

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE: KENTUCKY

4. Cost Sharing Provisions Under the Commonwealth Global 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.

Service	Type of Charge		Amount and Basis for Determination
	Deduct.	Coins. Co-pay	
Prescription Drugs		X X	\$1 for each generic drug; or atypical antipsychotic drug that does not have a generic equivalent; \$2 for each preferred brand name drug that does not have a generic equivalent, and is available under the supplemental rebate program; or 5% co-insurance or not to exceed \$20 for each non-preferred brand name drug. The Department for Medicaid Services (DMS) shall reduce a pharmacy provider's reimbursement by \$1 for each generic drug, (atypical antipsychotic drug that does not have a generic equivalent, or preferred brand name drug; DMS shall reduce a pharmacy provider's reimbursement by 5% of the cost or not to exceed \$20 of each non-preferred brand name drug dispensed. A cap of \$225 per calendar year (January 1 - December 31) per recipient will apply to prescription drug co-payments. Additionally, the maximum amount of cost sharing shall not exceed 5% of a family's total income for a quarter. The average payment per prescription drug is \$51.48 for FY 2005.
Audiology			\$0.00
Chiropractor		X	\$2.00 for each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for a chiropractic service is \$39.60 in FY 2005. Coverage of chiropractic services shall be limited to twenty-six (26) visits per recipient per twelve (12) month period.
Dental		X	\$2.00 for each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for a dental service is \$128.27 in FY 2005.
Hearing Aid Dealer			A co-payment will not be imposed on hearing aids. However, members will be limited to \$800 maximum per ear every 36 months; 1 hearing aid evaluation per year (by audiologist); 1 complete hearing evaluation per year (by audiologist); 3 follow-up visits within 6 months following 1 additional follow up at least 6 months following fitting of hearing aid. Hearing coverage is limited to an individual under age twenty-one (21).
Podiatry		X	\$2.00 for each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for a podiatry service is \$61.02 in FY 2005.
Otolaryngology*		X	\$2.00 for each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment to an otolaryngologist for a general ophthalmological service is \$44.02 in FY 2005.
General ophthalmological services*		X	\$2.00 for each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for an ophthalmological service is \$29.84 in FY 2005.
Eyewear			A co-payment will not be imposed on eyewear. However, members will be responsible for any eyewear charges over \$200 per year. Eyewear coverage is limited to an individual under age twenty-one (21).
Office visit for care by a physician,** physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, or nurse midwife		X	\$2.00 per each visit. The average payment for this service is \$37.12 in FY 2005. DMS shall reduce a provider's reimbursement by \$2.00.
Physician Service		X	(\$2.00 per each service. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for this service is \$37.12 in FY 2005.

\*CPT codes 92042, 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

STATE: KENTUCKY

Cost Sharing Provisions Under the Commonwealth Global Choices Benefit Plan, continued.

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins	Co-pay	
Visit to a rural health clinic, primary care center, or federally qualified health center			X	\$2.00 per each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for this service is \$39.21 in FY 2005.
Outpatient hospital service			X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00. The average payment for this service is \$211.55 in FY 2005.
Emergency room visit for a non-emergency service		X		5% co-insurance not to exceed \$6 for each visit. DMS shall reduce a provider's reimbursement by the amount of co-insurance. The average payment for this service is \$190.77 in FY 2005.
Inpatient hospital admission			X	\$50.00 per admission. DMS shall reduce a provider's reimbursement by \$50.00. The average payment for this service is \$2512.78 in FY 2005.
Physical Therapy			X	\$2.00 per each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for this service is \$25.14 in FY 2005.
Speech, Hearing, Language Therapy			X	\$1.00 per each visit. DMS shall reduce a provider's reimbursement by \$1.00. The average payment for this service is \$20.85 in FY 2005.
Durable Medical Equipment		X		3% co-insurance per service, not to exceed \$15 per month. DMS shall reduce a provider's reimbursement by the amount of co-insurance or \$15 if applicable. The average payment for this service is \$96.68 in FY 2005.
Ambulatory Surgical Center			X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00. The average payment for this service is \$528.76 in FY 2005.
Laboratory, diagnostic, or x-ray service			X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00. The average payment for this service is \$48.11 in FY 2005.
				A cap of \$225 per calendar year (January 1 - December 31) per recipient will apply to co-payments for services under state regulation. Additionally, the total aggregate amount of cost sharing shall not exceed 5% of a family's total income for a quarter as allowed under Section 1916A of the Social Security Act. The state will enforce the cap that is the least of each family's total income as stated on Attachment 4.18-F page 3.

- B. The following shall not be subject to a copayment:
- (a) Individuals excluded in accordance 42 CFR 447.53.
  - (b) A service provided to a recipient who has reached his or her 18<sup>th</sup> birthday but has not turned 19.
  - (c) Individuals who are pregnant.
  - (d) Individuals receiving hospice services.
- 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.
- D. In addition to the Global Choices cost-sharing provisions are cost-sharing provisions established elsewhere in the State Plan for the Comprehensive Choices, Family Choices and Optimum Choices benefit packages.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: KENTUCKY

Cost Sharing Provisions Under the Commonwealth Global Choices Benefit Plan: (continued)

D. In addition to the Global Choices cost-sharing provisions are cost-sharing provisions established elsewhere in the State Plan for the Comprehensive Choices, Family Choices and Optimum Choices benefit packages.

Populations Covered under Commonwealth Global Choices Benefit Plan:

E. All other children and individuals who are nursing facility level of care will be covered under the Family choices and comprehensive Choices plans outlined in the DRA SPA 06-010. The following grid outlines the populations covered under Global Choices, which will serve as the default state plan package:

MEG	Eligibility Group	Eligibility Category	Description
MEG #1 "Global Choices" • SSI-Related • Caretaker Relatives • Women with Breast or Cervical Cancer • Special Needs Children • Pregnant Women	<b>Mandatory SSI-Related</b>		
	SSI Members	A	Aged individuals 65 and over who receive SSI who do not meet NF level of care
		AP	Aged individuals 65 and over who receive SSI and State Supp who do not meet NF level of care
		B	Blind individuals who receive SSI who do not meet NF level of care, including children
		BP	Blind individuals who receive SSI and State Supp who do not meet NF level of care
		C	Disabled individuals who receive SSI who do not meet NF level of care including children
		DP	Disabled individuals who receive SSI and State Supp who do not meet NF level of care
	Pass Through (deemed SSI or SSP members)	F	Aged individuals 65 and over who lost SSI or SSP benefits and are now eligible for "Pass through" Medicaid who do not meet NF level of care
		G	Blind individuals who lost SSI or SSP benefits and are now eligible for "Pass through" Medicaid who do not meet NF level of care
		H	Disabled individuals who lost SSI or SSP benefits and are now eligible for "Pass through" Medicaid who do not meet NF level of care
	<b>Mandatory Caretaker Relatives</b>		
	Caretaker Relatives of children eligible per Section 1931	C	Caretaker Relatives of children who receive KTAP and are deprived due to death, incapacity or absence
		E	Caretaker Relatives of children who do not receive KTAP and are deprived due to death, incapacity or absence
T		Caretaker Relatives of children who do not receive KTAP and are deprived due to unemployment	

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

STATE: KENTUCKY

## Populations Covered under Commonwealth Global Choices Benefit Plan, continued:

			Caretaker Relatives of children who receive KTAP and are deprived due to unemployment.
Caretaker Relatives of children who lose eligibility due to increased earnings, time-limited deductions or increased child support	L	07	Caretaker Relatives of children deprived of parental support due to death, incapacity, or absence and get time-limited Medicaid due to increased earnings, time-limited deductions or increased child support
	N	07	Caretaker Relatives of children deprived of parental support due to unemployment who get time-limited Medicaid due to increased earnings, time-limited deductions or increased child support
<b>Mandatory Special Needs Children (No Cost Sharing)</b>			
Children w/adoption assistance or foster care payments under Title IV-E of the Act	S		Federally subsidized adopted special needs children who receive grants from social services
	X		Foster care children who receive a grant through Title IV-E
<b>Mandatory Pregnant Women (No Cost Sharing)</b>			
Pregnant Women	I	P3	Pregnant Women w/income < 33% FPL
<b>Optional SSI-Related</b>			
State Supplementation (SSP) Members	FP		Aged individuals 65 and over who receive State Supp who do not meet NF level of care
	GP		Blind individuals who receive State Supp who do not meet NF level of care
	HP		Disabled individuals who receive State Supp who do not meet NF level of care
Medically Needy Aged, Blind or Disabled Individuals	J	02	Aged individuals 65 and over with excess income who become financially eligible through spenddown
	K	02	Blind individuals with excess income who become financially eligible through spenddown
	M	02	Disabled individuals with excess income who become financially eligible through spenddown

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

STATE: KENTUCKY

Populations Covered under Commonwealth Global Choices Benefit Plan, continued:

<b>Optional Caretaker Relatives</b>			
Medically Needy caretaker relatives	L	02	Caretaker Relatives of children deprived of parental support due to death, incapacity, or absence, with income under the medically needy scale or with excess income who become financially eligible through spenddown
	N	02	Caretaker Relatives of children deprived of parental support due to unemployment with income under the medically needy scale or with excess income who become financially eligible through spenddown
<b>Optional Women eligible through the Breast and Cervical Cancer Treatment Program</b>			
BCCTP	V		Women eligible in the Breast and Cervical Cancer Treatment Program
<b>Optional Special Needs Children (No Cost Sharing)</b>			
Children in non-Title IV-E foster care	P		Children under 18 foster care family homes or private institutions totally or partially dependent upon and supervised by a public or private child care agency
Children in Psychiatric Residential Treatment Facilities	U		Children under age 18 in a Psychiatric Residential Treatment Facility (PRTF)
<b>Optional Pregnant Women (No Cost Sharing)</b>			
Pregnant Women	1	P3	Pregnant Women w/income >133% FPL <185% FPL
Medically needy pregnant women	Y	02	Pregnant women with income under medically needy income scale or income eligible through spenddown
Presumptively Eligible pregnant women	PE	P3	Pregnant Women w/income <185% FPL determined presumptively eligible by a qualified provider

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE: KENTUCKY

B. The method used to collect cost sharing charges for medically 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.

TN No. 02-05  
Supersedes  
TN No. 85-12

Approval Date: NOV 19 1985

Effective Date: 8/01/02

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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 447.53(b) are described below:

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 447.53(b). MMIS will identify the exempt recipients by age for children under age 18, 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 receive each month. Providers will use the Medicaid card to identify those recipients who should pay a copayment.

- 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: KENTUCKYA. Cost Sharing Provisions Under the Commonwealth Global Choices Benefit Plan: The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coinc.	Co-pay	
Prescription Drugs		X	X	\$1 for each generic drug or atypical antipsychotic drug that does not have a generic equivalent, \$2 for each preferred brand name drug that does not have a generic equivalent and is available under the supplemental rebate program, or 5% co-insurance or out to exceed \$20 for each non-preferred brand name drug. The Department for Medicaid Services (DMS) shall reduce a pharmacy provider's reimbursement by \$1 for each generic drug, atypical antipsychotic drug that does not have a generic equivalent, or preferred brand name drug; DMS shall reduce a pharmacy provider's reimbursement by 5% of the cost or not to exceed \$20 of each non-preferred brand name drug dispensed. A cap of \$225 per calendar year (January 1 – December 31) per recipient will apply to prescription drug co-payments. Additionally, the maximum amount of cost sharing shall not exceed 5% of a family's total income for a quarter. The average payment per prescription drug is \$51.88 for FY 2005.
Audiology				\$0.00
Chiropractor			X	\$2.00 for each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for a chiropractic service is \$39.60 in FY 2005. Coverage of chiropractic services shall be limited to twenty-six (26) visits per recipient per twelve (12) month period.
Dental			X	\$2.00 for each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for a dental service is \$128.27 in FY 2005.
Hearing Aid Dealer				A co-payment will not be imposed on hearing aids. However, members will be limited to \$800 maximum per year every 36 months; 1 hearing aid evaluation per year (by audiologist); 1 complete hearing evaluation per year (by audiologist); 3 follow-up visits within 6 months following 1 additional follow up at least 6 months following fitting of hearing aid. Hearing coverage is limited to an individual under age twenty-one (21).
Podiatry			X	\$2.00 for each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for a podiatry service is \$61.02 in FY 2005.
Optometry*			X	\$2.00 for each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment to an optometrist for a general ophthalmological service is \$44.02 in FY 2005.
General ophthalmological services*			X	\$2.00 for each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for an ophthalmological service is \$29.84 in FY 2005.
Eyewear				A co-payment will not be imposed on eyewear. However, members will be responsible for any eyewear charges over \$200 per year. Eyewear coverage is limited to an individual under age twenty-one (21).

\*CPT codes 92002, 92004, 92012, and 92014.

\*\*CPT codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214

YN No. 06-012

Approval Date: 01/22/09

Effective Date: 07/01/09

Supersedes TN No. 06-006

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE, KENTUCKY

Cost Sharing Provisions Under the Commonwealth Global Choices Benefit Plan, continued:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Co-pay	
Office visit for care by a physician,** physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, or nurse midwife			X	\$2.00 per visit. The average payment for this service is \$37.12 in FY 2005. DMS shall reduce a provider's reimbursement by \$2.00.
Physician Service			X	\$2.00 per each service. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for this service is \$37.12 in FY 2005.
Visit to a rural health clinic, primary care center, or federally qualified health center			X	\$2.00 per visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for this service is \$39.21 in FY 2005.
Outpatient hospital service			X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00. The average payment for this service is \$211.55 in FY 2005.
Emergency room visit for a non-emergency service		X		5% co-insurance not to exceed \$6 for each visit. DMS shall reduce a provider's reimbursement by the amount of co-insurance. The average payment for this service is \$190.77 in FY 2005.
Inpatient hospital admission			X	\$50.00 per admission. DMS shall reduce a provider's reimbursement by \$50.00. The average payment for this service is \$2512.78 in FY 2005.
Physical Therapy			X	\$2.00 per each visit. DMS shall reduce a provider's reimbursement by \$2.00. The average payment for this service is \$25.14 in FY 2005.
Specin. Hearing, Language Therapy			X	\$1.00 per each visit. DMS shall reduce a provider's reimbursement by \$1.00. The average payment for this service is \$20.85 in FY 2005.
Durable Medical Equipment		X		3% co-insurance per service, not to exceed \$15 per month. DMS shall reduce a provider's reimbursement by the amount of co-insurance or \$15 if applicable. The average payment for this service is \$96.68 in FY 2005.
Ambulatory Surgical Center			X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00. The average payment for this service is \$528.76 in FY 2005.
Laboratory, diagnostic, or x-ray service			X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00. The average payment for this service is \$48.11 in FY 2005.
				A cap of \$225 per calendar year (January 1 – December 31) per recipient will apply to co-payments for services under state regulation. Additionally, the total aggregate amount of cost sharing shall not exceed 5% of a family's total income for a quarter as allowed under Section 1916A of the Social Security Act. The state will enforce the cap that is the least of each family's total income as stated on Attachment 4.18-F page 3.

**B.** The following shall not be subject to a copayment:

- (a) Individuals excluded in accordance 42 CFR 447.57.
- (b) A service provided to a recipient who has reached his or her 18<sup>th</sup> birthday but has not turned 19.
- (c) Individuals who are pregnant.
- (d) 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

STATE: KENTUCKY

Cost Sharing Provisions Under the Commonwealth Global Choices Benefit Plan, continued.

D. In addition to the Global Choices cost-sharing provisions are cost-sharing provisions established elsewhere in the State Plan for the Comprehensive Choices, Family Choices and Optimum Choices benefit packages.

Populations Covered under Commonwealth Global Choices Benefit Plan:

E. All other children and individuals who are nursing facility level of care will be covered under the Family choices and comprehensive Choices plans outlined in the DRA SPA 06-010. The following grid outlines the populations covered under Global Choices, which will serve as the default state plan package:

MEG	Eligibility Group	Eligibility Category	Description
MEG #1 "Global Choices" <ul style="list-style-type: none"> <li>• SSI-Related</li> <li>• Caretaker Relatives</li> <li>• Women with Breast or Cervical Cancer</li> <li>• Special Needs Children</li> <li>• Pregnant Women</li> </ul>	<b>Mandatory SSI-Related</b>		
	SSI Members	A	Aged individuals 65 and over who receive SSI who do not meet NF level of care
		AP	Aged individuals 65 and over who receive SSI and State Supp who do not meet NF level of care
		B	Blind individuals who receive SSI who do not meet NF level of care, including children
		BP	Blind individuals who receive SSI and State Supp who not meet NF level of care
		D	Disabled individuals who receive SSI who do not meet NF level of care including children
		DP	Disabled individuals who receive SSI and State Supp who do not meet NF level of care
	Pass Through (deemed SSI or SSP members)	F	Aged individuals 65 and over who lost SSI or SSP benefits and are now eligible for "Pass through" Medicaid who do not meet NF level of care
		G	Blind individuals who lost SSI or SSP benefits and are now eligible for "Pass through" Medicaid who do not meet NF level of care
		H	Disabled individuals who lost SSI or SSP benefits and are now eligible for "Pass through" Medicaid who do not meet NF level of care
	<b>Mandatory Caretaker Relatives</b>		
	Caretaker Relatives of children eligible per Section 1931	C	Caretaker Relatives of children who receive KTAP and are deprived due to death, incapacity or absence
		E	Caretaker Relatives of children who do not receive KTAP and are deprived due to death, incapacity or absence
		I	Caretaker Relatives of children who do not receive KTAP and are deprived due to unemployment

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

## STATE: KENTUCKY

## Populations Covered under Commonwealth Global Choices Benefit Plan, continued:

			Caretaker Relatives of children who receive KTAP and are deprived due to unemployment
Caretaker Relatives of children who lose eligibility due to increased earnings, time-limited reductions or increased child support	L	07	Caretaker Relatives of children deprived of parental support due to death, incapacity, or absence and get time-limited Medicaid due to increased earnings, time-limited deductions or increased child support
	N	07	Caretaker Relatives of children deprived of parental support due to unemployment who get time-limited Medicaid due to increased earnings, time-limited deductions or increased child support
<b>Mandatory Special Needs Children (No Cost Sharing)</b>			
Children w/adoption assistance or foster care payments under Title IV-E of the Act	S		Federally subsidized adopted special needs children who receive grants from social services
	X		Foster care children who receive a grant through Title IV-E
<b>Mandatory Pregnant Women (No Cost Sharing)</b>			
Pregnant Women		P3	Pregnant Women w/income <133% FPL
<b>Optional SSI-Related</b>			
State Supplementation (SSP) Members	FP		Aged individuals 65 and over who receive State Supp who do not meet NF level of care
	GP		Blind individuals who receive State Supp who do not meet NF level of care
	HP		Disabled individuals who receive State Supp who do not meet NF level of care
Medically Needy Aged, Blind or Disabled Individuals	J	02	Aged individuals 65 and over with excess income who become financially eligible through spenddown
	K	02	Blind individuals with excess income who become financially eligible through spenddown
	M	02	Disabled individuals with excess income who become financially eligible through spenddown

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

STATE: KENTUCKYPopulations Covered under Commonwealth Global Choices Benefit Plan, continued:

<b>Optional Caretaker Relatives</b>			
Medically Needy caretaker relatives	L	02	Caretaker Relatives of children deprived of parental support due to death, incapacity, or absence, with income under the medically needy scale or with excess income who become financially eligible through spenddown
	N	02	Caretaker Relatives of children deprived of parental support due to unemployment with income under the medically needy scale or with excess income who become financially eligible through spenddown
<b>Optional Women eligible through the Breast and Cervical Cancer Treatment Program</b>			
BCCTP	V		Women eligible in the Breast and Cervical Cancer Treatment Program
<b>Optional Special Needs Children (No Cost Sharing)</b>			
Children in non-Title IV-E foster care	P		Children under 18 foster care family homes or private institutions totally or partially dependent upon and supervised by a public or private child care agency
Children in Psychiatric Residential Treatment Facilities	U		Children under age 18 in a Psychiatric Residential Treatment Facility (PRTF)
<b>Optional Pregnant Women (No Cost Sharing)</b>			
Pregnant Women	I	P3	Pregnant Women w/income >133% FPL <185% FPL
Medically needy pregnant women	Y	02	Pregnant women with income under medically needy income scale or income eligible through spenddown
Presumptively Eligible pregnant women	PE	P3	Pregnant Women w/income <185% FPL determined presumptively eligible by a qualified provider

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE: KENTUCKY

B. The method used to collect cost sharing charges for medically 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.

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TN No. 02-05  
Supersedes  
TN No. 85-12

Approval Date: NOV 1 1992 Effective Date: 8/01/02

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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 447.53(b) are described below:

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 447.53(b). MMIS will identify the exempt recipients by age for children under age 18, 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.

- 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)(i)(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.

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TN No. 92-1  
Supersedes None Approval Date NOV 14 1994 Effective Date 1-1-92  
TN No. None  
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.

TW No. 92-1  
Supersedes None Approval Date NOV 14 1994 Effective Date 1-1-92  
TN No. None 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.

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TN No. 92-1 Approval Date NOV 14 1994 Effective Date 1-1-92  
Supersedes \_\_\_\_\_  
TN No. None 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. 92-1  
Supersedes None Approval Date NOV 14 1994 Effective Date 1-1-92  
TN No. None

HCFA ID: 7986E

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**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 7<sup>th</sup> 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.

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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 FPL:**

**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 of the 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 1905(e) 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)(i)(XVIII) and 1902(m) 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.  / Pharmacists 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.  / 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)(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 1905(e) 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(n)(2)(B) 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 3.1-C pages 10.17-10.24, Attachment 4.18-A pages 1, 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. No cost sharing will be imposed for the following individuals:

- 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 B 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)(i)(XVI) 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.

TN No. 06-012  
Supersedes  
TN No. None

Approval Date: 01/22/09

Effective Date: 1/1/09

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, KYHealth 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)-(d) and Attachment 4.18-C page 1 (b)-(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 E.

- F. Cost sharing for preferred drugs may not be charged for the following populations or services:

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TN No: 06.012  
Supersedes  
TN No: None

Approval Date: 9/12/09

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, 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.

Ci. 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.