

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909



January 27, 2009

Ms. Elizabeth A. Johnson
Commissioner
Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6W-A
Frankfort, Kentucky 40621-0001

Attention: Kevin Skeeters

RE: Kentucky Title XIX State Plan Amendment, Transmittal #06-012

Dear Ms. Johnson:

We have reviewed the proposed amendment to the Kentucky Medicaid State Plan that was submitted under transmittal number 06-012. This amendment clarifies previously approved Kentucky's Medicaid benchmark benefit packages implement under Section 1937 of the Social Security Act (the Act) including the methods of determining income for cost sharing and the tracking of cost sharing.

Based on the information provided, we are pleased to inform you that Medicaid State Plan Amendment 06-012 was approved on January 22, 2009. The effective date for this amendment is July 1, 2006. We are also enclosing the approved HCFA-179 and plan pages.

If you have any questions or need any further assistance, please contact Maria Donatto at 404-562-3697.

Sincerely,

A handwritten signature in black ink, appearing to read "Mary Kaye Justis".

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 06-012	2. STATE Kentucky
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE April 1, 2006	

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

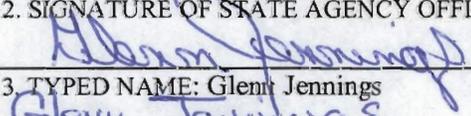
6. FEDERAL STATUTE/REGULATION CITATION: Deficit Reduction Act of 2005 [Section 1937 of the Social Security Act]	7. FEDERAL BUDGET IMPACT: a. FFY 2006 (Decrease of expenditures by approximately 1,790,845.73 for Comprehensive Choices (July 1 – Sept. 30, 2006) Budget neutral for Family Choices 753,333.33 for Optimum Choices (July 1 – Sept. 30 2006) b. FFY 2007 (Decrease of expenditures by approximately 24,090,174 for Comprehensive Choices Budget neutral for Family Choices 7,310,000 for Optimum Choices
--	---

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 3.1-A, pages 7.2.1(e), 7.1.4, 7.2.1(b), 7.5.3 Att. 3.1-B, pages 18, 23, 23.3, 31.2 Att. 3.1-C, pages 10.17 – 10.20, 10.22 - 10.24 Att. 4.18-A, pages 1, 1(a), 1(b), Att 4.18-C pages 1, 1(a), 1(b)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Att. 3.1-A, pages 7.2.1(e), 7.1.4, 7.2.1(b), 7.5.3 Att. 3.1-B, pages 18, 23, 23.3, 31.2 Att. 3.1-C, pages 10.17 – 10.20, 10.24 Att. 4.18-A, pages 1, 1(a), 1(b), Att 4.18-C pages 1, 1(a), 1(b)
---	---

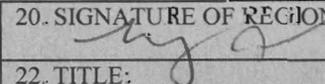
10. SUBJECT OF AMENDMENT:
Alternative Benefits – Family Choices benefit package table, copayment denial of service for pharmacy providers, ARNP as a Physician Office Service, a \$200 limit for eye glasses for recipients under twenty-one (21) years old per member per year and a member of the Global Choices Benefit Package, no reduction of the \$2 dental services co-payment from the provider's reimbursement in the Global Choices benefit package, reduces the 5% co-insurance for non-emergency services from the provider's reimbursement, and clarifies that member's are responsible for any hearing aid charges over \$1,400 per ear every 36 months.

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Review delegated
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED to Commissioner, Department for Medicaid
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Services

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
13. TYPED NAME: Glenn Jennings <u>Glenn Jennings</u>	
14. TITLE: Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED:	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: 07/21/06	18. DATE APPROVED: 01/22/09

PLAN APPROVED -- ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/06	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Mary Kaye Justis, RN, MBA	22. TITLE: Acting Associate Regional administrator Division of Medicaid & Children's Health Opns

23. REMARKS:
Approved with following changes as authorized by State Agency on email dated 01/26/09:
Additional to Block #8 Atch 3.1-A page 7.5.1; Atch 3.1-B page 31; Atch 4.19-B pages 20.9, 20.9 (b), 20.37 (b) new; and 20.43 thru 20.44 new; Atch 4.18-F pages 3-6 and Atch 4.18-G pages 1-2.
Block # 9 Same as 8

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.

Commonwealth Global Choices

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

- (b) Optometrists' services are provided to both the categorically needy and the medically needy. Such coverage includes writing of prescriptions, diagnosis, and provision of treatment to the extent such services are within the lawful scope of practice (licensed authority) of optometrists licensed in the state of Kentucky. The following limitations are also 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 state 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.

- (c) Chiropractic services are provided with the following limitations:

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

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.

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 List that are prescribed for outpatient use by a physician, osteopath, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner. Drugs that are on the Preferred Drug List are specified in the Medicaid Drug List. Drugs added to the Preferred Drug list are based on recommendations submitted by the Pharmacy and Therapeutics Advisory Committee to the Secretary of the Cabinet for Health and Family Services for approval. Drugs not on the Preferred Drug List are subject to the prior authorization process as listed below. Drugs that require prior authorization are specified in the Medicaid Drug List. 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 State has established a preferred drug list with prior authorization for drugs not included on the preferred drug list. 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 1927(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 List 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” to an LTE drug;
 - (b) A drug that has reached the termination date established by the drug manufacturer;

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

Eyeglasses are not covered for adults. 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. 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.

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.

Commonwealth Global Choices

- (6) Medical care and Any Other Type of Remedial Care
- (b) Optometric services are provided to both the categorically needy and the medically needy. Such coverage includes writing of prescriptions, diagnosis, and provision of treatment to the extent such services are within the lawful scope of practice (licensed authority) of optometrists and ophthalmologists licensed in the state of Kentucky. The following limitations are also 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.

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

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.

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 List that are prescribed for outpatient use by a physician, osteopath, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner. Drugs that are on the Preferred Drug List are specified in the Medicaid Drug List. Drugs added to the Preferred Drug list are based on recommendations submitted by the Pharmacy and Therapeutics Advisory Committee to the Secretary of the Cabinet for Health and Family Services for approval. Drugs not on the Preferred Drug List are subject to the prior authorization process as listed below. Drugs that require prior authorization are specified in the Medicaid Drug List. 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 State has established a preferred drug list with prior authorization for drugs not included on the preferred drug list. 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 1927(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 List 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" to an LTE drug;
 - (b) A drug that has reached the termination date established by the drug manufacturer;

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 (E PSDT).

c. Prosthetics

Prosthetic devices are covered under durable medical equipment in accordance with Attachment 3.1-B, page 39.

d. Eyeglasses

Eyeglasses are not covered for adults. 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. 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.

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

The Following table outlines the benefit package for Family Choices. The cost sharing requirements listed in this benefit grid will apply to all members of Family Choices. For the Family Choices populations, these cost sharing requirements shall supersede any other cost sharing requirements described elsewhere in the state plan.

Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children – Medicaid Expansion Program	KCHIP Children – Separate CHIP Program
Medical Out-of-Pocket Maximum	\$225 per 12 months	\$225 per 12 months	\$225 per 12 months	\$225 per 12 months
Pharmacy Out-of-Pocket Maximum	\$225 per 12 months	\$225 per 12 months	\$225 per 12 months	\$225 per 12 months
Acute Inpatient Hospital Services	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Laboratory, Diagnostic and Radiology Services	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Outpatient Hospital/ Ambulatory Surgical Centers	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Physician Office Services*	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Behavioral Health Services**	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Allergy Services	\$0 co-pay	\$0 co-pay	<ul style="list-style-type: none"> • \$2 co-pay for office visit and testing • \$0 co-pay for injections 	<ul style="list-style-type: none"> • \$2 co-pay for office visit and testing • \$0 co-pay for injections
Preventive Services	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Emergency Ambulance	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children – Medicaid Expansion Program
Dental Services Including but not limited to two cleanings per 12 months and one set of x-rays per 12 months	\$0 co-pay	\$0 co-pay	\$0 co-pay
Family Planning	\$0 co-pay	\$0 co-pay	\$0 co-pay
Physical Therapy Limited to 15 visits per 12 months	\$0 co-pay	\$0 co-pay	\$0 co-pay
Speech Therapy Limited to 15 visits per 12 months	\$0 co-pay	\$0 co-pay	\$0 co-pay
Hospice (non-institutional)	\$0 co-pay	\$0 co-pay	\$0 co-pay
Non-Emergency Transportation	\$0 co-pay	\$0 co-pay	\$0 co-pay
Chiropractic Services Limited to twenty-six visits per 12 months	\$0 co-pay	\$0 co-pay	\$0 co-pay

TN No: 06-012
Supersedes
TN No: 06-010

Approval Date: 01/22/09

Effective Date: 07/01/06

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children – Medicaid Expansion Program
Prescription Drugs	\$0 co-pay	\$0 co-pay	\$1 generic \$2 preferred \$3 non-preferred brand prescriptions. DMS will deduct the full amount of the copay from the provider's reimbursement.
Emergency Room	\$0 co-pay	\$0 co-pay	5% coinsurance or up to a maximum of \$6 for non-emergency use per visit.
Hearing Aids and Audiometric Services	\$0 co-pay	\$0 co-pay	\$0 co-pay
	\$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);	\$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);	\$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);
Vision Services General ophthalmology and optometry	\$0 co-pay	\$0 co-pay	\$0 co-pay
	\$400 maximum on eyewear per year. Eyewear coverage is limited to an individual under age twenty-one(21).	\$400 maximum on eyewear per year. Eyewear coverage is limited to an individual under age twenty-one(21).	\$400 maximum on eyewear per year. Eyewear coverage is limited to an individual under age twenty-one(21).
Prosthetic Devices	\$0 co-pay	\$0 co-pay	\$0 co-pay
	\$1,500 per 12 months	\$1,500 per 12 months	\$1,500 per 12 months
Home Health Services	\$0 co-pay	\$0 co-pay	\$0 co-pay

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Benefit/Service	Children of Caretaker Relatives	Categorically Needy Children	KCHIP Children – Medicaid Expansion Program
DME	\$0 co-pay	\$0 co-pay	\$0 co-pay
Substance Abuse EPSDT only	\$0 co-pay	\$0 co-pay	\$0 co-pay

* **Physician Office Services** includes physicians, Advanced Registered Nurse Practitioners (ARNPs), certified pediatric and family nurse practitioners, nurse midwives, FQHCs, rural health clinics (RHCs), primary care centers (PCCs) and physician assistants.

****Behavioral Health Services** include mental health rehab/stabilization, behavioral support, psychological services and inpatient psychiatric services.

ALTERNATIVE BENEFITS

**STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE**

Comprehensive Choices and Optimum Choices Cost Sharing & Limits Individuals receiving institutional services will not have co-pays other than their patient responsibility		
Benefit/Service	State Plan	NF Level of Care (including ABI)/ICF MR DD Level of Care
Durable Medical Equipment	3% coinsurance to maximum of \$15 per month (NF residents' DME are included in NF rate)	3% coinsurance to maximum of \$15 per month (NF residents' DME are included in NF rate)
Podiatry Services	\$2 co-pay	\$2 co-pay
Vision Services General ophthalmology and optometry	\$2 co-pay	\$0 co-pay
		\$400 maximum on eyewear per 12 months; children under 21 ONLY (99000 series evaluation and management codes).
Dental Services Including but not limited to Children under 21, two cleanings per 12 months, one set of x-rays per 12 months, Adults 21 and over, one cleaning per 12 months and one set of x-rays	\$2 co-pay	\$0 co-pay
Family Planning Services and Supplies	\$0 co-pay	\$0 co-pay
Physical Therapy	\$0 co-pay	\$0 co-pay
		30 visits per 12 months

TN No: 06-012

Approval Date: 01/22/09

Effective Date: 07/01/06

Supersedes

TN No: 06-010

ALTERNATIVE BENEFITS

**STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE**

Comprehensive Choices and Optimum Choices Cost Sharing & Limits		
Individuals receiving institutional services will not have co-pays other than their patient responsibility		
Benefit/Service	State Plan	NF Level of Care (including ABI)/ICF MR DD Level of Care
Speech, Hearing and Language Therapy	\$0 co-pay	\$0 co-pay
		30 visits per 12 months
Hospice (non-institutional)	\$0 co-pay	\$0 co-pay
Behavioral Health Services **	\$0 co-pay	\$0 co-pay
Transportation Services (as described in the current 1915b waiver)	\$0 co-pay	\$0 co-pay
Emergency Ambulance	\$0 co-pay	\$0 co-pay
Chiropractic Services	\$2 co-pay	\$0 co-pay
	Aged 21 & over, 15 visits per 12 months; Under 21 years of age, 7 visits per 12 months	Coverage of chiropractic services shall be limited to twenty-six (26) visits per recipient per twelve (12) month period regardless of age.
Prescription Drugs	For members who do NOT have Medicare Part D: \$1 co-pay generic \$2 co-pay preferred brand 5% coinsurance for non-preferred brand prescriptions	For members who do NOT have Medicare Part D: \$1 co-pay generic \$2 co-pay preferred brand 5% or not to exceed \$20 coinsurance for non-preferred brand prescriptions. DMS will reduce a provider's reimbursement by the amount of the Copay for members with the Optimum benefit package.
		Limit of four prescriptions per month; maximum of 3 brand
Emergency Room Visit for a Non-emergency Service	5% co-insurance for each visit. DMS shall reduce a provider's reimbursement by the amount of co-insurance.	5% co-insurance not to exceed \$6 for each visit.
Hearing and Audiometric Services	\$2 co-pay	\$0 co-pay
		\$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);

TN No: 06-012Approval Date: 01/22/09Effective Date: 07/01/06

Supersedes

TN No: 06-010Implementation Date: 05/15/06

ALTERNATIVE BENEFITS
STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Comprehensive Choices and Optimum Choices Cost Sharing & Limits		
Individuals receiving institutional services will not have co-pays other than their patient responsibility		
Benefit/Service	State Plan	NF Level of Care (including ABI)/ICF MR DD Level of Care
Prosthetic Devices	\$0 co-pay	\$0 co-pay
Home Health Services	\$0 co-pay	\$0 co-pay
End Stage Renal Disease and Transplants	\$0 co-pay	\$0 co-pay

* **Physician Office Services** includes physicians, Advanced Registered Nurse Practitioners (ARNPs), certified pediatric and family nurse practitioners, nurse midwives, FQHCs, rural health clinics (RHCs), primary care centers (PCCs) and physician assistants.

****Behavioral Health Services** include mental health rehab/stabilization, behavioral support, psychological services and inpatient psychiatric services under the age of 21.

*** A pharmacy provider may require, in accordance with Public Law 109-171, Section 6041, a recipient to pay a copayment, coinsurance amount or premium related to a benefit as a condition for providing the benefit.

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

- A. 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 \$51.88 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 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.
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).
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 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

STATE: KENTUCKY

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

Service	Type of Charge		Amount and Basis for Determination
	Deduct.	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 18th 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.
- 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" <ul style="list-style-type: none"> • SSI-Related • Caretaker Relatives • Women with Breast or Cervical Cancer • Special Needs Children • Pregnant Women 	Mandatory SSI-Related		
	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
		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
	Mandatory Caretaker Relatives		
	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: 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.	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 \$51.88 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 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.
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

TN No. 06-012Approval Date: 01/22/09Effective Date: 07/01/06Supersedes TN No: 06-006

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: KENTUCKYCost 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.
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 18th 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"> • SSI-Related • Caretaker Relatives • Women with Breast or Cervical Cancer • Special Needs Children • Pregnant Women 	Mandatory SSI-Related		
	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
	Mandatory Caretaker Relatives		
	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/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(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.

- 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. / 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(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 3.1-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 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, 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)-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:

- 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:

X / Providers are permitted to require, as a condition for the provision of prescriptions, the payment of cost sharing.

H. Availability of Information

X / 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.

IV. Vision Care Services**A. Definitions.**

For purposes of determination of payment, “usual and customary actual 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 optometrists’ usual and customary actual billed charges up to 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.

Fixed upper limits not determined in accordance with the RBRVS methodology (due to factors such as availability) shall be set by the department using the following methodology.

The fixed upper limit for the procedure shall be consistent with the general array of rates for the type of service. “General array of fixed rates” means that the rate upper limit set for the procedure will be at the same relative Level, so far as possible, as the rates for procedures which are similar in nature. The listing of similar services is referred to as the “general array.” The actual upper limit is derived by using not **less** than 3 other sources such as Medicare, Workman’s Compensation, other federal programs, other state or local governments, and health insurance organizations or if a rate is not available from these sources then we solicit rates from at least 3 of the highest volume in-state providers of the services. After obtaining at **least** 3 rates, the rates are added together then divided by the number of rates to obtain an average rate which is then compared to similar procedures paid in comparable circumstances by the Medicaid program to set the upper limit.

- (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) The upper payment limit for the following dispensing services shall be established by ~~increasing~~ the limit in effect on ~~6/30/00~~ **to a fee** no less than the Medicare allowable fee established for the service
- (a) Fitting of spectacles;
 - (b) Special spectacles fitting; and
 - (c) Repair and adjustment of spectacles.

- (4) Reimbursement for materials (eyeglasses or parts of eyeglasses) shall be made at the optical laboratory cost of the materials not to exceed 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 of reasonable and economical rates at which the materials are widely and

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;
 - 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 a 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 lesser 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;
 - 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 a 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.

Payment for EPSDT Special Service Limited by Medicaid

For the services listed above in section XXIX subsection (1), the department shall reimburse for an expanded EPSDT service based upon the established methodology for other similar services under the Kentucky Medicaid Program.” The reimbursement of the expanded EPSDT service shall not exceed 100 percent of the usual and customary charges. 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. If an expanded EPSDT service is provided before prior authorization is received, the provider shall assume the financial risk that the prior authorization may not be subsequently approved.

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) Payment for covered chiropractors' services shall be based on the chiropractors' usual and customary actual billed charges up to 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).

(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) For services provided on or after July 1, 1990, chiropractors practicing in geographic areas with no more than one (1) primary care physician per 5,000 population, as reported by the United States Department of Health and Human Services, shall be reimbursed at the chiropractors' usual and customary actual billed charges up to 125 percent of the fixed upper limit per procedure established by the Department.

(3) 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).