CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
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Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

October 1, 2013

Jackie Glaze
Associate Regional Director
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

RE: State Plan Amendment 13-019 - Removal of KenPAC

Dear Ms. Glaze:

Enclosed for your review and approval is Kentucky Title XIX State Plan Amendment No. 13-0019. The purpose of this State Plan Amendment is to remove the KenPAC program from the State Plan as this was replaced at the implementation of Managed Care. As this SPA does not make any changes to reimbursement, no public notice or funding questions are required.

Any questions or correspondence relating to this SPA should be sent to Sharley Hughes.

Please let me know if you have any questions relating to this matter.

Sincerely,

Lawrence Kissner
Commissioner

LK/sjh

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13-019

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $0.00
b. FFY 2015 $0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page 66
Att. 3.1-F, Page 1 - 15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
The purpose of this State Plan Amendment is to remove the KenPAC program from the State Plan as it was replaced with the implementation of Managed Care

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Lawrence Kissner

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 10/1/13

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1994

State/Territory: Kentucky

Citation 4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928 (c) (2) (C)(ii) of the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

☐ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

☐ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

☒ sets a payment rate below the level of the regional maximum established by the DHS Secretary.*

☐ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State. *

The State pays the following rate for the administration of a vaccine:

$3.30 per administration fee (with a limit of 3 administration fees per recipient, per date of service).

*At the request of Anita Moore, 1/20/95, this change was made

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

The state's administration fee was established by using Medicare's administration fee of $3.28 rounded to the nearest ten (10) cents. The state believes the use of Medicare's fee in combination with ~~Kentucky's KenPAC Program~~Kentucky's Managed Care Organizations preventive and care management will assure adequate access to immunization.

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Kentucky enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans – see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. – vii. below)

B. General Description of the Program and Public Process.

The State enrolls Medicaid beneficiaries into PCCMs. The PCCM receives a monthly case management fee of $4.00 per member per month. Services are paid on a fee-for-service basis.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

☐ i. MCO

☒ ii. PCCM (including capitated PCCMs that qualify as PAHPs)

☐ iii. Both

Citation	Condition or Requirement
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	2. The payment method to the contracting entity will be: ☐ i. fee for service; ☐ ii. capitation; ☒ iii. a case management fee; ☐ iv. a bonus/incentive payment; ☐ v. a supplemental payment, or ☐ vi. other. (Please provide a description below).
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. *Not applicable* If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ☐ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ☐ ii. Incentives will be based upon specific activities and targets. ☐ iii. Incentives will be based upon a fixed period of time. ☐ iv. Incentives will not be renewed automatically. ☐ v. Incentives will be made available to both public and private PCCMs. ☐ vi. Incentives will not be conditioned on intergovernmental transfer agreements. ☐ vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

Citation Condition or Requirement

The PCCM program, Kentucky Patient Access and Care System (KenPAC) was initially implemented by the state as a 1915 (b) waiver in 1985. By the time that the state implemented the program under 1932 authority, it was a mature PCCM model that required only minimal changes to be compliant with the requirements of the Balanced Budget Act.

The State began planning in 2000 to enroll the SSI population into KenPAC. Meetings were held with various advocacy groups and community agency representatives. Relationships were formed to assist the State in its outreach and education efforts. Additionally, forums were held across the State to allow for questions from recipients, advocacy groups, and other community agencies. Notifications were sent to recipients in January 2001 and a Help Desk was established within the agency. Enrollment was phased in over several months.
Ongoing participation is assured through regular meetings of the Physician Technical Advisory Committee. A toll-free telephone line is available for public and recipient questions and complaints.

1932(a)(1)(A) 5. The state plan program will ___/will not _X__ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory __X___/ voluntary_____ enrollment will be implemented in the following county/area(s):

The Lock In program will be in all counties of the state except the current 16 counties covered through Passport. Passport (PHP) does their own Lock In Program and oversees their locked in population/members for the 16 counties in the greater Louisville area

i. county/counties (mandatory)

ii. county/counties (voluntary)

ii. area/areas (mandatory)

iii. area/areas (voluntary)

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(e)(1) 1 ☐ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

Citation	Condition or Requirement
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ☒ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. ☒ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. ☒ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as 1905(a)(4)(C) defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. ☒ The state assures that all the applicable requirements 42 CFR Part 38 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. ☒ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. ☒ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 74.40	8. ☒ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. *Enrollment in KenPAC is limited to AFDC related recipients, Family Related Medicaid recipients, Poverty Related Women and Children, Kentucky Children's Health Insurance Program (KCHIP), SSI recipients age nineteen or above, SSI related Medicaid recipients and State Supplementation recipients.* 2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Citation	Condition or Requirement
	The following populations are exempt from enrollment in KenPAC:
	Individuals who meet the eligibility requirements for receipt of both Medicaid and Medicare (dual eligibles); American Indians who are registered members of a Federally recognized tribe; Children under 19 years of age who are eligible for SSI under Title XVI, described in section 1902(e)(3) of Title XIX of the Social Security Act, receiving foster care or adoption assistance under part E of Title IV, receiving foster care or otherwise in an out-of-home placement, in the custody of the Department of Juvenile Justice and placed outside of the home, or receiving services through a family- centered, community based coordinated care system receiving grant funds under 42 USC 501(a)(1)(D).
	Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
	Not applicable
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ☐ Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients, who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ☐ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Citation | Condition or Requirement

1932(a)(2)(B)
42 CFR 438(d)(1)

i. ☐ Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients, who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. ☐ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. ☐ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

1932(a)(2)(A)(iii)
42 CFR 438.50(d)(3)(ii)

iv. ☐ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

1932(a)(2)(A)(v)
42 CFR 438.50(3)(iii)

v. ☐ Children under the age of 19 years who are in foster care or other out-of-the-home placement.

1932(a)(2)(A)(iv)
42 CFR 438.50(3)

vi. ☐ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

1932(a)(2)(A)(ii)
42 CFR 438.50(3)(v)

vii. ☐ Children under the age of 19 years who are receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

1932(a)(2)
42 CFR 438.50(d)

Children receiving services through a family-centered, community-based, coordinated care system receiving grant funds under 42 USC 501(a)(1)(D) are children receiving comprehensive services including case management through the Commission for Children with Special Health Care Needs of the Cabinet for Health Services.

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: ☐ i. program participation, ☐ ii. special health care needs, or ☐ iii. both The state plan identifies these children in terms of program participation. (See definition in Number 1 above)
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. ☒ i. yes ☐ ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* As many children as possible will be identified through the Medicaid Management Information System (MMIS) through Aid Category. Others receiving comprehensive services will be identified by the Commission for Children with Special Health Care Needs. (This is applicable to items I – iv below) i. Children under 19 years of age who are eligible for SSI under title XVI; ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; iii. Children under 19 years of age who are in foster care or other out-of-home placement; iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* *If either the Commission for Children with Special Health Care Needs or a child's parent identifies that the child is enrolled in KenPAC, they may contact the Department and the Department will immediately disenroll the child from KenPAC with the appropriate exclusion code. Services provided to such children will not require authorization. Providers will be given emergency authorizations for claims processing until the child can be disenrolled.*
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients who are also eligible for Medicare. *The state utilized a Medicaid Management Information System (MMIS) to identify these recipients. They are identified in the system by a specific code.* ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. *The state utilized a Medicaid Management Information System (MMIS) to identify these recipients. They are identified in the system by a specific code.*

Citation	Condition or Requirement
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment Recipients are not enrolled in KenPAC if they participate in the Kentucky Health Insurance Premium Payment Program (KHIPP); are residing in a nursing facility; are residing in an intermediate care facility for the mentally retarded and developmentally disabled, are residing in a psychiatric hospital or psychiatric residential treatment facility; are a Hospice recipient; are enrolled in another managed care program; have an eligibility period that is only retroactive; are eligible as medically needy (spenddown); are in Administrative Hearing Status Related to KenPAC; are a Lock-In recipient; are Home and Community Based Waiver recipients; are Qualified Medicare Beneficiaries (QMB); are Qualified Disabled Working Individuals (QDWI); are Specified Low-income Medicare Beneficiaries (SLMB); are aliens who are approved for time-limited Medicaid due to an emergency medical condition; are receiving care coordination through the Hemophilia Treatment Program of the Kentucky Commission for Children with Special Health Care Needs; or are recipients for whom the primary payer is a third party payer other than Medicaid and whose health care is coordinated by a primary care provider.
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis *This is not applicable since Kentucky does not have voluntary enrollment.*
	H. Enrollment process.
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: *The State assures that default enrollment will be based upon maintaining prior provider patient relationships whenever possible. The mandatory assignment process uses an algorithm, which considers the age, sex, place of residence, PCP availability, and equitable PCP distribution. The recipient will be notified of his or her assignment to a PCP. (Applicable to i, ii, and iii below)* i. the existing provider-recipient relationship (as defined in H.1.i). ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information: i. The state will __X__/will not ____ use a lock-in for managed care managed care. ii. The time frame for recipients to choose a health plan before being auto-assigned will be ten (10) days. iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* *Recipients are notified in writing of their auto assignment to a PCP, stating the reason for the auto assignment.* iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)* *If recipient is auto-assigned upon initial enrollment, the notice notifying the recipient of auto assignment contain this information* v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)* *The department generates a systems report that identifies KenPAC members not assigned to a primary care physician. Information contained in the report is transferred to the department's fiscal agent who forwards this information to Medicaid. It is then entered into two systems, one for non-SSI recipients and one for SSI recipients, and tested for accuracy. Member letters for PCP selection are then generated and mailed to the unassigned members requesting they select a primary care provider. After 10 business days, the system identifies recipients who have not selected a provider and auto assigns them to a PCP utilizing provider use over the past 18 months, gender, age, and medical service area.*

Citation Condition or Requirement

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

A monthly report is generated from the Eligibility System that will be used by the Department to monitor changes in default assignments

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. X The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. X The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. X The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

This provision is not applicable to this 1932 State Plan Amendment.

4. X The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

This provision is not applicable to this 1932 State Plan Amendment.

Citation Condition or Requirement

5. _X_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___ This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will _X_ /will not ___ use lock-in for managed care.

2. The lock-in will apply for _12_ months (up to 12 months).

3. Place a check mark to affirm state compliance.

_X_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(e).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

The recipient may request disenrollment with cause if the recipient was homeless or a migrant worker at the time of enrollment and was enrolled by default.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

_X_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

KenPAC recipients are free to seek the following services without prior authorization from the PCP:
1. Dental;
2. Mental Health;
3. Community Mental Health Centers;
4. Psychiatric Residential Treatment Centers;
5. Ophthalmology;

Citation | Condition or Requirement

6. Optometry;
7. Maternity Care;
8. Podiatry;
9. General Transportation;
10. Emergency Transportation;
11. Non-emergency Transportation;
12. EPSDT;
13. Kentucky Early Intervention Program;
14. Audiology;
15. Family Planning;
16. Local Health Department Preventive Services Program;
17. Chiropractic;
18. Newborn Care;
19. Specialized Childrens Service Clinic;
20. Health Access Nurturing Development Service;
21. School-based Services;
22. Emergency Services;
23. Urgent care; and
24. Departmental exemptions on case-by-case basis.

Citation	Condition or Requirement

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

Not applicable

1. The state will____/will not____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. ____ The selective contracting provision in not applicable to this state plan.