



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Ernie Fletcher
Governor

275 E. Main Street, 6W-A
Frankfort, KY 40621
(502) 564-4321
Fax: (502) 564-0509
www.chfs.ky.gov

Mark D. Birdwhistell
Secretary

Glenn Jennings
Commissioner

March 30, 2007

Renard L. Murray, D.M.
Associate Regional Administrator
Centers for Medicare and Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

Dear Dr. Murray:

Kentucky Title XIX State Plan Transmittal No. 07-001
Clarifications on KyHealth Choices benefit packages

Enclosed for your review and approval is Kentucky Title XIX Transmittal Number 07-001. This plan amendment clarifies and adjusts the previously submitted and approved KyHealth Choices plan amendments as follows:

1. Includes language about Dental Hygienist, Resident, and Student;
2. Includes language that an emergency admission is to be medically necessary and clinically appropriate;
3. Adds procedures to be prior authorized under physician services;
4. Adds procedures to be prior authorized, limits physical and speech therapy, and other coverage requirements under outpatient hospital services;
5. Adds exception language to cost sharing to Family, Comprehensive, and Optimum Choices;
6. Adds language about medical and pharmacy combined out-of-pocket cost to be limited to five percent of a family's income for a quarter;
7. Due to pending pages in SPA 06-012, pages have been added to the end of Attachment 3.1-C that add language stated above that will eventually be integrated into the pending pages upon their approval;
8. For KCHIP Children under the Medicaid expansion, there is added language about a \$1,500 per year limit for prosthetic devices, and language making the parent or guardian liable for any uncollected cost sharing on the child's behalf;
9. Added language prohibiting pharmacy entities from paying cost sharing;

Page 2
March 30, 2007

10. Added language that Managed Care entities cannot exceed copayment limits in the state plan, but can reduce or have no copayment; and
11. Revised durable medical equipment language.

If additional information is needed, please contact my office at 502-564-4321.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn Jennings". The signature is written in a cursive style with a large, looping initial "G".

Glenn Jennings
Commissioner

Enclosure

SRT/NW/SO/KWS

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
07-001

2. STATE
Kentucky

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

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

4. PROPOSED EFFECTIVE DATE
January 1, 2007

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:

Deficit Reduction Act of 2005 [Section 1937 of the Social Security Act]

7. FEDERAL BUDGET IMPACT:

a. FFY 2006 (Decrease of expenditures by approximately 1,790,845.73 for Comprehensive Choices (July 1 – Sept. 30, 2006) Budget neutral for Family Choices 753,333.33 for Optimum Choices (July 1 – Sept. 30 2006)
b. FFY 2007 (Decrease of expenditures by approximately 24,090,174 for Comprehensive Choices Budget neutral for Family Choices 7,310,000 for Optimum Choices

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 3.1-A, pages 7.4.1, 7.1.1, 7.2.1(a)(1), 7.1.1(a), 7.1.1(a)(1);
Att. 3.1-B, pages 13.2, 13.2.1, 22(a), 13, 27;
Att. 3.1-C, pages 10.21, 10.41, 10.42; and
Att. 4.19-B page 20.14

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

Att. 3.1-A, pages 7.4.1, 7.1.1, 7.2.1(a)(1), 7.1.1(a), 7.1.1(a)(1);
Att. 3.1-B, pages 13.2, 13.2.1, 22(a), 13, 27;
Att. 3.1-C, pages 10.21, 10.41, 10.42; and
Att. 4.19-B page 20.14

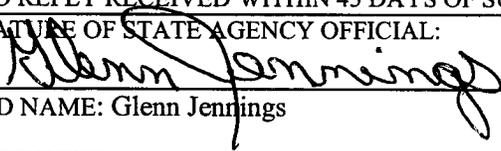
10. SUBJECT OF AMENDMENT: Alternative Benefits – Includes language about Dental Hygienist, Resident, and Student; Includes language that an emergency admission is to be medically necessary and clinically appropriate; adds procedures to be prior authorized under physician services; adds procedures to be prior authorized, limits physical and speech therapy, and other coverage requirements under outpatient hospital services; adds exception language to cost sharing to Family, Comprehensive, and Optimum Choices; adds language about medical and pharmacy combined out-of-pocket cost to be limited to five percent of a family's income for a quarter; due to pending pages in SPA 06-012, pages have been added to the end of Attachment 3.1-C that add language stated above that will eventually be integrated into the pending pages upon their approval; for KCHIP Children under the Medicaid expansion, there is added language about a \$1,500 per year limit for prosthetic devices, and language making the parent or guardian liable for any uncollected cost sharing on the child's behalf; added language prohibiting pharmacy entities from paying cost sharing; added language that Managed Care entities cannot exceed copayment limits in the state plan, but can reduce or have no copayment; and revised durable medical equipment language.

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

OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: Glenn Jennings

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 3/30/07

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:

REMARKS:

13. Dental Services

- A. A listing of dental services available to recipients age 21 and over is maintained at the central office of the single state agency.
- B. Out-of-Hospital Dental Services
A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.
- C. In-Hospital Care
A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.
- D. Oral Surgery
A listing of oral surgery dental services available to Medicaid recipients is maintained at the central office the single state agency.
- E. Dental Hygienist
A dental hygienist may provide a service without direct practitioner contact if the dental hygienist provides the service under general supervision of a practitioner in accordance with state licensure requirements.
- F. Dental Resident, Student, or Dental Hygiene Student
A dental resident, student, or dental hygiene student may provide services under the direction of a program-participating provider in or affiliated with an American Dental Association-accredited institution.

1. Inpatient Hospital Services

- a. Payment is made for medically necessary and clinically appropriate inpatient hospital care. Except for an emergency admission, each admission must have prior approval of appropriateness by the designated peer review organization in order for the admission to be covered under the Medicaid program. An emergency admission must be determined medically necessary and clinically appropriate within seventy-two hours of the admission in order to be covered by the department. Weekend stays associated with a Friday or Saturday admission (hours will not be reimbursed unless an emergency exists. Covered admissions are limited to those admissions primarily indicated in the management of acute or chronic illness, injury, or impairment, or for maternity care that could not be rendered on an outpatient basis. Admissions relating to only observation or only diagnostic purposes or for elective cosmetic surgery shall not be covered. Laboratory tests not specifically ordered by a Physician and not done on a preadmission basis where feasible will not be covered unless an emergency exists which precludes such preadmission testing
- b. A recipient may transfer from one hospital to another hospital when such transfer is necessary for the patient to receive medical care which is not available in the first hospital. In such situations, the admission resulting from the transfer is an allowable admission.
- c. The following listed surgical procedures are not covered on an inpatient basis, except when a life threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a hospital:
- (a) Biopsy: breast, cervical node, cervix, lesions (skin subcutaneous, submucous), lymph node (except high axillary excision, etc.), and muscle.
 - (b) Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts/condylomas, anterior nose bleeds, and cervix.
 - (c) Circumcision.
 - (d) Dilation: dilatation and curettage (diagnostic or therapeutic nonobstetrical); dilatation/probing of lacrimal duct.
 - (e) Drainage by incision or aspiration: cutaneous, subcutaneous, and joint
 - (f) Exam under anesthesia (pelvic).

5. Physicians' Services (Continued)

N. The following procedures shall require prior authorization by the department prior to reimbursement:

- 1) Magnetic resonance imaging (MRI);
- 2) Magnetic resonance angiogram (MRA);
- 3) Magnetic resonance spectroscopy;
- 4) Positron emission tomography (PET);
- 5) Cineradiography/videoradiography;
- 6) Xeroradiography;
- 7) Ultrasound subsequent to second (2nd) obstretic ultrasound;
- 8) Unlisted procedure;
- 9) Myocardial imaging;
- 10) Cardiac blood pool imaging;
- 11) Radiopharmaceutical procedures;
- 12) Gastric restrictive surgery or gastric bypass surgery;
- 13) A procedure that is commonly performed for cosmetic purposes;
- 14) A surgical procedure that requires completion of a federal consent form

- g) Excision: bartholin cyst, condylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, and subcutaneous fistulas.
 - h) Extraction: foreign body, and teeth (per existing policy).
 - i) Graft, skin (pinch, splint of full thickness up to defect size 3/4 inch diameter).
 - j) Hymenotomy.
 - k) Manipulation and/or reduction with or without x-ray; cast change: dislocations depending upon the joint and indication for procedure, and fractures.
 - l) Meatotomy/ urethral dilation, removal calculus and drainage of bladder without incision.
 - m) Myringotomy with or without tubes, otoplasty.
 - n) Oscopy with or without biopsy (with or without salpingogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, otoscopy, and sigmoidoscopy or proctosidmoidoscopy.
 - o) Removal: IUD, and fingernail or toenails.
 - p) Tenotomy hand or foot.
 - q) Vasectomy.
 - r) Z-plasty for relaxation of scar/contracture.
- d. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of Hope vs. Childers. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2a. Outpatient Hospital Services

To be covered by the department, the following hospital outpatient services shall be prior authorized and meet the additional requirements of the outpatient hospital services section:

- a) Computed tomographic angiography (CTA);
- b) Magnetic resonance imaging (MRI);
- c) Magnetic resonance angiogram (MRA);
- d) Magnetic resonance spectroscopy;
- e) Positron emission tomography (PET);
- f) Cineradiography/videoradiography;
- g) Xeroradiography;
- h) Ultrasound subsequent to second (2nd) obstetric ultrasound;
- i) Unlisted procedure;
- j) Myocardial imaging;
- k) Cardiac blood pool imaging;
- l) Radiopharmaceutical procedures;
- m) Gastric restrictive surgery or gastric bypass surgery;
- n) A procedure that is commonly performed for cosmetic purposes;
- o) A surgical procedure that requires completion of a federal consent form

Outpatient Hospital Speech and Physical Therapy services shall be limited to those limits found in Attachment 3.1-A page 7.4.4(b) for Global Choices, and Attachment 3.1-C pages 10.22 and 10.23 for Comprehensive Choices and Optimum Choices. The Speech and Physical therapy limits may be over-riden if the department determines that additional visits beyond the limit are medically necessary. Except for recipients under age twenty-one (21), prior authorization is required for each visit that exceeds the Speech and Physical therapy limits established in Attachment 3.1-C page 10.18.

An outpatient hospital service not identified in the above paragraph shall be:

- a) Medically necessary; and
- b) clinically appropriate.

The above prior authorization requirements do not apply to:

- a) An emergency service;
- b) A radiology procedure if the recipient has a cancer or transplant diagnosis code; or
- c) A service provided to a recipient in an observation bed.

A following covered hospital outpatient services shall be furnished by or under the supervision of a duly licensed physician, or if applicable, a duly licensed dentist:

- a) A diagnostic service ordered by a physician;
- b) A therapeutic service, except for occupational therapy, ordered by a physician;
- c) An emergency room service provided in an emergency situation as determined by a physician; or
- d) A drug, biological, or injection administered in the outpatient hospital setting.

A covered hospital outpatient service for maternity care may be provided by:

- a) An advanced registered nurse practitioner (ARNP) who has been designated by the Kentucky Board of Nursing as a nurse midwife; or
- b) A registered nurse who holds a valid and effective permit to practice nurse midwifery issued by the Cabinet for Health and Family Services.

The following services shall not be considered a covered hospital outpatient service:

- a) An item or service that does not meet the hospital outpatient services prior authorization requirements;
- b) A service for which:
 - (i) An individual has no obligation to pay; and
 - (ii) No other person has a legal obligation to pay.
- c) A medical supply or appliance, unless it is incident to the performance of a procedure or service in the hospital outpatient department and included in the rate of payment established by the Medical Assistance Program for hospital outpatient services;
- d) A drug, biological, or injectable purchased by or dispensed to a patient; or
- e) A routine physical examination.

Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of *Hope vs. Childers*. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification

- d. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of *Hope vs. Childers*. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2a. Outpatient Hospital Services

To be covered by the department, the following hospital outpatient services shall be prior authorized and meet the additional requirements of the outpatient hospital services section:

- a) Computed tomographic angiography (CTA);
- b) Magnetic resonance imaging (MRI);
- c) Magnetic resonance angiogram (MRA);
- d) Magnetic resonance spectroscopy;
- e) Positron emission tomography (PET);
- f) Cineradiography/videoradiography;
- g) Xeroradiography;
- h) Ultrasound subsequent to second (2nd) obstetric ultrasound;
- i) Unlisted procedure;
- j) Myocardial imaging;
- k) Cardiac blood pool imaging;
- l) Radiopharmaceutical procedures;
- m) Gastric restrictive surgery or gastric bypass surgery;
- n) A procedure that is commonly performed for cosmetic purposes;
- o) A surgical procedure that requires completion of a federal consent form

Outpatient Hospital Speech and Physical Therapy services shall be limited to those limits found in Attachment 3.1-B page 30 for Global Choices, and Attachment 3.1-C pages 10.22 and 10.23 for Comprehensive Choices and Optimum Choices. The Speech and Physical therapy limits may be over-ridden if the department determines that additional visits beyond the limit are medically necessary. Except for recipients under age twenty-one (21), prior authorization is required for each visit that exceeds the Speech and Physical therapy limits established in Attachment 3.1-C page 10.18.

An outpatient hospital service not identified in the above paragraph shall be:

- a) Medically necessary; and
- b) clinically appropriate.

The above prior authorization requirements do not apply to:

- a) An emergency service;
- b) A radiology procedure if the recipient has a cancer or transplant diagnosis code; or
- c) A service provided to a recipient in an observation bed.

A following covered hospital outpatient services shall be furnished by or under the supervision of a duly licensed physician, or if applicable, a duly licensed dentist:

- a) A diagnostic service ordered by a physician;
- b) A therapeutic service, except for occupational therapy, ordered by a physician;
- c) An emergency room service provided in an emergency situation as determined by a physician; or
- d) A drug, biological, or injection administered in the outpatient hospital setting.

A covered hospital outpatient service for maternity care may be provided by:

- a) An advanced registered nurse practitioner (ARNP) who has been designated by the Kentucky Board of Nursing as a nurse midwife; or
- b) A registered nurse who holds a valid and effective permit to practice nurse midwifery issued by the Cabinet for Health and Family Services.

The following services shall not be considered a covered hospital outpatient service:

- a) An item or service that does not meet the hospital outpatient services prior authorization requirements;
- b) A service for which:
 - (i) An individual has no obligation to pay; and
 - (ii) No other person has a legal obligation to pay.
- c) A medical supply or appliance, unless it is incident to the performance of a procedure or service in the hospital outpatient department and included in the rate of payment established by the Medical Assistance Program for hospital outpatient services;
- d) A drug, biological, or injectable purchased by or dispensed to a patient; or
- e) A routine physical examination.

Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with the federal court order in the case of *Hope vs. Childers*. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification

2b. Rural Health Clinic Services

Other ambulatory services furnished by a rural health clinic shall have the same limitations when provided by the rural health clinic as when provided by the usual ambulatory care provider as specified in the relevant subsections of Attachment 3.1-A pertaining to those ambulatory services, except that limitations pertaining to qualifications of provider shall not apply. Reimbursement is not made for the service of physician assistants.

5. Physicians' Services (Continued)

J. The following procedures shall require prior authorization by the department prior to reimbursement:

- 1) Magnetic resonance imaging (MRI);
- 2) Magnetic resonance angiogram (MRA);
- 3) Magnetic resonance spectroscopy;
- 4) Positron emission tomography (PET);
- 5) Cineradiography/videoradiography;
- 6) Xeroradiography;
- 7) Ultrasound subsequent to second (2nd) obstetric ultrasound;
- 8) Unlisted procedure;
- 9) Myocardial imaging;
- 10) Cardiac blood pool imaging;
- 11) Radiopharmaceutical procedures;
- 12) Gastric restrictive surgery or gastric bypass surgery;
- 13) A procedure that is commonly performed for cosmetic purposes;
- 14) A surgical procedure that requires completion of a federal consent form

-
- a. Payment is made for medically necessary and clinically appropriate inpatient hospital care. Except for an emergency admission, each admission must have prior approval of appropriateness by the designated peer review organization in order for the admission to be covered under the Medicaid program. An emergency admission must be determined medically necessary and clinically appropriate within seventy-two hours of the admission in order to be covered by the department. exists. Covered admissions are limited to those admissions primarily indicated in the management of acute or chronic illness, injury, or impairment, or for maternity care that could not be rendered on an outpatient basis. Admissions relating to only observation or only diagnostic purposes or for elective cosmetic surgery shall not be covered. Laboratory tests not specifically ordered by a Physician and not done on a preadmission basis where feasible will not be covered unless an emergency exists which precludes such preadmission testing
- b. A recipient may transfer from one hospital to another hospital when such transfer is necessary for the patient to receive medical care which is not available in the first hospital. In such situations, the admission resulting from the transfer is an allowable admission.

13. Dental Services

- A. A listing of dental services available to recipients age 21 and over is maintained at the central office of the single state agency.
- B. Out-of-Hospital Dental Services
A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.
- C. In-Hospital Care
A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.
- D. Oral Surgery
A listing of oral surgery dental services available to Medicaid recipients is maintained at the central office the single state agency.
- E. Dental Hygienist
A dental hygienist may provide a service without direct practitioner contact if the dental hygienist provides the service under general supervision of a practitioner in accordance with state licensure requirements.
- F. Dental Resident, Student, or Dental Hygiene Student
A dental resident, student, or dental hygiene student may provide services under the direction of a program-participating provider in or affiliated with an American Dental Association-accredited institution.

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. The department shall impose no cost sharing for the following:

- (a) A service furnished to an individual who has reached his or her 18th birthday, but has not turned nineteen (19) required to be provided medical assistance under 42 U.S.C. 1396a(a)(10)(A)(i)(I), including services furnished to an individual with respect to whom aid or assistance is made available under Title IV, Part B (42 U.S.C. 620 to 629i) to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under Title IV, Part E (42 U.S.C. 670 to 679b), without regard to age;
- (b) A preventive service (for example, well baby and well child care and immunizations) provided to a child under eighteen (18) years of age regardless of family income;
- (c) A service furnished to a pregnant woman;
- (d) A service furnished to a terminally ill individual who is receiving hospice care as defined in 42 U.S.C. 1396d(o);
- (e) A service furnished to an individual who is an inpatient in a hospital, nursing facility, intermediate care facility for individuals with mental retardation or a developmental disability, or other medical institution, if the individual is required, as a condition of receiving services in the institution under Kentucky's Medicaid Program, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
- (f) An emergency service as defined by 42 C.F.R. 447.53;
- (g) A family planning service or supply as described in 42 U.S.C. 1396d (a)(4)(C); or
- (h) A service furnished to a woman who is receiving medical assistance via the application of 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa)

Benefit/Service	State Plan	NF Level of Care (Including ABI)/CF 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
Medical and Pharmacy Combined Out-of-Pocket Maximum	No Maximum	5% of family's income for a quarter
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
EPSDT Services for Children under 21	\$0 co-pay	\$0 co-pay
Maternity Services Nurse mid-wife services, pregnancy-related services and services for other conditions that might complicate pregnancy and 60 days postpartum pregnancy related services.	\$0 co-pay	\$0 co-pay
Preventive and Screening Services	\$0 co-pay	\$0 co-pay

Family, Comprehensive, and Optimum Choices Limits

On Attachment 3.1-C page 10.17 the following changes are needed:

- a. A row needs to be added to the grid indicating that the out-of-pocket maximum for both Medical and Pharmacy shall not exceed five (5) percent of a family's income for a quarter. This would apply to Children of Caretaker Relatives, Categorically Needy Children, and KCHIP Children.
- b. At the end of the last paragraph add, "The department shall impose no cost sharing for the following:
 - (a) A service furnished to an individual who has reached his or her 18th birthday, but has not turned nineteen (19) required to be provided medical assistance under 42 U.S.C. 1396a(a)(10)(A)(i)(I), including services furnished to an individual with respect to whom aid or assistance is made available under Title IV, Part B (42 U.S.C. 620 to 629i) to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under Title IV, Part E (42 U.S.C. 670 to 679b), without regard to age;
 - (b) A preventive service (for example, well baby and well child care and immunizations) provided to a child under eighteen (18) years of age regardless of family income;
 - (c) A service furnished to a pregnant woman;
 - (d) A service furnished to a terminally ill individual who is receiving hospice care as defined in 42 U.S.C. 1396d(o);
 - (e) A service furnished to an individual who is an inpatient in a hospital, nursing facility, intermediate care facility for individuals with mental retardation or a developmental disability, or other medical institution, if the individual is required, as a condition of receiving services in the institution under Kentucky's Medicaid Program, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
 - (f) An emergency service as defined by 42 C.F.R. 447.53;
 - (g) A family planning service or supply as described in 42 U.S.C. 1396d (a)(4)(C); or
 - (h) A service furnished to a woman who is receiving medical assistance via the application of 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa).

On Attachment 3.1-C page 10.20, the following changes are needed:

- a. In the DME row under KCHIP Children – Medicaid Expansion, add, "\$1,500 limit on prosthetic devices per year."
- b. In the notes below the grid a third statement reads, "****A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined in 42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor or agent of a pharmaceutical manufacturer, shall not make a copayment or coinsurance amount for a recipient."
- c. In the notes below the grid a fourth statement reads:

****A managed care entity shall not impose, on a recipient receiving services through a managed-care entity operating in accordance with state regulations, a copayment, coinsurance or premium that exceeds a copayment, coinsurance or premium established in Attachment 3.1-C, Attachment 4.18-A, and Attachment 4.18-C.

May impose upon a recipient receiving services through a managed-care entity:

1. A lower copayment, coinsurance or premium than established in this administrative regulation; or

2. No copayment, coinsurance or premium.

d. In the notes below the grid a fifth statement reads:

If the recipient is covered under the KCHIP Medicaid Expansion and is unable to pay the required cost sharing, a parent or guardian shall be responsible for any uncollected amount that is considered debt to providers.

On Attachment 3.1-C page 10.24 , the following changes are needed:

a. In the behavioral health services note delete, "under the age of 21"

b. In the notes below the grid a third statement reads, "****A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined in 42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor or agent of a pharmaceutical manufacturer, shall not make a copayment or coinsurance amount for a recipient."

c. In the notes below the grid a fourth statement reads:

****A managed care entity shall not impose, on a recipient receiving services through a managed-care entity operating in accordance with state regulations, a copayment, coinsurance or premium that exceeds a copayment, coinsurance or premium established in Attachment 3.1-C, Attachment 4.18-A, and Attachment 4.18-C.

May impose upon a recipient receiving services through a managed-care entity:

1. A lower copayment, coinsurance or premium than established in this administrative regulation; or
2. No copayment, coinsurance or premium.

Durable Medical Equipment, Supplies, Prosthetics and Orthotics

1. General DME Items

For DME items that do not require manual pricing and a HCPCS code is designated on the Medicaid fee schedule, reimbursement shall be based on the Medicaid fee schedule, not to exceed the supplier's usual and customary charge.

2. Manual Pricing of DME Items

a. Any item that does not have a HCPCS code and is a covered item will use a miscellaneous code which will require prior authorization and will be reimbursed at invoice plus twenty (20) percent or as designated on the Medicaid fee schedule, not to exceed the supplier's usual and customary.

b. DME items that are not on the Medicaid fee schedule and have been determined to be a covered service will require prior authorization and will be reimbursed at invoice plus twenty (20) percent.

c. DME items designated as MSRP (manufacturer's suggested retail price) will require prior authorization and will be reimbursed at MSRP less a percentage designated by the percent on the Medicaid fee schedule, not to exceed the supplier's usual and customary charge.