

State Kentucky

Attachment 3.1-C

## STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

Page 9.1

- I. Standards designed to assure high quality care are described as follows:

Standards governing the provision of provider services have been established for each provider group covered under the Program. The established standards have been reviewed and evaluated and in part developed by the respective health professional groups and subsequently recommended by the Technical Advisory Committees and the Advisory Council for Medical Assistance. The following basic standards apply to all providers who participate in the Program:

- A. Vendor licensure
- B. Vendor participation authorization
- C. Vendor claim certification

In addition to these basic standards, specific standards have been developed for the providers of the various levels of institutional care to assure that the care and services rendered to patients is in accordance with the health and medical care needs of the patients.

Standards have also been established for providers of non-institutional services such as home health agencies, independent laboratories, community mental health centers, pharmacies, screening clinics, family planning clinics and ambulance transportation services. These standards cover such elements as administration, staffing/treatment plans, and fiscal plans.

Individual providers of health and medical care service, such as physicians, dentists, optometrists, ophthalmic dispensers, audiologists, and hearing aid dealers are required to meet the respective acceptable standards of health and medical practice within the community.

- II. Methods of assuring high quality care are described as follows:

- A. Systematic surveillance of services rendered
  - 1. Development of comprehensive utilization review programs for each service element of the Program.
  - 2. Periodic review of the kinds, amounts and durations of medical care received by all Program recipients
  - 3. Periodic review of the medical practices of all individuals, practitioners, agencies and institutions

74-1

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4. On-site visits to evaluate the kinds of medical care provided to Program recipients
  5. Involvement of health care and medical professionals in the review and analysis of exceptions within the system.
- B. Identification of recipients who inappropriately utilize the pharmacy and physician benefits of the Program. Through an intensified patient education program and pre-selection of providers by these recipients, an effort is made to improve the utilization patterns of these recipients.
  - C. On-site visits to medical institutions by a medical review team to evaluate the care and services provided to Program recipients. These teams are composed of at least a physician, a nurse, and a social worker.
  - D. Methods exist that assure that direct service workers and their supervisors are knowledgeable about health problems and ways to assist people to secure medical and remedial care and services.
  - E. Close scrutiny of all provider claim forms is performed by para-medical personnel and medical professionals to assure that the service rendered was in accordance with accepted norms of practice for the specific condition indicated.
  - F. The Program requires that providers of service be in compliance with established standards as a prerequisite to enrollment as a provider under the Program. Continuous compliance with established Program standards is determined through a process of periodic on-site surveys and evaluations of facilities and services.

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

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1937(a),  
1937(b)

The State elects to provide alternative benefits under Section 1937 of the Social Security Act.

**A. Populations**

The State will provide the benefit package to the following populations:

- a.  Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

**Family Choices which means children covered pursuant to:  
Sections 1902 (a)(10)(A)(i)(I) and 1931 of the Act  
Sections 1902(a)(52) and 1925 of the Act (Excluding children eligible under Part A or E of title IV)  
Sections 1902 (a)(10)(A)(i)(IV) as described in 1902 (i)(1)(B) of the Act  
Sections 1902 (a)(10)(A)(i)(VI) as described in 1902 (i)(1)(C) of the Act  
Sections 1902 (a)(10)(A)(i)(VII) as described in 1902 (i)(1)(D) of the Act  
42 CFR 457.310**

- b.  Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

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

List the populations/individuals who will be offered opt-in alternative coverage:

**Comprehensive Choices**

The **Comprehensive Choices** package will be available to all individuals who meet the nursing facility level of care and receive services through either a nursing facility or one of the following 1915 c waivers: **Acquired Brain Injury, Home and Community Based or Model II.**

<b>Comprehensive Choices TC 4</b>	<b>Federal Poverty Level</b>
<b>Mandatory State Plan Populations</b>	
Aged individuals who receive SSI and meet NF level of care and are in hospice	Up to 74 %
Disabled individuals who receive SSI and meet NF level of care and are in hospice	Up to 74 %
<b>Non-Mandatory State Plan Populations</b>	
Aged individuals who do not receive SSI and meet NF level of care	Up to 221 %
Disabled individuals who do not receive SSI and meet NF level of care, including those served by the ABI waiver	Up to 221 %
Aged individuals who do not receive SSI and meet NF level of care and are in hospice	Up to 221 %
Disabled individuals who do not receive SSI and meet NF level of care and are in hospice	Up to 221 %

**Optimum Choices**

The **Optimum Choices** package will be available to all individuals who meet the intermediate care facility for individuals with mental retardation or a developmental disability level of care and receive services through either an intermediate care facility for individuals with mental retardation or a developmental disability or through the 1915 c Supports for Community Living waiver.

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

Optimwin Choices EG-A	Federal Poverty Level
<b>Mandatory State Plan Populations</b>	
Aged individuals who receive SSI and meet ICF MR DD level of care and are in hospice	Up to 74 %
Disabled individuals who receive SSI and meet ICF MR DD level of care and are in hospice	Up to 74 %
<b>Non-Mandatory State Plan Populations</b>	
Aged individuals who do not receive SSI and meet ICF MR DD level of care	Up to 221 %
Disabled individuals who do not receive SSI and meet ICF MR DD level of care	Up to 221 %
Aged individuals who do not receive SSI and meet ICF MR DD level of care and are in hospice	Up to 221 %
Disabled individuals who do not receive SSI and meet ICF MR DD level of care and are in hospice	Up to 221 %

**Employer Sponsored Insurance (ESI):**

Except for the following exclusions, ESI will be available to all members who elect ESI coverage. Individuals excluded from the ESI option include all children, including but not limited to, those covered pursuant to: Section 1634(c) and 1634(d)(2) of the Act; Sections 1902(a)(10)(A)(i)(I) and 1931 of the Act; Section 1902(a)(10)(A)(i)(II) of the Act; Sections 1902(a)(10)(A)(i)(IV) as described in 1902 (l)(1)(B) of the Act; Sections 1902(a)(10)(A)(i)(VI) as described in 1902 (l)(1)(C) of the Act; Sections 1902(a)(10)(A)(i)(VII) as described in 1902 (l)(1)(D) of the Act;

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

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Sections 1902(a)(52) and 1925 of the Act; 42 CFR  
435.120, 435.134, 435.135, 435.137, 435.138,  
435.145, 435.227, 435.320, 435.322, and 435.324;  
42 CFR 457.310

Individuals who voluntarily elect ESI coverage will be subject to the benefit package, cost sharing and co-payment provisions of the ESI. The ESI benchmark equivalent plan will be the Kentucky State Employee Essential Health Insurance Plan (please see Appendix 1 to Attachment 3.1-C). Kentucky Medicaid will not provide wrap around services to individuals enrolled in ESI. For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

The State will send to each eligible member a letter notifying them of the benefits and cost sharing associated with participation in the Comprehensive Choices and Optimum Choices benefit packages. The cost sharing under the Comprehensive Choices plan and the Optimum Choices plan is less than the cost sharing under the Global Choices plan due to the unique level of care.

The State will send to each eligible member a letter notifying them of the Employer Sponsored Insurance option. When an individual initially applies for Kentucky Medicaid or applies for recertification, the

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**ALTERNATIVE BENEFITS**

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

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eligibility intake worker will offer the individual the opportunity to opt in to Employer Sponsored Insurance. The worker will provide informational materials to the individual explaining ESI and noting that the ESI may offer less benefits than those offered via the traditional Medicaid benefit package. The material shall contain a statement that the individual may opt out of the ESI plan at any time and revert back to appropriate Medicaid coverage.

If the individual elects ESI coverage, he/she will be asked to sign appropriate documentation denoting his/her election and the eligibility worker will request a copy of the individual's ESI plan Schedule of Benefits.

The worker will forward the ESI Schedule of Benefits along with the individual's ESI opt-in form to the Medicaid contractor that administers the State's Health Insurance Premium Plan (HIPP) program for the State. The contractor will determine if the benefits offered under the ESI plan are equivalent to the benchmark plan and if the plan is cost effective and meets economy and efficiency principles.

If the ESI plan benefits equal the benchmark plan benefits, is cost effective for the State and meets economy and efficiency principles a letter will be sent to the individual accepting their request to opt in to the ESI plan. If the ESI plan fails to meet the above tests, the individual will be sent a letter notifying that their request

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TN No.: 06-010  
Supersedes  
TN No.: New

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Approval Date: 05/03/06

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Effective Date: 04/01/06

Implementation Date: 05/15/06

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

---

for ESI was not accepted due to failing to meet whichever criteria it did not meet. Thus, the State will ultimately maintain discretion as to whether or not to offer ESI coverage to an individual.

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

*Please see the attached benefit grid for Comprehensive Choice and Optimum Choices. Cost sharing for this population is reduced under this benefit design.*

*The Kentucky State Employee Essential Health Insurance Plan (please see attached) will be the benchmark equivalent plan utilized for individuals selecting Employer Sponsored Insurance.*

c.  Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:

**Targeted disease management benefits will be made available to certain counties based on diagnosis of applicable disease state.**

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography

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TN No.: 06-010  
Supersedes  
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Approval Date: 05/03/06

Effective Date: 04/01/06

Implementation Date: 05/15/06

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

---

limitations, or any other requirements or limitations.  
*Please see the attached listing of disease management program descriptions and their corresponding geographic locations. All Medicaid eligibles with an appropriate diagnosis code, who are capable of meeting the participation requirements of the related disease management program, may elect to participate in the disease management program if offered in their county of residence. All enrollments will be opt-in, participation will not be mandated.*

B. Description of the Benefits

The State will provide the following alternative benefit packages (check all that apply).

1937(b)

1.  Benchmark Benefits

a.  **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.

b.  **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State's employee benefits plan package.

c.  **Coverage Offered Through a Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has

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TN No.: 06-010  
Supersedes  
TN No.: New

Approval Date: 05/03/06

Effective Date: 04/01/06

Implementation Date: 05/15/06

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

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the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO's benefit package.

d. X/ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State's plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

*Please see the attached Family Choices benefit description, Comprehensive Choices benefit description, Optimum Choices benefit description and Disease Management program descriptions.*

2. X/ **Benchmark-Equivalent Benefits.** Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan: **The Employer Sponsored Insurance (ESI) plan will be equivalent to the State's State Employee Essential Health Insurance Plan which is attached.**

**The State will send to each eligible member a letter notifying them of the Employer Sponsored Insurance option. When an individual initially applies for Kentucky Medicaid or applies for recertification, the eligibility intake worker will offer the individual the opportunity to opt in to Employer Sponsored Insurance. The worker will provide informational materials to the individual explaining ESI and noting that the ESI may**

TN No.: 06-010  
Supersedes  
TN No.: New

Approval Date: 05/03/06

Effective Date: 04/01/06

Implementation Date: 05/15/06

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

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offer less benefits than those offered via the traditional Medicaid benefit package. The material shall contain a statement that the individual may opt out of the ESI plan at any time and revert back to appropriate Medicaid coverage.

If the individual elects ESI coverage, he/she will be asked to sign appropriate documentation denoting his/her election and the eligibility worker will request a copy of the individual's ESI plan Schedule of Benefits.

The worker will forward the ESI Schedule of Benefits along with the individual's ESI opt-in form to the Medicaid contractor that administers the State's Health Insurance Premium Plan (HIPP) program for the State. The contractor will determine if the benefits offered under the ESI plan are equivalent to the benchmark plan and if the plan is cost effective and meets economy and efficiency principles.

If the ESI plan benefits equal the benchmark plan benefits, is cost effective for the State and meets economy and efficiency principles a letter will be sent to the individual accepting their request to opt in to the ESI plan. If the ESI plan fails to meet the above tests, the individual will be sent a letter notifying that their request for ESI was not accepted due to failing to meet whichever criteria it did not meet. Thus, the State will ultimately maintain discretion as to whether or not to offer ESI coverage to an individual.

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TN No.: 06-010  
Supersedes  
TN No.: New

Approval Date: 05/03/06

Effective Date: 04/01/06

Implementation Date: 05/15/06

**ALTERNATIVE BENEFITS**

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

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a.  / The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the population being served; 5) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. Attach a copy of the report.

b.  / The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of

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TN No.: 06-010  
Supersedes  
TN No.: New

Approval Date: 05/03/06

Effective Date: 04/01/06

Implementation Date: 05/15/06

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT  
BENCHMARK BENEFIT PACKAGE  
BENCHMARK EQUIVALENT BENEFIT PACKAGE

---

that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c.  / The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1)  / **Inclusion of Basic Services** - This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

/ Inpatient and outpatient hospital services;

/ Physicians' surgical and medical services;

/ Laboratory and x-ray services;

/ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices

/ Other appropriate preventive services, as designated by the Secretary.

/ Clinic services (including health center services) and other ambulatory health care services.

/ Federally qualified health care services

/ Rural health clinic services

/ Prescription drugs

/ Over-the-counter medications

/ Prenatal care and pre-pregnancy family services and Supplies

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TN No.: 06 010

Supersedes

TN No.: New

Approval Date: 05/03/06

Effective Date: 04/01/06

Implementation Date: 05/15/06

**ALTERNATIVE BENEFITS**

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

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- / Inpatient Mental Health Services not to exceed 30 days in a calendar year
- / Outpatient mental health services furnished in a State-operated facility and including community-based services
- / Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
- / Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.
- / Nursing care services, including home visits for private duty nursing, not to exceed 30 days per calendar year
- / Dental services
- / Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year
- / Outpatient substance abuse treatment services
- / Case management services
- / Care coordination services
- / Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- / Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services.
- / Premiums for private health care insurance coverage
- / Medical transportation
- / Enabling services (such as transportation, translation, and outreach services)
- / Any other health care services or items specified by the Secretary and not included under this section

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

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

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**The State will maintain a list of all services covered by each ESI plan utilized by individuals who voluntarily select ESI coverage.**

- (2) Additional benefits for voluntary opt-in populations:  
 / Home and community-based health care services  
 / Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

*Please see attached Kentucky state employee benefit grid and the table outlining the differences between that plan and Family Choices.*

3. Wrap-around/Additional Services

- a.  / The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).

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TN No.: 06-010  
Supersedes  
TN No.: New

Approval Date: 05/03/06

Effective Date: 04/01/06

Implementation Date: 05/15/06

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

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EPSDT services will be provided by the State to insure that the full EPSDT benefit is available when medically necessary.

b.  / The State has elected to also provide wrap-around or additional benefits.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

C. Service Delivery System

Check all that apply.

1.  / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.
2.  / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1915(b)(1).
3.  / The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirement.
4.  / Alternative benefits provided through premium assistance for benchmark-equivalent in employer sponsored coverage.

TN No.: 06-010  
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Effective Date: 04/01/06

Implementation Date: 05/15/06

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT  
BENCHMARK BENEFIT PACKAGE  
BENCHMARK EQUIVALENT BENEFIT PACKAGE

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5.  Alternative benefits will be provided through a combination of the methods described in items 1-4. Please specify how this will be accomplished.

At the inception of the Family Choices program, the alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider, except that it will be operated with a primary care case management system consistent with section 1915(b)(1).

Post implementation the State intends to bid out the plan to be administered through a managed care entity.

Premium assistance will be provided to recipients opting into employer sponsored insurance coverage with benchmark-equivalent benefits.

D. Additional Assurances

a.  The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

b.  The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

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TN No.: 06-010  
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**ALTERNATIVE BENEFITS**  
**STATE PLAN AMENDMENT**  
**BENCHMARK BENEFIT PACKAGE**  
**BENCHMARK EQUIVALENT BENEFIT PACKAGE**

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E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

X The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

G. Implementation Date

X The State will implement this State Plan amendment on May 15, 2006.

II. Signature

Date: 4-19-06

Authorizing Official: Shannon Turner, JD  
Commissioner

Authorizing Official's

Signature: \_\_\_\_\_

TN No.: 06-010

Supersedes

TN No.: New

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Implementation Date: 05/15/06

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

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**Family Choices Attachments**

The Family Choices benefit package was based on the Kentucky state employee benefit package with modifications to assure nominal cost sharing. Some benefit limit and design changes were also made to the package. Limits imposed under the Family Choices plan are soft limits which means additional visits may be authorized if medically necessary; in contrast, the limits in the state employee health benefit plan are hard limits and may not be exceeded. The differences are detailed in the following table:

<b>State Employee Benefit</b>	<b>Family Choices Benefit</b>
Chiropractic Services- 26 per visits per year	Chiropractic Services- 7 visits per 12 months
Speech Therapy- 30 visits per year	Speech Therapy- 15 visits per year
Physical Therapy- 30 visits per year	Physical Therapy- 15 visits per year
Occupational Therapy- 30 visits per year	Occupational Therapy- 15 visits per year
EPSDT (not fully covered)	EPSDT
Home Health- limited to 60 visits per year	Home Health- 25 visits per 12 months
Skilled Nursing Facility Services- limited to 30 days per year	Skilled Nursing Facility Services no day limitation

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**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 and Chronical Relatives	Category A Needy Children	KCHIP Children Medicaid Extension Program	Medicaid Medically Needing Attention
<b>Medical Out-of-Pocket Maximum</b>	\$225 per 12 months	\$225 per 12 months	\$225 per 12 months	\$225 per 12 months
<b>Pharmacy Out-of-Pocket Maximum</b>	\$225 per 12 months	\$225 per 12 months	\$225 per 12 months	\$225 per 12 months
<b>Acute Inpatient Hospital Services</b>	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
<b>Laboratory, Diagnostic and Radiology Services</b>	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
<b>Outpatient Hospital/ Ambulatory Surgical Centers</b>	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
<b>Physician Office Services*</b>	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
<b>Behavioral Health Services**</b>	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
<b>Allergy Services</b>	\$0 co-pay	\$0 co-pay	<ul style="list-style-type: none"> <li>• \$2 co-pay for office visit and testing</li> <li>• \$0 co-pay for injections</li> </ul>	<ul style="list-style-type: none"> <li>• \$2 co-pay for office visit and testing</li> <li>• \$0 co-pay for injections</li> </ul>
<b>Preventive Services</b>	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
<b>Emergency Ambulance</b>	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay

## ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT  
BENCHMARK BENEFIT PACKAGE  
BENCHMARK EQUIVALENT BENEFIT PACKAGE

General/SED/EC	Children Parents/ Relatives	Non-Parentally Naturally Children	Child Inpatient Expansion Program
<b>Dental Services</b>  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
<b>Family Planning</b>	\$0 co-pay	\$0 co-pay	\$0 co-pay
<b>Physical Therapy</b>  Limited to 15 visits per 12 months	\$0 co-pay	\$0 co-pay	\$0 co-pay
<b>Speech Therapy</b>  Limited to 15 visits per 12 months	\$0 co-pay	\$0 co-pay	\$0 co-pay
<b>Hospice (non-Institutional)</b>	\$0 co-pay	\$0 co-pay	\$0 co-pay
<b>Non-Emergency Transportation</b>	\$0 co-pay	\$0 co-pay	\$0 co-pay
<b>Chiropractic Services</b>  Limited to twenty-six visits per 12 months	\$0 co-pay	\$0 co-pay	\$0 co-pay

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## 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 \$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);	\$0 co-pay \$600 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);	\$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);
Vision Services General ophthalmology and optometry	\$0 co-pay \$400 maximum on eyewear per year. Eyewear coverage is limited to an individual under age twenty-one(21).	\$0 co-pay \$400 maximum on eyewear per year. Eyewear coverage is limited to an individual under age twenty-one(21).	\$0 co-pay \$400 maximum on eyewear per year. Eyewear coverage is limited to an individual under age twenty-one(21).
Prosthetic Devices	\$0 co-pay \$1,500 per 12 months	\$0 co-pay \$1,500 per 12 months	\$0 co-pay \$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	Child Care Relative	Child Care Non-Relative	Child Care Foster Care
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 Benefit Plan**

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

Benefit/Service	State Plan	NR Level of Care (including ABI/ICF) / MR/DD Level of Care
Medical Out-of-Pocket Maximum	No Maximum	\$225 per 12 months
Pharmacy Out-of-Pocket Maximum	No Maximum	\$225 per 12 months
Acute Inpatient and Critical Access Hospital Services	\$50 co-pay per admission	\$10 co-pay
Outpatient Hospital/Ambulatory Surgical Centers	\$3 co-pay	\$3 co-pay
Laboratory, Radiology and Diagnostic Services	\$0 co-pay	\$0 co-pay
Physician Services*	\$2 co-pay	\$0 co-pay
EPSDI Services for Children under 21	\$0 co-pay	\$0 co-pay
Maternity Services	\$0 co-pay	\$0 co-pay
Nurse mid-wife services, pregnancy-related services and services for other conditions that might complicate pregnancy and 60 days postpartum pregnancy related services		
Preventive and Screening Services	\$0 co-pay	\$0 co-pay

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

Comprehensive Choice and Optimum Choice Cost Sharing - In-It 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

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## ALTERNATIVE BENEFITS

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

Benefit/Service	State Plan	NE Level of Care (including ABU/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 Aged 21 & over, 15 visits per 12 months; Under 21 years of age, 7 visits per 12 months	\$0 co-pay 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 fee 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);

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

Comprehensive Choices and Optimum Choices Cost Sharing & Limits		
Individuals receiving comprehensive services will not have co-pay or patient responsibility.		
Benefit/Service	State Plan	NR 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.

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

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**Disease Management and Get Healthy Benefits**

Kentucky Medicaid will offer the following disease management programs described on pages 10.26 through 10.40.

- Diabetes Initiative
- COPD/Adult Asthma Initiative
- Pediatric Obesity Initiative
- Cardiac - Heart Failure Initiative
- Pediatric Asthma Initiative

Medicaid members may select from one of the following Get Healthy Benefits upon successful participation for one year in a disease management program and completion of a Centers for Disease Control and Prevention recommended age and periodicity screening guidelines:

- Limited allowance for dental services not to exceed \$50
- Limited allowance for vision hardware services not to exceed \$50
- Five visits to a nutritionist (registered dietician) for meal planning and counseling
- Two months of smoking cessation through a local health department, including two months of nicotine replacement therapy

Members will have six months after selecting a Get Healthy Benefit to access the benefit. Failure to access the benefit in within six months will result in loss of the benefit.

Additionally, any individual who no longer participates in the Medicaid program will be immediately ineligible to access a Get Healthy Benefit.

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

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**Diabetes Initiative**

**Program Description**

The Department for Medicaid Services (DMS), Division of Medical Management and Quality Assurance (MMQA) implemented this initiative to provide the following goals:

- To improve quality of life for members with diabetes.
- To educate the members to be better prepared to manage their diabetes.
- Promote appropriate use of healthcare resources.
- Decrease work absences.
- Improve self-management of diabetes.
- Standards of Care adopted and guidelines followed by providers and members.

This initiative has targeted the age ranges of eighteen (18) years of age and older. The counties selected to participate in the pilot include Bell and Floyd.

Introductory letters were initially forwarded to providers and members. We wish to continue to encourage our healthcare providers for their input and assistance with this initiative. DMS MMQA continues to look forward to partnering with our providers, health departments and community resources to improve the lives of Kentuckians affected by diabetes.

Specific guidelines (for example) include the American Diabetes Association (ADA). A chart abstraction was performed that included diabetic history, symptoms/findings- blood pressure, A1c, proteinuria, lipid profile, microalbuminuria, foot exam, eye exam.

Member and provider mailings to continue every quarter. A newsletter is one format to provide educational information. Staff are available to assist with member calls, and nursing staff to answer questions as needed.

**Clinical Guidelines and Standards**

- American Diabetes Association (ADA)

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

**Summary Data and Map  
Diabetes**

**Member Population = Females and Males with an age range over the age of 18  
CY 2005**



Original Member Letter and Provider Letter Mail Out

County Name	Unduplicated Member Count	Unduplicated Provider Count	Member Opt Out
BELL	526	24	13
Floyd	755	29	26
<b>Grand Total</b>	1,281	53	39

First Quarter Original Member Newsletter Mail Out

County Name	Unduplicated Member Count
BELL	513
Floyd	729
<b>Grand Total</b>	1,242

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

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Eve Brochure Original and First Quarter New Member Mail Out

County Name	Unduplicated Member Count	Member Opt Out	FH Identified	Undup. 1Q Member Count	GRNAD TOTAL FOR MAIL OUT
BELL	526	13	15	617	
Floyd	755	26	21	490	
<b>Grand Total</b>	<b>1,281</b>	<b>39</b>	<b>36</b>	<b>1,107</b>	<b>2,078</b>

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

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**COPD/Adult Asthma Initiative**

**Program Description**

The Department for Medicaid Services Division of Medical Management and Quality Assurance has implemented the COPD/Adult Asthma Disease Management Program. The pilot counties selected include Letcher, Perry, and Whitley.

The goals of this program:

- Improve quality of life for members with COPD and /or asthma.
- Educate members to be better prepared to manage their COPD and/or asthma.
- Prevent acute exacerbations of asthma.
- Prevent admissions to the hospital and emergency department visits.
- Promote appropriate use of healthcare resources.
- Minimize work absences.

Introductory letters to be forwarded to healthcare providers and members. Members identified to have COPD and/or asthma will receive newsletters to include an example of an asthma action plan (following the National Heart, Lung, and Blood Institute Guidelines), COPD, asthma and smoking cessation educational information. The members will be encouraged to contact their healthcare providers to schedule an appointment for evaluation, and establishment of a plan of treatment.

The Department for Medicaid Services, Division of Medical Management and Quality Assurance to partner with our providers, health departments, and community resources to improve the lives of Kentuckians affected by COPD and/or asthma.

**Clinical Guidelines and Standards**

- National Heart, Lung, and Blood Institute (NHLBI)
- National Institutes of Health (NIH)

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

**Summary Data and Map**  
**COPD / Adult Asthma**  
**Member Population = Females and Males with an age range over the age of 18**  
**CY 2005**



Original Member Letter and Provider Letter Mail Out

County Name	Unduplicated Member Count	Unduplicated Provider Count
<b>LETCHER</b>	153	29
<b>Perry</b>	183	47
<b>Whitley</b>	211	62
<b>Grand Total</b>	547	138

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

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**Pediatric Obesity Initiative**

**Program Description**

The target population for this program is members age 5-12 identified with diagnosis of obesity.

The goals of this program are to:

- Improve the quality of life.
- Educate the parent and child to promote healthy weight and physical activity.
- Prevent medical complications and co-morbidity's.
- Promote appropriate use of health care resources.
- Decrease school absences.
- Improve self-esteem.

The methods for identifying these members were paid claims and pharmacy data. We will also accept member and provider referrals to this program.

The Department for Medicaid Services, Division of Medical Management/Quality Assurance is asking the providers assistance in coordinating this implementation. We are planning to approach public health and the school system as partners in this program. The providers will receive a letter that includes a copy of the member letter, HRA assessment "Food for Thought" questionnaire and a tips for healthy eating and physical activity. The Regional Medicaid Nurse will be available to support this program via provider and member education.

Information will be distributed through mailings; the goal is to make this information available via web site, health fairs or classes and partnerships with pharmaceutical companies. This program will be implemented the week of September 26, 2005. Additional mailings will include educational materials on nutrition guidelines, food pyramid and physical activity education.

**Clinical Guidelines and Standards**

- Center for Disease Control (CDC)
- National Heart, Lung, and Blood Institute (NHLBI)
- American Academy of Pediatrics (AAP)

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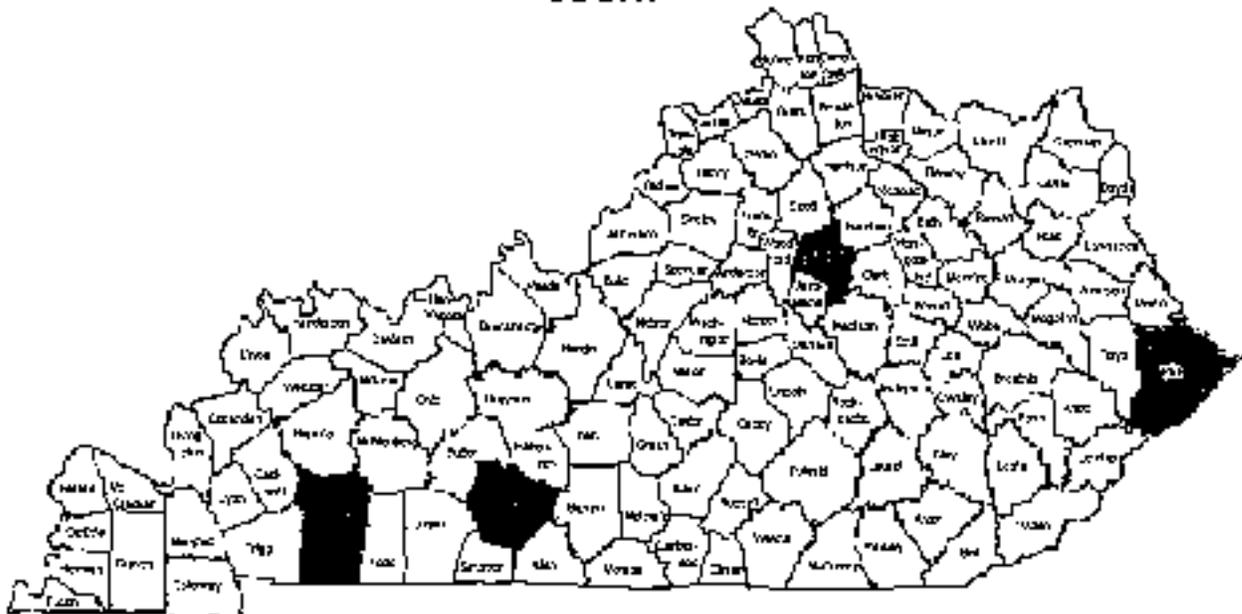
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**ALTERNATIVE BENEFITS**

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

**Summary Data and Map  
Pediatric Obesity  
Member Population = Females and Males with an age range 5 to 12  
CY 2005**



**Original Member Letter and Provider Letter Mail Out**

County Name	Unduplicated Member Count	Unduplicated Provider Count	Member Opt Out
CHRISTIAN	41	33	3
Fayette	92	95	2
Pike	124	65	0
Warren	16	53	0
<b>Grand Total</b>	<b>273</b>	<b>246</b>	<b>5</b>

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

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**First Quarter Original and New Member Newsletter and Provider Newsletter Mail Out**

County Name	Unduplicated Member Count	Unduplicated 1Q New Member Count	Members found in both original and 1Q Data	Provider Count
CHRISTIAN	39	13	12	33
Fayette	90	95	51	95
Pike	124	58	49	65
Warren	16	27	10	53
<b>Grand Total</b>	<b>269</b>	<b>193</b>	<b>122</b>	<b>246</b>

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**ALTERNATIVE BENEFITS**

**STATE PLAN AMENDMENT**

**BENCHMARK BENEFIT PACKAGE**

**BENCHMARK EQUIVALENT BENEFIT PACKAGE**

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**Cardiac – Heart Failure Initiative**

**Program Description**

The first initiative for the Cardiac Disease Management Program will be Heart Failure. The target population for this program is members 20 years and older (including dual members of Medicare and Medicaid) identified with diagnosis of Heart Failure. We will exclude diagnosis of heart failure with renal failure requiring renal dialysis and members in long term care facilities.

The goals of this program are:

- To improve quality of care.
- Prevent or delay complications.
- Promote continuity of care.
- Promote efficient use of healthcare resources.
- Improve self-management of heart failure.

The methods for identifying these members were paid claims and pharmacy data. We will also accept member and provider referrals to this program.

The Department for Medicaid Services, Division of Medical Management/Quality Assurance is asking the providers assistance in coordinating this implementation. We are partnering with the Kentucky Heart Disease and Stroke Prevention Program in the Department of Public Health and the American Heart Association. The providers will receive a newsletter containing some of the educational information that was provided in the member's newsletter, and "Tracking Your Symptoms" chart. Also included in the provider packet will be the American Heart Association "Get With The Guideline<sup>SM</sup> – Heart Failure" and the web site for "The American College of Cardiology/American Heart Association (ACC/AHA) 2005 Practice Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult" summary article. The Medicaid Nurse will be available to support this program via provider and member education.

Educational materials and information will be distributed through mailings. The goal is to make these educational materials and information available via the World Wide Web, health fairs or classes and partnerships with pharmaceutical companies. This program will be implemented the week of October 21, 2005. Additional mailings will include educational materials on specific topics concerning Heart Failure.

"The American College of Cardiology/American Heart Association 2005 Practice Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult" and the American Heart Association "Get With The Guideline<sup>SM</sup> Heart Failure" are the guidelines used in this Cardiac Disease Management program.

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

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**Clinical Guidelines and Standards**

- “American College of Cardiology / American Heart Association 2005 Guidelines for Heart Failure Update for the Diagnosis and Management of Chronic Heart Failure”.
- AHA “Get With The Guideline<sup>SM</sup> - Heart Failure”.
- QAPI Heart Failure Quality Indicators.

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

**Summary Data and Map**  
**Cardiac – Heart Failure Initiative**  
**Member Population = Females and Males of all ages**  
**CY 2005**



Original Member Newsletters and Provider Newsletter Mail Out

County Name	Unduplicated Member Count	Unduplicated Provider Count
CLAY	139	50
Fayette	272	131
McCreary	99	32
<b>Grand Total</b>	<b>510</b>	<b>213</b>

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

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**Pediatric Asthma Initiative**

**Program Description**

The Department of Medicaid Services (DMS), Division of Medical Management and Quality Assurance (MMQA) implemented this initiative to provide the following goals:

- To improve quality of life for children with asthma.
- To educate the parent and child to be better prepared to manage asthma.
- To prevent acute exacerbations of asthma episodes.
- Promote appropriate use of healthcare resources.
- Decrease school absences.
- Improve self-management of asthma.

This initiative has targeted the age ranges of five (5) to seventeen (17) years of age. The counties selected to participate in the pilot include Perry, Pike and Powell.

An introduction letter was previously forwarded to providers and members. We wish to continue to encourage our healthcare providers for their input and assistance with this initiative. DMS MMQA continues to look forward to partnering with our providers, health departments and community resources to improve the lives of Kentuckians affected by asthma.

We have adopted specific guidelines for example of the National Heart, Lung, and Blood Institute (NHLBI). A chart abstraction was performed that included demographics, history, medications, utilization of services and education.

First mailing (for example) included an Asthma Action Plan (source: NHLBI) and Asthma Fact Sheet with information about "Asthma Is a Lung Disease", and "Managing Asthma and Asthma Triggers". Staff are available to assist with member calls, and nursing staff to answer questions as needed.

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

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**Clinical Guidelines and Standards**

- National Heart, Lung, and Blood Institute (at this time, we have adopted primarily) (NHLBI)
- National Institutes of Health (NIH)

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

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**Summary Data and Map**  
**Pediatric Asthma**  
**Member Population = Females and Males with an age range 5 to 17**  
**CY 2005**



Original Member Letter and Provider Letter Mail Out

County Name	Unduplicated Member Count	Unduplicated Provider Count	Member Opt Out
PERRY	206	19	2
Pike	774	43	18
Powell	104	3	1
<b>Grand Total</b>	<b>1,084</b>	<b>65</b>	<b>21</b>

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

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First Quarter Original and New Member Newsletter Mail Out

County Name	Unduplicated Member Count	Unduplicated 1Q New Member Count	GRAND TOTAL FOR 1Q MAIL OUT
PERRY	204	806	
Pike	755	1,504	
Powell	103	261	
<b>Grand Total</b>	<b>1,063</b>	<b>2,571</b>	<b>3,634</b>

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**BENEFITS**

**Commonwealth Essential**

Covered Services	Commonwealth Essential	
	In-network	Out-of-Network
Annual Deductible	Single - \$750 Family - \$1,500	Single - \$1,500 Family - \$3,000
Out-of-pocket maximum (excludes prescription drug expenses and emergency room co payments)	Single - \$3,500 Family - \$7,000	Single - \$7,000 Family - \$14,000
Lifetime maximum	Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas, or mental health and chemical dependency services)	25%*	50%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy; injections, lab fees, X-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	25%*	50%*
Diagnostic testing – laboratory tests, X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*
Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician’s office.	25%*	50%*

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## BENEFITS

### Commonwealth Essential

Covered Services	Commonwealth Essential	
	In-network	Out-of-Network
Preventive care – annual gynecological exam, well child care, and routine physical early detection tests, subject to age and periodicity limits	Plan pays 100% up to a maximum of \$200 per covered individual. Plan pays 100% of eligible immunizations.	
Emergency Services		
Emergency room treatment (Emergency room Co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*
Emergency room physician charges	25%*	50%*
Urgent care center treatment	25%*	50%*
Ambulance services	25%*	50%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval.	25%*	50%*
Prescription drugs – Retail (30 day supply)	25%	
1 <sup>st</sup> Tier	Min \$10	Max \$25
2 <sup>nd</sup> Tier	\$20	\$50
3 <sup>rd</sup> Tier	\$35	\$100
Prescription drugs – Mail Order (90 day supply)	25%	
Generic	Min \$20	Max \$50
Preferred Brand	\$40	\$100
Non-preferred Brand	\$70	\$200
Audiometric services in conjunction with a disease, illness or injury	25%*	50%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*

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## BENEFITS

### Commonwealth Essential

Covered Services	Commonwealth Essential	
	In-network	Out-of-Network
Autism Service Rehabilitative and therapeutic care services	25%*	50%*
Respite care for children ages two through 21 (\$500 maximum per month)	25%*	50%*
Hospice care – subject to precertification by the plan	Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*
Prosthetic devices	25%*	50%*
Home health – limited to 60 visits per year	25%*	50%*
Physical therapy – limited to 30 visits per year	25%*	50%*
Occupational therapy – limited to 30 visits per year	25%*	50%*
Speech therapy – limited to 30 visits per year	25%*	50%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of \$1,400 per ear	25%*	50%*

\*Services subject to deductible

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**Transportation (For Categorically Needy and Medically Needy)**

- A. The Department for Medicaid Services assures that medically necessary transportation of recipients to and from providers of service will be provided. The methods that will be used are as follows:
1. Any appropriate means of transportation which can be secured without charge through volunteer organizations, public services such as fire department and public ambulances, or relatives will be used.
  2. If transportation is not available without charge, payment will be made for the least expensive means of transportation suitable to the recipient, whenever determined to be medically necessary through preauthorization, postauthorization, or through the patient's meeting certain specified criteria relating to destination, point of departure, and condition.
  3. When transportation is required on a predictable basis, an amount to cover the transportation is allowed as a spenddown by the medically needy.
  4. When medical transportation is required, a preauthorization system at the local level is used for nonemergency transportation.
  5. Payments for locally authorized medical transportation shall be made directly to participating providers by the Medicaid Program.
  6. All Medicaid participating medical transportation providers, including private automobile carriers, shall have a signed participation agreement with the Department for Medicaid Services prior to furnishing the medical transportation service.
  7. Locally authorized medical transportation shall be provided on an exceptional postauthorization basis for nonemergency, medically necessary transportation under the following conditions: the client can justify the need for medical transportation arose and was provided; was provided outside the normal working hours; payments for the transportation has not been made; client was traveling to or from a medical service covered under the state plan, except for pharmaceutical services; and service was determined medically necessary by the state agency.

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- B. Ambulance service shall be reimbursable only when it is the least expensive and most appropriate for the recipient's medical needs and the following criteria shall be met.
1. Emergency ambulance services to the nearest appropriate medical facility are provided without preauthorization when the emergency treatment is specified and rendered.
  2. Nonemergency ambulance services to a hospital, clinic, physician's office, or other health facility to secure medically necessary Medicaid covered services for a "stretcher bound" Medicaid recipient. "Stretcher bound" denotes the inability to get up from bed without assistance, the inability to ambulate, and the inability to sit in a chair or wheelchair.
  3. Any determination of medical necessity of transportation, and provision of preauthorization and postauthorization, is made by the Department for Medicaid Services or by the Department's authorized representative. Transportation only within the medical service area is approved unless preauthorized by the agency (or postauthorized in certain instances), unless previously designated criteria for transportation not requiring authorization are met.

State/Territory: Kentucky

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

General Coverage Criteria. The following general coverage criteria shall be applicable with regard to organ transplants.

1. For an organ transplant to be covered under the Medicaid Program, it must be the opinion of the transplant surgeon that the transplant is medically necessary; the failure to perform the organ transplant would create a life-threatening situation; and the prognosis must be that there is a reasonable expectation the transplant will be successful and result in prolonged life of quality and dignity.
2. The hospital and physician performing the transplant must be recognized by the Medicaid Program as being competent to perform the transplant. A staff and functioning unit at the hospital designed for and/or accustomed to performing transplants of the nature envisioned, recognized as competent by the medical community, will ordinarily be considered competent by the program.

Reimbursement for Organ Transplants. Hospital payments for organ transplants will be set at eighty (80) percent of actual usual and customary charges with total payments not to exceed \$75,000 per transplant without regard to usual program limits on hospital length-of-stay. An exception to the maximum payment limit can be made by the Commissioner, Department for Medicaid Services on a case by case basis when the maximum payment limit restricts medically appropriate care or prohibits the availability of the needed transplant procedure or service. Physician payments for organ transplants will be at the usual Medicaid Program rates.

Application of Organ Transplants Policy. It is the intent of the Department for Medicaid Services that the organ transplant policy be applied uniformly and consistently so that the similarly situated individuals will be treated alike. To accomplish this goal the Department will use the methodology specified in this section in receiving and processing requests for coverage and payments for organ transplants.

1. All requests for authorization for organ transplants must be sent to the Commissioner, Department for Medicaid Services.

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2. The Commissioner will assign the request to appropriate staff for investigation, report and recommendation. The report must show whether the person requesting the transplant is Medicaid eligible (or approximately when the person will become eligible); the type of transplant requested; the name of the facility (and physician if considered necessary) where the transplant is to be performed; any fee arrangement that has been made with the facility and/or physician (or a statement as to whether there is a disagreement with regard to fees); the proposed date of the transplant; the prognosis; a finding as to whether the facility/physician is considered qualified for the transplant being considered; and a finding as to whether program criteria for coverage is met.
3. After consideration of the report and recommendation, the Commissioner will determine whether the general coverage criteria are met and payments for the transplant should be made. If the decision is to provide coverage, Medicaid Program staff will assist the recipient with necessary arrangements for the transplant. If the decision is negative, the recipient will be notified of the manner in which the request does not meet agency guidelines.

Scope of Coverage. This organ transplant policy is applicable with regard to the following types of transplants: heart, lung, bone marrow and liver. Other types of transplants will also be covered under this policy upon identification and request except when special treatment of the transplant services is not considered necessary (i.e., usual program coverage and reimbursement is considered adequate), or when the transplant is considered by the Department for Medicaid Services to be experimental in nature. The Medicaid Program will not cover experimental transplants, i.e., those which have not previously been proven effective in resolving the health problems for which the transplant is the proposed preferable treatment mode.

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