment of penalties shall not be made from monies used for direct resident care nor shall the payment of penalties be a reimbursable cost under Medicaid.
- L. The costs associated with private club memberships shall be excluded from allowable costs.

SECTION 650. ANCILLARY COST

- A. Reasonable cost of ancillary services provided as a part of total care are reimbursable, but may be subject to maximum allowable cost limits under Federal regulations.

Ancillary services include:

Physical therapy
Occupational Therapy
Speech Therapy
Laboratory procedures
X-Ray
Oxygen
Respiratory therapy (excluding the routine administration of oxygen)

Appropriate time and cost records of therapy services shall be maintained. All contracted services shall be documented by invoices which clearly delineate charges for the service(s) provided to include the resident who received the service, the date the service was provided, the length of time the service required, and the person providing the service. Supplies and equipment shall be itemized separately from treatment on these invoices.

- B. DIRECT ANCILLARY COSTS. The direct ancillary costs of Physical, Occupational, Speech and Respiratory Therapy shall include only costs of equipment used exclusively for the specific therapy services, and the salary costs, excluding fringe benefits, of qualified therapy personnel who perform the service, or persons who perform the service under the on-site supervision of qualified therapy personnel.

Personnel qualified for respiratory therapy direct ancillary cost purposes shall be those qualified individuals either licensed by the Kentucky Board of Respiratory Care or the Kentucky Board of Nursing. This definition applies without regard to whether they are facility or hospital-based, or are an independent contractor.

- C. The cost of providing general nursing care, including the routine administration of oxygen, routine suctioning¹ or for standby services shall not be direct ancillary costs. Acquisition, after December 1, 1979, of therapy equipment with a total value of \$1,000 for each asset shall have prior approval by the Department for Medicaid Services in order to be recognized as an allowable cost by the Medicaid Program.

SECTION 660. UNALLOWABLE COSTS

- A. COSTS EXCLUDED FROM ALLOWABLE COSTS

1. Ambulance service

2. Private duty nursing
3. Luxury items or services
4. Dental services
5. Noncompetitive agreement costs
6. Cost of meals for other than residents and provider personnel
7. Dry cleaning of the resident's personal clothing
8. Drug costs -
9. An allowance for a return on equity is not reimbursable.

SECTION 670. SCHEDULE OF IMPLEMENTATION

The reimbursement system outlined in this part of the Cost-Based Facility Reimbursement Manual took effect July 1, 1991 rate setting. The reimbursement system in effect as of July 1, 1990 shall remain in effect for Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled (ICFMRIDD) through June 30, 1991 with the following exceptions:

- A. Effective October 1, 1990, drugs shall no longer be treated as an ancillary for ICF- MR/DD facilities.
- B. Drugs shall be billed through the Pharmacy Program. The pharmacist shall bill Medicaid directly and the facility shall no longer act as a conduit for drug billings.
- C. Those medical supplies previously billed as drugs that cannot be billed through the Pharmacy Program shall be treated as routine-cost for services provided on or after October 1, 1990.

SECTION 680. INTRODUCTION TO THE COST-BASED PAYMENT SYSTEM

This payment system is designed for ICF-MR facilities that are providing services to Medicaid recipients and are to be reimbursed by the Department for Medicaid Services. Effective for costs used in rate setting as of July 1, 1991 except as specified in this manual supplement, policies and procedures as stated in the Department for Medicaid Services. Cost-Based Facilities Reimbursement shall be applicable to ICF-MR/JDD facilities.

The intent of this reimbursement system is to recognize the reasonable costs associated with the services and level of care provided by ICF—MR facilities.

SECTION 690. OCCUPANCY LIMITATION EXCEPTIONS

If a facility is mandated by a court to reduce the number of beds, the occupancy limitations shall not be applied while alternative placement of residents is being attempted in order to comply with the court ruling. During the transition period, defined by the court, the facility shall be allowed a rate adjustment, not more often than monthly, which utilizes the actual facility occupancy.

SECTION 700. DEFINITION OF ROUTINE AND ANCILLARY SERVICES

The definitions of routine and ancillary services as stated in the Cost-Based Facility Reimbursement Manual shall be applicable to the ICF- MR/DD facilities. Psychological and psychiatric services shall be billed as ancillary services by an ICF-MR/DD.

SECTION 705. MEDICARE UPPER PAYMENT LIMIT (UPL) — ROUTINE COSTS

The estimate of the amount that would be paid under Medicare payment principles ("the Medicare UPL") is based on the following methodology. A base year shall be established utilizing cost and utilization data from all state owned or operated ICF/MR/DD facilities most recent desk audited cost reports for state fiscal year (SFY) 2005. Excluding capital and ancillary costs from these cost reports, a weighted mean cost per day will be computed by dividing the total aggregate routine costs for state owned or operated ICF/MR/DDs by the total aggregate cost report days for state owned or operated ICF/MR/DDs. The weighted mean cost per day will be multiplied by 112% to determine an adjusted weighted mean cost per day. The adjusted weighted mean cost per day will be trended forward by applying a rate of change equal to the Global Insight Skilled Nursing Facility Market basket without capital for the rate year. This process will determine the estimated Medicare reimbursement cost per day for the rate year. To determine the Medicare UPL for SFY 2006, take the trended Medicare cost per day multiplied by the actual Medicaid patient days for the current fiscal year (SFY 2005). The current fiscal year patient days will be determined using actual Medicaid patient days from the previous SFY. Medicare UPL calculations for future SFYs will be determined by trending the prior year estimated Medicare reimbursement cost per day forward by the Global Insight Skilled Nursing Facility Market basket without capital for the rate year and multiplying this by actual Medicaid patient days from the previous SFY. This Medicare UPL process will remain in effect for each SFY until the designation of a new base year. A new base year shall be established no more frequently than once every three years based on the most recent desk audited cost report data available.

The Medicare UPL for non-state but government owned or operated and non-governmental ICF/MR/DDs shall be calculated using the same method as the state owned or operated ICF/MR/DDs; however, the aggregate cost and utilization data will come from their own most recent desk audited cost reports.

For each rate year, the estimated Medicare UPL calculated as described above shall only increase to take into account any cost that ICF/MR/DD facilities are required to incur to comply with the conditions described in Att. 4.19-D, page 3 or Section 300 of Att.4.19-D, Exhibit B, page 28 that were not in effect during the Medicare UPL base year. The increase will be equal to the average per diem cost of complying with such requirements times the total number of Medicaid patient days in the Medicare UPL current year as defined-above. The year-end cost settlement will incorporate the additional payments.

SECTION 706. MEDICARE UPPER PAYMENT LIMIT (UPL) — ANCILLARY AND CAPITAL COSTS

Ancillary and capital costs will be limited to actual allowable cost based on Medicare Principles of Reimbursement. Allowable cost will be determined based on the provider's annual cost reports that have been audited and cost settled by Kentucky's Department for Medicaid Services. The total allowable ancillary and capital costs will be added to the routine cost determined in Section 705. This total cost will be the final annual Medicare UPL.

SECTION 710. LEASE OR RENT ARRANGEMENTS

All lease or rent arrangements occurring after 2/23/77 shall be limited to the owner's historical cost of ownership. For lease or rent arrangements occurring prior to 2/23/77, the Medicaid Program shall determine the allowable costs of the arrangement based on the general reasonableness of costs.

SECTION 720. ALLOWABLE COST BASIS ON PURCHASE OF FACILITY AS AN ONGOING OPERATION

The allowable cost basis of a facility purchased as an ongoing operation after July I, 1976, shall be determined in accordance with the policies outlined in the Cost-Based Facility Reimbursement Manual.

SECTION 730. INTEREST EXPENSE - EXCEPTION TO BORROWER-LENDER RELATIONSHIP

Exceptions to the general rule regarding interest on loans from controlled sources of funds shall be made in the following circumstances. Interest on loans to facilities by partners, stockholders, or related organizations made prior to July I, 1975 shall be allowable as cost provided that the terms and conditions of payment of the loans have been maintained in effect without modification subsequent to July 1, 1975.

SECTION 740. REIMBURSEMENT FOR SERVICES OF PHYSICIANS, DENTISTS AND HOSPITALS

If physician (excluding psychiatry) or dental services are provided by an employee or if physician, dental or hospital services are provided under an ongoing contractual arrangement, all reasonable costs including direct resident services shall be recognized as routine service facility costs and shall not be billed to the Medicaid Program directly by the physician, dentist, or hospital. This provision shall apply only to staff personnel while performing services that are in the scope of their employment or contractual agreement with the facility.

SECTION 750. EDUCATIONAL COST

The cost associated with providing educational services to residents of ICF-MRs shall not be an allowable expense for reimbursement purposes. Education services provided in facilities or areas within an ICF - MR or on its property which are specifically identified for providing these services by or under contract with the state or local educational agency shall not be reimbursable. Examples of these costs are salaries, building depreciation costs, overhead, utilities, etc. Whether or not educational services are provided in a specifically identified facility or area, reimbursement shall not be available for education or related services provided to a client during the periods of time the Individual Education Plan (IEP) requires that educational and related services be provided. All the services described in the IEP shall be excluded for Medicaid reimbursement, whether provided by state employees, by staff of the ICF-MR or by others.

Related services may be reimbursed if the services are performed as a reinforcement and continuation of the same type of instruction before or after the formal training as part of the individual's program of active treatment.

Educational services not eligible for reimbursement shall be those which are:

- A. Provided in the building, rooms, or area designated or used as a school or educational facility;
- B. Provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students;

-
- C. Included in the LEP for the specific student or required by Federal and State educational statutes or regulations; and,
 - D. Related services provided to a student under twenty-two (22) years of age.

SECTION 760. PURCHASE AND DISPOSAL OF SPECIALIZED MEDICAL EQUIPMENT

- A. Specialized medical equipment such as eyeglasses, dentures, adaptive wheelchairs, etc., shall be a part of routine cost when purchased by the provider. These items shall be either expensed in the year of acquisition when appropriate or capitalized and depreciated when meeting the criteria for the acquisitions. Examples of items to be expensed shall be most eyeglasses, dentures and other such items. Items to be capitalized and depreciated shall be adaptive wheelchairs, braces if applicable, etc. If an individual resident's family wishes to purchase any of these items for the resident, they may do so but any reimbursement to the facility shall be offset against the cost of the equipment to the extent the cost is reported on the facility's books.
- B. When a resident is discharged or voluntarily leaves a facility, the specialized equipment may be taken by the resident. If the facility charges the resident for the equipment and the equipment was originally expensed, this revenue shall be offset against the cost of medical supplies or administrative and general cost in the period when the resident leaves. If the equipment was capitalized and depreciated, then the transaction shall be handled as any disposable of appreciable asset would be. If, however, the facility does not charge the resident for the equipment when they leave, then any remaining depreciation shall be included in the period when the discharge occurred.

SECTION 770. INTRODUCTION TO INSTITUTIONS FOR MENTAL DISEASES

- A. This payment system is designed for the publicly operated cost-based nursing facilities defined as Institutions for Mental Disease (IMDs) which are providing services to Medicaid recipients and are to be reimbursed under the Department for Medicaid Services. This reimbursement system shall become effective with the rate setting on July 1, 1991.

-
- B. The cost report submission requirements and the rate computation methodology effective July 1, 1991 shall be the same as those for other cost-based facilities.
 - C. The intent of this reimbursement system shall be to recognize the reasonable costs associated with the services and level of care provided by IMD facilities.

SECTION 780. DEFINITION

For purposes of this system, an IMD is a publicly operated cost-based facility primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Coverage shall be limited to individuals age sixty-five (65) and above.

SECTION 790. INTRODUCTION TO DUAL LICENSE PEDIATRIC FACILITIES

- A. This payment system shall be designed for dual licensed pediatrics facilities that are providing services to Medicaid recipients and shall be reimbursed by the Department for Medicaid Services. Except as specified in this manual supplement, policies and procedures as stated in the Department for Medicaid Services Cost-Based Facility Reimbursement Manual. This reimbursement system shall be effective with the rate setting on July 1, 1991.
- B. The cost report submission requirements and the rate computation methodology rates effective July 1, 1991 shall be the same as those for all other cost-based facilities. -
- C. The intent of this reimbursement system shall be to recognize the reasonable costs associated with the services and level of care provided by Dual License Pediatric Facilities.

SECTION 800. DEFINITION

A facility having Dual Licensed Pediatric Facility beds and providing pediatric care only shall be classified as a pediatric Dual Licensed facility and shall receive reimbursement in accordance with the payment mechanism developed for that class of facility.

SECTION 810. INTRODUCTION TO THE COST-BASED FACILITY COST REPORT

The Annual Cost-Based Facility Cost Report provides for the submission of cost and statistical data which shall be used in rate setting and in reporting to various governmental and private agencies. All required information is pertinent and shall be submitted as accurately as possible.

In general, costs shall be reported as they appear in the provider's accounting records. Schedules shall be provided for any adjustments or reclassifications that are necessary.

In the cost finding process, direct costing between Certified Cost-Based Facility and Non-certified Cost-Based Facility shall be used wherever possible. If direct costing is utilized, it shall be utilized, if possible, for all costs of a similar nature. Direct costing shall not be utilized on a selective basis in order to distort the cost finding process.

SECTION 1. SCHEDULE A - CERTIFICATION AND OTHER DATA;

This schedule shall be completed by all facilities.

- A. TYPE OF CONTROL. In Sections 1 through 3 indicate as appropriate the ownership or auspices under which the facility operates.
- B. Section B is provided to show whether the amount of costs to be reimbursed by the Medicaid Program includes costs resulting from services, facilities, and supplies furnished to the vendor by organizations related to the vendor by common ownership or control. Section B shall be completed by all vendors.
- C. Section C shall be completed when the answer in Part B is yes. The amount reported in Section C shall agree with the facility's books.
- D. Section D shall be completed when the answer in Part B is yes.
- E. Section E is provided to show the total compensation paid for the period to sole proprietors, partners, and corporation officers, as owner(s) of Certified Nursing Facilities. Compensation is defined in the Principles of Reimbursement as the total benefit received (or receivable) by the owner for the services he renders to the institution. It shall include salary

amounts paid for managerial, administrative, professional, and other services; amounts paid by the institution for the personal benefit of the owner; and the cost of assets and services which the owner receives from the institution and deferred compensation. List the name, title and function of owner(s), percent of workweek devoted to business, percent of stock owned, and total compensation.

- F. Section F is provided to show total compensation paid to each employed person(s) to perform duties as administrators or assistance administrators. List each administrator or assistance administrator who has been employed during the fiscal period. List the name, title, percent of customary workweek devoted to business, percent of the fiscal period employed, and total compensation for the period.
- G. Section G shall be completed by all providers.
- H. Section H shall be completed by all providers.

SECTION 2. SCHEDULE B - STATEMENT OF INCOME AND EXPENSES:

If a facility has an income statement that provides the same detail as this schedule, this statement may be submitted in lieu of Schedule B. This schedule shall be prepared for the reporting period. During preparation, consideration shall be given to the following items:

- A. Line 1. The amount entered on this line shall be the gross charges for services rendered to residents before reductions for charity, bad debts, contractual allowances, etc. -
- B. Line 2. Record total bad debts, charity allowances, contractual adjustments, etc. on this line. This line shall include the difference between amounts paid by the resident or 3rd party payor and the standard charge of the facility.
- C. Line 3. Subtract line 2 from line 1.
- D. Line 4. Enter total operating expenses from Schedule D-4, Line 26, Column 2.
- E. Line 5. Subtract line 4 from line 3.

- F. Lines 6a, 6b, 7a, and 7b. Complete these lines in accordance with the definitions of restricted and unrestricted as presented in the Principles of Reimbursement in this manual.
- G. Line 12. Include on this line rent received from the rental portions of a facility to other related or non-related parties, i.e., the rental of space to a physician, etc.
- H. Line 14. Purchase discounts shall be applied to the cost of the items to which they relate. However, if they are recorded in a separate account, the total of the discounts shall be entered on this line.
- I. Line 31. Total lines 6a through 30.
- J. Line 33-48. Enter amount of other expenses, including those incurred by the facility, which do not relate to resident care.
- K. Line 49. Total lines 33 through 48.
- L. Line 50. Subtract line 49 from line 32.

SECTION 3. SCHEDULE C -BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

Non-profit facilities shall complete only column 1. Proprietary facilities shall complete the entire schedule. -

- A. Column 1. Enter the balance recorded in the facility's books of accounts at the end of the reporting period (accrual basis of accounting is required as indicated in the Principles of Reimbursement). Attachments may be used if the lines on the schedule are not sufficient. The capital accounts shown on lines 41 through 45, are those applicable to the type of business organization under which the provider operates as follows:
 - Individual Proprietor - Proprietor's Capital Account
 - Partnership - Partner's Capital Accounts
 - Corporation - Capital Stock and Other Accounts
- B. Column 2. This column shall be used to show amounts of assets and liabilities included in a facility's balance sheet, which do not relate to the provider of resident care. Entries to this column shall be detailed on

Schedule C-i. NOTE: It shall not be necessary to attempt to remove the portion of assets applicable to other levels of care on this schedule. Some examples of adjustments, which may be required, include:

1. Line 2 - Notes and Accounts Receivable. The notes and accounts receivable total to be entered in column 2 shall represent total amounts expected to be realized by the provider from non-resident care services.
2. Lines 11, 13, 15, 17, 19- Fixed Assets. The amounts to be entered in column 2 shall be based on the historical cost of those assets, or in the case of donated assets, the fair market value at the time of donation, which are not related to resident care.
3. Line 12, 14, 16, 18, and 20- Accumulated Depreciation. The amounts in column 2 shall be the adjustment necessary to reflect accumulated depreciation on the straight-line method to the effective date of entry into this reimbursement program and amounts claimed thereafter, and shall also be adjusted for disposals and amounts of accumulated depreciation on assets not related to resident care. Assets not related to resident care shall be removed on lines 11, 13, 15, 17, and 19 respectively.
4. LINE 22 - INVESTMENTS. Investments includable in the equity capital balance sheet in column 3 shall be limited to those related to resident care. Primarily, these shall be temporary investments of excess operating funds. Operating funds invested for long periods of time shall be considered excess and not related to resident care needs and shall accordingly be removed in column 2.
5. LINE 25 - OTHER ASSETS. Examples of items which may be in this asset category and their treatment for equity capital purposes are as follows:
 - a. Goodwill purchased shall be includable in equity capital.
 - b. Organization Expense. Expenses incurred in organizing the business shall be] includable in equity capital. (Net of Amortization)
 - c. Discounts on Bonds Payable. This account represents a deferred charge to income and shall be includable in equity capital. Other asset amounts not related to resident care shall be removed in column 2.

6. LINES 37, 38 - LOANS FROM OWNERS. Do not make adjustments in column 2 with respect to funds borrowed by basic IC or IC/MR facilities prior to July 1, 1975 or by Skilled Nursing Facilities prior to December 1, 1979, provided the terms and conditions of the loan agreement have not been modified subsequent to July 1, 1975, or December 1, 1979, respectively. Such loans shall be considered a liability in computing equity capital as interest expense related to such loans is included in allowable costs.

If the terms and conditions of payment of loans made prior to July 1, 1975 for IC facilities and December 1, 1979 for Skilled Nursing facilities, have been modified subsequent to July 1, 1975 and December 1, 1979, respectively, such loans shall not be included as a liability in column 6, and therefore shall be adjusted in column 5. Loans made by owners after these dates shall also be treated in this manner.

- C. For Schedule C, line 1-45, adjust the amounts entered in column 1 (increase and decrease) by the amounts entered in column 2 and extend the net amounts to column 3. Column 3 is provided for the listing of the balance sheet amounts that represent equity capital for the Department for Medicaid Services purposes at the end of the reporting period.

SECTION 4. SCHEDULE C-I - ADJUSTMENT TO EQUITY CAPITAL

This schedule shall be used to explain all adjustments made by the facility on Schedule C, column 2, in order to arrive at the adjusted balance sheet for equity capital purposes.

SECTION 5. OVERVIEW OF THE ALLOCATION PROCESS - SCHEDULE D-1 THROUGH D-5

These schedules provide for separating the operating expenses from the facility's financial records into five (5) cost categories: 1) Nursing Services Costs, 2) Other Care Related Costs, 3) Other Operating Costs, 4) Capital Costs and 5) Ancillary Costs. These schedules also provide for any necessary adjustments and reclassifications to certain accounts. Schedules D-1 through D-5 shall be completed by all facilities. All accounts that can be identified as belonging to a

specific cost center shall be reported to the appropriate section of Schedules D-1 through D-5. Capital cost shall be reported on schedule D-4 and not allocated to specific cost centers.

All listed accounts will not apply to all providers and some providers may have accounts in addition to those listed. These shall be listed on the lines labeled "Other Expense."

The flow of the Schedules D-1 through D-4 is identical. Salaries shall be reported on the salary lines and all salaries for each cost center shall be sub-totaled on the appropriate line. The entries to the columns on these schedules shall be as follows:

- A. Column 2. The expenses in this column shall agree with the provider's accounting books and records.
- B. Column 3. This column shall be utilized for reclassification of expenses as appropriate. Such reclassifications shall be detailed on Schedule D-6.
- C. Column 4. This column shall be for adjustments to allowable costs as may be necessary in accordance with the general policies and principles. All adjustments shall be detailed on Schedule D-7.
- D. Column 5. Enter the sum of columns 2, 3, and 4,
- E. Column 6. This column shall be completed for each line for which an entry is made to column 5 in order to indicate the basis of the separation of the costs reported to Column 5 between Column 7 (Certified Cost-based facility Alloc. of Costs) and Column 8 (Non-Certified and Non-Cost-based facility Alloc. of Costs). A "D" shall be entered to this column on each line on which the adjusted costs (Column 5) are direct costed between Columns 7 and 8. An "A" shall be entered to this column on each line on which the adjusted costs in Column 5 are allocated between Columns 7 and 8 on the basis of the allocation ratios on Schedule F. All accounts which can be direct costed from the provider's records shall be direct costed to Columns 7 and 8. Accounts which are direct costed shall be direct costed in full. Any accounts which cannot be direct costed shall be allocated using statistics from Schedule F. Providers shall ensure that all costs which are reported to column 7 are reasonable, necessary and related to Certified Cost-based facility resident care.
- F. Columns 7 and 8. The adjusted balance figures from Column 5 are to be allocated between Certified Cost-based facility Costs (Column 5) and Non-Certified Non-Facility costs (Column 7). Any accounts that cannot

be direct costed shall be allocated using statistics from Schedule F. All costs entered to Column 7 shall be reviewed by the provider to ensure that they are necessary, reasonable and related to Certified Cost-based facility resident care.

- G. Column 9: This column shall be completed only by Hospital-Based providers. Instructions regarding this column can be found in the instructions for the Schedules, which include Column 9 (i.e. D-3 and D-4).

SECTION 6. SCHEDULE D-1 - NURSING SERVICES COST

- A. The costs associated with nursing services, which shall be included in the nursing service cost category, are as follows:
1. Nursing assessment of the health status of the resident and planning of appropriate interventions to overcome identified problems and maximize resident strengths;
 2. Bedside care and services;
 3. Administration of oral, sublingual, rectal and local medications topically applied, and appropriate recording of the resident's responses;
 4. Training, assistance, and encouragement for self-care as required for feeding, grooming, ambulation, toilet, and other activities of daily living including movement within the nursing home facility;
 5. Supportive assistance and training in resident transfer techniques including transfer from bed to wheelchair or wheelchair to commode;
 6. Care of residents with behavior problems and severe emotional problems requiring nursing care or supervision;
 7. Administration of oxygen;
 8. Use of nebulizers;
 9. Maintenance care of resident's colostomy, ileostomy, and urostomy;
 10. Administration of parenteral medications, including intravenous solutions;
 11. Administration of tube feedings;
 12. Nasopharyngeal aspiration required for maintenance of a clean airway;
 13. Care of suprapubic catheters and urethral catheters;
 14. Care of tracheostomy, gastrostomy, and other tubes in a body;

15. Costs of equipment and supplies that are used to complement the services in the nursing service cost category including incontinence pads, dressings, bandages, enemas, enema equipment, diapers, thermometers, hypodermic needles and syringes, and clinical reagents or similar diagnostic agents;
 16. Costs for education or training including the cost of lodging and meals of nursing service personnel;
 17. The salaries and wages of persons performing nursing services including salaries of the director, and assistant director of nursing, supervising nurses, medical records personnel, registered professional nurses, licensed practical nurses, nurse aides, orderlies, and attendants;
 18. The salaries or fees of medical directors, physicians, or other professionals performing consulting services on medical care which are not reimbursed separately on a fee for service basis; and
 19. The costs of travel necessary for training programs for nursing personnel required to maintain licensure, certification, or professional standards.
- B. If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Nursing Facility Costs). Any account that is direct costed shall be directed costed in full. Any account which cannot be direct costed shall be allocated using Schedule F, Statistic A. Multiply the Column 5 amount by the Certified Cost-based facility percentage from Schedule F, Statistic A, and enter the product in Column 7. Subtract Column 7 from Column 5 and enter the result in Column 8. Providers shall ensure that all costs reported to Column 7 are necessary, reasonable, and related to Certified Cost-based facility resident care.

SECTION 7. SCHEDULE D-2 - OTHER CARE RELATED COSTS

A. General

The costs that shall be reported in the other care-related services cost category include:

1. Food costs, not including preparation;

2. Direct costs of other care-related services, such as social services and resident activities;
3. The salaries and wages of activities directors and aides, social workers and aides, and other care-related personnel including salaries or fees of professionals performing consultation services in these areas which are not reimbursed separately under the Medicaid Program;
4. The costs of training including the cost of lodging and meals to meet the requirements of laws or rules for keeping an employee's salary, status, or position, or to maintain or update skills needed in performing the employee's present duties.

B. Specific Instructions

1. Lines 1-30: If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Cost-based facility Costs.) Any account which is direct costed shall be direct costed in full. If accounts cannot be direct costed use the nursing allocation percentage (Schedule F, Statistic A, Line 3) to calculate Certified Nursing Facility Other Care Related Costs. Multiply the Certified Cost-based facility percentage times the amount in Column 5 and enter the products in Column 7. Subtract Column 7 from Column 5 and enter the results in Column 8.
2. Line 31 : If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Cost-based facility Costs.) Any account, which is direct, costed between Certified Cost-based facility and Non-Certified Cost-based facility shall be direct costed in full. Any account that cannot be direct costed shall be allocated using the dietary allocation percentage (Schedule F, Statistic C, Line 1, Column 2). Multiple the Certified Cost-based facility percentage times the amount in Column 5 and enters the product in Column 7.

Subtract the amount in Column 7 from Column 5 and enter the result in Column 8.

SECTION 8. SCHEDULE D-3 - OTHER OPERATING COSTS

- A. Lines I through 19: If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Cost-based facility Costs.) Any account, which is direct costed, shall be direct costed in full. If an account cannot be direct costed, use the dietary allocation percentage (Schedule F, Statistic C, Line 1, and Column 2) to allocate Dietary Costs. Multiply the Certified Cost-based facility percentage times the amounts in Column 5 and enter the products in Column 7. Subtract the amounts in Column 7 from Column 5 and enter the results in Column 8.
- B. Lines 21 through 55: [-] If an account can be direct costed, between Certified Cost-Based Facility and Non-Certified Cost-Based Facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) either Column 7, Certified Cost-Based Facility Costs, or Column 8, Non-Certified and Non-Cost-Based Facility Costs.) Any account, which is direct costed, shall be direct costed in full. Any account that cannot be direct costed shall be allocated using the Certified Cost-based facility square foot percentage (Schedule F, Statistic B, Line 1, and Column 2). Multiply the percentage times amounts in Column 5 and enter the products in Column 7. Multiply the "Other" percentage (Schedule F, Statistic B, Line 2, and Column 2) times the amounts in Column 5 and enter the products in Column 8. For Hospital-Based Facilities only: add the ancillary square foot percentages (Schedule F, Statistic B, Lines 3 through 8, Column 2) together. Use the sum to allocate Housekeeping & Plant Operation costs of the ancillary cost centers to Column 9.
- C. Line 57 through 74 and 76 through 130: [] If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s), (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified

and Non-Cost-Based Facility Costs.) If an account cannot be direct costed, use the nursing allocation-percentage (Schedule F, Statistic A, Line 3) to calculate Certified Cost-Based Facility Laundry and Administrative & General costs. Multiply the Certified Cost-Based Facility percentage times amounts in Column 5 and enter the products in Column 7. Subtract the amounts in Column 7 from Column 5 and enter the results in Column 8.

SECTION 9. SCHEDULE D-4 - CAPITAL COSTS

- A. If an account can be direct costed, between Certified Cost-based facility and Non-Certified Cost-based facility² the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Cost-based facility Costs.) If an account cannot be direct costed, allocate capital costs using square footage (Schedule F, Statistic B, Column 2). Multiply the Certified Cost-based facility percentage on Line 1 times amounts in Column 5 and enter the products in Column 7. Multiply the "Other" percentage on Line 2 times amounts in Column 5 and enter the products in Column 8. For Hospital-Based Facilities only: add the ancillary square footage percentages from Schedule F, Statistic B (Lines 3 through 8, Column 2) together. Use the sum to allocate capital costs of the ancillary cost centers to Column 9.
- B. Lines 24 through 28 are provided for the computation of total costs per books, net reclassifications, net adjustments, and total adjusted costs for comparison and analysis.
1. Line 24: The entries to this line Columns 2 through 9 shall be the total of the entries to Columns 2 through 9 of Schedules D-1 through D-3 and D-4 through Line 22.
 2. Line 25, Column 7: The entry to this line shall be the sum of Schedule D-5, Column 8, Lines 12, 21, 30, 42, 51, 60, and 67.
 3. Line 26, Column 7: The entry to this line shall be the sum of Column 7, Lines 24 and 25.
 4. Line 27: The entries to this line columns 2 through 5 shall be the total of the entries to columns 2 through 5 of Schedule D-5. Add the entries from the appropriate column, Schedule D-5, Lines 12, 21, 30, 42, 51, 60 and 67 to compute the proper entry.

-
5. Line 28: The entries to this line shall be the totals of lines 24 and 27.
- a. Column 2: The amount entered to Line 26, Column 2 shall agree with the total costs of the facility as reported in its general ledger.
 - b. Column 3: The total reclassifications (the amount entered to Line 26, Column 3) shall net out to be zero (0).
 - c. Column 4: The amount entered to Line 26, Column 4 shall be the total of all adjustments entered to Scheduled D-1 through D-5. It shall agree with the total adjustments reported on Schedule D-7 (D-7, Line 53, Column 3).

SECTION 10. SCHEDULE D-5- ANCILLARY COSTS

- A. Column 2: Ancillary costs as shown in the provider's books shall be entered to the appropriate lines. All ancillary salaries shall be reported to the salaries lines and sub-totaled on the appropriate line.
- B. Column 3: This column shall be utilized for reclassification of Column 2 costs as may be necessary for compliance with the general policies and principles. Reclassifications shall be detailed on Schedule D-6.
- C. Column 4: This column shall be utilized for adjustments to allowable ancillary costs as may be necessary for compliance with the general policies and principles. Adjustments shall be detailed on-Schedule D-7.
- D. Column 5: Enter the sum of Columns 2, 3, and 4. The amount entered here shall be the total ancillary cost of the facility as defined by the general policies and procedures.
- D. Column 6: The cost entered to Column 5 shall be analyzed to identify the direct and indirect ancillary cost portions as defined in the general policies and principles. The direct ancillary Cost shall be entered to Column 6.
- E. Column 7: This column shall be utilized to report the indirect ancillary portion (as defined in the general policies and principles) of the amount entered to Column 5. Subtract Column 6 from Column 5 and enter the difference.

1. Lines 11, 20, 29, 41, 50, 59, and 66 shall be completed by Hospital- Based Providers only. The purpose of these lines shall be to compute each ancillary cost center's share of plant operations and maintenance, housekeeping and capital costs. The Column 7 amounts are derived by multiplying the appropriate Hospital Ancillary Square Foot Percentage (Schedule F, Statistic B, Column 4) by the amount on Schedule D-4, Line 24, Column 9.
- G. Column 8: This column shall be used for reporting the Certified Cost Based Nursing Facility's share of indirect cost. For each ancillary cost center, multiply the appropriate Certified Cost-based facility Ancillary Charge Percentage (Schedule F, Statistic D, Column 3) times the amounts reported in Column 7 to arrive at the correct amounts for Column 8.

SECTION 11. SCHEDULE D-6-RECLASSIFICATION OF EXPENSES

This work sheet provides for the reclassification of certain amounts necessary to effect proper cost allocation under cost finding. All providers that do not direct cost payroll fringe benefits to individual cost centers shall use this schedule to allocate fringe benefits to the various cost centers. Fringe benefits shall be reclassified to individual cost centers on the ratio of the salaries unless another, more accurate and documentable method can be determined. The reclassification to each cost center shall be entered to the appropriate Schedule D-1 through D-5 line titled "Employee Benefits Reclassification."

SECTION 12. SCHEDULE D.7-ADJUSTMENT TO EXPENSES

This schedule details the adjustments to the expenses listed on Schedule D-1 through D-5, column 4. Line descriptions indicate the nature of activities, which affect allowable costs as defined in this manual or result in costs incurred for reasons other than resident care, and thus require adjustment. Lines 22 through 52 are provided for other adjustments not specified earlier. A brief description shall be provided.

The adjusted amount entered in Schedule D-7, column 3, shall be noted "A" in Schedule D-7, column 2, when the adjustment is based on costs. When costs are not determinable, "B" shall be entered in column 2 to indicate that the revenue received for the service is the basis for the adjustment.

SECTION 13. SCHEDULE E - ANCILLARY SETTLEMENT

This schedule is designed to determine the Medicaid share of direct and indirect ancillary costs.

- A. Column 2: Enter direct ancillary cost for each ancillary cost center from Schedule D-5, Column 6.
- B. Column 3: Multiply the direct costs (Column 2) by the corresponding Medicaid charge percentages (Schedule F, Section D, Column 5, Lines I through 7).
- C. Column 4: Enter the total amount received from the Medicaid Program (including any amount receivable from the Medicaid Program at the report date) for ancillary services rendered to Medicaid Certified Cost-based facility recipients during the period covered by the cost report.
- D. Column 5: Subtract the Column 5 amount from the Column 4 amount and enter the difference in Column 6.

SECTION 14. SCHEDULE F - ALLOCATION STATISTICS

- A. Section A - Nursing Hours or Salaries

This allocation statistic shall be used as the basis for allocating the line item costs reported to Schedule D-1, Lines 1-33; Schedule D-2, Lines 1- 30; and D-3, Lines 57-1 30, which cannot be direct, costed to the levels of care. The allocation statistic may be based on the ratio of direct cost of nursing salaries, the ratio of direct nursing hours, a valid time study (as defined by the Department for Medicaid Services), another method which has been approved by the Department for Medicaid Services or, if no other reasonable basis can be determined, resident days. The computation of this statistic shall account for the direct salary costs associated with all material non-certified nursing activities of the facility (such as adult day care or home health services, for example). The computed statistic shall be reasonable and based on documented data. The method used in arriving at the allocation shall be identified at the appropriate place on Schedule F, Ratio A. For Hospital-Based Facilities Only: The salary costs of all departments and services of the hospital, including all ancillary departments as defined in the general policies and principles of the

Department for Medicaid Services, shall be included in the calculation of this statistic. Allocations of costs between Certified Cost-based facility and acute cost centers on the basis of resident days will be accepted only when the resulting allocation statistic can be documented and shown to be reasonable.

1. Line 1: Enter the Certified Cost-based facility figure (i.e., salaries or direct hours)
2. Line 2: Enter the "Other" nursing and direct service figure (i.e. salaries or direct hours)
3. Line 3: Divide Line 1 by the sum of Lines 1 and 2 and enter the percentage on Line 3. The percentage shall be carried out to four decimal places (i.e. xx.xxxx%).
4. NOTE: If salary cost figures are used in computing this allocation statistic, the amounts entered in Lines 1 and 2 shall usually agree to entities on the salary lines of Schedule D-1. If the Schedule F, Ratio A salary figures do not agree to Schedule D-1 salary lines, providers shall review both schedules to ensure that both schedules are correct. The provider shall be able to reconcile Schedule F, Ratio A to Schedule D-1 salary lines upon request.

B. Section B - Square Footage

1. Freestanding facilities shall only complete Columns 1 and 2 of this section. Hospital facilities shall complete all four columns.
 - a. Column 1, Lines 1-10: Enter the square feet in each applicable area of the facility. Direct resident room areas shall be allocated between Certified Cost-based facility and "Other" (PC, Non-certified, Acute, etc.). General resident areas, such as hallways, nursing stations, lounges, etc., which are utilized 100% by one level of care shall be directly allocated to the appropriate cost center. General resident areas used by more than one level of care and general service departments (administrator offices, dietary areas, etc.) shall be allocated between levels of care based on the ratio of Certified Cost-based facility room square footage to total room square footage. In freestanding facilities, ancillary departments shall be

considered general service departments and allocated to levels of care. In Hospital-Based facilities, direct ancillary square footage shall be entered on Lines 3 through 8.

b. Column 2, Lines 1-10: Percentages in Column 2 shall be derived by dividing Column 2, Lines 1 through 9, by Line 10 of Column 1. Line 10 shall be the sum of Lines 1 through 9 and should equal 100.0000%.

2. Columns 3 and 4 shall only be completed by Hospital-Based Facilities. These two columns compute allocation factors to allocate the indirect ancillary costs allocated to the pooled ancillaries in Column 9 of Schedules D-3 and D-4 to the individual ancillary cost centers on Schedule D-5.

- a. Column 3, Lines 3-9: The entries to these lines shall be identical to the entries on the same line number of Ratio B, Column 1.
- b. Column 3, Line 10: The entry to this line shall be the sum of the entries to Lines 3-9.
- c. Column 4, Lines 3-9: The entries to these lines shall be the percentages resulting from dividing the direct square footage allocated to each ancillary service in Column 3, Lines 3-9 by the total direct ancillary square footage computed at Column 3, Line 10. Percentages shall be carried to four digits (i.e., xx.xxxx%).
- d. Column 4, Line 10: The entry to this line shall be the sum of Column 4, Lines 3-9 and shall equal 100.0000%.

C. Section C - Dietary

Identify the method used in arriving at the number of meals served. An actual meal count for 3 X in resident days shall be used. If 3 X in resident days is used, the provider shall ensure that bed reserve days are not included in this calculation.

1. Column 1: Enter total meals in each category.
2. Column 2: To arrive at percentages, divide Lines 1 and 2 in Column 1 by Line 3 in Column 1.

D Section D - Ancillary Charges

1. Column 1: Enter the total charges for each type of ancillary service on Lines I through 7. Add Lines 1 through 7 and enter total on Line 8.
2. Column 2: Enter the total charge for each type of ancillary service provided to all Certified Cost-based facility residents (both Medicaid and non-Medicaid) on Lines I through 7. Add Lines I through 7 and enter the sum to Line 8.
3. Column 3: For each Line 1 through 8 divide total CNF resident charges as reported in Column 2 by the total resident charges (all facility residents) reported in Column 1. Enter the resulting percentage in column 3. Percentages shall be carried to four decimal places (i.e., xx.xxxx%).
4. Column 4: Enter the total charges for each type of ancillary service provided to Medicaid residents in certified beds on Lines 1 through 7. Add Lines I through 7 and total on Line 8.
5. Column 5: For each Line I through 8 divide Medicaid charges in Column 4 by total charges in Column 1. Enter the resulting percentage in Column 3. Percentages shall be carried out to four decimals (i.e. xx xxxx%).

E. Section E - Occupancy Statistics

1. Lines 1 and 2. Enter the number of licensed bed days. Temporary changes due to alterations, painting, etc. do not affect bed capacity.
2. Line 3. Total licensed bed days available shall be determined by multiplying the number of licensed beds in the period by the number of days in the period. Take into account increases and decreases in the number of licensed beds and the number of days elapsed since the changes. If actual bed days are greater than licensed bed days available, actual bed days shall be used.
3. Line 4. Enter resident days for all residents in the facility. A resident day shall be the care of one resident during the period between one census taking period on two successive days, including bed reserve days. The day of admission shall be included and the day of discharge excluded. Do not include both. When a resident is admitted and discharged on the same day, this period shall be counted as one day.

4. Line 5. Percentage of occupancy shall be the percentage obtained by dividing total resident days by bed days available. The percentage calculation shall not be carried beyond one decimal place (xx.x%).
5. Line 6. A Medicaid resident day of care shall be an in-resident or bed reserve day covered under the Medicaid Program. A resident days covered by the Medicare Program for which a co-insurance or deductible is made by the Medicaid Pr

ANNUAL COST REPORT
 SCHEDULE A
 CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For the Period From: _____ Leap Year 365
 To: _____

- A. Type of Contract
- | | | |
|--|--|--|
| 1. Voluntary Non-Profit | 2. Proprietary | 3. Government |
| Church <input type="checkbox"/> | Individual <input type="checkbox"/> | <input type="checkbox"/> State _____ |
| Other (Specify) <input type="checkbox"/> | Partnership <input type="checkbox"/> | <input type="checkbox"/> County _____ |
| _____ | Corporation <input type="checkbox"/> | <input type="checkbox"/> City _____ |
| _____ | Other (Specify) <input type="checkbox"/> | <input type="checkbox"/> Other (Specify) _____ |
| | | _____ |
| | | _____ |

- B. Statement of cost of services from Related Organizations
1. In the amount of cost to be reimbursed by the Medicaid Program, are any cost included which are the result of transactions with a related organization?
- Yes No (IF "Yes" complete parts C & D). All Vendors are to complete E & F, if applicable.

C. Cost Incurred as the result of transactions with related organizations.

Schedule	Line #	Item	Amount
----------	--------	------	--------

D. Name & percent of direct or indirect ownership of the related organization.

Name of Owner	Name of Related Organization	Percent
---------------	------------------------------	---------

E. Statement of Compensation of Owners

Name	Title & Function	Percent of Customary Work Week Devoted to Business	Partners % of Operating Profit or Loss	Corp Ofc % of Vendor's Stock Owned	Total Compensation
------	------------------	--	--	------------------------------------	--------------------

ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For the Period From: _____
To: _____

F. Statement of Compensation Paid to Administrators and/or Assistant Administrators (Other than Owners).

Name	Title	Percent of Customary Work Week Devoted to Business	Percent Of Period Employed	Total Compensation For the Period
------	-------	--	----------------------------	-----------------------------------

G. Has the facility has a change of ownership in the past fiscal year? A change of ownership is defined as the transfer of assets of a facility. The sale of stock in a facility does not constitute a change of ownership.

Yes No

If yes, indicate the new owners and the percent owned. (If corporate owned, not individuals.)

Name	Percent Owned
------	---------------

H. Certification by Officer of Facility

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medicaid Cost Report for the period ended _____ and that, to the best of my knowledge and belief, they are true and correct statements prepared from the books and records of _____ in accordance with applicable program directives, except as noted.

(Signed)

Officer or Administrator of Facility

Title

ANNUAL COST REPORT
 SCHEDULE B
 STATEMENT OF INCOME AND EXPENSES

VENDOR NAME:	VENDOR NUMBER:	FYE
1. Total Patient Revenues		
2. Less Allowances and discounts on patients' accounts		
3. Net Patient Revenues		\$
4. Less: Total operating expenses		
5. Net income from services to patients		\$
OTHER INCOME		
6a. Unrestricted contributions, donations, bequests, etc.		
6b. Restricted contributions, donations, bequests, etc		
7a. Income from unrestricted investments		
7b. Income from restricted investments		
8. Vending machine commission		
9. Revenue from meals sold to employees and guests		
10. Revenue from sale of drugs, supplies, etc. sold to non-patients		
11. Revenue from telephone and telegraph services		
12. Revenue from rental of non-patient facilities		
13. Revenue from Beauty/Barber Shop		
14. Purchase discounts		
15. Other (specify)		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		
26.		
27.		
28.		
29.		
30.		
31. Total other income		
32. Total of line 5 and line 31		
33.		
34.		
35.		
36.		
37.		
38.		
39.		
40.		
41.		
42.		
43.		
44.		
45.		
46.		
47.		
48.		
49. Total Other Expenses		
50. NET INCOME FOR THE PERIOD (line 32 less line 49)		

TN # 00-04
 Supersedes
 TN # 96-10

Approved Aug 10, 2001

Eff. Date 1-1-00

ANNUAL COST REPORT
 SCHEDULE C
 BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME:

VENDOR NUMBER:

FYE

		(1)	(2)	(3)
		<u>ASSETS</u>		
		Per Books	Adjustments	Balance
Current Assets				\$
1.	Cash			\$
2.	Notes and Accounts Receivable			\$
3.	Other Receivables			\$
4.	Less Allowance for Uncollectable Accounts			\$
5.	Inventory			\$
6.	Prepaid Expenses			\$
7.	Investments			\$
8.	Other (Specify)			\$
				\$
				\$
9.	<i>Total Current Assets</i>	\$	\$	\$
Fixed Assets				\$
10.	Land			\$
11.	Building and Leasehold Improvements			\$
12.	Less Accumulated Depreciation			\$
13.	Fixed Equipment			\$
14.	Less Accumulated Depreciation			\$
15.	Major Movable Equipment			\$
16.	Less Accumulated Depreciation			\$
17.	Motor Vehicles			\$
18.	Less Accumulated Depreciation			\$
19.	Minor Equipment			\$
20.	Less Accumulated Depreciation			\$
				\$
21.	<i>Total Fixed Assets</i>	\$	\$	\$
Other Assets				\$
22.	Investments			\$
23.	Lease Deposits			\$
24.	Due from Owners or Officers (Specify)			\$
				\$
				\$
				\$
				\$
25.	Other (Specify)			\$
				\$
				\$
				\$
26.	<i>Total Other Assets</i>	\$	\$	\$
27.	Total Assets	\$	\$	\$

TN # 00-04
 Supersedes
 TN # 96-10

Approved Aug 10, 2001

Eff. Date 1-1-00

ANNUAL COST REPORT
 SCHEDULE C (cont.)
 BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME: _____ VENDOR NUMBER: _____ FYE _____

	(1)	(2)	(3)
<u>LIABILITIES</u>			
Current Utilities	Per Books	Adjustments	Balance
28. Accounts Payable			\$
29. Notes Payable			
30. Current Portion of Long Term Debt			
31. Salaries and Fees Payable			
32. Payroll Taxes Payable			
33. Income Taxes Payable			
34. Deferred Income Payable			
35. Other (Specify)			
<hr/>			
36. <i>Total Current Liabilities</i>	\$	\$	\$
<u>Long Term Liabilities</u>			
37. Mortgage Payable			\$
38. Notes Payable			
<hr/>			
39. <i>Total Long Term Liabilities</i>	\$		\$
<hr/>			
40. <i>Total Liabilities</i>	<u>\$</u>	<u>\$</u>	<u>\$</u>

CAPITAL AND OWNERS' EQUITY

41. Common Stock			\$
42. Preferred Stock			
43. Treasury Stock			
44. Retained Earnings			
45. Other (Specify)			
<hr/>			
<hr/>			
46. <i>Total Capital and Owners' Equity</i>	\$	\$	\$
<hr/>			
47. <i>Total Liabilities and Capital</i>	<u>\$</u>	<u>\$</u>	<u>\$</u>

TN # 00-04
 Supersedes
 TN # 96-10

Approved AUG 10, 2001

Eff. Date 1-1-00

ANNUAL COST REPORT
 SCHEDULE C-1
 BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL ADJUSTMENTS

VENDOR NAME:

VENDOR NUMBER:

FYE

	EXPLANATION	AMOUNT	CLASSIFICATION ADJUSTED ACCOUNT	LINE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53				
54				
55				
56	TOTAL			

TN # 00-04
 Supersedes
 TN # 96-10

Approved AUG 10, 2001

Eff. Date 1-1-00

ANNUAL COST REPORT – SCHEDULE D-1- NURSING SERVICES COSTS

Attachment 4.19-D Exhibit B Page 86-G	VENDOR NAME:	VENDOR NUMBER:					FYE	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Per Books	Reclassifications	Adjustments	Adjusted Balance	Direct Cost or Alloc.	Certified Nursing Facility Alloc. Of Costs	Non-Certified & Non-Nursing Fac. Alloc. Of Costs.
1	Director of Nursing Salary							
2	R.N. Salaries							
3	L.P.N. Salaries							
4	C.M.A. Salaries							
5	Aides Salaries							
6	Other Salaries							
7	Other Salaries							
8	Other Salaries							
9	<i>Subtotal - Salaries</i>							
10	Employee Benefits Reclassification							
11	Nursing Contracted Services							
12	Medical Records Salaries							
13	Medical Director Fees							
14	Pharmacy Consultant Fees							
15	Physician Services							
16	Nursing Education & Training							
17	Nursing Travel Expense							
18	Medical Supplies							
19	Adult Diapers & Underpads							
20	Nursing Equipment Rental							
21	Nursing Small Equip. Purchases							
22	Other Expenses							
23	Other Expenses							
24	Other Expenses							
25	Other Expenses							
26	Other Expenses							
27	Other Expenses							
28	Other Expenses							
29	Other Expenses							
30	Other Expenses							
31	Other Expenses							
32	Other Expenses							
33	Other Expenses							
34	<i>Total</i>							

Eff. Date 1-1-00

Approved AUG 10, 2001

TN # 00-04
Supersedes
TN # 96-10

ANNUAL COST REPORT – SCHEDULE D-2- OTHER CARE RELATED COSTS

Attachment 4.19-D Exhibit B Page 86-H	VENDOR NAME:	VENDOR NUMBER:						FYE
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Per Books	Reclassifications	Adjustments	Adjusted Balance	Direct Cost or Alloc.	Certified Nursing Facility Alloc. Of Costs	Non-Certified & Non-Nursing Fac. Alloc. Of Costs.
1	Activities Salaries							
2	Social Services Salaries							
3	Other Salaries							
4	Other Salaries							
5	Other Salaries							
6	<i>Subtotal - Salaries</i>							
7	Employee Benefits Reclassification							
8	Activities Supplies							
9	Social Services Supplies							
10	Training & Education Expense							
11	Travel Expense							
12	Other Expenses							
13	Other Expenses							
14	Other Expenses							
15	Other Expenses							
16	Other Expenses							
17	Other Expenses							
18	Other Expenses							
19	Other Expenses							
20	Other Expenses							
21	Other Expenses							
22	Other Expenses							
23	Other Expenses							
24	Other Expenses							
25	Other Expenses							
26	Other Expenses							
27	Other Expenses							
28	Other Expenses							
29	Other Expenses							
30	Other Expenses							
31	Raw Food							
32	<i>Total</i>							

Eff. Date 1-1-00

Approved AUG 10, 2001

TN # 00-04
Supersedes
TN # 96-10

ANNUAL COST REPORT – SCHEDULE D-3- OTHER OPERATING COSTS

Attachment 4.19-D
Exhibit B
Page 86-J

VENDOR NAME:	VENDOR NUMBER:									FYE
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)		
	Per Books	Reclass-ifications	Adjustments	Adjusted Balance	Direct Cost or Alloc.	Certified Nursing Facility Alloc. Of Costs	Non-Certified & Non-Nursing Fac. Alloc. Of Costs.	Ancillary Hospital-Based Facility Only		
32										
33										
34										
35										
36										
37										
38										
39										
40										
41										
42										
43										
44										
45										
46										
47										
48										
49										
50										
51										
52										
53										
54										
55										
56										
57										
58										
59										
60										
61										
62										
63										
64										

Eff. Date 1-1-00

Approved AUG 10, 2001

TN # 00-04
Supersedes
TN # 96-10

ANNUAL COST REPORT – SCHEDULE D-3- OTHER OPERATING COSTS

Attachment 4.19-D
Exhibit B
Page 86-K

VENDOR NAME:

VENDOR NUMBER:

FYE

Eff. Date 1-1-00

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Per	Reclass-		Adjusted	Direct	Certified	Non-Certified &	Ancillary
	Books	ifications	Adjustments	Balance	Cost or	Nursing Facility	Non-Nursing Fac.	Hospital-Based
					Alloc.	Alloc. Of Costs	Alloc. Of Costs.	Facility Only
65								
66								
67								
68								
69								
70								
71								
72								
73								
74								
75								
76								
77								
78								
79								
80								
87								
82								
83								
84								
85								
86								
87								
88								
89								
90								
91								
92								
93								
94								
95								
96								
97								

Approved AUG 10, 2001

TN # 00-04
Supersedes
TN # 96-10

ANNUAL COST REPORT – SCHEDULE D-3- OTHER OPERATING COSTS

Attachment 4.19-D
Exhibit B
Page 86-L

VENDOR NAME:

VENDOR NUMBER:

FYE

Eff. Date 1-1-00

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Per	Reclass-		Adjusted	Direct	Certified	Non-Certified &	Ancillary
	Books	ifications	Adjustments	Balance	Cost or	Nursing Facility	Non-Nursing Fac.	Hospital-Based
					Alloc.	Alloc. Of Costs	Alloc. Of Costs.	Facility Only
98		Contracted Services						
99		Utilization Review						
100		Travel & Seminars						
101		Advertising – Help Wanted						
102		Advertising – Other						
103		Small Equipment Purchases						
104		Licenses & Fees						
105		Interest Expense – Non-capital						
106		Other Expense						
107		Other Expense						
108		Other Expense						
109		Other Expense						
110		Other Expense						
111		Other Expense						
112		Other Expense						
113		Other Expense						
114		Other Expense						
115		Other Expense						
116		Other Expense						
117		Other Expense						
118		Other Expense						
119		Other Expense						
120		Other Expense						
121		Other Expense						
122		Other Expense						
123		Other Expense						
124		Other Expense						
125		Other Expense						
126		Other Expense						
127		Other Expense						
128		Other Expense						
129		Other Expense						
130		HEALTH CARE PROVIDER TAX						
131		<i>Total Admin & General Exp</i>						

Approved AUG 10, 2001

TN # 00-04
Supersedes
TN # 96-10

ANNUAL COST REPORT – SCHEDULE D-4- CAPITAL COSTS

Attachment 4.19-D

Exhibit B

Page 86-M

VENDOR NAME:

VENDOR NUMBER:

FYE

Eff. Date 1-1-00

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
		Per	Reclass-		Adjusted	Direct	Certified	Non-Certified &	Ancillary
		Books	ifications	Adjustments	Balance	Cost or	Nursing Facility	Non-Nursing Fac.	Hospital-Based
						Alloc.	Alloc. Of Costs	Alloc. Of Costs.	Facility Only
1	Depreciation – Building								
2	Depreciation – Equipment								
3	Interest Expense – Capital Related								
4	Rent								
5	Land Improvements								
6	Leasehold Improvements								
7	Amortization of Start up Costs								
8	Other Capital Costs								
9	Other Capital Costs								
10	Other Capital Costs								
11	Other Capital Costs								
12	Other Capital Costs								
13	Other Capital Costs								
14	Other Capital Costs								
15	Other Capital Costs								
16	Other Capital Costs								
17	Other Capital Costs								
18	Other Capital Costs								
19	Other Capital Costs								
20	Other Capital Costs								
21	Other Capital Costs								
22	Other Capital Costs								
23	<i>Total</i>								
24	<u>Grand Totals</u>	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
25	Totals of Schedules D-1 through D-4								
26	Total of Schedule of D-8, Column 8								
27	Total Routine CNF Cost								
28	Totals from Schedule D-5								
	Total Costs								

Approved AUG 10, 2001

TN # 00-04
Supersedes
TN # 96-10

ANNUAL COST REPORT – SCHEDULE D-5 – ANCILLARY COSTS

Attachment 4.19-D
Exhibit B
Page 86-N

VENDOR NAME:	VENDOR NUMBER:	FYE:					
(1)	(2) Per Books	(3) Reclassifications	(4) Adjustments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
<u>Physical Therapy</u>							
1 Physical Therapist Salaries							
2 Physical Therapist Asstnts, Salaries							
3 Physical Therapist Aides Salaries							
4 Other Salaries							
5 <i>Subtotal Salaries</i>							
6 Employee Benefits Reclassification							
7 Contracted Services							
8 Equipment Depreciation							
9 Other Expenses							
10 Other Expenses							
11 Hospital-Based Indirect Ancillary							
12 <i>Total</i>	<u>(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 3, Col 4)</u>						
<u>X-Ray</u>							
13 Professional Salaries							
14 Other Salaries							
15 <i>Subtotal Salaries</i>							
16 Employee Benefits Reclassification							
17 Supplies							
18 Equipment Depreciation							
19 Other Expenses							
20 Hospital-Based Indirect Ancillary							
21 <i>Total</i>	<u>(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 4, Col. 4)</u>						
<u>Laboratory</u>							
22 Professional Salaries							
23 Other Salaries							
24 <i>Subtotal Salaries</i>							
25 Employee Benefits Reclassification							
26 Supplies							
27 Equipment Depreciation							
28 Other Expenses							
29 Hospital-Based Indirect Ancillary							
30 <i>Total</i>	<u>(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 5, Col. 4)</u>						

Eff. Date 1-1-00

Approved AUG 10, 2001

TN # 00-04
Supersedes
TN # 96-10

ANNUAL COST REPORT – SCHEDULE D-5 – ANCILLARY COSTS

Attachment 4.19-D
Exhibit B
Page 86-O

VENDOR NAME:	VENDOR NUMBER:	FYE:					
(1)	(2) Per Books	(3) Reclassifications	(4) Adjustments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
<u>Oxygen/Respiratory Therapy</u>							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							

Eff. Date 1-1-00

Approved AUG 10, 2001

TN # 00-04
Supersedes
TN # 96-10

SCHEDULE D-6
RECLASSIFICATIONS OF EXPENSES

Attachment 4.19-D
Exhibit B
Page 86-Q

VENDOR NAME:

VENDOR NUMBER:

FYE:

Line	(1) Explanation	(2) Increase Amount	(3) Decrease Amount	(4) Cost Center Affected (Schedule & Line # Affected) (cc D3-1)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53				
54				
55				
56				
57				
58				
59				
60				
61	<i>Total</i>			

TN # 00-04
Supersedes
TN 96-10

Approved AUG 10, 2001

Eff. Date: 1-1-00

SCHEDULE D-7
RECLASSIFICATIONS OF EXPENSES

Attachment 4.19-D
Exhibit B
Page 86-R

VENDOR NAME:

VENDOR NUMBER:

FYE:

	(1)	(2)	(3)	(4)
		Basis for Adjustment (A) or (B)	Amount	Sch & Line # Affected (cc D3-1)
<u>Line</u>	<u>Explanation</u>			
1	Laundry & Linen			
2	Employee & Guest Meals			
3	Gift, Flower & Coffee Shop			
4	Grants, Gifts, & Income Designated By the donor for a specific purpose			
5	Beauty & Barber Shop			
6	Excess Owners Compensation			
7	Telephone Serv (Pay Serv. Excluded)			
8	Radio & Television Service			
9	Vending Machine Commission			
10	Sale of drugs to other than Patients			
11	Sale of Medical & Surgical Supplies To other than Patients			
12	Sale of Medical Record & Abstracts			
13	Sale of Scrap, Waste, Etc.			
14	Rental of Quarters to Emp & Others			
15	Rental of Facility Space			
16	Trade, Qty, Time & Other Discounts			
17	Rebates & Refunds of Expenses			
18	Interest Not Allowed			
19	Recovery of Insured Loss			
20	Depreciation			
21	Gain or Loss of Disposition of Assets			
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53	<i>Total</i>			

TN # 00-04
Supersedes
TN # 96-10

Approved AUG 10, 2001

Eff. Date: 1-1-00

ANNUAL COST REPORT – SCHEDULE E – ANCILLARY SETTLEMENT

VENDOR NAME:

VENDOR NUMBER:

FYE:

	(1)	(2) Direct (From Sch. D-5, Col 6)	(3) Medicaid Direct	(4) Medicaid Payments	(5) Receivable From KMAP (Payable to KMAP)
1	Physical Therapy				
2	X-Ray				
3	Laboratory				
4	Oxygen/Respiratory Therapy				
5	Speech				
6	Other				
7	Drugs				
8	<i>Total</i>				

Medicaid Services use only	
TENTATIVE	ANCILLARY
ANCILLARY	SETTLEMENT
<input type="checkbox"/>	<input type="checkbox"/>

Eff. Date 1-1-00

Approved AUG 10, 2001

TN # 00-04
Supersedes

STATISTICS

VENDOR NAME: _____

FYE _____

FYE _____

VENDOR NUMBER: _____
 DAYS

MONTHS _____

A. NURSING SALARIES Leap Year 365

1	CERTIFIED NURSING FACILITY		
2	OTHER		
3	CERT. NURSING FAC. PERCENTAGE		
ALLOCATION METHOD:			
	PATIENT DAYS <input type="checkbox"/>	VALID TIME STUDY <input type="checkbox"/>	
	DIRECT COST <input type="checkbox"/>	DIRECT HOURS <input type="checkbox"/>	
	OTHER APPROVED METHOD <input type="checkbox"/>		

B. SQUARE FOOTAGE

		(1) SQ. FT.	(2) PERCENT	(3) HOSPITAL-BASED SQ. FT.	(4) HOSPITAL-BASED PERCENT
1	CERT. NURSING FACILITY				
2	OTHER				
3	PHYSICAL THERAPY*				
4	X-RAY*				
5	LABORATORY*				
6	OXYGEN/RESP. THERAPY*				
7	SPEECH*				
8	OTHER*				
9	DRUGS*				
10	TOTAL				

*For Hospital-Based Certified Nursing Facility Only

C. DIETARY

		MEALS	PERCENT
1	CERT. NURSING FACILITY		
2	ALL OTHER		
3	TOTAL		
ALLOCATION METHOD:			
	MEAL COUNT: <input type="checkbox"/>	3*INPATIENT DAYS: <input type="checkbox"/>	

D. ANCILLARY CHARGES

		(1) TOTAL	(2) CNF	(3) CNF %	(4) MEDICAID	(5) MEDICAID %
1	PHYSICAL THERAPY					
2	X-RAY					
3	LABORATORY					
4	OXYGEN/RESP. THERAPY					
5	SPEECH					
6	OTHER					
7	DRUGS					
8	TOTAL					

E. OCCUPANCY STATISTICS

		(1) CERTIFIED NURSING FACILITY	(2) OTHER LONG-TERM CARE	(3) ACUTE CARE
1	LICENSED BEDS AT BEGINNING OF PERIOD			
2	LICENSED BEDS AT END OF PERIOD			
3	BED DAYS AVAILABLE			
4	TOTAL PATIENT DAYS			
5	% OCCUPANCY			
6	KMAP PATIENT DAYS			
7	% KMAP OCCUPANCY			

F. ADDITIONAL STATISTICS

1	DIRECT ROUTINE NURSING HOURS – CERTIFIED NURSING FACILITY ONLY	
2	TOTAL DIRECT DIETARY HOURS	
3	TOTAL DIRECT HOUSEKEEPING HOURS	

TN # 00-04
 Supersedes
 TN # 96-10

Approved AUG 10, 2001

Eff. Date 1-1-00

DISCLOSURE SECTION

VENDOR NAME:

FYE:

VENDOR NUMBER:

A. STATEMENT OF ORGANIZATIONS CONTRACTED WITH

NAME	TYPE OF BUSINESS	DATE OF CONTRACT
------	------------------	------------------

B. PROTESTED AMOUNTS (NON-ALLOWABLE COST REPORT ITEMS)

ITEM	AMOUNT	SCHEDULE AND LINE
------	--------	-------------------

TN # 00-04
Supersedes
TN # 96-10

Approved AUG 10, 2001

Eff. Date 1-1-00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Kentucky

Attachment 4.19-E
Page 20.1

Timely Claims Payment

Definition of A Claim

- (1) "Claim" means:
 - (a) For physician, podiatry, dental, vision care, hearing aid dealers, home health, primary care clinics, mental health center clinics, pharmacy, hospital outpatient, and independent laboratory services, a line item of service;
 - (b) For tuberculosis and mental hospital services, all services for one recipient within a bill; and
 - (c) For all other services, a bill for services.

State Kentucky

Requirements for Third Party Liability
Identifying Liable Resources

The Title XIX single state agency is committed to compliance with all third party recovery requirements, including those shown in 42 CFR 433, Subpart D, Third Party Liability. For purposes of clarification, we state herein that the \$250 threshold applies only with regard to accident/trauma claims; there is a \$25 threshold amount for waiver claims such as pharmacy; there is no threshold amount for all other claims. The Kentucky Department for Medicaid Services may look back three (3) years for payment for any healthcare item or services submitted not later than three (3) years after the date such item or service was provided.

- (b) (1) An agreement has been developed with the Department for Social Insurance (DSI) for collecting and forwarding health insurance information for Kentucky's Title XIX recipients. The local DSI field worker collects TPL data during initial application and during the redetermination process. The information collected includes the name of the policy holder, relationship of policy holder to recipient, the social security number of the policy holder, the policy number, and type of coverage held and name and address of insurance company. The information is added daily to the TPL data base and claims are edited against the data each processing cycle. Social Security Numbers of absent parents are being obtained from Title IV-D agencies. Addresses of employers of absent parents are obtained from unemployment insurance.

Data exchanges have been arranged with Worker's Compensation and will be done quarterly. SWICA information is obtained during application and at least quarterly. SSA information is obtained during the application process from recipients for whom the information was not previously requested.

Data exchanges have been, and will continue to be, attempted as required by regulation with Motor Vehicle Registration.

State Kentucky

-
- (2) The state follows up within 30 days on all information obtained from SWIC, SSA wage and earnings files, and Title IV- A by entering any valid or appropriate data into the TPL avoidance file, or by utilizing the data for collection. The state will follow up the data exchanges with health insurers and worker's compensation files within sixty (60) days from the date of receipt of the tapes.
 - (3) The state has attempted, and will continue its efforts, to develop a state motor vehicle accident report file.
 - (4) Claims involving trauma diagnosis codes are processed in accordance with 42 CFR 433.138(3) and 433.139 with accumulated claims in excess of \$250 pursued for possible third party payment or recovery. A monthly listing is produced which identifies all recipients for whom \$250 or more has been paid within a prior ninety (90) day period with an indicator of trauma or accident. Each case is actively pursued for possible collection. The time frames within which incorporation of information from accident/trauma diagnosis code TPL procedures must be accomplished is thirty (30) days.
 - (5) Providers are not required to bill the third party in situations where the third party liability is derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency. Kentucky uses the pay and chase method.
 - (6) The state assures that the requirements of 42 CFR 433.145 through 433.148 are met for assignment for rights to benefits. Kentucky's statute KRS 205.624 (see Attachment 4.22-A, Exhibit A) requires assignment of third party payments. The application for Medical Assistance/AFDC and the Medical Assistance identification Card have a statement notifying the applicant/recipient of the third party assignment.

205.624. Assignment to cabinet by recipient of rights to third party payments - Right of recovery by cabinet. - (1) An applicant or recipient shall be deemed to have made to the cabinet an assignment of his rights to third party payments to the extent of medical assistance paid on behalf of the recipient under title XIX of the Social Security Act. The applicant or recipient shall be informed in writing by the cabinet of such assignment.

- (2) The cabinet shall have the right of recovery which a recipient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the cabinet for such care and treatment of the recipient under the provisions of title XIX of the Social Security Act.
- (a) If a payment for medical assistance is made, the cabinet, to enforce its right, may:
1. Intervene or join in an action or proceeding brought by the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors against a third party who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled recipient, in state or federal court; or
 2. Institute and prosecute legal proceedings against a third party who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled recipient, in state or federal court, either alone or in conjunction with the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors; or
 3. Institute the proceedings in its own name or in the name of the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors.
- (b) The injured, diseased, or disabled person may proceed in his own name, collecting costs without the necessity of joining the cabinet or the Commonwealth as a named party, provided the injured, diseased, or disabled person shall notify the cabinet of the action or proceeding entered into upon commencement of the action or proceeding. The injured, diseased, or disabled person must notify the cabinet of any settlement or judgment of his or her claim.
- (c) In the case of an applicant for or recipient of medical assistance whose eligibility is based on deprivation of parental care or support due to absence of a parent from the home, the cabinet may:
1. Initiate a civil action or other legal proceedings to secure repayment of medical assistance expenditures for which the absent parent is liable; and
 2. Provide for the payment of reasonable administrative costs incurred by such other state or county agency requested by the cabinet to assist in the enforcement of securing repayment from the absent parent. Enact. Acts 1980, ch. 252, § 4.

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I)

The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Requirements for Third Party Liability -
Payment of Claims

1. For accident/trauma claims, the state has established a two hundred and fifty dollar threshold amount in determining whether to seek reimbursement from liable third parties based on an accumulation of claims processed within a prior ninety day period, but with recoupment applied to all accumulated accident/trauma claims processed within a prior two year period.
2. The exception to the above policy is accident cases in litigation over \$250 (two hundred and fifty dollars). These cases will be pursued from the date the accident occurred, regardless of the ninety day period and two—year time period.
3. Effective July 1, 1988, for claims that are not cost avoided pursuant to Kentucky's approved waiver, there is a \$25 threshold with the \$25 accumulated throughout each calendar quarter.
4. The provider's compliance with the billing requirement in situations involving medical support enforcement by the state Title IV-D agency is determined by having the liable third parties notify the state at the time of the state's quarterly billing if the provider has not complied with the billing requirement. Duplicate payments will be recouped.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans
A	Cost Effectiveness
	(1) Enrollment in a group health insurance plan shall be considered cost effective when the cost of paying the premiums, coinsurance, deductibles and other cost-sharing obligations, and additional administrative costs is estimated to be less than the amount paid for an equivalent set of Medicaid services.
	(1) When determining cost effectiveness of a group health insurance plan, the department shall consider the following information:
	a. The cost of the insurance premium, coinsurance, and deductible;
	b. The scope of services covered under the insurance plan, including exclusions for pre-existing conditions, exclusions to enrollment, and lifetime maximum benefits imposed;
	c. The average anticipated Medicaid utilization:
	1. By age, sex, and coverage group for persons covered under the insurance plan; and
	2. Using a statewide average for the geographic component;
	d. The specific health-related circumstances of the persons covered under the insurance plan; and
	e. Annual administrative expenditures of an amount determined by the department per Medicaid participant covered under the group health insurance plan.
B.	Cost Effectiveness Review.
	(1) The department shall complete a cost effectiveness review:
	a. At least once every six (6) months for an employer-related group health insurance plan; or
	b. Annually for a non-employer-related group health insurance plan.
	(2) The department shall perform a cost effectiveness re-determination if:
	a. A predetermined premium rate, deductible, or coinsurance increases;
	b. Any of the individuals covered under the group health plan lose full Medicaid eligibility; or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

- c. There is a:
 - 1. Change in Medicaid eligibility;
 - 2. Loss of employment when the insurance is through an employer;
or
 - 3. A decrease in the services covered under the policy.
- (3) Changes in enrollment
 - a. A health insurance premium payment program participant, who is a Medicaid enrollee, or a person on that individual's behalf, shall report all changes concerning health insurance coverage to the participant's local Department for Community Based Services (DCBS), Division of Family Support within ten (10) days of the change.
 - b. Except as allowed in section (4) below, if a Medicaid enrollee who is a health insurance premium payment program participant fails to comply with paragraph (a) of this subsection, the department shall disenroll the HIPP program participating Medicaid enrollee, and any family member enrolled in the HIPP program directly through the individual if applicable, from the HIPP program.
- (4) The department shall not disenroll an individual from HIPP program participation if the individual demonstrates to the department, within thirty (30) days of notice of HIPP program disenrollment, good cause for failing to comply with subsection (3) of this section.
- (5) Good cause for failing to comply with subsection (3) of this section shall exist if:
 - a. There was a serious illness or death of the individual, parent, guardian, or caretaker or a member of the individual's, parent's guardian's, or caretaker's family;
 - b. There was a family emergency or household disaster – for example a fire, flood, tornado, or similar;
 - c. The individual, parent, guardian, or caretaker offers a good cause beyond the individual's, parent's, guardian's, or caretaker's control; or
 - d. There was a failure to receive the department's request for information or notification for a reason not attributable to the individual, parent, guardian, or caretaker or lack of a forwarding address shall be attributable to the individual, parent, guardian, or caretaker.
- C Coverage of Non-Medicaid Family Members.
 - (1) If determined to be cost effective, the department shall enroll a family member who is not a Medicaid enrollee into the HIPP program if the family member has group health insurance plan coverage through which the department can obtain health insurance coverage for a Medicaid-enrollee in the family.
 - (2) The needs of a family member who is not a Medicaid enrollee shall not be taken into consideration when determining cost effectiveness of a group health insurance plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

- (3) The department shall:
- a. Pay a HIPP program premium on behalf of a HIPP program participating family member who is not a Medicaid enrollee; and
 - b. Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a HIPP program-participating family member who is not a Medicaid enrollee.

State/Territory: Kentucky

Citation

Sanctions for Psychiatric Hospitals

1902(y)(1),
1902(y)(2)(A)
And Section
1902(y)(3)
of the Act
(P.L. 101-508,
Section 4755(a)(2))
1902(y)(1)(A)
of the Act

(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.

(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.

1902(y)(1)(B)
of the Act

(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:

1. terminate the hospital's participation under the State plan;
or
2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or
3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.

1902(y)(2)(A)
of the Act

(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State: Kentucky

Citation

Sanctions for MCOs and PCCMs

1932(e)
42 CFR 428.726

- (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:
- (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:
- (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by (MS under 42 CFR 438.730(e).
 - Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

Medicaid cards are held in the local public assistance offices for pick-up by homeless individuals.

TN No. 87-15
Supersedes
TN No. None

Approval Date JAN 22, 1988

Effective Date 10-1-87

THE HEALTH CARE SURROGATE ACT OF KENTUCKY

Also enacted into law by the 1990 session of the Kentucky General Assembly and the Governor was Senate Bill No. 88, the Health Care Surrogate Act of Kentucky, which is codified at KRS 311.970-386 and allows an adult of sound mind to make a written declaration which would designate one or more adult persons who could consent or withdraw consent for any medical procedure or treatment relating to the grantor when the grantor no longer has the capacity to make such decisions. This law requires that the grantor, being the person making the designation, sign and date the designation of health care surrogate which, at his option, may be in the presence of two adult witnesses who also sign or he may acknowledge his designation before a notary public without witnesses. The health care surrogate cannot be an employee, owner, director or officer of a health care facility where the grantor is a resident or patient unless related to the grantor.

Except in limited situations, a health care facility would remain obligated to provide food and water, treatment for the relief of pain, and life sustaining treatment to pregnant women, notwithstanding the decision of the patient's health care surrogate.

DURABLE POWER OF ATTORNEY

A person may execute, pursuant to KRS 386.093, a document known as a durable power of attorney which would allow someone else to be designated to make decisions regarding health, personal, and financial affairs notwithstanding the later disability or incapacity of the person who executed the durable power of attorney.

TN No. 91-31

Supersedes

TN No. None

Approval Date 1-7-92

Effective Date: 3/3/91

Revision: HCFA-PM-95-4 (HSQS)
JUNE 1995

Attachment 4.35-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at S488.404(b)(1):

None

TN No. 95-13
Supersedes
TN No. 89-36

Approval Date: 1-16-96

Effective Date: 7/1/95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

TN No. 95-13
Supersedes
TN No. 89-36

Approval Date: 1-16-96

Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at S1919(h)(2)(A)) for applying the remedy.

- | | | | |
|-------------------------------------|--|--------------------------|---|
| <input checked="" type="checkbox"/> | Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.) | <input type="checkbox"/> | Specified Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.) |
|-------------------------------------|--|--------------------------|---|

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-D

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

- | | | | |
|-------------------------------------|--|--------------------------|---|
| <input checked="" type="checkbox"/> | Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.) | <input type="checkbox"/> | Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.) |
|-------------------------------------|--|--------------------------|---|

TN No. 95-13
Supersedes
TN No. None

Approval Date: 1-16-96

Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy Alternative Remedy

(Will use the criteria and notice requirements specified in the regulation.)

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents: Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A))

- | | | | |
|-------------------------------------|--|--------------------------|---|
| <input checked="" type="checkbox"/> | Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.) | <input type="checkbox"/> | Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.) |
|-------------------------------------|--|--------------------------|---|

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

Not applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

Not applicable

TN No. 92-2
Supersedes
TN No. None

Approval Date 2-26-92

Effective Date: 2-1-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

Not applicable

TN No. 92-2
Supersedes
TN No. None

Approval Date 2-26-92

Effective Date: 2-1-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

DEFINITION OF SPECIALIZED SERVICES

Mental Illness;

Specialized services (active treatment) is defined as the implementation of an individualized plan of care developed and supervised by a physician and provided by an interdisciplinary team of qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of serious mental illness, which necessitates continuous supervision by trained mental health personnel. Specialized services (active treatment) require the level of intensity provided in a psychiatric inpatient service.

Mental Retardation

Specialized services (active treatment) is defined as the continuous aggressive and consistent implementation of a program of specialized and generic training, treatment, health and related services, which are comparable to services an individual would receive in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), and in the Alternative Intermediate Services for Mental Retardation (AIS/MR) Waiver Program where 24-hour supervision is available that is directed toward: (1) the acquisition of the skills necessary for the person to function with as much self - determination and independence as possible; and (2) the prevention or deceleration of regression or loss of current optimal functional status. {NOTE: Continuous is defined as the interaction, at all times and in all settings, between staff and individuals served, in the implementation of specific Individual Program Plan (IPP) objectives.}

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CATEGORICAL DETERMINATIONS

**Advance Group Determination for Nursing Facility Level of Care
(Provisional Admission for up to 14 Days)**

An advance group determination, or provisional admission, is one in which the Level I reviewer, after nursing facility certification, takes into account certain diagnoses or the need for a particular service which clearly indicates that admission into or residence in a nursing facility is normally needed. Persons who enter the nursing facility under the provisional admissions category do not require an individualized evaluation to determine that specialized services are needed prior to admission. However, a request for a Level II PASARR should be made within nine (9) days of admission with each provisional admission if they are not going to be discharged within the fourteen (14) days. This allows the PASARR evaluator five (5) days to provide a verbal determination.

Provisional Admissions
(Nursing Facility Placement up to 14 Days)

- 1) A diagnosis of delirium as defined in the OSMITIR, allows for a fourteen (14) day admission pending further assessment, when an accurate diagnosis cannot be made until the delirium clears.
- 2) Respite is allowed to in-home care givers to whom the person with mental illness or mental retardation is expected to return following a fourteen (14) day or less stay.

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

REVISED
Attachment 4.40-A
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

State staff participate in regular and periodic provider training events. This participation includes serving as presenters and panel members as well as conducting sessions on regulations changes and implementation. Provider representatives include both administration and direct case staff. State staff also participate in resident council meetings and will be providing other training for facility residents and/or responsible parties as time and staff permit.

TN No. 93-6
Supersedes
TN No. None

Approval Date: 8-12-97

Effective Date 1-1-93

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect
and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

All allegations of abuse, neglect and misappropriation of resident property are immediately investigated by Division of Licensing and Regulation and Department for Social Services in a joint effort. During this investigation the accused individual is advised of the alleged incident. Prior to a final determination of substantiation the accused individual is afforded the opportunity to appeal. All substantiated investigations are subject to the appropriate appeal process. Substantiated cases of Nurse Aide abuse, neglect and/or misappropriation are entered on a centralized registry maintained by the State Survey Agency. The accused individual and all appropriate authorities are notified of the final determination and action taken.

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

REVISED
Attachment 4.40-C
Page 1
OMB No.:

STATE PLAN UNDER TITLE: XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

In addition to federal procedures, the Division of Licensing and Regulation is prohibited by state law from giving any advance notice of long-term care facility surveys. Surveys to be conducted in a given month are sent to our regional offices. Schedulers in regional offices do not release schedules to staff until approximately one week prior to survey. Master schedules in regional offices are closely guarded.

Kentucky uses a flexible survey schedule where some facilities are surveyed in ranges of 9 to 15 months. Survey schedules are also based on performance in previous surveys and the number of complaints made against a facility.

TN No. 93-6
Supersedes
TN No. None

Approval Date 8-12-97

Effective Date 1-1-93
HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following procedures to measure and reduce inconsistency in the application of survey results among surveyors.

Annual training sponsored by Licensing and Regulation plus quarterly in-service training in Regional Offices on specific problem areas that need addressing for statewide consistency in the application of the survey process. Basic training and other specialized courses are provided by HCFA. Also, all survey packets received in Central Office are reviewed by compliance analysts.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

- (i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;
- (ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or
- (iii) the State has reason to question the compliance of the facility with such requirements.

Refer to Attachment 4.40-C

All allegations of facility violations are investigated by the Division of Licensing and Regulation. All deficiencies resulting in Level A noncompliance are followed up for correction.

**Method for establishing Employee Education
Of False Claim Policies and Procedures**

1. The Department will query the Decision Support System (DSS) for FFY 2006 Fee-for-Service and Encounter Data as of January 1, 2007 to identify entities for the purposes of section 6032 of the Deficit Reduction Act of 2005 with distinct Federal Employer Identification Number (FEIN) receiving over \$5,000,000.
2. Each entity from the query in step 1, will be sent a provider letter reminding them that their provider agreement requires them to comply with all applicable State and Federal laws and advising them that the Deficit Reduction Act of 2005 section 6032 contains a new requirement that must be met. Any entity paid through the Medicaid FMAP signs the aforementioned provider agreements in order to receive a provider number and the ability to bill. This includes Passport, Transportation Brokers, and other state agencies. The letter will include a form that must be signed and returned certifying that they meet the following requirements from section 1902(a)(68) of the Social Security Act:
 - A. Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs(as defined in section 1128B(f));
 - B. include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
 - C. include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;
3. The entities will attach relevant documents in meeting the requirements from 1902(a)(68) of the Social Security Act. Relevant documents include but are not limited to policy memos, employee handbook, and any document that demonstrates how the entity satisfies the requirements. Responses will be due to the Department by September 1, 2007.
4. The Department will evaluate the entities responses, and certify the response as valid or state the reasons the conditions were not met in a response back to the entity by December 31, 2007.
5. For future years beginning with FFY 2009, a reassessment will occur at least every three years to ensure compliance with 1902(a)(68) of the Social Security Act. The following deadlines will apply in the given year:
 - A. Un-duplicated providers from the previous FFY's DSS query meeting the same criteria in step 1 as of January 1 following the end of the respective FFY will be sent the entity letters from step 2 by March 31 of the respective year;
 - B. Entity response to the letter will be due by June 30 of the respective year; and
 - C. The Department will send the response to the entity by September 30 of the respective year. The Department letter will validate the entities response' or state the reasons the conditions were not met.

MEDICAL ASSISTANCE PROGRAM

STATE OF KENTUCKY

KENTUCKY CITATION LISTING

1. Kentucky revised statutes, Chapter 18, on State Personnel, as amended through February 22, 1972, including the understanding contained in the March 16, 1972, letter from Carl V. Beeler, then Chief, Division of Intergovernmental Personnel Programs, USCSC, to Miss Cattle Lou Miller, Kentucky Commissioner of Personnel, that in the Grant-Aided Agencies the Federal standards must determine which assistant or deputy may be exempted from coverage. Also included is the understanding contained in paragraph 3 of the March 16, 1972, letter that the only effect of Section 3 (1) and Section 4 (1) and (2), of House Bill Number 120, is to remove the Commissioner of Personnel class from Merit System coverage and to revise the method of appointment to authorize direct appointment by the Governor.
2. Personnel rules of the Kentucky Department of Personnel, as amended through March 9, 1973, including the understanding contained in the October 31, 1961, letter from the Kentucky Commissioner of Personnel to the Regional Merit System Representative that provisional appointments will not be made or continued if there are as many as three (3) available eligibles for a position.
3. Policy memoranda in effect through November 25, 1970, which were issued by the Commissioner of Personnel to all Department and Agency Heads.

MEDICAL ASSISTANCE PROGRAM

STATE OF Kentucky METHODS OF ADMINISTRATION - CIVIL RIGHTS

The state agency's implementing methods of administration of the medical assistance program to ensure non-discrimination have been submitted and are on file.

I. Assignment of Responsibility

Responsibility for ensuring that Title VI compliance is maintained rests with the Coordinator, Civil Rights, Department for Human Resources. In accordance with administrative structure of the Department for Human Resources, Title VI reviews of hospitals, nursing homes and intermediate care facilities are conducted by the Division for Licensing and Regulation, Bureau for Administration and Operations, in conjunction with the Division's on-site validation surveys.

II. Dissemination of Information

A check insert was sent to all recipients of assistance in 1965 to advise that the adult and children's programs and medical assistance would be administered in accordance with the Civil Rights Act of 1964. The insert specified that no discrimination would be made due to race, color, or national origin, and that applicant or recipient who felt he was discriminated against for these reasons had the right to appeal. A pamphlet titled "Kentucky Public Assistance and Civil Rights" was prepared to explain the Civil Rights Act and was mailed to recipients of assistance payments to further advise them of the provisions of the Act. A copy of the pamphlet is given to each new applicant. Any applicant or recipient who appears not to understand his civil rights is given a complete verbal explanation to supplement the written material, and it is agency practice that in any initial interview with an applicant for assistance the worker summarizes the Title VI provisions and provides answers to any questions.

The Civil Rights pamphlet specifies the agency's compliance with Title VI, explains that applicants and recipients of federally aided programs will not be discriminated against by the agency or vendors of services, and that the applicant or recipient who feels he has been discriminated against may request a hearing with the agency or make the allegation of discrimination to the Kentucky Commission on Human Rights, Frankfort, Kentucky, or the Secretary of Health, Education, and Welfare, in Washington, DC.

MEDICAL ASSISTANCE PROGRAM

STATE OF: Kentucky METHODS OF ADMINISTRATION - CIVIL RIGHTS

The Manual of Operation of the Bureau for Social Insurance specifies that the Federal Government has been assured that public assistance programs will be administered in such a manner that no person is to be excluded from any benefits under the program or otherwise subjected to any discrimination on the grounds of race, color or national origin. Pamphlets, check inserts and similar civil rights material made available to applicants/recipients are also made available to staff, and circulars, memoranda, and similar communicative devices are used to further advise staff of actions required for compliance with the Civil Rights Act. Agency training and orientation for new workers provide explanation of Title VI of the Civil Rights Act and instructs workers in techniques of non-discrimination. Supervisory personnel are also from time to time, used to re-emphasize to agency workers the importance of non-discrimination and to correct any local practices which may be interpreted as discriminatory, whether real or potential.

Vendors are provided with Civil Rights information by pamphlets, Circulars or other appropriate means, and where required by Federal regulation their agreement to participate includes their agreement not to discriminate due to race, color or national origin. The billing system is designed so as to contain a statement to the effect that services provided under the Medical Assistance Program are provided without discrimination due to race, color or national origin.

The General Public is made aware of the agency's continuing compliance with Title VI by the use of public information releases to newspapers or other-news outlets at intervals as necessary.

III Maintaining and Assuring Compliance

Pursuant to federal regulations and utilizing federal guidelines on-site reviews are conducted at least annually of all participating hospitals, skilled nursing facilities and intermediate care facilities, unless a satisfactory and similar review for Title XVIII purposes has been accomplished for that period of time. The on-site review is conducted by trained personnel of the Division for Licensing and Regulation, Bureau for Administration and Operation, as an integral part of their annual on-site validation survey of these facilities, and includes a- survey of the physical facility, interviews with appropriate facility employees and patients, and an evaluation as to any actual or potential areas of discrimination.

MEDICAL ASSISTANCE PROGRAM

STATE OF Kentucky METHODS OF ADMINISTRATION CIVIL RIGHTS

The Bureau does not conduct regular on-site reviews for Civil Rights compliance monitoring of physicians, dentists, etc. However, the Bureau for Social Insurance has personnel assigned to specific area development districts who have as one of their functions vendor liaison to assist vendors in overcoming problems related to client identification, billing, program changes, etc. These liaison personnel do as a part of their assigned responsibility visit the offices, clinics and other facilities of individual vendors and would observe any overt or manifest indications of discriminatory practice or treatment. Whether discovered through the Title VI on-site review or other contact, any suspected discriminatory practice is investigated to determine the facts of the situation, and an evaluation as to actual or potential discrimination is made.

Should a discriminatory practice be found, the Bureau takes immediate action to secure compliance. In accordance with federal directives the individual, organization, or agency found to be in actual or potential non-compliance with the Civil Rights Act and agency practice in the provision of medical and related services is afforded the opportunity to voluntarily comply with the requirements. In the event efforts to solicit voluntary compliance fail, all available sanctions provided for in the law and regulations are invoked, including removal of a vendor from participatory status in all appropriate instances.

IV. Handling Complaints

At the time the client alleges discriminatory treatment, the local worker explores the situation and attempts to resolve it to the satisfaction of the client on an informal basis. If such resolution is not possible, the client may appeal through the usual hearing process, or file a complaint of discrimination based on race, color, or national origin.

When the client alleges that he is being denied eligibility for a money payment or medical assistance through discriminatory agency policy, or discriminatory application of agency policy, he would ordinarily use the hearing process which provides for determinations as to eligibility for benefits. The process includes a hearing before a Hearing Officer of the Bureau, recourse to the Appeal Board for a review of the Hearing Officer's decision, and final recourse to the judicial system. The complainant is afforded the right to counsel, or other representation of his choice, throughout the process. He may submit written or oral statements or other material to substantiate his allegation, and may appear personally to present evidence or have the case judged on the merits of the evidence previously introduced, during the review by the Appeal Board.

MEDICAL ASSISTANCE PROGRAM

STATE OF Kentucky METHODS OF ADMINISTRATION – CIVIL RIGHTS

A finding of discrimination established through the hearing process is considered binding on the agency, and decisions made to alleviate current discrimination or prevent future occurrences of a similar nature are implemented to the fullest possible extent by the agency.

When the client reports discrimination in the manner of provision of services, or refusal of access to medical benefits to which he is entitled, due to race, color or national origin, he would ordinarily use the complaint of discrimination process, which provides for correction of the situation through removal of a vendor in non-compliance status from participating status with the program. The complaint of discrimination is formally filed through completion of the Complaint of Discrimination form, which is immediately forwarded to the Area Manager for action.

Following action by the Area Manager, the client has further recourse to the Coordinator, Civil Rights, Department for Human Resources and to be Kentucky Commission on Human Rights. The client is afforded opportunity to substantiate his complaint of discrimination, and appropriate investigation is made at each responsible level. The Coordinator, Civil Rights, will maintain a file of all complaints made on the basis of discrimination, and the resolution of such complaints. (See attached Flow Chart, Attachment 7.2-A.1.)

The Ombudsman, Department for Human Resources, will receive complaints on discrimination that are addressed to that office by the client, and will forward such claims to the Coordinator, Civil Rights, for resolution.

The Director of the Division for Medical Assistance will remove from participatory status any vendor practicing discrimination if voluntary compliance cannot be secured, based on a finding of the Coordinator, Civil Rights, Department for Human Resources, or the Kentucky Human Rights Commission.

Recruitment and Training Programs

Agency recruitment is in accordance with Title VI of the Civil Rights Act, Chapter 18 of the Kentucky Revised Statutes, State Personnel Rules, and Public Assistance Regulation Number 14. Race, color, or national origin are not factors in recruiting, hiring, upgrading, conditions of employment, dismissals, referrals and training programs. In-service training is provided on a uniform basis to all employees, and training staff of the agency is the basis of merit, and minority group employees are made aware of such training programs and given the opportunity to participate.

MEDICAL ASSISTANC PROGRAM

STATE OF Kentucky

FLOW CHART - HANDLING CIVIL RIGHTS COMPLAINTS

Description and analysis, Flow Chart: Methods of Handling Complaints of Discrimination due to Race, Color, or National Origin.

1. The Bureau for Social Insurance worker receives the complaint and resolves it informally if possible. Based on a preliminary determination of facts, the client is advised as to the most appropriate appeal procedure. The Complaint Form, PA-664, is completed in all appropriate instances by the client (with the assistance of the worker) and is forwarded to the BSI Area Manager for corrective action.
2. The Area Manager conducts a preliminary or limited investigation to establish the basic facts of the situation. If discrimination is established, the Area Manager will attempt to informally persuade the person or facility practicing discrimination to amend the practice in question. The client will be notified of the disposition of the complaint, and the complaint and a copy of the resolution statement to the client will then be forwarded to the Coordinator, Civil Rights, Department for Human Resources. When the Area Manager is unable to resolve the complaint, the evidentiary data secured will be forwarded to the Coordinator for his further use. The Area Manager will maintain a Civil Rights Complaint File. The client may request further action by the Coordinator, Civil Rights, if not satisfied with the Area Manager's complaint resolution.
3. The Coordinator, Civil Rights, Department for Human Resources, will acknowledge receipt of any unresolved complaint and conduct/direct an immediate investigation to fully establish the facts and circumstances alleged in the complaint. If discriminatory practices are found, the Coordinator will seek to secure voluntary compliance through informal persuasion, and will notify the client of the resolution. Should a discriminatory practice not be voluntarily ended, a statement of findings would be forwarded to the Director, Division for Medical Assistance, for corrective action. A resolution by the Coordinator not satisfactory to the client would result in the complaint being forwarded to the Kentucky Commission on Human Rights for further action.
4. When a statement of findings is forwarded to the Director, Division for Medical Assistance, for corrective action the Director will afford the vendor the opportunity to voluntarily comply, prior to removal of the vendor from participatory status. When the complaint is referred to the Commission on Human Rights (HRC) for resolution, the HRS establishes legitimacy and validity of the complaint, conducts any necessary investigations and holds a hearing as appropriate, and attempts informal persuasion to secure voluntary compliance. A report of compliance or hearing report is issued.
5. When the report of HRC is reviewed by the Director, Division for Medical Assistance, the Director ensures that required corrective action is taken. When voluntary compliance by a vendor cannot be secured, removal of the vendor from participatory status will be accomplished.

Department for Human Resources, Bureau for Social Insurance Flow Chart depicting the handling of complaints of discrimination due to race, color or country of national origin.

