

YOUR GUIDE TO KENTUCKY MEDICAID

WHAT'S INSIDE YOUR MEDICAID GUIDE?

This guide gives you a lot of information about Medicaid, including:

- How to contact Medicaid Member Services
- Medicaid covered services
- Your rights and responsibilities as a Medicaid member
- Ways to stay healthy and well
- How to file a complaint or ask for a hearing
- Important phone numbers

This Guide covers basic Medicaid information. It also contains information on the Kentucky Children's Health Insurance Program (KCHIP) and the Kentucky Patient Access and Care Program (KenPAC). If you are Medicaid eligible through a waiver program or any other special Medicaid program and have questions, call our Member Services number at 1-800-635-2570.

Recibe un guia para miembros de Medicaid en espanol, llama por telefono a 1-800-635-2570.

FRAUD AND ABUSE OF MEDICAID SERVICES

WHAT IS MEDICAID FRAUD?

- Lying when you apply for Medicaid or KCHIP
- Letting someone else use your Medical card
- Not reporting changes in income and family status
- Not telling Medicaid that you have other health insurance

WHAT IS MEDICAID ABUSE?

- Too many emergency room visits for problems that are not emergencies. See page 22.
- Using too many or unnecessary pain medicines
- Too many unnecessary prescriptions being filled

When a person is found to be abusing his Medical card, he may be put in Medicaid's **Lock-In Program**. If you are put in the Lock-In Program, you are assigned a provider. This provider will take care of your health care needs. This provider will refer you to a specialist if you need one. You may also be asked to go to one pharmacy to have all prescriptions filled. This program helps you manage your care and our dollars.

If you do not agree with being in Lock-in, you have the right to appeal and receive a hearing. For information on requesting a hearing, see page 40 of this guide.

If you suspect someone, even a doctor, of Medicaid fraud or abuse, call Medicaid's Fraud and Abuse hotline at 1-800-372-2970. All information is confidential.

WHAT COULD HAPPEN IF I COMMIT FRAUD AND GET CAUGHT?

- You must repay the amount spent.
- You could be prosecuted for a crime and go to jail.
- You could lose your Medicaid benefits for **up** to a year, in addition to any criminal penalties.

MEDICAID MEMBER GUIDE

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PROVIDER RIGHTS AND RESPONSIBILITIES

PROVIDERS HAVE RIGHTS TOO!

Your provider has the right to ask you to follow the rules of the office or clinic. If you, or others with you, do not follow the rules, your provider has the right to ask you to go to another provider.

Some rules your provider may have:

- Show-up on time for appointments.
- Call to cancel if you cannot keep your appointment.
- Show your **current** medical card at every visit.
- Tell provider's staff if you have a new address or phone number.
- Tell provider's staff if you have any other insurance besides Medicaid.
- Treat your provider, and their staff with respect.
- Follow your provider's instructions.

WHEN YOU MAKE AN APPOINTMENT

- Make sure the provider takes Medicaid.
- Take your current Medical card with you.
- Write down questions to ask your provider.
- Keep your appointment or call to cancel.

PROVIDERS HAVE RESPONSIBILITIES TOO!

A Medicaid provider may not bill a Medicaid member for a service that was denied due to incorrect billing. A provider may bill you under the following conditions:

1. If a service not covered under Kentucky Medicaid and you were informed before the service was provided.
2. If a Provider is not signed up with Kentucky Medicaid.

Source: Kentucky Provider Agreement section 5.(3)

Medicaid providers are also responsible for appropriately collecting co-pays from Medicaid members. See page 17.

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Your health information is personal. HIPAA is a federal law that requires DMS to protect the privacy of your health information. DMS is required to protect your privacy in all aspects of our business. We have policies about protecting your information. These policies comply with State and Federal laws. DMS uses and gives out your health information only where required by law or where necessary for business. Health information that DMS would have on you would include information on your eligibility, other insurance and claims we have paid on your behalf.

In March 2003, a notice was sent out to all Medicaid members in the state of Kentucky telling them about HIPAA. The notice describes:

- How DMS may use and give out your protected health information to take care of your treatment, claims payment, other health care needs or for other purposes required by law.
- What your rights are regarding access to and control of your health information.
- How DMS protects your health information.

If you have questions about your privacy rights or would like a copy of the notice that was sent out, call **Medicaid Member Services**.

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MEDICAID MEMBER SERVICES

Medicaid Member Services is here to help you with any questions or concerns you have about the Kentucky Medicaid Program. Anytime you have a question about benefits, how Medicaid works, or how to get care, give us a call. Member Services hours are from 8:00 – 4:30 Eastern Standard Time (EST), Monday-Friday.

Medicaid Member Services

1-800-635-2570

Toll Free!

or

visit our website to get Medicaid information:

<http://chs.state.ky.us/dms>

For persons with
TDD (Telecommunications Device for the Deaf) or
TTY (Tele-Text Typewriter) equipment
Call 7-1-1 Kentucky Relay for assistance.

Alternative formats available: (Braille, audiocassette)
Call Member Services to request

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- To go to providers that take your Kentucky Medical card.
- To show your current Medical card at every provider appointment.
- To keep all appointments with your provider and to be on time.
- To call your provider and cancel if you cannot keep your appointment.
- To pay your co-pay if it is indicated on your card.
- To follow the rules of your provider's office or clinic.
- To ask your provider about anything you do not understand about your medical care.
- To be respectful and courteous toward your provider and staff as well as Medicaid staff.
- To be truthful about yourself and your medical problems.
- To report suspected fraud and abuse.
- To understand your rights and responsibilities as a Medicaid member

VERY IMPORTANT RIGHTS

You have the right to:

- Choose your provider
- Get medical care when you need it
- Not be discriminated against

VERY IMPORTANT RESPONSIBILITIES

You have the responsibility to:

- Keep appointments or call to cancel
- Show your current medical card at all appointments
- Pay any co-pay
- Report changes to your income and family status to your local office.

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WHAT IS MEDICAID?

Medicaid is a joint federal and state program that helps pay health care costs for people with low incomes and limited resources. Medicaid IS NOT Medicare. Kentucky Medicaid is administered by the Cabinet for Health Services through the Department for Medicaid Services (DMS) Title XIX (19) of the Social Security Act. DMS contracts with the Department for Community Based Services (DCBS) to determine Medicaid eligibility. Aged, blind and disabled persons who receive Supplemental Security Income benefits (SSI) are automatically eligible for Medicaid.

Medicaid's goals are to maintain the health of members and to improve the quality of services and access to services. Medicaid pays for most health care costs for its Members. Medicaid can only reimburse providers who are signed up with Medicaid. Ask every provider you see as a patient if he/she is signed up for Medicaid or call Member Services.

A list of services covered by Medicaid is on page 19 of this guide.

WHO IS ELIGIBLE FOR MEDICAID?

To be eligible for Kentucky Medicaid, you must be in an eligible group, meet income guidelines and meet resource limits. For information on KCHIP eligibility, see page 8.

ELIGIBLE GROUPS:

- Persons 65 years of age or older
- Blind or permanently disabled persons
- Families with dependent children
- Children under 18 and children in foster care
- Pregnant women

YOUR RIGHTS AND RESPONSIBILITIES

As a person who receives benefits through the Medicaid program, you are a member of a program that offers you a wide variety of healthcare benefits. As a member of this program, you have certain rights. Along with those rights come responsibilities for how you use Medicaid services. Medicaid feels that members should be treated with respect and dignity and that their privacy should be respected. Knowing your rights and responsibilities as a Medicaid member will help you get the best possible care.

YOU HAVE THE RIGHT:

- To quality medical care without regard to race, color, religion, sex, age, or national origin.
- To be treated with respect and dignity and to have your privacy respected.
- To choose a provider and change that provider within program guidelines.
- To receive medical care in a timely manner.
- To ask questions and be informed about your health care and treatment.
- To ask if services are not covered, that you be informed before the services are provided.
- To be part of all decisions about your health care.
- To a second opinion when surgery is indicated.
- To have your medical records and care kept private.
- To look at and/or get copies of your medical records.
- To access services without barriers.
- To complain or ask for a hearing if you have problems with your health care.
- To receive information in alternative formats and other languages if needed.

YOU HAVE THE RESPONSIBILITY:

- To provide, to the best of your ability, information that Medicaid and your providers need in order to care for you and your family.
- To follow the instructions and care plans that you have agreed on with your providers.
- To call your provider first, when you need medical care.

INCOME GUIDELINES:

Some work expenses and child-care expenses may be deducted from your income. For more information, talk to your local DCBS office.

Monthly Income Amounts for Families“

Size of Family	Monthly Income**
1	No more than \$217
2	No more than \$267
3	No more than \$308
4	No more than \$383
5	No more than \$450

“For each additional member add \$60 to the monthly income amount.

““Change every year

For pregnant women and children up to age 1*

Size of Family	Monthly Income**
1	No more than \$1,436
2	No more than \$1,926
3	No more than \$2,416
4	No more than \$2,907
5	No more than \$3,397

“For each additional family member, add \$491 to the monthly income amount.

““Change every year

For children up to the age of 19“

Size of Family	Monthly Income“““
1	No more than \$1,552
2	No more than \$2,082
3	No more than \$2,612
4	No more than \$3,142
5	No more than \$3,672

*For each additional family member add \$530 to the monthly income.

““Change every year

MEDICAL CARE OUTSIDE OF KENTUCKY

If you are outside of Kentucky and have an emergency, call 911 or go to the nearest emergency room. If you get emergency care from a provider that is not signed up with Kentucky Medicaid you may be responsible for the bill. If you go to a provider that is not signed up with Kentucky Medicaid, the provider will have to enroll with Kentucky Medicaid in order to get paid. If the provider does not want to sign up with Kentucky Medicaid, you may be billed for the service. Be sure and tell every provider you see that you have Kentucky Medicaid.

You may be outside of Kentucky and need medical care that is not an emergency but requires urgent care. Urgent care is NOT life threatening, but sometimes it cannot wait until you get home. Again, If you get urgent care from a provider that is not signed up with Kentucky Medicaid you may be responsible for the bill. Tell every provider you see that you have Kentucky Medicaid.

Only Kentucky Medicaid providers can be paid for providing your Kentucky Medicaid covered services. To sign up with Medicaid, providers should call Provider Enrollment at 1-877-838-5085.

If a provider tells you that they do not want to sign up with Kentucky Medicaid, the provider has the right to bill you for services they give you. *Tell every provider you go to for services that you have a Kentucky Medicaid card.*

“What if I travel outside of Kentucky and have an accident or become sick...will my card pay for medical services in another state or country?”

”Kentucky Medicaid works best in Kentucky! The only way Kentucky Medicaid can pay a provider in another state or country is if that provider is signed up with Kentucky Medicaid. If the provider does not want to sign up with Kentucky Medicaid, you may be responsible for the bill.

If your income is higher than the guideline on the table, you may still be eligible for Medicaid. If the amount of your medical bills is equal to or higher than the monthly income guideline, talk to your local DCBS office.

RESOURCE LIMITS:

The resource limit for one person is \$2000, for couples, \$4000. Resources include checking and savings accounts, cash on hand, stocks, bonds, CD's, etc.

Resources that are not counted are:

- Ahome
- Burial reserve up to \$1500 for one person
- Equity in income producing non-homestead property up to \$6000.
- An automobile that is used for employment or to get to medical treatment or if specially equipped, for handicapped persons
- Equity in other automobiles up to \$4500.

HOW CAN I APPLY FOR MEDICAID?

To apply, contact your local Department for Community Based Services (DCBS) office. Persons who cannot get to the office may have someone apply for them or phone or write the office. Aged, blind or disabled persons receiving Supplemental Security Income (SSI) benefits are automatically eligible for Medicaid.

When you apply take the following:

- Social Security Number(s)
- Other health insurance information
- Proof of pregnancy and due date
- Last 3 months bank statements showing checking or savings account, life insurance polices, stocks and bonds for each person applying.

YOUR MEDICAL CARD

If eligible, you will get a Medical Assistance Identification card, known as the 'medical card', every month. The card lists persons in the household who get Medicaid, eligibility dates and identification numbers. Be sure to look over the card to make sure everything is correct. It is your responsibility to make sure the information on your card is correct. If you change your name, address, etc.,

DO YOU HAVE BOTH MEDICARE AND MEDICAID?

If you have both Medicare and Medicaid, Medicaid is payor of last resort. In other words, if you have Medicare and Medicaid, Medicare will pay first. Medicaid pays last. Here's how it works:

- You see your provider and show your Medicare and Medicaid cards.
- Since you have Medicare, the provider bills Medicare first.
- Medicare pays their part.
- If there is anything left to pay, Medicaid is billed.
- Medicaid will pay up to the amount Medicaid would usually pay for that service.
- Medicaid will only pay for services that are Medicaid covered service.
- Your provider must accept Medicare and Medicaid payments as full payment. You should not be billed for any remainder as long as your provider is enrolled with Kentucky Medicaid and the service is covered by Medicaid.

There are services that Medicare does not cover but Medicaid will. You must go to a Medicaid provider in order for Medicaid to pay for them. They are:

- Transportation
- Pharmacy Drugs
- Some Vision services
- Some Dental services

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you need to report it immediately. Refer to page **42** of this guide for reporting mistakes or changes to your medical card. Be sure to take your card with you to **all** medical appointments.

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Do You Have Other Insurance?

If you have Medicaid and have other health insurance, Medicaid needs to know. Medicaid is payor of last resort. In other words, if you have other health insurance, that other insurance must be billed first. Medicaid pays last. You must call your local office to tell them if you have other health insurance. Also, call your local office if you drop or cancel your insurance. Telling us about other health insurance helps stop double payments for the same services and makes sure your medical bills get paid.

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KCHIP

WHAT IS KCHIP?

KCHIP is the Kentucky Children's Health Insurance Program. KCHIP is for children, birth through 18 years, who have no other type of insurance. A family's annual income can be up to 200% federal poverty level. See chart on page 10.

WHAT DOES KCHIP COVER?

KCHIP provides a full range of health benefits. Here are a few of the services your children may use most often:

- Health checkups and screenings
- Prescription medicines
- Immunizations (shots)
- Doctor visits
- Vision exams and eyeglasses
- Hearing services
- Dentalcare
- Hospital care
- Mental health services

WILL THERE BE ANY COSTS?

Eighteen-year-olds covered by KCHIP will be responsible for co-pays for some services. For more information on co-pays, see page 17. If your total co-payments total \$670 in a year, call 1-877-KCHIP-18. You may not have to make any more co-payments for the rest of the year.

Some KCHIP and TMA (Transitional Medical Assistance) families will pay a \$20 or \$30 premium each month. For example, a family of four with children in KCHIP that makes \$2,301-\$3,067 each month before taxes will pay a \$20 premium. The premium will be \$20 a month no matter how many children are in the family. If you owe the premium, you will receive a letter that tells you what to do.

- **Be good to your lungs.** Don't smoke. If you smoke, ask your provider for help in stopping. Smoking increases your chances of getting heart disease, lung disease, strokes, diabetes and cancer.
- **Good safety tips.** Wear your seat belt. Don't start the car until your children are buckled in their car seats. Never drive after drinking alcohol. Wear a helmet if you ride a bicycle or motorcycle. Put smoke detectors in your home. Check the hot water heater temperature setting to avoid burns.

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How Do I Apply For KCHIP?

Call your local Department for Community Based Services (DCBS) office to schedule an appointment or go directly to the local office. Calling ahead to make an appointment may reduce the time you have to wait to apply. To find out where the local DCBS office is in your area, call 1-877-KCHIP-18 or visit us at http://cfc.state.ky.us/office_phone_list.asp.

WHAT WILL I NEED TO TAKE WITH ME WHEN I APPLY?

When you go to the DCBS office, you need to take the following things:

1. Proof of Income:

- or wages, take copies of pay stubs for the last two months or a letter from your employer. The letter should include your wage, your employer's name, address, phone number and original signature. For self-employment, take a copy of your last income tax return.
- For unearned income, take the most recent award letter or other proof of amount. Examples are KTAP, disability, pension, child support, alimony, cash gifts, annuities, interest, social security, veteran's benefits, etc. For child support include copies of checks, a statement from the non-custodial parent or a statement from the child support collection agency in your county.

2. Proof of expenses for childcare or disabled adult living in the home:

- Bring copies of receipts or a statement from the care provider.

3. Health Insurance information:

- Name of the insurance company
- Group number and policy number
- Effective date
- Name of policy holder
- Names of people who are covered

PREVENTIVE CARE

WE WANT YOU TO STAY WELL !

What is Preventive Care? It is learning how to take good care of yourself and your family in order to stay well. A good way to stay well is by scheduling regular check-ups.

Children - Schedule regular check-ups for:

- Routine well child visits
- Eye exams
- Hearing exams
- Dental exams
- Lead screening
- Immunizations (shots) by participating providers and Health Departments

Adults - Schedule regular check-ups for:

- Yearly physical exam
- Blood pressure screening
- Cholesterol checks
- Pelvic exams and Pap tests
- Mammograms
- Flu shots from the Health Department only
- Immunizations

Good ways to take care of yourself and your family:

- **Eat good foods.** Eat fruits and vegetables. Many illnesses such as heart disease, diabetes, and high blood pressure can be prevented or controlled by eating a healthy diet.
- **Be good to your body.** Take a walk. Get physical and feel better! Exercise helps you manage your weight, control your blood pressure and cholesterol. Exercise makes your muscles, heart and bones stronger.

Question: "How will I know when I need to schedule a check-up"?

Answer: "Ask your provider. They will keep track of check-ups that are needed."

2004 KCHIP INCOME LIMITS
200% FEDERAL POVERTY LEVEL

Number of Family Members (include parents and children)	Total Monthly Family Income (before taxes)	Total Annual Family Income (before taxes)
1	1,552	18,620
2	2,082	24,980
3	2,612	31,340
4	3,142	37,700
5	3,672	44,060
6	4,202	50,420
7	4,732	56,780
8	5,262	63,140

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TRANSPORTATION

Medicaid offers transportation to Medicaid covered services for Medicaid Members. There are three types of transportation services; non-emergency/non-ambulance, emergency ambulance and non-emergency ambulance/stretcher.

1. Non-Emergency/Non Ambulance transportation - call the transportation broker in your area. The toll-free number is listed in the back of this guide.

Medicaid offers non-emergency transportation to Medicaid covered services. This transportation service includes; taxi, van, wheelchair rides and public transit. Each county in Kentucky has a transportation broker. A broker is a company that schedules your rides, such as rides to routine office visits, adult day care, etc. These services are available only to those who do not have a car in the household.

Medicaid does not cover rides to pick up medicines at the pharmacy.

For more details, call your broker. If you do not know how to contact your broker, call the Department for Transportation toll-free at 1-888-941-7433.

2. Emergency Ambulance - call 911 or your local emergency number.

An ambulance should only be used for emergency transportation to a hospital emergency room. An emergency is when you believe a medical situation, if left untreated, would be a threat to your life or long-term health. If an ambulance is used when it is not an emergency, you may have to pay the bill.

3. Non-Emergency Ambulance / Stretcher – call your local Medicaid ambulance provider.

Medicaid covers ambulance transportation to and from medical appointments when your provider says you must be transported on a stretcher and cannot ride in a car, such as a person who is bedridden or paralyzed. Call your local Medicaid ambulance provider. If you don't know who that is, call your local DCBS office for assistance.

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How Will Your KCHIP Health Coverage work?

You will choose a Primary Care Provider (PCP) for your child. The PCP will serve as your child's "medical home". This means having someone you can turn to who knows your child's health history and needs. The PCP is the first place to go for your child's health care. The PCP will also decide when it's best for your child to see a specialist or receive other support services and make referrals.

You should visit your PCP for regular well-child checkups to make sure your child is growing up strong and healthy.

WORKING CLOSELY WITH YOUR DCBS CASEWORKER

Your DCBS caseworker can help you get the most benefit from your KCHIP or Medicaid coverage and is your link to other important services. Your caseworker needs to know right away if there are changes in your family such as:

- Family or household income changes
- Pregnancy or new baby
- Someone gets married or divorced
- Someone gets a new job, a raise or loses a job
- Someone gets health insurance

Your caseworker can also help you if you lose your KCHIP card or need to change your PCP.

YOUR KCHIP CARD

You will receive a KCHIP or Medicaid card in the mail at the beginning of every month. Check your card each month to be sure the information on your card is right. If the card has the wrong information, contact your caseworker. Always take your current KCHIP card with you when you get healthcare services. If you don't, you may have to pay for the service. Also, don't ever let anyone else use your card. If you lose your card, contact your caseworker right away.

BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)

WHAT IS THE BCCTP PROGRAM?

The Breast and Cervical Cancer Treatment Program (BCCTP) offers Medicaid coverage to women who have been screened for breast or cervical cancer under the Kentucky Women's Cancer Screening Program and found to need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix.

HOW DO I BECOME ELIGIBLE?

To get BCCTP you must meet the following:

- You have been screened for breast or cervical cancer under the Kentucky Women's Cancer Screening Program and found to need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix.
- You are not covered under any other insurance.
- You are not eligible for Medicaid under any other eligibility group.
- You are not yet 65 years old.

HOW DO I APPLY FOR BCCTP?

To apply for BCCTP visit your local health department. They will fax your application to DMS to see if you are eligible. When you apply, take your social security number and other health insurance policies. If you are eligible, you will be given an Identification notice to get full Medicaid covered services from Medicaid providers. Medicaid's covered services listed on page 19.

HOW LONG WILL I BE COVERED BY BCCTP?

Coverage lasts as long as you are being treated for breast or cervical cancer. The length of coverage depends upon the length of treatment. You may get coverage for three months prior to the date you apply, in some cases.

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FOR MORE INFORMATION...

KCHIP is now on the Internet! Check us out at <http://chs.kv.gov/kch&>

Call Medicaid Member Services if you're having problems with your card, finding a doctor in your area, or you just want more information about covered services:

1-800-635-2570

or

For persons with
TDD (Telecommunications Device for the Deaf) or
TTY (Tele-Text Typewriter) equipment
Call 7-1-1 Kentucky Relay for assistance.

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WHAT PRENATAL SERVICES ARE COVERED BY THE PE PROGRAM?

- office visits to your PCP
- lab tests, x-rays (including ultrasounds)
- medicines
- office visit to a dentist
- transportation

The PE program will not cover visits to specialists, surgical or other procedures or if you are admitted to the hospital.

HOW LONG WILL PE COVERAGE LAST?

PE coverage will last around 90 days from the date on your first PE card. The PE card you get from your provider's office will tell you the exact date your PE coverage will end. To get full Medicaid benefits, apply as soon as possible.

HOW DO I GET MORE THAN PE COVERAGE?

To apply for full Medicaid benefits contact your local DCBS office as soon as possible. Medicaid's covered services are listed on page 19.

Take the following with you:

- The PE card your doctor's office gave you
- Your social security number
- A letter from your provider saying you are pregnant and your due date
- Proof of your income.

CAN I SEE ANY PROVIDER WHILE I'M COVERED BY PE?

- A pediatrician, an internist, a family doctor, a general doctor or an OB/GYN
- Nurse practitioner, nurse midwives
- Physician assistant who works in a rural health center or primary care center.

WHAT IF I HAVE PROBLEMS OR NEED MORE INFORMATION?

Call Medicaid Member Services.

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KENPAC

WHAT IS KENPAC?

KenPAC stands for the Kentucky Patient Access and Care Program. KenPAC is Kentucky's managed care program. The KenPAC program connects you to a provider of your choice who will coordinate all your health care needs. This provider will be your primary care provider (PCP). The goal is to improve the your health care. Most Kentucky Medicaid Members are enrolled in KenPAC.

WHAT DOES KENPAC COVER?

The Medicaid covered services listed on page 19 are covered under the KenPAC program. Again, children may get more services (special services) than those listed, when their doctor says they need it.

WHO IS ENROLLED IN KENPAC?

Most people that get Kentucky Medicaid will be in the KenPAC program.

The following **will not** be in KenPAC program:

- people who get both Medicare and Medicaid;
- children (age 18 and under) who receive SSI benefits;
- children in foster care;
- people enrolled in Passport Health Plan;
- people in a nursing home, mental hospital, or ICF-MR(Intermediate Care Facility for people with Mental Retardation);
- people in a Medicaid community based waiver programs;
- people with a Spend Down medical card; and
- people in the Kentucky Health Insurance Premium Program.

WHAT IS A PRIMARY CARE PROVIDER (PCP)?

The word "primary" means first. Your Primary Care Provider (PCP) is who you call first when you need medical care. Your PCP will help you coordinate your medical care. They will see you for routine care and work with you to schedule specialist care.

PRESUMPTIVE ELIGIBILITY

WHAT IS PRESUMPTIVE ELIGIBILITY?

The Presumptive Eligibility (or PE) program allows pregnant women to get temporary medical coverage for prenatal care. To see if you are eligible, apply at your provider's office. If you are eligible, you will be given an Identification Notice to get prenatal services from Medicaid providers. **This short-term program allows you to get medical coverage for prenatal care while you go through your application process for full Medicaid benefits. To apply for full Medicaid benefits contact your local DCBS office as soon as possible.**

HOW CAN I BE ELIGIBLE FOR PE?

To be eligible, you must be pregnant and:

- Have not yet applied for Medicaid; and
- Your income must be less than the amounts below. If you have questions, ask your doctor's office staff for help.

For pregnant women*

Size of Family	Monthly Income**
1	No more than \$1,436
2	No more than \$1,926
3	No more than \$2,416
4	No more than \$2,907
5	No more than \$3,397

*For each additional family member, add \$491 to the monthly income amount.

***Changes every year

If you have already applied for PE benefits at another provider's office for this same pregnancy, you are not eligible to apply again.

WHO CAN BE MY PRIMARY CARE PROVIDER?

- A pediatrician, an internist, a family doctor, a general doctor or an OB/GYN
- Nurse practitioner
- Physician assistant who works in a rural health center or primary care center.

CAN I CHANGE MY PRIMARY CARE PROVIDER?

You can change your KenPAC provider:

- Within the first 90 days after you enroll
- At your yearly renewal for medical coverage or Supplemental Security Income (SSI) members, once a year, during your birth month
- At any time, if you have a good reason and permission from your worker or DMS. Good reason example: If you move to a different county.

WHAT WILL MY PRIMARY CARE PROVIDER DO FOR ME?

- Be available by phone 24 hours a day, 7 days a week (or offer a back-up)
- Take care of all your basic health care needs
- Refer you to specialists who are Medicaid providers
- Keep immunizations (shots) and screenings for children up to date

WHAT IF I NEED TO SEE A SPECIALIST?

If you need specialty care, your PCP will talk to you about seeing another doctor, a specialist. Your PCP will give you a referral to the specialist. Always talk to your PCP before going to another doctor. Without a referral, you may be billed for the visit.

WHAT ARE MY MEDICAL BENEFITS WITH KENPAC?

Your medical benefits are the same *as* with regular Medicaid. See page 19.

Children may receive special services through EPSDT. Health services can be covered if approved by Medicaid as medically necessary.

Children on KCHIP Phase III (purple medical cards) can get EPSDT screenings but do NOT get EPSDT special services or non-emergency transportation services. See page 8 for more on KCHIP.

If you have questions about EPSDT services, call Medicaid Member Services.

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ARE THERE SERVICES I CAN GET WITHOUT A REFERRAL ?

There are services called Direct Access Services that do not require a referral from your PCP. For more information on direct access services, see page 21.

NEED HELP CHOOSING OR FINDING A PRIMARY CARE PROVIDER?

Contact your local DCBS office. SSI members, call Medicaid Member Services at 1-800-635-2570. Persons with TDD (Telecommunications Device for the Deaf) or TTY (Tele-Text Typewriter) equipment should call 7-1-1 Kentucky Relay for assistance.

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EPSDT

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

EPSDT is the part of the Medicaid program that makes health check-ups available to your child or teen at no cost to you. These check-ups help to make sure your child is growing up healthy. If your provider finds a problem, it can be treated and watched.

Children and teens on Medicaid can get regular check-ups at no cost. Check-ups include:

A complete examination	Growth-development check
Vaccines and shots	Nutrition
Eye exam	Lab tests
Dental exam	Mental health and substance abuse
Speech and hearing exam	Health education for parents
Testing for HIV/AIDS and STDs	

You can get check-ups for your child or teen from their primary care/EPAC provider or local health department. After receiving the first check-up, there may be additional check-ups when the following ages are reached:

Physical: 0-1 month, 2, 4, 6, 9, 12, 15, 18, 24 months; and 3, 4, 5, 6, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 years

Dental: 6-12, 12-24 months; and 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 years

If you do not know how to schedule an appointment, your DCBS worker will help you make an appointment with the physician to do the check-up. If you reside in a county that is included in Passport, Passport will help you with the appointment. If a problem is found, the screening provider will help make appointments for treatment. If you need assistance arranging for transportation services to appointments, please contact your transportation broker.

PASSPORT HEALTH PLAN

ARE YOU A PASSPORT HEALTH PLAN MEMBER?

Passport is a Medicaid health care plan serving Medicaid members living in the following counties:

Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington.

PASSPORT HEALTH PLAN MEMBERS WILL:

- Be asked to choose a primary care provider (PCP)
- Receive a Passport Health Plan Member Handbook
- Receive a Passport Health Plan ID card (plus, you will still get a monthly medical card)
- Call Passport with any health care problems you have.
- Go to pharmacies and doctors that are part of Passport's provider network.
- Have the right to complain or appeal any decision about your health care.

Read your Passport Member Handbook or call for more information:

Passport Health Plan Member Services

1-800-578-0603

A free call!

1-800-691-5566 TDD/TTY

Only for persons with TDD (Telecommunications Device for the Deaf) or TTY (Tele-Text Typewriter) equipment.

“Person on Waiver, SLMB, QMB, or persons in a nursing home, mental hospital, ICF-MR **should not** be in Passport Health Plan. Call Passport for more information.

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feel that your symptoms are life threatening or would cause long term damage, call your provider first.

Some situations that are usually not emergencies and could be treated at your provider's office:

- Colds
- Sore Throat
- Earache
- Removal of stitches
- Constipation
- Pregnancy tests
- Backache
- Vaginal discharge
- Migraines
- Rash
- Flu

Do NOT go to the emergency room for routine care!

Go to the emergency room only for true emergencies!

Emergencies are when you think the symptoms you are having, without treatment, could be life threatening or cause long lasting damage.

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CO-PAYS

Co-pays came about by a change in state law (KRS205.6312). Co-pays are one way to help with the problem of rising health care costs. It is called co-pay because you pay some and Medicaid will pay the rest.

If you have to pay a co-pay, you will see the words "Subject to Co-payment" and a star (*) next to your name on your medical card.

If the above appears on your card, you are required to pay a co-pay of \$1 for every prescription you get at the pharmacy. Example: If you have four prescriptions, you must pay a co-pay on each one of those prescriptions which would be \$4.

You will also be required to pay a \$2 co-pay for certain types of provider visits and services if you are eligible for those services. These visits and services include:

- Dentists
- Eye doctors (Ophthalmologists and Optometrists)
- Eye exams done by physicians, Advanced Registered Nurse Practitioners (ARNPs), Rural Health Clinics and Primary Care Centers. You will be charged only for eye exams done by these providers
- Foot doctors (Podiatrists)
- Hearing doctors (Audiologists and Hearing Aid Dealers)
- Chiropractors

Your part of the co-pay must be paid at the time you go to the provider or receive the service. If you think your provider is not charging you correctly or refuses to give you service, call Medicaid Member Services.

THOSE WHO DO NOT PAY CO-PAYS

Federal law says that some members are not required to pay co-pays. If no co-pay indicator is printed on your card, you do not have to pay. Listed below are those who **do not** have to pay a co-pay:

EMERGENCY CARE

You are sick or have been injured. Is it an emergency? Do you think the symptoms you are having, without treatment, could be life threatening or cause long-lasting damage?

Call 911 or go to the nearest Emergency Room (ER).

If you are not sure if it is an emergency call your provider to ask if you should go to the emergency room.

After the emergency, call your provider for follow-up care. Do not go back to the emergency room for follow-up care.

Some situations that are emergencies and need treatment right away:

- Loss of consciousness (black-outs)
- Convulsions (seizures)
- Miscarriage or pregnancy with vaginal bleeding
- Broken bone
- Unusual or severe bleeding
- Physical Attack/Rape
- Severe cuts or burns
- Head or eye injuries
- Difficulty breathing
- Severe vomiting or diarrhea that does not go away
- Poisoning or drug overdose
- High fever
- Chest pains
- Motor vehicle accident with injury
- Choking
- Loss of speech
- Paralysis

Sometimes members go to the emergency room for problems that could be treated in the provider's office. Using the emergency room for these problems causes back-ups in the emergency room and is costly to Medicaid. If you don't

- Children under age 18
- Women who are pregnant or within 60 days after delivering a baby
- Members in nursing homes, personal care homes, family care homes or intermediate care facilities for people with mental retardation(ICF/MR)
- Members receiving hospice services
- Foster children
- American Indians or Alaskan Natives served through KCHIP

Federal and State laws are subject to change.

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DIRECT ACCESS SERVICES

Direct access services are services you can get without a referral from your usual provider. Even if you are in the KenPAC program, you can go to any Kentucky Medicaid provider, clinic or health department to get these services. You do not need a referral from your primary care provider.

- Dental
- Vision
- Hearing
- Mental health
- Family planning, includes OB/GYN
- Maternity and normal newborn care
- Sexual Transmitted Disease screening
- Immunizations (shots)
- HIV / AIDS testing
- Chiropractic
- Footdoctor
- Transportation
- EPSDT screening
- Tuberculosis screening

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WHAT SERVICES ARE COVERED BY MEDICAID?

Below are **some** of the services Medicaid covers. There may be limits or prior authorization rules - call Member Services for details.

- Provider / Clinic visits –routine, urgent and emergency care
- Outpatient services – hospital services when you don't stay overnight
- Hospital stays
- Specialty care
- Emergency care and ambulance transportation in emergencies.
- Transportation to and from Medicaid covered services (if you don't have a car)
- Mental Health Services
 - Family Planning – including birth control and OB/GYN
 - Medical care during pregnancy
 - Maternity and newborn care
 - Disease screening and treatment for Sexual Transmitted Diseases, Tuberculosis, HIV and AIDS
 - Prescription drugs
 - X-rays and Laboratory services
 - Durable Medical Equipment and Supplies (DME)–such as wheelchairs, crutches, etc
 - Chiropractic care
 - Home Health - including physical, occupational and speech therapies
 - Home and Community Based services - waivers
 - Nursing Home Care
 - Hospice
 - Immunizations (shots)by participating providers and Health Departments
 - EPSDT screening and services (health check-ups for children)
 - Basic dental care
 - Basic vision care
 - Basic hearing care

*Medicaid can only pay for services that are determined to be medically necessary. Also, providers must be Medicaid providers. Call Member Services for details.

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WHAT SERVICES ARE NOT COVERED BY MEDICAID?*

Below are **some** but not all, of the services Medicaid does not cover. Call Member Services if you have questions.

- Services from providers who are not Kentucky Medicaid Providers
- Services that are not medically necessary
- Transportation to pick up prescriptions at drug stores
- Some injections and allergy serums
- Massage therapies, hypnosis
- Abortion, In-vitro fertilization, paternity testing, hysterectomy for sterilization purposes
- Hospital stays for procedures that could be done as outpatient
- Cosmetic surgeries
- Fertility drugs, smoking cessation drugs,
- Braces for teeth, dentures, partials, and bridges for persons over 21
- Glasses for persons over 20, contact lenses, trifocals
- Hearing aids for persons over 21, binaural hearing aids
- Private duty nursing
- Fans, air conditioning, humidifiers, computers, home repairs

*Services that Medicaid usually doesn't cover may be covered for children under 21 through EPSDT Special Services. For information on EPSDT, see page 24.

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