CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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June 16, 2014

LaVern Baty
Center for Medicare and Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

RE: Children's State Health Insurance Program (CHIP) State Plan Amendment (SPA)-Response to 06/05/14 Letter

Dear Ms. Baty,

This letter is being sent to address questions pertaining to the Children's State Health Insurance Program (CHIP) State Plan Amendment (SPA) number 13 submitted by Kentucky. The SPA proposed to make necessary changes to comply with provisions outlined in the Affordable Care Act and with an effective date of January 1, 2014.

In a letter dated June 5, 2014, CMS requested additional information in order to proceed with the review of SPA number 13. Below are the responses provided by the State to address specific concerns related to the SPA:

I. **Budget Issues**

- Page 96: Budget Table – Please complete the line for the 10% Administrative Cap. This line has been left blank. Please note that the administrative cap is equal to the "Net Benefit Costs" divided by "9". See 42 (CFR §475.618(c)(3).

  State response: The budget table has been corrected.

- Page 96: Budget Table-the proposed SPA submitted March 31, 2014, indicated a cost of "0"on the line item titled "Cost of Proposed SPA Changes" However, the revised proposed SPA sent electronically on June 2, 2014, indicated a cost of $18,634,205 for this line time. Please clarify.

  State response the budget table has been corrected. The $18,634,205 is the 10% Administrative Cap amount and was inadvertently listed on this line instead of the 10% Administrative Cap line.

II. **Section 6.2 Forms of Coverage to Children the State Elects to Provide**

- Pages 22-78: In the revised proposed SPA submitted on June 2, 2014, the state checked "6.1.4.1. Coverage the same a Medicaid State plan" stating that "the KCHIP benefit package will be essentially the same as the State's Title XIX Medicaid plan with the exception of non-emergency transportation and EPSDT special services" as well as provided a comprehensive description of items 6.2.1.-6.2.6., 6.2.8.-6.2.13., and 6.2.15-6.2.23. Please clarify whether the descriptions for each are the same as what is in the Medicaid State plan or whether the descriptions indicate how these services differ in KCHIP from Kentucky's Medicaid State plan.

  State response: The descriptions for each service are the same as in the Medicaid State plan.
- Page 75: In the proposed SPA submitted on March 31, 2014, "6.2.21. Care coordination services" was checked. In the revised proposed SPA submitted electronically on June 2, 2014, section 6.2.21. has been left blank. Please clarify which one is correct.

  State response: Care coordination is not a covered service.

III. **Section 8 Cost-Sharing and Payment**

- Page 88: Please confirm that the copayments detailed in 8.2.3. in the proposed SPA replace the text in Kentucky's current state plan.

  State response: The copayments detailed in 8.2.3 in the proposed SPA replace the text in Kentucky's current state plan.
- Pages 88 and 96: It was noted in the budget table on p.96 that the Managed Care Organizations (MCOs) may or may not impose the copayments outlined in the proposed SPA. Therefore, do the copayments outlined in the proposed SPA beginning on p. 88 represent maximum copayments that the MCOs may charge? Please explain.

  State response: The copayments on page 88 represent maximum copayments. The MCOs may not impose copayments that exceed the limits outlined in this SPA.

The State is available to address any additional items or concern in order to order to obtain a favorable review of this SPA. Please let me know if additional information is necessary.

Sincerely,

Lisa D. Lee, Deputy Commissioner
Program Director, Kentucky Children's Health Insurance Program (KCHIP)

C: File
Jackie Glaze, CMS

Attachment(s)

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Kentucky
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))
Lawrence Kissner, Commissioner
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Lee Guice Position/Title: Director, Policy and Operations
Name: Lisa Lee Position/Title: Deputy Commissioner
Name: Neville Wise Position/Title: Deputy Commissioner

*Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children's Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered

under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

  Medicaid Expansion- CHIP SPA Requirements
  In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:
  - 1 (General Description)
  - 2 (General Background)

  They will also be required to complete the appropriate program sections, including:
  - 4 (Eligibility Standards and Methodology)
  - 5 (Outreach)
  - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
  - 10 (Annual Reports and Evaluations).

  Medicaid Expansion- Medicaid SPA Requirements
  States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
  - 3 (Methods of Delivery and Utilization Controls)
  - 4 (Eligibility Standards and Methodology)
  - 6 (Coverage Requirements for Children's Health Insurance)
  - 7 (Quality and Appropriateness of Care)
  - 8 (Cost Sharing and Payment)
  - 11 (Program Integrity)
  - 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be

required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

Section 1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

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1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2. ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3. ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

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Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. **Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.**

Original Plan
Effective Date: ____

Implementation Date: ____

SPA #____#13 **Purpose of SPA:** ____Update service delivery model and cost sharing provisions
Proposed effective date:____:01/01/2014

Proposed implementation date: ____01/01/2014

1.4- TC **Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.**
____Not applicable. There are no federally recognized American Indian Tribes in Kentucky.
TN No: Approval Date Effective Date

Section 2. **General Background and Description of Approach to Children's Health Insurance Coverage and Coordination**

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics

- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

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Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. **Health Services Initiatives-** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

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2.3-TC **Tribal Consultation Requirements-** (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

Section 3. **Methods of Delivery and Utilization Controls**

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans), contracts with indemnity health insurance plans, and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to the CMS Regional Office servicing them for review and approval.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding.
If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability, neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

3.1. **Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of

financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

The Department for Medicaid Services contract standards require that participating managed care organizaitons (MCO) have adequate utilization management staff and procedures to assure that services provided to enrollees are medically necessary and appropriate. The utilization management contract standards address the contractor's written utilization management program, procedures, staff, timelines, and standards for service denials. National Committee for Quality Assurance (NCQA) and applicable Kentucky managed care regulations and guidelines were used to developm the standards.

Monitoring compliance with utilization management contract standards are accomplished through MCO cooperation with annual on-site reviews performed by the Kentucky Cabinet for Health Services and via contract with an external review entity that evaluates utilization management.

This language replaces the existing description.

☒ **Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS Regional Office for review and approval. (Section 2103(f)(3))**

The State asures that all managed care contracts comply with relevant provisions of section 1932 of the Act.

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR 457.490(b))

3.2. **Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically**

necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42CFR 457.490(b))

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Section 4. **Eligibility Standards and Methodology**

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. ☒ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group:

4.1. ☒ **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

4.1.1 ☐ Geographic area served by the Plan if less than Statewide:

4.1.2 ☒ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

4.1.2.1-PC ☐ Age: through birth (SHO #02-004, issued November 12, 2002)

4.1.3 ☐ Income of each separate eligibility group (if applicable):

4.1.3.1-PC ☐ 0% of the FPL (and not eligible for Medicaid) through % of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 ☒ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state):

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7 ☒ Access to or coverage under other health coverage:

4.1.8 ☒ Duration of eligibility, not to exceed 12 months:

4.1.9 ☐ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

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Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards

include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☒ States should specify whether Social Security Numbers (SSN) are required.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☐ Continuous eligibility

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1) "lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☒ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
(4) An alien who belongs to one of the following classes:
  (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
  (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
  (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
  (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
  (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
  (vi) Aliens currently in deferred action status; or
  (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;
(6) An alien who has been granted withholding of removal under the Convention Against Torture;
(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☒ Elected for children under age ——19

4.1.1-LR ☒ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily

available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS ☐ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. **Assurances** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS ☐ These standards do not discriminate on the basis of diagnosis.

4.2.2-DS ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3-DS ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other

public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

KCHIP will rely on several features to establish eligibility and promote continuing enrollment. It is anticipated that the outreach effort of KCHIP and others will create a pool of potential eligible children. These children will include:

- Children without insurance but Medicaid eligible.
- Children without insurance but with family incomes higher than allowed under Medicaid.
- Children whose insurance coverage has been terminated for reasons other than voluntary action by them or their parents, e.g., job loss, coverage changed, death of a parent or divorce (See Section 4.4.4.).
- Children without insurance being served by other health care programs, i.e., WIC, well child, free clinics, federally funded 330 agencies.

Through eligibility determinations, this pool of potential eligible recipients will be channeled to Medicaid or KCHIP as appropriate. The goal is to make eligibility determination and enrollment into KCHIP as simple as possible for the applicant and plan provider while meeting all statutory requirements of Title XXI.

Kentucky uses a joint application process for KCHIP/Medicaid. The application process was updated October 1, 2013 to include a web based application process. The updated application was the result of a collaborative effort with Kentucky's Health Benefit Exchange, KYNect. Applications can be completed on line, downloaded from the KCHIP website, obtained by calling a toll free number, or obtained at a variety of localities throughout the state including the local DCBS office, health departments, physician offices, primary care centers, and hospitals. The local Department for Community Based Service Office will determine eligibility for KCHIP and Medicaid.

If the child is determined eligible for KCHIP/Medicaid, the information will be entered into a management information system and an approval notice and medical card will be generated and mailed.

Recertification

Recertification will be required every 12 months with requirements for recipients to notify the state within 30 days of any changes in financial or coverage status impacting eligibility. If the recipient is determined to be ineligible for the program due to this change, coverage will be discontinued. These changes will include, but not be limited to, change in family income beyond KCHIP eligibility levels, eligibility for Medicaid coverage, or availability of coverage through employer.

Families will automatically receive a recertification form for KCHIP by mail, or the DCBS caseworker will contact them by phone. The form and verification of income are to be provided to the local DCBS office.

If recertification is not returned, a second notice is sent. The case is discontinued if the recipient does not respond after two notices. If the recertification form and required documentation is returned to the office within 30 days after the date of discontinuance, the case will be re-determined based on the information received and the family will not need to complete a new application for benefits.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

☒ Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. ☐ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility ☐ Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are

determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

4.4.2. ☒ children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

4.4.4. ☒ the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)

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4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

4.4.5. ☐ Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

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Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

5.1.1. (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

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Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

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5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of

low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

5.3. **Strategies** Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

Section 6. **Coverage Requirements for Children's Health Insurance**

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. ☒ Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☒ **Coverage the same as Medicaid State plan**

For children in families with incomes from 150% TO 200% FPL, Kentucky will provide a KCHIP benefit package that will be essentially the same as the State's Title XIX Medicaid plan with the exception of non emergency transportation and EPSDT special services.

Kentucky's EPSDT Special Services coverage includes medically necessary and appropriate health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses, and conditions identified by EPSDT screening services, which are not covered under the Kentucky State Medicaid Plan (Title XIX). Excluded from EPSDT Special Services coverage are any services listed as exclusions in 1905(a), including, but not limited to physical structural changes to a residence, recreational equipment, specified educational tools, including computers, and environmental devices, including air conditioners.
Descriptions regarding the amount, duration, and scope of each service as well as limitations are outlined below each service. Sections 6.2.18 and 6.2.19 are newly added services.

6.1.4.2. ☐ **Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver**

6.1.4.3. ☐ **Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population**

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in □457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ **Coverage that includes benchmark coverage plus additional coverage**

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6.1.4.5. ☐ **Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)**

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used.

Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ **Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)**

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☐ **Other (Describe)**

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. **The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)**

6.2.1. ☒ **Inpatient services (Section 2110(a)(1))**

To be covered by the department:

(1) Prior to a nonemergency admission, including an elective admission or a weekend admission, the department shall have made a determination that the nonemergency admission was:

(a) Medically necessary; and

(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and

(2) Within seventy-two (72) hours after an emergency admission, the department shall have made a determination that the emergency admission was:

(a) Medically necessary; and

(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.

Covered Admissions. The department shall reimburse for an admission 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

Noncovered Services. Inpatient hospital services not covered shall include:

(1) The department shall not reimburse an acute care hospital reimbursed via a diagnosis-related group (DRG) methodology, a critical access hospital, a long-term acute care hospital, a psychiatric hospital, a rehabilitation hospital, or a Medicare-designated psychiatric or rehabilitation distinct part unit for the following:

(a) A service which is not medically necessary including television, telephone, or guest meals;

(b) Private duty nursing;

(c) Supplies, drugs, appliances, or equipment which are furnished to the patient for use outside the hospital unless it would be considered unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which he is an inpatient;

(d) A laboratory test not specifically ordered by a physician and not done on a preadmission basis unless an emergency exists;

(e) Private accommodations unless medically necessary and so ordered by the attending physician;

(f) The following listed surgical procedures, except if 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:

1. Biopsy: breast, cervical node, cervix, lesions (skin, subcutaneous, submucous), lymph node (except high axillary excision), or muscle;

2. Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts or condylomas, anterior nose bleeds, or cervix;

3. Circumcision;

4. Dilation: dilation and curettage (diagnostic or therapeutic nonobstetrical); dilation or probing of lacrimal duct;

5. Drainage by incision or aspiration: cutaneous, subcutaneous, or joint;

6. Pelvic exam under anesthesia;

7. Excision: bartholin cyst, condylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, or subcutaneous fistulas;

8. Extraction: foreign body or teeth;

9. Graft, skin (pinch, splint or full thickness up to defect size three-fourths (3/4) inch diameter);

10. Hymenotomy;

11. Manipulation and reduction with or without x-ray; cast change: dislocations depending upon the joint and indication for procedure or fractures;

12. Meatotomy or urethral dilation, removal calculus and drainage of bladder without incision;

13. Myringotomy with or without tubes, otoplasty;

14. Oscopy with or without biopsy (with or without salpingogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, gastroscopy, hysteroscopy, laryngoscopy, laparoscopy, peritoneoscopy, otoscopy, and sigmoidoscopy or procto sidmoidoscopy;

15. Removal; IUD, fingernail or toenails;

16. Tenotomy hand or foot;

17. Vasectomy; or

18. Z-plasty for relaxation of scar or contracture.

(g) A service for which Medicare has denied payment;

(h) An admission relating only to observation or diagnostic purposes; or

1.a. Medically necessary, and

b. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and

2. For a lock-in recipient:

a. Provided by the lock-in recipient's designated hospital pursuant to 907 KAR 1:677; or

b. A screening or emergency service that meets the requirements of subsection (6)(a) of this section.

(2) The prior authorization requirements established in subsection (1) of this section shall 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.

(3) A referring physician, a physician who wishes to provide a given service, or an advanced practice registered nurse may request prior authorization from the depart-ment.

(i) Cosmetic surgery, except as required for prompt repair of accidental injury or for the improvement of the functioning of a malformed or diseased body member.

(2) The department shall not reimburse an acute care hospital reimbursed via a DRG-methodology pursuant to 907 KAR 10:825 for treatment for or related to a never event.

(3) A hospital shall not seek payment for treatment for or related to a never event through:

(a) A recipient;

(b) The Cabinet for Health and Family Services for a child in the custody of the cabinet; or

(c) The Department for Juvenile Justice for a child in the custody of the Department for Juvenile Justice.

(4) A recipient, the Cabinet for Health and Family Services, or the Department for Juvenile Justice shall not be liable for treatment for or related to a never event.

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

Coverage Criteria. (1) To be covered by the department:

(a) The following shall be prior authorized and meet the requirements established in paragraph (b) of this subsection:

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

(b) An outpatient hospital service, including those identified in paragraph (a) of this subsection,

(4) The 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 services as occupational therapy services shall not be covered under this administrative regulation, 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.

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

(a) An advanced practice registered nurse [(APRN)] 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 mid-wifery issued by the Cabinet for Health and Family Services.

(6) The department shall cover:

(a) A screening of a lock-in recipient to determine if the lock-in recipient has an emergency medical condition; or

(b) An emergency service to a lock-in recipient if the department determines that the lock-in recipient had an emergency medical condition when the service was provided.

Section 3. Hospital Outpatient Services Not Covered by the Department. The follow-ing services shall not be considered a covered hospital outpatient service:

(1) An item or service that does not meet the requirements established in Section 2(1) of this administrative regulation;

(2) A service for which:

(a) An individual has no obligation to pay; and

(b) No other person has a legal obligation to pay;

(3) A medical supply or appliance, unless it is incidental to the performance of a pro-cedure or service in the hospital outpatient department and included in the rate of pay-ment established by the Medical Assistance Program for hospital outpatient services;

(4) A drug, biological, or injection purchased by or dispensed to a recipient;

(5) A routine physical examination; [or]

(6) A nonemergency service, other than a screening in accordance with Section 2(6)(a) of this administrative regulation, provided to a lock-in recipient:

1. In an emergency department of a hospital; or

2. If provided by a hospital that is not the lock-in recipient's designated hospital pur-suant to 907 KAR 1:677; or

No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving speech therapy from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for speech therapy provided to the same recipient during the same time period via the out-patient hospital services program.

6.2.3. ☒ Physician services (Section 2110(a)(3))

Covered Services. (1) To be covered by the department, a service shall be

(a) Medically necessary;
(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
(c) Except as provided in subsection (2) of this section, furnished to a recipient through direct physician contact; and
(d) Eligible for reimbursement as a physician service.
(2) Direct physician contact between the billing physician and recipient shall not be required for:
(a) A service provided by a:
1. Medical resident if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.174 and 415.184;
2. Locum tenens physician who provides direct physician contact; or
3. Physician assistant in accordance with Section 7 of this administrative regulation;
(b)[(c)] A radiology service, imaging service, pathology service, ultrasound study, echographic study, electrocardiogram, electromyogram, electroencephalogram, vascular study, or other service that is usually and customarily performed without direct physician contact;
(c)[(d)] The telephone analysis of emergency medical systems or a cardiac pacemaker if provided under physician direction;
(d) A sleep disorder service; or
(e) A telehealth consultation provided in accordance with 907 KAR 3:170].
(3) A service provided by another licensed medical professional shall be covered if the other licensed medical professional is:
(a) Employed by the supervising physician; and
(b) Licensed in the state of practice.
(4) A sleep disorder service shall be covered if performed in:
(a) A hospital; or
(b)1. A sleep laboratory if the sleep laboratory has documentation demonstrating that it complies with criteria approved by the:
a. American Sleep Disorders Association; or
b. American Academy of Sleep Medicine; or
2. An independent diagnostic testing facility that:
a. Is supervised by a physician trained in analyzing and interpreting sleep disorder recordings; and
b. Has documentation demonstrating that it complies with criteria approved by the:
(i) American Sleep Disorders Association; or
(ii) American Academy of Sleep Medicine

Service Limitations. (1) A covered service provided to a lock-in recipient shall be limited to a service provided by the lock-in recipient's designated primary care provider or designated controlled substance prescriber unless:
(a) The service represents emergency care; or
(b) The lock-in recipient has been referred to the provider by the lock-in recipient's designated primary care provider.
(2) An EPSDT screening service shall be covered in accordance with 907 KAR 11:034.
(3) A laboratory procedure performed in a physician's office shall be limited to a procedure for which the physician has been certified in accordance with 42 C.F.R. Part 493.
(4) Except for the following, a drug administered in a physician's office shall not be covered as a

separate reimbursable service through the physicians' program:

(a) Rho (D) immune globulin injection;

(b) An injectable antineoplastic drug;

(c) Medroxyprogesterone acetate for contraceptive use, 150 mg;

(d) Penicillin G benzathine injection;

(e) Ceftriaxone sodium injection;

(f) Intravenous immune globulin injection;

(g) Sodium hyaluronate or hylan G-F for intra-articular injection;

(h) An intrauterine contraceptive device;

(i) An implantable contraceptive device;

(j) Long acting injectable risperidone; or

(k) An injectable, infused, or inhaled drug or biological that:

1. Is not typically self-administered;

2. Is not excluded as a noncovered immunization or vaccine; and

3. Requires special handling, storage, shipping, dosing, or administration.

(5) A service allowed in accordance with 42 C.F.R. 441, Subpart E or Subpart F, shall be covered within the scope and limitations of 42 C.F.R. 441, Subpart E and Subpart F.

(6) Coverage for:

(a) A service designated as a psychiatry service CPT code and provided by a physician other than a board certified or board eligible psychiatrist or an advanced practice registered nurse with a specialty in psychiatry shall be limited to four (4) services, per physician, per recipient, per twelve (12) months;

(b) An evaluation and management service shall be limited to one (1) per physician, per recipient, per date of service; or

(c) A fetal diagnostic ultrasound procedure shall be limited to two (2) per nine (9) month period per recipient unless the diagnosis code justifies the medical necessity of an additional procedure.

(7) An anesthesia service shall be covered if:

(a) Administered by:

1. An anesthesiologist who remains in attendance throughout the procedure; or

2. An individual who:

a. Is licensed in Kentucky to practice anesthesia;

b. Is licensed in Kentucky within his or her scope of practice; and

c. Remains in attendance throughout the procedure;

(b) Medically necessary; and

(c) Not provided as part of an all-inclusive CPT code.

(8) shall not be covered:

(a) An acupuncture service;

(b) An autopsy;

(c) A cast or splint application in excess of the limits established in 907 KAR 3:010;

(d)Except for therapeutic bandage lenses, contact lenses;

(e) A hysterectomy performed for the purpose of sterilization;

(f) Lasik surgery;

(g) Paternity testing;

(h) A procedure performed for cosmetic purposes only;

(i) A procedure performed to promote or improve fertility;

(j) Radial keratotomy;
(k) A thermogram;
(l) An experimental service which is not in accordance with current standards of medical practice; [or]
(m) A service which does not meet the requirements established in Section 3(1) of this administrative regulation;
(n) Medical direction of an anesthesia service; or
(o) Medical assistance for another provider preventable condition in accordance with 907 KAR 14:005.

Prior Authorization Requirements for Recipients Who are Not Enrolled with a Managed Care Organization. (1) The following procedures for a recipient who is not enrolled with a managed care organization shall require prior authorization by the department:
(a) Magnetic resonance imaging;
(b) Magnetic resonance angiogram;
(c) Magnetic resonance spectroscopy;
(d) Positron emission tomography;
(e) Cineradiography or videoradiography;
(f) Xeroradiography;
(g) Ultrasound subsequent to second obstetric ultrasound;
(h) Myocardial imaging;
(i) Cardiac blood pool imaging;
(j) Radiopharmaceutical procedures;
(k) Gastric restrictive surgery or gastric bypass surgery;
(l) A procedure that is commonly performed for cosmetic purposes;
(m) A surgical procedure that requires completion of a federal consent form; or
(n) An unlisted covered procedure or service.
(2)(a) Prior authorization by the department shall not be a guarantee of recipient eligibility.
(b) Eligibility verification shall be the responsibility of the provider.
(3) The prior authorization requirements established in subsection (1) of this section shall not apply to:
(a) An emergency service; or
(b) A radiology procedure if the recipient has a cancer or transplant diagnosis code.
(4) A referring physician, a physician who wishes to provide a given service, a podiatrist, a chiropractor, or an advanced practice registered nurse:
(a) May request prior authorization from the department; and
(b) If requesting prior authorization shall request prior authorization by:
1. Mailing or faxing:
a. A written request to the department with information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation; and
b. If applicable, any required federal consent forms; or
2. Submitting a request via the department's web-based portal with information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation.

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6.2.4. ☒ Surgical services (Section 2110(a)(4))

All surgical services must meet medical necessity requirements and must be provided by licensed providers operating within their scope of practice. Inpatient and outpatient surgical services will be covered when delivered by Medicaid enrolled providers. Surgical services will not be covered for cosemetic purposes.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

Clinic services include services provided by Federally Qualified Health Care Centers (FQHC), Rural Health Clinics (RHC), Primary Care Centers (PCC), and Local Health Departments, Specialized Children's Services Clinics that provide treatment for children who have been sexually abused, and Special intermediate care clinics that provide services to individuals with mental illness, intellectual disabilities, or developmental disabilities. All services must be medically necessary and provided by a licensed individual operating within his or her scope of practice. Covered services do not inlcude experimental or cosmetic services.

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

Covered Benefits and Drug List. (1) A covered outpatient drug, nonoutpatient drug, or diabetic supply covered via this administrative regulation shall be:

(a) Medically necessary;

(b) Approved by the Food and Drug Administration; and

(c) Prescribed for an indication that has been approved by the Food and Drug Administration or for which there is documentation in official compendia or peer-reviewed medical literature supporting its medical use.

(2) A covered outpatient drug covered via this administrative regulation shall be prescribed on a tamper-resistant pad unless exempt pursuant to subsection (3) of this section.

(3) The tamper-resistant pad requirement established in subsection (2) of this section shall not apply to:

(a) An electronic prescription;

(b) A faxed prescription; or

(c) A prescription telephoned by a prescriber.

(4) To qualify as a tamper-resistant pad prescription, a prescription shall contain:

(a) One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;

(b) One (1) or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and

(c) One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

(5)(a) Except as provided in paragraph (b) of this subsection, the department shall cover the diabetic supplies listed in this paragraph via the department's pharmacy program and not via the department's durable medical equipment program established in 907 KAR 1:479:

1. A syringe with needle (sterile, 1cc or less);

2. Urine test or reagent strips or tablets;
3. Blood ketone test or reagent strip;
4. Blood glucose test or reagent strips for a home blood glucose monitor;
5. Normal, low, or high calibrator solution, chips;
6. Spring-powered device for lancet;
7. Lancets per box of 100; or
8. Home blood glucose monitor.
(b) The department shall cover the diabetic supplies listed in this paragraph via the department's durable medical equipment program established in 907 KAR 1:479 if:
1. The supply has an HCPCS code of A4210, A4250, A4252, A4253, A4256, A4258, A4259, E0607 or E2100;
2. The supply has an a HCPCS code of A4206 and a diagnosis of diabetes is present on the corresponding claim; or
3. Medicare is the primary payor for the supply.
(6) The department shall have a drug list which:
(a) Lists:
1. Drugs, drug categories, and related items not covered by the department and, if applicable, excluded medical uses for covered drugs; and
2. Maintenance drugs covered by the department;
(b) Specifies those covered drugs requiring prior authorization or having special prescribing or dispensing restrictions;
(c) Specifies those covered drugs for which the maximum quantity limit on dispensing may be exceeded;
(d) Lists covered over-the-counter drugs;
(e) Specifies those legend drugs which are permissible restrictions under 42 U.S.C. 1396r-8(d), but for which the department makes reimbursement;
(f) May include a preferred drug list of selected drugs which have a more favorable cost to the department and which prescribers are encouraged to prescribe, if medically appropriate;
(g) May be updated monthly or more frequently by the department; and
(h) Shall be posted on the department's Internet pharmacy Web site.
(6)(a) The department may implement drug treatment protocols requiring the use of medically-appropriate drugs which are available without prior authorization before the use of drugs which require prior authorization.
(b) The department may approve a request from the prescriber or a pharmacist for exemption of a specific recipient from the requirement established in paragraph (a) of this subsection, based on documentation that drugs available without prior authorization:
(a) Were used and were not an effective medical treatment or lost their effectiveness;
(b) Are reasonably expected to not be an effective medical treatment;
(c) Resulted in, or are reasonably expected to result in, a clinically-significant adverse reaction or drug interaction; or
(d) Are medically contraindicated.

Exclusions and Limitations. (1) The following drugs shall be excluded from coverage:
(a) A drug which the Food and Drug Administration considers to be

1. A less-than-effective drug; or
2. Identical, related, or similar to a less-than-effective drug;
(b) A drug or its medical use in one (1) of the following categories unless the drug or its medical use is designated as covered in the drug list:
1. A drug if used for anorexia, weight loss, or weight gain;
2. A drug if used to promote fertility;
3. A drug if used for cosmetic purposes or hair growth;
4. A drug if used for the symptomatic relief of cough and colds;
5. Vitamin or mineral products other than prenatal vitamins and fluoride preparations;
6. An over-the-counter drug provided to a Medicaid nursing facility service recipient if included in the nursing facility's standard price;
7. A barbiturate;
8. A benzodiazepine;
9. A drug which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; or
10. A drug utilized for erectile dysfunction therapy unless the drug is used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the United States Food and Drug Administration;
(c) A drug for which the manufacturer has not entered into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a), unless there has been a review and determination by the department that it is in the best interest of a recipient for the department to make payment for the drug and federal financial participation is available for the drug;
(d) A drug dispensed as part of, or incident to and in the same setting as, an inpatient hospital service, an outpatient hospital service, or an ambulatory surgical center service;
(e) A drug for which the department requires prior authorization if prior authorization has not been approved; and
(f) A drug that has reached the manufacturer's termination date, indicating that the drug may no longer be dispensed by a pharmacy.
(2) If authorized by the prescriber, a prescription for a:
(a) Controlled substance in Schedule III-V may be refilled up to five (5) times within a six (6) month period from the date the prescription was written or ordered, at which time a new prescription shall be required; or
(b) Noncontrolled substance, except as prohibited in subsection (4) of this section, may be refilled up to eleven (11) times within a twelve (12) month period from the date the prescription was written or ordered, at which time a new prescription shall be required.
(3) For each initial filling or refill of a prescription, a pharmacist shall dispense the drug in the quantity prescribed not to exceed a thirty-two (32) day supply unless:
(a) The drug is designated in the department's drug list as a drug exempt from the thirty-two (32) day dispensing limit in which case the pharmacist may dispense the quantity prescribed not to exceed a three (3) month supply or 100 units, whichever is greater;
(b) A prior authorization request has been submitted on the Drug Prior Authorization Request Form (MAP-82001) and approved by the department because the recipient needs additional medication while traveling or for a valid medical reason, in which case the pharmacist may dispense the quantity prescribed not to exceed a three (3) month supply or 100 units, whichever is greater;

(c) The drug is prepackaged by the manufacturer and is intended to be dispensed as an intact unit and it is impractical for the pharmacist to dispense only a month's supply because one (1) or more units of the prepackaged drug will provide more than a thirty-two (32) day supply; or

(d) The prescription fill is for an outpatient service recipient, excluding an individual who is receiving supports for community living services in accordance with 907 KAR 1:145.

(4) A prescription fill for a maintenance drug for an outpatient service recipient who has demonstrated stability on the given maintenance drug, excluding an individual receiving supports for community living services in accordance with 907 KAR 1:145 or 907 KAR 12:010, shall be dispensed in a ninety-two (92) day supply unless:

(a) The department determines that it is in the best interest of the recipient to dispense a smaller supply; or

(b) The recipient is covered under the Medicare Part D benefit in which case the department shall not cover the prescription fill.

(5) The department may require prior authorization for a compounded drug that requires preparation by mixing two (2) or more individual drugs; however, the department may exempt a compounded drug or compounded drug category from prior authorization if there has been a review and determination by the department that it is in the best interest of a recipient for the department to make payment for the compounded drug or compounded drug category.

(6) A prescriber shall make his or her national provider identifier (NPI) available to a pharmacist, and the prescriber's NPI shall be recorded on each pharmacy claim.

(7) A refill of a prescription shall not be covered unless at least ninety (90) percent of the prescription, except for a refill for a recipient who is a resident of a personal care home or a resident of a facility reimbursed pursuant to 907 KAR 1:025 or 1:065, time period has elapsed.

(b) A refill of a prescription for a recipient who is a resident of a facility or entity referenced in paragraph (a) of this subsection shall not be covered unless at least eighty (80) percent of the prescription time has lapsed.

6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

Coverage. (1) The department shall reimburse for a procedure provided by an independent laboratory if the procedure:

(a) Is one that the laboratory is certified to provide by Medicare and in accordance with 907 KAR 1:575;

(b) Is a covered service within the CPT code range of 80047-89356 except as excluded in Section 3 of this administrative regulation;

(c) Is prescribed in writing or by electronic request by a physician, podiatrist, dentist, oral surgeon, advanced registered nurse practitioner, or optometrist; and

(d) Is supervised by a laboratory director.

(2) The department shall reimburse for a radiological service if the service

(a) Is provided by a facility that:

1. Is licensed to provide radiological services;

2. Meets the requirements established in 42 C.F.R. 440.30;

3. Is certified by Medicare to provide the given service;

4. Is a Medicare-participating facility;

5. Meets the requirements established in 42 C.F.R. Part 493 regarding laboratory certification, registration, or other accreditation as appropriate; and

6. Is a Medicaid-enrolled provider.

(b) Is prescribed in writing or by electronic request by a physician, oral surgeon, dentist, podiatrist, optometrist, advanced registered nurse practitioner, or a physician's assistant;

(c) Is provided under the direction or supervision of a licensed physician; and

(d) Is a covered service within the CPT code range of 70010-78999.

Exclusions. The department shall not reimburse for an independent laboratory or radiological service under this administrative regulation for the following services or procedures:

(1) A procedure or service with a CPT code of 88300-88399;

(2) A procedure or service with a CPT code of 89250-89356;

(3) A service provided to a resident of a nursing facility or an intermediate care facility for individuals with an intellectual disability; or

(4) A court-ordered laboratory or toxicology test.

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

——All services must be medically necessary and delivered by a licensed provider operating within his or her scope of practice. Services may be delivered by individual providers or in clinic settings. Serivces include prenatla care, pre-pregnancy family services and supplies. Services exclude abortions except in the case of rape, incest and life endangerment.

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

——Inpatient psychiatric hospital services must involve active treatment which is reasonably expected to improve the patient's condition or prevent further regression, so that eventually such services will no longer be necessary.

Periodic medical and social evaluations should determine at what point a patient's progress has reached the stage where his/her needs can be met appropriately outside the institution.

Federal regulations emphasize "active treatment" as one of the necessary elements of inpatient services. Active treatment is defined as the implementation of a professionally developed individual plan of care which sets forth treatment objectives and therapies enabling the individual's functioning to improve to the point that institutional care is no longer necessary. Limitations of Services include:

☐ Admissions for diagnostic purposes are covered only if the diagnostic procedures cannot be performed on an outpatient basis.

☐ Patients may be permitted home visits; however, this must be clearly documented on billing statements as payment cannot be made for these days.

☐ Private accommodations will be reimbursed only if medically necessary and so ordered by the attending physician.

☐ The physician's orders for and description of reasons for private accommodations must be maintained in the recipient's medical records. If a private room is the only room available, payment will be made until another room becomes available. If

all rooms on a particular floor or unit are private rooms, payment will be made.

Psychiatric Residential Treatment Facilities (PRTFs) services are covered for residents ages 6 to 21 who require treatment on a continuous basis as a result of a severe mental or psychiatric illness. PRTFs are designed to serve children who need long-term, more intensive treatment, and a more highly structured environment than they can received in family and other community-based alternatives to hospitalization. Less restrictive and more homelike than hospitals, these facilities also serve children who are transitioning from hospitals, but who are still not ready for the demands of living at home or in a foster home.

The following shall not be covered as PRTF services:

☐ Pharmacy services, which shall be covered as pharmacy services in accordance with 907 KAR 1:019

☐ Durable medical equipment, which shall be covered as a durable medical equipment benefit in accordance with 907 KAR 1:479

A PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.

Services shall not be covered if appropriate alternative services are available in the community.

The following shall not qualify for a PRTF service:

☐ An admission that is not medically necessary

☐ An individual with a major medical problem or minor symptoms

☐ An individual who might only require a psychiatric consultation rather than an admission to a psychiatric facility

☐ An individual who might need only adequate living accommodations, economic aid or social support services.

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

——Services provided by indpendent practitioners.

Covered Services. (1) Except as specified in the requirements stated for a given service, the services covered may be provided for a:

(a) Mental health disorder;

(b) Substance use disorder; or

(c) Co-occurring mental health and substance use disorder.

(2) The following shall be covered under this administrative regulation in according with the corresponding following requirements:

(a) A screening provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;
9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;
(b) An assessment provided by:
1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A licensed psychological practitioner;
9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;
(c) Psychological testing provided by:
1. A licensed psychologist;
2. A licensed psychological practitioner; or
3. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
(d) Crisis intervention provided by:
1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;

5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A licensed psychological practitioner;
9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;
(e) Service planning provided by:
1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A licensed psychological practitioner;
9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;
(f) Individual outpatient therapy provided by:
1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;

7. An advanced practice registered nurse;
8. A licensed psychological practitioner;
9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;
(g) Family outpatient therapy provided by:
1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A licensed psychological practitioner;
9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;
(h) Group outpatient therapy provided by:
1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(i) Collateral outpatient therapy provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(j) A screening, brief intervention, and referral to treatment for a substance use disorder provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(k) Medication assisted treatment for a substance use disorder provided by:

1. A physician;[or]

2. A psychiatrist; or

3. An advanced practice registered nurse;

(l) Day treatment provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(m) Comprehensive community support services provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(n) Peer support provided by:

1. A peer support specialist working under the supervision of a qualified mental health professional; or

2. A youth peer support specialist working under the supervision of a qualified mental health professional;

(o) Parent or family peer support provided by a family peer support specialist working under the supervision of a qualified mental health professional;

(p) Intensive outpatient program provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(q) Therapeutic rehabilitation program provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A licensed psychological practitioner;
9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service.
(3)(a) A screening shall:
1. Be the determination of the likelihood that an individual has a mental health disorder, substance use disorder, or co-occurring disorder;
2. Not establish the presence or specific type of disorder; and
3. Establish the need for an in-depth assessment.
(b) An assessment shall:
1. Include gathering information and engaging in a process with the individual that enables the provider to:
a. Establish the presence or absence of a mental health disorder or substance use disorder;
b. Determine the individual's readiness for change;
c. Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and
d. Engage the individual in developing an appropriate treatment relationship;
2. Establish or rule out the existence of a clinical disorder or service need;
3. Include working with the individual to develop a treatment and service plan; and
4. Not include psychological or psychiatric evaluations or assessments.
(c) Psychological testing shall include:
1. A psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities; and
2. Interpretation and a written report of testing results.
(d) Crisis intervention:
1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to:
a. The recipient; or
b. Another individual;
2. Shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization interventions, or crisis prevention activities for individuals;

3. Shall be provided:
a. On-site at the provider's office;
b. As an immediate relief to the presenting problem or threat; and
c. In a face-to-face, one-on-one encounter between the provider and the recipient;
4. May include verbal de-escalation, risk assessment, or cognitive therapy; and
5. Shall be followed by a referral to noncrisis services if applicable.
(e)1. Service planning shall involve:
a. Assisting a recipient in creating an individualized plan for services needed for maximum reduction of an intellectual disability; and
b. Restoring a recipient's functional level to the recipient's best possible functional level.
2. A service plan:
a. Shall be directed by the recipient; and
b. May include:
(i) A mental health advance directive being filed with a local hospital;
(ii) A crisis plan; or
(iii) A relapse prevention strategy or plan.
(f) Individual outpatient therapy shall:
1. Be provided to promote the:
a. Health and wellbeing of the individual; or
b. Recovery from a substance related disorder;
2. Consist of:
a. A face-to-face, one-on-one encounter between the provider and recipient; and
b. A behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;
3. Be aimed at:
a. Reducing adverse symptoms;
b. Reducing or eliminating the presenting problem of the recipient; and
c. Improving functioning; and
4. Not exceed three (3) hours per day unless additional time is medically necessary.
(g)1. Family outpatient therapy shall consist of a face-to-face behavioral health therapeutic intervention provided:
a. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and
b. To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment.
2. A family outpatient therapy session shall be billed as one (1) service regardless of the number of individuals (including multiple members from one (1) family) who participate in the session.
3. Family outpatient therapy shall:
a. Be provided to promote the:
(i) Health and wellbeing of the individual; or
(ii) Recovery from a substance related disorder; and
b. Not exceed three (3) hours per day per individual unless additional time is medically necessary.
(h)1. Group outpatient therapy shall:
a. Be provided to promote the:

(i) Health and wellbeing of the individual; or
(ii) Recovery from a substance related disorder;
b. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;
c. Be provided to a recipient in a group setting:
(i) Of nonrelated individuals; and
(ii) Not to exceed eight (8) individuals in size;
d. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;
e. Not include physical exercise, a recreational activity, an educational activity, or a social activity; and
f. Not exceed three (3) hours per day per recipient unless additional time is medically necessary.
2. The group shall have a:
a. Deliberate focus; and
b. Defined course of treatment.
3. The subject of group outpatient therapy shall be related to each recipient participating in the group.
4. The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.
(i)1. Collateral outpatient therapy shall:
a. Consist of a face-to-face behavioral health consultation:
(i) With a parent or caregiver of a recipient, household member of a recipient, legal representative of a recipient, school personnel, treating professional, or other person with custodial control or supervision of the recipient; and
(ii) That is provided in accordance with the recipient's treatment plan;
b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age; and
c. Not exceed three (3) hours per day per individual unless additional time is medically necessary.
2. Consent to discuss a recipient's treatment with any person other than a parent or legal guardian shall be signed and filed in the recipient's health record.
(j) Screening, brief intervention, and referral to treatment for a substance use disorder shall:
1. Be an evidence-based early intervention approach for an individual with non-dependent substance use to provide an effective strategy for intervention prior to the need for more extensive or specialized treatment; and
2. Consist of:
a. Using a standardized screening tool to assess an individual for risky substance use behavior;
b. Engaging a recipient, who demonstrates risky substance use behavior, in a short conversation and providing feedback and advice; and
c. Referring a recipient to:
(i) Therapy; or
(ii) Other additional services to address substance use if the recipient is determined to need other additional services.
(k) Medication assisted treatment for a substance use disorder:
1. Shall include:

a. Any opioid addiction treatment that includes a United States Food and Drug Administration-approved medication for the detoxification or maintenance treatment of opioid addiction along with counseling or other supports;

b. Comprehensive maintenance;

c. Medical maintenance;

d. Interim maintenance;

e. Detoxification; or

f. Medically supervised withdrawal;

2. May be provided in:

a. An opioid treatment program;

b. A medication unit affiliated with an opioid treatment program;

c. A physician's office except for methadone; or

d. Other community setting; and

3. Shall increase the likelihood for cessation of illicit opioid use or prescription opioid abuse.

(l)1. Day treatment shall be a nonresidential, intensive treatment program designed for a child under the age of twenty-one (21) years who has:

a. An emotional disability or neurobiological or substance use disorder; and

b. A high risk of out-of-home placement due to a behavioral health issue.

2. Day treatment services shall:

a. Consist of an organized, behavioral health program of treatment and rehabilitative services (substance use disorder, mental health, or co-occurring mental health and substance use disorder);

b. Have unified policies and procedures that:

(i) Address the program philosophy, admission and discharge criteria, admission and discharge process, staff training, and integrated case planning; and

(ii) Have been approved by the recipient's local education authority and the day treatment provider;

c. Include:

(i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;

(ii) Behavior management and social skill training;

(iii) Independent living skills that correlate to the age and development stage of the recipient; or

(iv) Services designed to explore and link with community resources before discharge and to assist the recipient and family with transition to community services after discharge; and

d. Be provided:

(i) In collaboration with the education services of the local education authority including those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);

(ii) On school days and during scheduled breaks;

(iii) In coordination with the recipient's individual educational plan if the recipient has an individual educational plan;

(iv) Under the supervision of a qualified mental health professional; and

(v) With a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider.

3. Day treatment shall not include a therapeutic clinical service that is included in a child's individualized education plan.

(m)1. Comprehensive community support services shall:

a. Be activities necessary to allow an individual to live with maximum independence in the community;

b. Be intended to ensure successful community living through the utilization of skills training, cueing, or supervision as identified in the recipient's treatment plan; and

c. Include:

(i) Reminding a recipient to take medications and monitoring symptoms and side effects of medications;

(ii) Teaching parenting skills;

(iii) Teaching community resource access and utilization;

(iv) Teaching emotional regulation skills;

(v) Teaching crisis coping skills;

(vi) Teaching how to shop;

(vii) Teaching about transportation;

(viii) Teaching financial management;

(ix) Developing and enhancing interpersonal skills; or

(x) Improving daily living skills[and

2. To provide comprehensive community support services, a provider shall:

a. Have the capacity to employ staff authorized pursuant to 908 KAR 2:250 to provide comprehensive community support services in accordance with subsection (2)(m) of this section and to coordinate the provision of services among team members; and

b. Meet the requirements for comprehensive community support services established in 908 KAR 2:250

(n)1. Peer support services shall:

a. Be social and emotional support that is provided by an individual who is employed by a provider group and who has experienced a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder to a recipient by sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified consumer who has been trained and certified in accordance with 908 KAR 2:220 or 908 KAR 2:240;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and

f. Be identified in each recipient's treatment plan.

2. To provide peer support services a provider shall:

a. Have demonstrated the capacity to provide the core elements of peer support services for the behavioral health population being served including the age range of the population being served;

b. Employ peer support specialists who are qualified to provide peer support services in accordance with 908 KAR 2:220 or 908 KAR 2:240; and

c. Use a qualified mental health professional to supervise peer support specialists.

(o)1. Parent or family peer support services shall:

a. Be emotional support that is provided by a parent or family member, who is employed by a provider group, of a child who has experienced a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder to a parent or family member with a child sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified parent or family member of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health disorder services and substance use disorder services who has been trained and certified in accordance with 908 KAR 2:230;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and

f. Be identified in each recipient's treatment plan.

2. To provide parent or family peer support services a provider shall:

a. Have demonstrated the capacity to provide the core elements of parent or family peer support services for the behavioral health population being served including the age range of the population being served;

b. Employ family peer support specialists who are qualified to provide family peer support services in accordance with 908 KAR 2:230; and

c. Use a qualified mental health professional to supervise family peer support specialists.

(p)1. Intensive outpatient program services shall:

a. Be an alternative to inpatient hospitalization or partial hospitalization for a mental health or substance use disorder;

b. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy;

c. Be provided at least three (3) hours per day at least three (3) days per week; and

d. Include:

(i) Individual outpatient therapy;

(ii) Group outpatient therapy;

(iii) Family outpatient therapy unless contraindicated;

(iv) Crisis intervention; or

(v) Psycho-education.

2. During psycho-education the recipient or recipient's family member shall be:

a. Provided with knowledge regarding the recipient's diagnosis, the causes of the condition, and the reasons why a particular treatment might be effective for reducing symptoms; and

b. Taught how to cope with the recipient's diagnosis or condition in a successful manner.

3. An intensive outpatient program services treatment plan shall:

a. Be individualized; and

b. Focus on stabilization and transition to a lesser level of care.

4. To provide intensive outpatient program services, a provider shall:

a. Be employed by a provider group; and

b. Have: