HCFA-PM-91-4 AUGUST 1991

(BPD)

ATTACHMENT 3.1-A

Page 1 0MB No.: 0938-

State/Territory:	Kentucky
<i>y</i>	

State/ 1	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.						
	$oxed{oxed}$ Provided: $oxed{\Box}$ No limitations $oxed{oxed}$ With limitations*						
2.a.	Outpatient hospital services.						
	oximes Provided: $oximes$ No limitations $oximes$ 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).						
	oximes Provided: $oximes$ No limitations $oximes$ With limitations* $oximes$ 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-45-4).						
	$\square$ Provided: $\square$ No limitations $\boxtimes$ With limitations*						
3.	Other laboratory and x-ray services.						
	$\square$ Provided: $\square$ No limitations $\boxtimes$ With limitations*						
*Desci	iption provided on attachment.						

TN No.: <u>14-003</u> Supersedes TN No. <u>92-1</u>

Effective Date: April 1 2014 HCFA ID: 7986E Approval Date: 07-23-14

Revision: HCFA-PM-92—7 October 1992

(MB)

ATTACHMENT 3.1-A Page 2 OMB NO:

State/Territory: Kentucky	ritory: Kentucky
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	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
	$oxed{oxed}$ Provided: $oxed{oxed}$ No limitations $oxed{oxed}$ 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*
*Descr	ription provided on attachment.
Supers	2. <u>11-011</u> edes Approval Date: <u>12-07-11</u> Effective Date: July 1, 2011 2. 94-14

State/Territory:	Kentucky
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Attachment 3.1-A Page 3

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

Comn	nonweal	th Global Choi	ces					
b.	Optor	netrists' service	es.					
		Provided:		No limitations		With limitations*	$\boxtimes$	Not Provided.
c.	Chiro	practors' servic	es.					
	X	Provided:		No limitations	X	With limitations*		Not provided.
d.	Other	Practitioners' S	Services					
	X	Provided:		No limitations	X	With limitations*		Not provided.
7. Ho	me Heal	th Services						
a.		nittent or part-ti health agency (			oy a home l	nealth agency or by a reg	gistered	nurse when no
	X	Provided:		No limitations	X	With limitations*		Not provided.
b.	Home	e health aide ser	vices pro	ovided by a home heal	th agency.			
	X	Provided:		No limitations	X	With limitations*		Not provided.
c.	Medio	cal supplies suit	table for	use in the home.				
	X	Provided:		No limitations	X	With limitations*		Not provided.
*Desc	ription	provided on atta	achmant					
Desc	inpulon j	provided on atta	acimient					
TN No	o.: <u>11-0</u>	03						
	o.: <u>06-0</u>	<u>07</u>		Approval Date: 05-	-12-11	Effec	ctive Dat	te: January 1, 2011

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

ATTACHMENT 3.1-A Page 3a 0MB No.: 0938-

Ctota/Tomitomu	Vantualre
State/Territory:	Kentuckv

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

Supers	o. <u>13-015</u> sedes o. <u>92-01</u>	A	Approval Date <u>12/20/2013</u>	Effective Date HCFA ID: 798	
*Desci	ription provided	on attachment.			
8.	➤ Provided:	rsing services.  ☐ No limitations	with limitations*	☐ Not Provided.	
0		□ No limitations	With limitations*	☐ Not Provided.	
d.		by, occupational the ical rehabilitation f		d audiology services provided by a home	health
	AND REM	IEDIAL CARE AN	ID SERVICES PROVIDED	TO THE CATEGORICALLY NEEDY	

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

ATTACHMENT 3.1-A Page 4 OMB NO.: 0938-0193

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

Superse		App	roval Date 6/13/23		Effective Date <u>1/1/23</u> HCFA ID: 0069P/0002P
TN No.	: <u>22-006</u>				
*Descri	ption provided on attachment.				
•	these services either in the State Plan	or ur ts, an	der EPSDT. The additional cleaning	adult	bult population starting January 1, 2023. Children already have access expansion includes the following: rently 1 per year), root canals as well as extractions, restorations and
	☑ Provided: ☐ No limitations		With limitations*	<u> </u>	Not Provided.
c.	Services for individuals with speech, he speech pathologist or audiologist).	aring,	and language disor	ders	(provided by or under the supervision of a
	☑ Provided: ☐ No limitations		With limitations*		Not Provided.
b.	Occupational therapy.				
	□ Provided:    □ No limitations		With limitations*	П	Not Provided.
	Physical therapy.				
11.	<ul><li>☑ Provided: ☐ No limitations</li><li>Physical therapy and related services.</li></ul>	Ц	With limitations*	Ш	Not Provided.
10.	Dental Services.		With limitations*	_	Not Provided
	☐ Provided: ☐ No limitations		With limitations*		Not Provided.
9.	Clinic Services.				

Revision: July 2000

HCFA-PM-85-3

(BERC)

Attachment 3.1-A Page 5 OMB No.: 0938-0193

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

TN No Supers TN No		Approval Date <u>6/14/2001</u> Effective Date <u>7/1/00</u> HCFA ID: 0069P/0002P
		rovided on attachment.
		oximes Provided: $oximes$ No limitations $oximes$ With limitations* $oximes$ Not Provided.
	a.	Diagnostic services.
13.		diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided ere in the plan.
		oximes Provided: $oximes$ No limitations $oximes$ With limitations* $oximes$ Not Provided.
	d.	Eyeglasses
		oximes Provided: $oximes$ No limitations $oximes$ With limitations* $oximes$ Not Provided.
	c.	prosthetic devices.
		$\square$ Provided: $\square$ No limitations $\square$ With limitations* $\boxtimes$ Not provided.
	b.	Dentures
		oximes Provided: $oximes$ No limitations $oximes$ With limitations* $oximes$ Not Provided.
	a.	Prescribed drugs.
12.		bed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in es of the eye or by an optometrist.

HCFA - Region VI November 1990

ATTACHMENT 3.1-A Page 6

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AMOUNT, DURATION, SCOPE OF MEDICAL	
AND REMEDIAL CARE AND SERVICES PROVEDED TO THE CATEGORIACLLY NEEDY	•
Screening Services	

	b.	Screening Services					
		☑ Provided:	$\square$ No limitations	☑ With limitations*	☐ Not Provided.		
	c.	Preventive Serv	vices				
		☑ Provided:	$\square$ No limitations	☑ With limitations*	☐ Not Provided.		
	d.	Rehabilitative s	services				
		☑ Provided:	$\square$ No limitations	☑ With limitations*	☐ Not Provided.		
14.	Service	s for individuals	s age 65 or older in institu	utions for mental disease	s.		
	a.	Inpatient hospi	tal services				
		☑ Provided:	☑ No limitations	$\square$ With limitations*	☐ Not Provided.		
	b.	Nursing facility	y services.				
		➤ Provided:	$\square$ No limitations	☑ With limitations*	☐ Not Provided.		

TN No. <u>90-37</u> Supersedes TI So. <u>85-2</u>

Approval Date <u>11/14/1994</u>

Effective Date 10/1/90

<sup>\*</sup>Description provided on attachment.

HCFA - Region VI November 1990

ATTACHMENT 3.1-A

Page 7

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

15.	a.	Services in an Intermediate Care Facility for the Mentally Retarded (other than in an institution for m diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in neguch care.					
		oximes Provided: $oximes$ No limitations $oximes$ With limitations* $oximes$ Not Pr	ovided.				
16.	Inpatie	ent psychiatric facility services for individuals under 22 years of age.					
	⊠ Pro	rovided: $\square$ No limitations $\boxtimes$ With limitations* $\square$ Not Provided.					
17.	Nurse-	-midwife services.					
	⊠ Pro	rovided: $oximes$ No limitations $oximes$ With limitations* $oximes$ Not Provided.					
18.	Hospic	ce care (in accordance with Section 1905(o) of the Act).					
	⊠ Pro	rovided:   No limitations   Provided in accordance Affordable Care Act	with Section 2302 of the				
	⊠ Wi	7ith limitations*					
*Descr	iption p	provided on attachment.					
Supers	. <u>11-007</u> edes . <u>90-37</u>	Approval Date <u>10-13-11</u> E	ffective Date July 1, 2011				

Revision: HCPA-PM-86-20 (BERC) September 1986 State/Territory: <u>Kentucky</u> Attachment 3.1-B

Page 1

0MB No.: 0938-0 193

## 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

 ${\rm *Description\ provided\ on\ attachment.}$ 

TN No.: <u>03-017</u> Supersedes TN No: <u>90-11</u> Approval Date: <u>2/20/2004</u> Effective Date: <u>10/16/2003</u>

## AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED

		711	100111,	MEDICALLY N		ROUP (5): ALL
1.	Inpat	ient hospital ser	vices oth	er than those provid	ded in an i	nstitution for mental diseases.
	X	Provided:		No limitations	$\boxtimes$	With limitations*
2.a.	Outpa	atient hospital se	ervices.			
	X	Provided:	X	No limitations		With limitations*
b.		health clinic se the plan).	rvices an	d other ambulatory	services	furnished by a rural clinic (which are otherwise covered
	X	Provided:		No limitations	X	With limitations*
c.						ner ambulatory services that are covered under the plant of the State Medicaid Manual (HCFA-Pub. 45-4).
	X	Provided:		No limitations	$\boxtimes$	With limitations*
3.	Other	laboratory and	x-ray sei	vices.		
	$\boxtimes$	Provided:		No limitations	X	With limitations*
4.a.	Nursi or old		ces (othe	er than services in a	an institut	ion for mental diseases) for individuals 21 years of age
		Provided:		No limitations		With limitations*
b.		and periodic s			treatment	services for individuals under 21 years of age, and
	X	Provided:				
c.	Famil	ly planning serv	ices and	supplies for individ	luals of ch	aildbearing age.
	X	Provided:		No limitations	X	With limitations*
d	1)	Face-to-Face	Tobacco	Cessation Counse	ling Servi	ces for Pregnant Women
	X	Provided:	⊠N	o limitations	□ With	limitations*
* Desc	ription	provided on att	achment			
Supers	o. <u>14-00</u> sedes o. <u>11-01</u>			Approval Date: 9	07-23-14	Effective Date: April 1, 2014

Revisi	ion: HCFA-PM- October 1992	92-7	(MB)			ATTACHMENT 3.1-B Page 2a 0MB NO:
State/	Territory:I	Kentucky	_			OND IVO.
		AMOUNT			PE OF SERVICES PRO Y GROUP(S): <u>All</u>	OVIDED
5.a.	Physicians' se elsewhere.	rvices, wheth	er furnished in	the office	e, the patient's home,	a hospital, a nursing facility, or
	Provided With	limitations*				
b.	Medical and su	rgical services	s furnished by a	dentist (in	accordance with section	n 1905(a)(5)(B) of the Act).
	Provided:	No l	imitations	X	With limitations:	
*Desc	ription provided	on attachment				

TN No. 93-9 Supersedes TN No. 92-1

Approval Date: Jun 4, 1993

Effective Date 4/1/1993

State/Territory:	Kentucky	Attachment 3.1-B
		Page 3

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

### Commonwealth Global Choices

6.		dedical care and any other type of remedial care recognized under State Law, furnished by licensed practitioners ithin the scope of their practice as defined by State Law.											
	a.	Podiatrists ser	vices.										
	X	Provided:		No limitations	$\boxtimes$	With Limitation	s* 🗆	Not provided					
	b.	Optometrists'	services.										
		Provided:		No limitations		With Limitation	s* 🗵	Not provided					
	c.	Chiropractics'	services										
	X	Provided:		No limitations	X	With Limitation	s* 🗆	Not provided					
	d.	Other Practition	oners' Se	rvices									
	X	Provided:		No limitations	X	With Limitation	s* 🗆	Not provided					
7.	Home I	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.											
	X	Provided:		No limitations	X	With Limitation	s* 🗆	Not provided					
	b.	Home health a	ide servi	ices provided by a home	health a	igency.							
	X	Provided:		No limitations	$\boxtimes$	With Limitation	s* 🗆	Not provided					
	c.	Medical supplies suitable for use in the home.											
	X	Provided:		No limitations	X	With Limitation	s* 🗆	Not provided					
	d.			pational therapy, or spec cal rehabilitation facility.		nology and audiolo	ogy services pro	ovided by a home					
	$\boxtimes$	Provided:		No limitations	$\boxtimes$	With Limitation	s* 🗆	Not provided					
*Descr	iption pr	ovided on attac	chment.										
Superse	. <u>11-003</u> edes . <u>06-007</u>	3		Approval Date: 5-12-1	11		Effective Date:	January 1 2011					

Revision: HCFA-PM-86-20 SEPTEMBER 1986

A-PM-86-20 (BERC)

ATTACHMENT 3.1-B Page 4

	OMB No.	0938-0193
State/Territory: Kentucky		
AMOUNT DUD ATION AND CODE OF CEDVICES DROVIDED		

8.	Priva	te duty nursing	services.					
	X	Provided:		No limitations	X	With limitations*		
9.	Clinic	e services.						
	X	Provided:		No limitations	X	With limitations*		
10.	Denta	al services.						
	X	Provided:		No limitations	X	With limitations*		
11.	. Physical therapy and related services.							
	a.	Physical ther	ару.					
	X	Provided:		No limitations	X	With limitations*		
	b.	Occupational	l therapy.					
	X	Provided:		No limitations	X	With limitations*		
	c.			als with speech, hear or audiologist.	ring, and	language disorders provided by or under supervision of		
	X	Provided:		No limitations	X	With limitations*		
12.		ribed drugs, der e or by an optor		nd prosthetic devices	s; and eye	eglasses prescribed by a physician skilled in diseases of		
	a.	Prescribed dr	ugs.					
	X	Provided:		No limitations	X	With limitations*		
	b.	Dentures.						
		Provided:		No limitations		With limitations*		
* Des	cription	provided on att	achment.					
Super	o. <u>13-0</u> sedes o. <u>86-7</u>	<u>15</u>		Approval Date 12	2/20/2013	3 Effective Date <u>01/01/2014</u>		

HCFA – Region VI July 2000 State/Territory: <u>Kentucky</u>

Attachment 3.1-B Page 5

			AMOUNT, DURA PROVIDED MEDICAL		COPE OF SERVICE ROUP(S): <u>ALL</u>	ES	-			
	c.	Prosthetic devices.								
		$\boxtimes$	Provided:		No limitations	X	With limitations*			
	d.	Eyeglasse	es.							
		X	Provided:		No limitations	X	With limitations*			
13.	Other this pl		screening, preventive, an	nd rehabilitative	services, i.e., other	r than tl	nose provided elsewhere in			
	a.	Diagnosti	ic services.							
		X	Provided:		No limitations	X	With limitations*			
	b.	Screening	g services.							
		X	Provided:		No limitations	X	With limitations*			
	c.	Preventiv	ve services.							
		X	Provided:		No limitations	X	With limitations*			
	d.	Rehabilit	ative services.							
		X	Provided:		No limitations	X	With limitations*			
14.	Servic	ces for indiv	viduals age 65 or older in i	nstitutions for n	nental diseases.					
	a.	Inpatient	hospital services.							
		X	Provided:	$\boxtimes$	No limitations		With limitations*			
	b.	Nursing f	facility services.							
		X	Provided:		No limitations	X	With limitations*			
*Desc	cription o	of limitation	s provided on attachment							
Super	o. <u>00-13</u> sedes o. <u>90-37</u>		Approval l	Date <u>June 14, 20</u>	001		Effective Date: 7-1-00			

Revision: HCFA-PM-86-20 (BERC) Attachment 3.1-B September, 1986 Page 6

State/Territory: Kentucky AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED MEDICALLY NEEDY GROUP(S) Intermediate Care Facility Services. X Provided: No limitations X With limitations\* 15. Services in an Intermediate Care Facility for the Mentally Retarded (other than such services in an a. 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. X No limitations X With limitations\* Provided: Inpatient psychiatric facility services for individuals under 22 years of age. 16. Provided: No limitations X With limitations\* 17. Nurse-midwife Services No limitations X X With limitations\* Provided: Hospice care (in accordance with section 1905(o) of the Act). 18. X X Provided: No limitations Provided in accordance with Section 2302 of the Affordable Care Act X With limitations\* \*Description provided on attachment

Approval Date: 10-13-11

Effective Date: July 1, 2011

TN No. <u>11-007</u> Supersedes

TN No <u>90-37</u>

HCFA-PM-91-4 AUGUST 1991

(BPD)

ATTACHMENT 3.1-B Page 7 0MB No. 0938-

HCFA ID: 7986E

				State/Territory:	Kentuc	ky	
		AN	MOUNT,	DURATION, AND S MEDICALLY NE			OVIDED
19.				s defined in, and to the (a)(19) or section 1915			plement 1 to Attachment 3.1-A (in
	X	Provided:	X	With limitations	□ N	ot provided	
20.	Extend	led services for	r pregnan	it women.			
	a.			d postpartum service month in which the 6			fter pregnancy ends and for any
		ĭ Prov	ided+:	☐ Additional	coverage +-	F	
	b.	Services for a	any other	medical conditions th	at may com	plicate pregnan	cy.
		× Prov	ided+:		coverage +-	+ 🗆	Not Provided
21.	Certifi	ed pediatric or	family n	urse practitioners' ser	vices		
		Provided: CFA 11-14-94 m 6d for limita		No Limitations itten)	X	With limitation	ons
+	if any	ed is a list of r , that are avai icate pregnancy	lable as	egories of services (e. pregnancy-related ser	g., inpatient vices or se	hospital, physi rvices for any	cian, etc.) and limitations on them, other medical condition that may
++				increases in covered nal services provided			ns for all groups described in this
*Descr	iption p	rovided on atta	achment.				
TN No Superso TN No			Appro	oval Date: July 31, 20	01		Effective Date: <u>10/20/1999</u>

22.	Respir	atory	care services (	in accor	dance with section	1902(e	e)(9)(A) through (C) o	f the A	ct).
		Prov	vided: □	l N	o limitations		With limitations*	X	Not provided.
23.	Any ot	her m	edical care an	d any ot	her type of remedia	l care i	recognized under State	e law, s	specified by the Secretary
	a.	Tran	sportation.						
		X	Provided:		No limitations	X	With limitations*		Not provided.
	b.	Serv	vices provided	in Relig	gious Nonmedical H	lealth (	Care Institutions.		
			Provided:		No limitations		With limitations*	X	Not provided
	c.	Rese	erved						
	d.	Nur	sing facility se	ervices fo	or individuals under	21 ye	ars of age.		
			Provided:		No limitations		With limitations*	X	Not provided
	e.	Eme	ergency hospit	al servic	ees.				
		X	Provided:		No limitations	X	With limitations*		Not provided.
	f.				a recipient's hom rson under supervis			with	a plan of treatment and
			Provided:		No limitations		With limitations*	X	Not provided.
* Desc	cription p	orovid	ed on attachm	ent.					
Super	o <u>03-016</u> sedes o. <u>01-16</u>			A	pproval Date: 12/0	9/2003	3		Effective Date 9/1/2003

23.

CMS 3/17/2006

ATTACHMENT 3.1-B Page 8a OMB No.

Effective Date: 06/01/06

### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

		State/Territory: Kentucky
	AN	MOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY
Any o Secreta		dical care and any other type of remedial care recognized under State law and specified by the
a 1.	Transp	portation No limitations
	X	With limitations
their n		n is limited to individuals requesting transportation who lack access to free transportation that meets needs. Transportation is only authorized for a Medicaid-covered service that has been determined essary.
a 2.	Broke	red Transportation
	X	Provided under section 1902(a)(70)
effecti	vely pro	ures it has established a non-emergency medical transportation program in order to more cost- ovide transportation, and can document, upon request from CMS, the transportation broker was impliance with the requirements of 45 CFR 92.36 (b)-(f).
(1)	The St 1902(a	tate will operate the broker program without the requirements of the following paragraphs of section a);
		(1) statewideness (indicate areas of State that are covered)
		(10)(B) comparability (indicate participating beneficiary groups)
	X	(23) freedom of choice (indicate mandatory population groups)
eligible	e for th	recipients covered under Kentucky's State Plan, excluding Qualified Medicare Beneficiaries, are enon-emergency medical transportation benefit. Recipients are restricted to using the regional provider assigned by the broker for the recipient's trip.
(2)	Transp	portation services provided will include:
	X	wheelchair van taxi

Approval Date: 05/03/06

TN No.: 06-008 Supersedes TN No.: New

CMS 3/17/2006

ATTACHMENT 3.1-B Page 8b OMB No.

### 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:
  - is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
  - 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
  - $\boxtimes$  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)

TN No.: 06-008 Approval Date: 05/03/06 Effective Date: 06/01/06

Supersedes TN No.: New

CMS 3/17/2006

ATTACHMENT 3.1-B Page 8c OMB No.

### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

		State/Territory:Kentucky							
	X	Blind with respect to States eligible to participate, under title XVI							
	X	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							
	X	Pregnant women							
	X	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)							
	X	Individuals described in section 1902(aa)							
	X	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:								
	X	(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							

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.

TN No.: <u>06-008</u> Approval Date: <u>05/03/06</u> Effective Date: <u>06/01/06</u>

Supersedes
TN No.: New

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 Approval Date: 05/03/06 Effective Date: 06/01/06

Supersedes
TN No.: New

Revisio	n:	October 1992		(MB)	ATTACHMENT 3.1-B Page 9		
				State/Territory:	<u>Kentucky</u>		
	AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): All						
24.	Horne 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	X	Not Provided			

TN No. <u>93-9</u> Approval Date <u>6/4/1993</u> Effective Date <u>4/1/1993</u>

TN No. <u>93-9</u> Supersedes TN No. <u>None</u> \_\_\_\_\_

#### Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy 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). $\times$ Provided $\times$ No limitations With limitations Not provided 27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A. X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service. No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service. 28. Licensed or Otherwise State-Approved Freestanding Birth Centers (i) No limitations With limitations Provided X None licensed or approved 28. Licensed or Otherwise State-recognized covered professionals providing services in the Freestanding Birth (ii) Center. Provided No limitations With limitations X Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

TN No.: 21-004 Approval Date: October 25, 2021 Effective Date: July 1, 2021

Supersedes TN No. <u>13-004</u>

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY									
27.	Medic	Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place.							
	$\boxtimes$	Provided		No limitations	X	With Limitations*		Not Provided	
*Desc	ription p	provided on attach	ment.						
Supers	o. <u>23-18</u> sedes o. <u>03-00</u>			Approval Date: 11	/13/2023	Effective Date:	07/01/2023		