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 (i.e. managed care organization (MCOs) and 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), or to mandate the enrollment of Medicaid beneficiaries who are Medicaid eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet eligible certain categories of "special needs" beneficiaries (see D.2.i.-vi.)

B. General Description of the Program and Public Process.

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

1. Describe the contracting entities by indicating if they are an MCO or PCCM.

The State enrolls Medicaid beneficiaries into PCCMs

42 CFR 438.50 (b)(2)
42 CFR 438.50 (b)(3)

2. Discuss the payment method to be utilized (i.e. fee for service, capitation, case management fee, bonus/incentive and/or supplemental payments).

The PCCM receives a monthly case management fee of $4.00 per member per month. Services are paid on a fee-for-service basis.

42 CFR 438.50 (b)(4)

3. 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.

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

Citation	Condition or Requirement
	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)	4 Affirm if the state plan program will implement mandatory enrollment into managed care on a statewide basis. If not, identify the county/areas where mandatory enrollment will be implemented. The state plan program will be implemented in all areas of the state where the state does not operate a managed care program under an 1115 waiver. Counties without an adequate number of PCCMs will be excluded.
	C. State Assurances and Compliance with the Statute and Regulations. The state assures all the applicable requirements that include but are not limited to the following statute and regulations are met.
1932 (a)(1)(A)(i)(I) 1903 (m) 42 CFR 438.50 (c)(1)	1. Section 1903 (m) of the Act, for MCOs and MCO contracts.
1932 (a)(1)(A)(i)(I) 1905 (t) 42 CFR 438.50 (c)(2) 1902 (a)(23)(A)	2. Section 1905 (t) of the Act for PCCMs and PCCM contracts.
1932 (a)(1)(A) 42 CFR 438.50 (c)(3)	3. 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.
1932 (a)(1)(A) 42 CFR 431.51	4 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in Section 1905 (a)(4)(C).
1932 (a)(1)(A) 42 CFR 438 42 CFR 438.50 (c)(4) 1903 (m)	5. 42 CFR 438 for MCOs and PCCMs.

Citation	Condition or Requirement
1932 (a)(1)(A) 42 CFR 438.6 (c) 42 CFR 438.50 (c)(6)	6. 42 CFR 438.6 (c) for payments under any risk contracts.
1932 (a)(1)(A) 42 CFR 447.362 42 CFR 438.50 (c)(6)	7. 42 CFR 447.362 for payments under any non-risk contracts.
45 CFR 74.40	8. 45 CFR 74.40 for procurement of contracts.
	D. Eligible groups
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. 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 601(a)(1)(D). Use a check mark to indicate if the state will enroll any of the mandatory exempt groups on a voluntary basis.
1932 (a)(2)(B) 42 CFR 438 (d)(1)	i Recipients who are also eligible for Medicare ___The State will allow these individuals to voluntarily enroll in the managed care program
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

Citation		Condition or Requirement
		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 will allow these individuals to voluntarily enroll in the managed care program.
1932 (a)(2)(A)(ii) 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 ___The State will allow these individuals to voluntarily enroll in the managed care program.
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(a)(3) of the Act. ___The State will allow these individuals to voluntarily enroll in the managed care program.
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. ___ The State will allow these individuals to voluntarily enroll in the managed care program.
1932 (a)(2)(A)(iv) 42 CFR 438.50 (3)(iv)	vi.	Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E. ____ The State will allow these individuals to voluntarily enroll in the managed care program.
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. ____ The State will allow these individuals to voluntarily enroll in the managed care program
	E.	Identification of Mandatory Exempt Groups.
1932 (a)(2)	1	Describe how the state defines children who receive services that are funded

Citation		Condition or Requirement
42 CFR 438.50 (d)		under section 501(a)(1)(D) of title V?
		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.
1932 (a)(2) 42 CFR 438.50 (d)	2	Specify if the state's definition of these children is in terms of program participation or special health care needs.
		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.	Does the scope of these title V services include services received through a family-centered, community-based, and coordinated care system?
		Yes.
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:
		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.
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?
		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

Citation		Condition or Requirement
		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:
		i. Recipients who are also eligible for Medicare. The state utilizes 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 utilizes a Medicaid Management Information System (MMIS) to identify these recipients They are identified in the system by a specific code.
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.

Citation	Condition or Requirement
42 CFR 438.50	G. List all other eligible groups that 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

1932 (a)(4)
42 CFR 438.50

2. State process for enrollment by default

Describe how the state's default enrollment process will preserve:

i. The existing provider-recipient relationship;
ii. The relationship with providers that have traditionally served Medicaid recipients;
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).

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 above)

1932 (a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following items:

i. Indicate if the state will use a lock-in for managed care

Yes.

Citation	Condition or Requirement
	ii. Give the time frame for recipients to choose a health plan before being auto-assigned. Recipients have ten days from notification of their right to choose a PCP before they will be auto-assigned.
	iii Describe the state's process for notifying Medicaid recipients of their auto-assignment. 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 enrol ment. If recipient is auto-assigned upon initial enrollment, the notice notifying the recipient of auto assignment contains this information.
	v. Describe the default assignment algorithm used for auto-assignment 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.
	vi Describe how the state will monitor any changes in the rate of default assignment. 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. <u>State assurances on the enrollment process.</u> 1. The state assures it has an enrollment system that allows recipients who are

Citation	Condition or Requirement
	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. 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).
	_X_ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52 (a) for MCOs and PCCMs.
	3. 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.)
	_X_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56 (g) if recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.
1932 (a)(4) 42 CFR 438.50	J. Disenrollment.
	1. Affirm if the state uses lock-in for managed care and identify how many months (up to 12 months) will the lock-in apply.
	KenPAC recipients are locked in for 12 months
	2. The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56 (c)
	KenPAC's policy regarding disenrollment fully complies with the requirements of 42 CFR 438.50(c).
	3 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.
1932 (a)(5)	The state assures that its state plan program is in compliance with 42 CFR

Citation		Condition or Requirement
42 CFR 438.50 42 CFR 438.10		438.10 (i) for information requirements specific to MCOs and PCCM programs operated under section 1932 (a)(1)(A)(i) state plan amendments.
1932 (a)(5)(D)	L.	Description of excluded services 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
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 Children's 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.