

- (i) Access to a board-certified or board-eligible psychiatrist for consultation;
- (ii) Access to a psychiatrist, other physician, or advanced practice registered nurse for medication management;
- (iii) Adequate staffing to ensure a minimum recipient-to-staff ratio of fifteen (15) recipients to one (1) staff person;
- (iv) The capacity to provide services utilizing a recognized intervention protocol based on recovery principles;
- (v) The capacity to employ staff authorized to provide intensive outpatient program services in accordance with this section and to coordinate the provision of services among team members;
- (vi) The capacity to provide the full range of intensive outpatient program services as stated in this paragraph;
- (vii) Demonstrated experience in serving individuals with behavioral health disorders;
- (viii) The administrative capacity to ensure quality of services;
- (ix) A financial management system that provides documentation of services and costs; and
- (x) The capacity to document and maintain individual case records.

5. Intensive outpatient program services shall be provided in a setting with a minimum recipient-to-staff ratio of fifteen (15) to one (1).

(q)1. A therapeutic rehabilitation program shall be:

- a. A rehabilitative service for an
 - (i) Adult with a serious mental illness; or
 - (ii) Individual under the age of twenty-one (21) years who has a serious emotional disability; and
- b. Designed to maximize the reduction of an intellectual disability and the restoration of the individual's functional level to the individual's best possible functional level.

2. A recipient in a therapeutic rehabilitation program shall establish the recipient's own rehabilitation goals within the person-centered service plan.

3. A therapeutic rehabilitation program shall:

- a. Be delivered using a variety of psychiatric rehabilitation techniques;
- b. Focus on:
 - (i) Improving daily living skills;
 - (ii) Self-monitoring of symptoms and side effects;
 - (iii) Emotional regulation skills;
 - (iv) Crisis coping skill; and
 - (v) Interpersonal skills; and
- c. Be delivered individually or in a group.

(4)(a) The following requirements shall apply to any provider of a service to a recipient for a substance use disorder or co-occurring mental health disorder and substance use disorder:

1. The licensing requirements established in 908 KAR 1:370;
2. The physical plant requirements established in 908 KAR 1:370;
3. The organization and administration requirements established in 908 KAR 1:370;
4. The personnel policy requirements established in 908 KAR 1:370;
5. The quality assurance requirements established in 908 KAR 1:370;
6. The clinical staff requirements established in 908 KAR 1:370;
7. The program operational requirements established in 908 KAR 1:370; and
8. The outpatient program requirements established in 908 KAR 1:370.

~~(b) The detoxification program requirements established in 908 KAR 1:370 shall apply to a provider of a detoxification service.~~

~~(5) The extent and type of a screening shall depend upon the problem of the individual seeking or being referred for services.~~

~~(6) A diagnosis or clinic impression shall be made using terminology established in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.~~

~~(7) The department shall not reimburse for a service billed by or on behalf of an entity or individual who is not a billing provider.~~

~~Noncovered Services or Activities. (1) The following services or activities shall not be covered under this administrative regulation:~~

~~(a) A service provided to:~~

~~1. A resident of:~~

~~a. A nursing facility; or~~

~~b. An intermediate care facility for individuals with an intellectual disability;~~

~~2. An inmate of a federal, local, or state:~~

~~a. Jail;~~

~~b. Detention center; or~~

~~c. Prison;~~

~~3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis.~~

~~(b) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the independent provider.~~

~~(c) A consultation or educational service provided to a recipient or to others.~~

~~(d) Collateral therapy for an individual aged twenty-one (21) years or older.~~

~~(e) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of "face-to-face".~~

~~(f) Travel time;~~

~~(g) A field trip;~~

~~(h) A recreational activity;~~

~~(i) A social activity; or~~

~~(j) A physical exercise activity group.~~

~~(2)(a) A consultation by one (1) provider or professional with another shall not be covered under this administrative regulation except as specified in Section 3(3)(k) of this administrative regulation.~~

~~(b) A third party contract shall not be covered under this administrative regulation.~~

~~Community Mental Health Center Services:~~

~~Services covered by Community Mental Health Center Services shall include:~~

~~(a) Rehabilitative mental health and substance use disorder services including:~~

~~1. Individual outpatient therapy;~~

~~2. Group outpatient therapy;~~

~~3. Family outpatient therapy;~~

- 4. Collateral outpatient therapy;
- 5. Therapeutic rehabilitation services;
- 6. Psychological testing;
- 7. Screening;
- 8. An assessment;
- 9. Crisis intervention;
- 10. Service planning;
- 11. A screening, brief intervention, and referral to treatment;
- 12. Medication assisted treatment for a substance use disorder;
- 13. Mobile crisis services;
- 14. Assertive community treatment;
- 15. Intensive outpatient program services;
- 16. Residential crisis stabilization services;
- 17. Partial hospitalization;
- 18. Residential services for substance use disorders;
- 19. Day treatment;
- 20. Comprehensive community support services;
- 21. Peer support services; or
- 22. Parent or family peer support services; or
- (b) Physical health services including:
 - 1. Physical examinations; or
 - 2. Medication prescribing and monitoring.
- (2)(a) To be covered, a service listed in this section shall be:
 - 1. Provided by a community mental health center that is:
 - a. Currently enrolled in the Medicaid Program in accordance with 907 KAR 1:672; and
 - b. Except as established in paragraph (b) of this subsection, currently participating in the Medicaid Program in accordance with 907 KAR 1:671; and
 - 2. Provided in accordance with:
 - a. This administrative regulation; and
 - b. The Community Mental Health Center Services Manual.
- (b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

—General Coverage. (1)(a) Except as provided in subsection (2)(b) of this section, coverage for an item of durable medical equipment, a medical supply, a prosthetic, or an orthotic shall:

- 1. Be based on medical necessity and reasonableness;
- 2. Be clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
- 3. Require prior authorization in accordance with Section 7 of this administrative regulation;
- 4. Be provided in compliance with 42 C.F.R. 440.230(c); and

5. Be restricted to an item used primarily in the home.
- (b) Coverage of prosthetic devices shall not exceed \$1,500 per twelve (12) month period per member of the family choices benefit plan.
- (2) Unless otherwise established in this administrative regulation,
- (a) Except as provided in paragraph (b) of this subsection, the criteria referenced in subsection (1)(a) of this section that was in effect on the date the durable medical equipment, prosthetic, orthotic, or medical supply is provided shall be used as the basis for the determination of coverage, subject to medical necessity override by the department to ensure compliance with 42 C.F.R. 440.230(c).
- (b) If criteria referenced in subsection (1)(a) of this section does not exist or is unavailable for a given item or service, the Medicare criteria in effect on the date the durable medical equipment, prosthetic, orthotic, or medical supply is provided shall be used as the basis for the determination of coverage, subject to medical necessity override by the department to ensure compliance with 42 C.F.R. 440.230(c).
- (3) Unless specifically exempted by the department, a DME item, medical supply, prosthetic, or orthotic shall require a CMN that shall be kept on file by the supplier for the period of time mandated by 45 C.F.R. 164.316.
- (4) An item for which a CMN is not required shall require a prescriber's written order.
- (5) If Medicare is the primary payor for a recipient who is dually eligible for both Medicare and Medicaid, the supplier shall comply with Medicare's CMN requirement and a separate Medicaid CMN shall not be required.
- (6) A required CMN shall be:
- (a) The appropriate Medicare CMN in use at the time the item or service is prescribed.
- (b) A MAP-1000, Certificate of Medical Necessity, or
- (c) A MAP-1000B, Certificate of Medical Necessity, Metabolic Formulas and Foods.
- (7) A CMN shall contain:
- (a) The recipient's name and address;
- (b) A complete description of the item or service ordered;
- (c) The recipient's diagnosis;
- (d) The expected start date of the order;
- (e) The length of the recipient's need for the item;
- (f) The medical necessity for the item;
- (g) The prescriber's name, address, telephone number, and National Provider Identifier (NPI), if applicable; and
- (h) The prescriber's signature and date of signature.
- (8) Except as specified in subsections (9) and (10) of this section, a prescriber shall examine a recipient within sixty (60) days prior to the initial order of a DME item, medical supply, prosthetic, or orthotic.
- (9) Except as specified in subsection (11) of this section, a prescriber shall not be required to examine a recipient prior to subsequent orders for the same DME item, medical supply, prosthetic, or orthotic unless there is a change in the order.
- (10) A prescriber shall not be required to examine a recipient prior to the repair of a DME item, prosthetic, or orthotic.
- (11) A change in supplier shall require a new CMN signed and dated by a prescriber who shall have seen the recipient within sixty (60) days prior to the order.

- (12) A CMN shall be updated with each request for prior authorization.
- (13) The department shall only purchase a new DME item.
- (14) A new DME item that is placed with a recipient initially as a rental item shall be considered a new item by the department at the time of purchase.
- (15) A used DME item that is placed with a recipient initially as a rental item shall be replaced by the supplier with a new item prior to purchase by the department.
- (16) A supplier shall not bill Medicaid for a DME item, medical supply, prosthetic, or orthotic before the item is provided to the recipient.
- (17) A supplier shall not ship supplies to a recipient unless the supplier has:
- First had direct contact with the recipient or the recipient's caregiver, and
 - Verified:
 - That the recipient wishes to receive the shipment of supplies;
 - The quantity of supplies in the shipment; and
 - Whether or not there has been a change in the use of the supply.
- (18) A verification referenced in subsection (17) of this section for each recipient shall be documented in a file regarding the recipient.
- (19) If a supplier ships more than one (1) month supply of an item, the supplier shall assume the financial risk of nonpayment if the recipient's Medicaid eligibility lapses or a HCPCS code is discontinued.
- (20) A supplier shall have an order from a prescriber before dispensing any DMEPOS item to a recipient.
- (21) A supplier shall have a written order on file prior to submitting a claim for reimbursement.

Purchase or Rental of Durable Medical Equipment. (1) The following items shall be covered for purchase only:

- A cane,
 - Crutches,
 - A standard walker,
 - A prone or supine stander,
 - A noninvasive electric osteogenesis stimulator, or
 - Other items designated as purchase only in the Medicaid DME Program Fee Schedule.
- (2) The following items shall be covered for rental only:
- An apnea monitor,
 - A respiratory assist device having bivalve pressure capability with backup rate feature,
 - A ventilator,
 - A negative pressure wound therapy electric pump,
 - An electric breast pump,
 - The following oxygen systems:
 - Oxygen concentrator,
 - Stationary compressed gas oxygen,
 - Portable gaseous oxygen,
 - Portable liquid oxygen, or
 - Stationary liquid oxygen, or
 - Other items designated as rental only in the Medicaid DME Program Fee Schedule.

(3) With the exception of items specified in subsections (1) or (2) of this section, durable medical equipment shall be covered through purchase or rental based upon anticipated duration of medical necessity.

(4)(a) A MAP-1001 form shall be completed if a recipient requests an item or service not covered by the department.

(b) A recipient shall be financially responsible for an item or service requested by the recipient via a MAP 1001 that is not covered by the department.

(c) A MAP 1001 shall be completed as follows:

1. The DME supplier shall ensure that the recipient or authorized representative reads and understands the MAP 1001.

2. The recipient or authorized representative shall indicate on the MAP 1001 if the recipient chooses to receive a noncovered service.

3. The DME supplier shall complete the supplier information on the MAP 1001.

4. The DME supplier shall provide a copy of the completed MAP 1001 to the recipient, and

5. The DME supplier shall maintain the completed MAP 1001 on file for at least the period of time mandated by 45 C.F.R. 164.316.

(d) If an item or service was denied due to the supplier not meeting the timeframes to obtain a prior authorization or the item or service does not meet medical necessity for a prior authorization, the MAP 1001 shall not be used to obligate the recipient for payment.

Special Coverage. (1) An augmentative communication device or other electronic speech aid shall be covered for a recipient who is permanently unable to communicate through oral speech if:

(a) Medical necessity is established based on a review by the department of an evaluation and recommendation submitted by a speech-language pathologist, and

(b) The item is prior authorized by the department.

(2) A customized DME item shall be covered only if a noncustomized medically appropriate equivalent is not commercially available.

(3) A physical therapy or occupational therapy evaluation shall be required for:

(a) A power wheelchair, or

(b) A wheelchair for a recipient who, due to a medical condition, is unable to be reasonably accommodated by a standard wheelchair.

(4) Orthopedic shoes and attachments shall be covered if medically necessary for:

(a) A congenital defect or deformity,

(b) A deformity due to injury, or

(c) Use as a brace attachment.

(5) A therapeutic shoe or boot shall be covered if medically necessary to treat a nonhealing wound, ulcer, or lesion of the foot.

(6) An enteral or oral nutritional supplement shall be covered if:

(a) The item is prescribed by a licensed prescriber,

(b) Except for an amino acid modified preparation or a low-protein modified food product specified in subsection (7) of this section, it is the total source of a recipient's daily intake of nutrients,

(c) The item is prior authorized, and

(d) Nutritional intake is documented on the CMN.

(7) An amino acid modified preparation or a low-protein modified food product shall be covered

(a) If prescribed by a physician for the treatment of an inherited metabolic condition specified in KRS 205.560;

(b) If not covered through the Medicaid outpatient pharmacy program;

(c) Regardless of whether it is the sole source of nutrition; and

(d) If the item is prior authorized.

(8) A DME item intended to be used for postdischarge rehabilitation in the home may be delivered to a hospitalized recipient within two (2) days prior to discharge home for the purpose of rehabilitative training.

(9) An electric breast pump shall be covered for the following:

(a) Medical separation of mother and infant;

(b) Inability of an infant to nurse normally due to a significant feeding problem; or

(c) An illness or injury that interferes with effective breast feeding.

(10) Rental of an airway clearance vest system for a three (3) month trial period shall be required before purchase of the equipment.

Coverage of Repairs and Replacement of Equipment. (1) The department shall not be responsible for repair or replacement of a DME item, prosthetic, or orthotic if the repair or replacement is covered by a warranty.

(2) Reasonable repair to a purchased DME item, prosthetic, or orthotic shall be covered as follows:

(a) During a period of medical need;

(b) If necessary to make the item serviceable;

(c) If no warranty is in effect on the requested repair; and

(d) In accordance with Section 6(2) of this administrative regulation.

(3) Extensive maintenance to purchased equipment, as recommended by the manufacturer and performed by authorized technicians, shall be considered to be a repair.

(4) The replacement of a medically necessary DME item, medical supply, prosthetic, or orthotic shall be covered for the following:

(a) Loss of the item;

(b) Irreparable damage or wear; or

(c) A change in a recipient's condition that requires a change in equipment.

(5) Suspected malicious damage, culpable neglect, or wrongful disposition of a DME item, medical supply, prosthetic, or orthotic shall be reported by the supplier to the department if the supplier is requesting prior authorization for replacement of the item.

Limitations on Coverage. (1) The following items shall be excluded from Medicaid coverage through the DME Program:

(a) An item covered for Medicaid payment through another Medicaid program;

(b) Equipment that is not primarily and customarily used for a medical purpose;

(c) Physical fitness equipment;

(d) Equipment used primarily for the convenience of the recipient or caregiver;

(e) A home modification;

(f) Routine maintenance of DME that includes:

1. Testing;

2. Cleaning;

- 3. Regulating; and
- 4. Assessing the recipient's equipment:
 - (g) Except as specified in Section 7(1)(j) of this administrative regulation, backup equipment;
 - (h) An item determined not medically necessary, clinically appropriate, or reasonable by the department; or
 - (i) Diabetic supplies, except for:
 - 1. Those for which Medicare is the primary pavor;
 - 2. Those with an HCPCS code of A4210, A4250, A4252, A4253, A4256, A4258, A4259, E0607 or E2100; or
 - 3. Those with a HCPCS code of A4206 if a diagnosis of diabetes is present on the corresponding claim.
 - (2) An estimated repair shall not be covered if the repair cost equals or exceeds:
 - (a) The purchase price of a replacement item; or
 - (b) The total reimbursement amount for renting a replacement item of equipment for the estimated remaining period of medical need.

(3) Durable medical equipment, prosthetics, orthotics and medical supplies shall be included in the facility reimbursement for a recipient residing in a hospital, nursing facility, intermediate care facility for individuals with an intellectual disability, or an institution for individuals with a mental disease and shall not be covered through the durable medical equipment program.

6.2.13. Disposable medical supplies (Section 2110(a)(13))

All disposable medical supplies must meet medical necessity and be provided by a Medicaid enrolled provider operating within his or her scope of practice.

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.14. Home and community-based health care services (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.15. Nursing care services (Section 2110(a)(15))

Coverage and Limit. (1) The department shall reimburse for a private duty nursing service if the service is:

- (a) Provided:
 - 1. By a:
 - a. Registered nurse employed by a:
 - (i) Private duty nursing agency that meets the requirements established in Section 3 of this administrative regulation; or
 - (ii) Home health agency that meets the requirements established in Section 3 of this administrative

regulation; or

b. Licensed practical nurse employed by a:

(i) Private duty nursing agency that meets the requirements established in Section 3 of this administrative regulation; or

(ii) Home health agency that meets the requirements established in Section 3 of this administrative regulation;

2. To a recipient in the recipient's home, except as provided in subsection (2) of this section; and

3. Under the direction of the recipient's physician in accordance with 42 C.F.R. 440.80;

(b)1. Prescribed for the recipient by a physician; and

2. Stated in the recipient's plan of treatment developed by the prescribing physician;

(c) Established as being needed for the recipient in the recipient's home;

(d) Prior authorized; and

(e) Medically necessary.

(2) A private duty nursing service may be covered in a setting other than in the recipient's home, if the service is provided during a normal life activity of the recipient that requires the recipient to be out of his or her home.

(3)(a) There shall be an annual limit of private duty nursing services per recipient of 2,000 hours.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limit are determined to be medically necessary.

No Duplication of Service. The department shall not reimburse for any of the following services providing during the same time that a private duty nursing service is provided to a recipient:

(1) A personal care service;

(2) A skilled nursing service or visit; or

(3) A home health aide service.

Conflict of Interest. The department shall not reimburse for a private duty nursing service provided to a recipient if the individual providing the service is:

(1) An immediate family member of the recipient; or

(2) A legally responsible individual who maintains his or her primary residence with the recipient.

6.2.16. **Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))**

—Abortions are only covered in the case of rape, incest, or life endangerment.

All abortions must be prior authorized.

6.2.17. **Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)**

— General Coverage Requirements. (1) A covered service shall be:

(a) Medically necessary;

(b) Except as provided in subsection (2) of this section, furnished to a recipient through direct practitioner contact; and

(c) Unless a recipient's provider demonstrates that dental services in excess of the following service limitations are medically necessary, limited to:

1. Two (2) prophylaxis per twelve (12) month period for a recipient under age twenty-one (21);

2. One (1) dental visit per month per provider for a recipient age twenty-one (21) years and over, and
3. One (1) prophylaxis per twelve (12) month period for a recipient age twenty-one (21) years and

over.

(2) A covered service provided by an individual who meets the definition of other licensed medical professional shall be covered if the:

- (a) Individual is employed by the supervising oral surgeon, dentist, or dental group;
- (b) Individual is licensed in the state of practice; and
- (c) Supervising provider has direct practitioner contact with the recipient, except for a service provided by a dental hygienist if the dental hygienist provides the service under general supervision of a practitioner in accordance with KRS 313.310.

(3)(a) A medical resident may provide services if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.170, 415.172, and 415.174.

(b) A dental resident, student, or dental hygiene student may provide services under the direction of a program participating provider in or affiliated with an American Dental Association accredited institution.

(4) Coverage shall be limited to services identified in 907 KAR 1:626, Section 3, in the following CDT categories:

- (a) Diagnostic;
- (b) Preventive;
- (c) Restorative;
- (d) Endodontics;
- (e) Periodontics;
- (f) Removable prosthodontics;
- (g) Maxillofacial prosthetics;
- (h) Oral and maxillofacial surgery;
- (i) Orthodontics; or
- (j) Adjunctive general services.

Diagnostic Service Coverage Limitations. (1)(a) Except as provided in paragraph (b) of this subsection, coverage for a comprehensive oral evaluation shall be limited to one (1) per twelve (12) month period, per recipient, per provider.

(b) The department shall cover a second comprehensive oral evaluation if the evaluation is provided in conjunction with a prophylaxis to an individual under twenty-one (21) years of age.

(c) A comprehensive oral evaluation shall not be covered in conjunction with the following:

- 1. A limited oral evaluation for trauma related injuries;
- 2. Space maintainers;
- 3. Root canal therapy;
- 4. Denture relining;
- 5. Transitional appliances;
- 6. A prosthodontic service;
- 7. Temporomandibular joint therapy;
- 8. An orthodontic service;
- 9. Palliative treatment, or

10. A hospital call.

(2)(a) Coverage for a limited oral evaluation shall:

1. Be limited to a trauma related injury or acute infection;
2. Be limited to one (1) per date of service, per recipient, per provider; and
3. Require a prepayment review.

(b) A limited oral evaluation shall not be covered in conjunction with another service except for:

1. A periapical x-ray;
2. Bitewing x-rays;
3. A panoramic x-ray;
4. Resin, anterior;
5. A simple or surgical extraction;
6. Surgical removal of a residual tooth root;
7. Removal of a foreign body;
8. Suture of a recent small wound;
9. Intravenous sedation; or
10. Incision and drainage of infection.

(3)(a) Except as provided in paragraph (b) of this subsection, the following limitations shall apply to coverage of a radiograph service:

1. Bitewing x-rays shall be limited to four (4) per twelve (12) month period, per recipient, per provider;
2. Periapical x-rays shall be limited to fourteen (14) per twelve (12) month period, per recipient, per provider;
3. An intraoral complete x-ray series shall be limited to one (1) per twelve (12) month period, per recipient, per provider;
4. Periapical and bitewing x-rays shall not be covered in the same twelve (12) month period as an intraoral complete x-ray series per recipient, per provider;
5. A panoramic film shall:
 - a. Be limited to one (1) per twenty-four (24) month period, per recipient, per provider; and
 - b. Require prior authorization in accordance with Section 15(2) and (3) of this administrative regulation for a recipient under age six (6);
6. A cephalometric film shall be limited to one (1) per twenty-four (24) month period, per recipient, per provider; or
7. Cephalometric and panoramic x-rays shall not be covered in conjunction with a comprehensive orthodontic consultation.

(b) The limits established in paragraph (a) of this subsection shall not apply to:

1. An x-ray necessary for a root canal or oral surgical procedure; or
2. An x-ray that exceeds the established service limitations and is determined by the department to be medically necessary.

Preventive Service Coverage Limitations. (1)(a) Coverage of a prophylaxis shall be limited to:

1. For an individual twenty-one (21) years of age and over, one (1) per twelve (12) month period, per recipient; and
2. For an individual under twenty-one (21) years of age, two (2) per twelve (12) month period, per recipient.

(b) A prophylaxis shall not be covered in conjunction with periodontal scaling or root planing.

(2)(a) Coverage of a sealant shall be limited to:

1. A recipient age five (5) through twenty (20) years;

2. Each six (6) and twelve (12) year molar once every four (4) years with a lifetime limit of three (3) sealants per tooth, per recipient; and

3. An occlusal surface that is noncarious.

(b) A sealant shall not be covered in conjunction with a restorative procedure for the same tooth on the same date of service.

(3)(a) Coverage of a space maintainer shall:

1. Be limited to a recipient under age twenty-one (21); and

2. Require the following:

a. Fabrication;

b. Insertion;

c. Follow-up visits;

d. Adjustments; and

e. Documentation in the recipient's medical record to:

(i) Substantiate the use for maintenance of existing intertooth space; and

(ii) Support the diagnosis and a plan of treatment that includes follow-up visits.

(b) The date of service for a space maintainer shall be considered to be the date the appliance is placed on the recipient.

(c) Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination thereof shall not exceed two (2) per twelve (12) month period, per recipient.

Restorative Service Coverage Limitations. (1) A four (4) or more surface resin-based anterior composite procedure shall not be covered if performed for the purpose of cosmetic bonding or veneering.

(2) Coverage of a prefabricated crown shall be:

(a) Limited to a recipient under age twenty-one (21); and

(b) Inclusive of any procedure performed for restoration of the same tooth.

(3) Coverage of a pin retention procedure shall be limited to:

(a) A permanent molar;

(b) One (1) per tooth, per date of service, per recipient; and

(c) Two (2) per permanent molar, per recipient.

(4) Coverage of a restorative procedure performed in conjunction with a pin retention procedure shall be limited to one (1) of the following:

(a) An amalgam, three (3) or more surfaces;

(b) A permanent prefabricated resin crown; or

(c) A prefabricated stainless steel crown.

Endodontic Service Coverage Limitations. (1) Coverage of the following endodontic procedures shall be limited to a recipient under age twenty-one (21).

(a) A pulp cap direct;

(b) Therapeutic pulpotomy; or

(c) Root canal therapy.

(2) A therapeutic pulpotomy shall not be covered if performed in conjunction with root canal therapy.

(3)(a) Coverage of root canal therapy shall require:

1. Treatment of the entire tooth;
2. Completion of the therapy; and
3. An x-ray taken before and after completion of the therapy.

(b) The following root canal therapy shall not be covered:

1. The Sargenti method of root canal treatment; or
2. A root canal on one (1) root of a molar.

Periodontic Service Coverage Limitations. (1) Coverage of a gingivectomy or gingivoplasty procedure shall require prepayment review and shall be limited to:

(a) A recipient with gingival overgrowth due to a:

1. Congenital condition;
2. Hereditary condition; or
3. Drug-induced condition; and

(b) One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period.

1. Coverage of a quadrant procedure shall require a minimum of a three (3) tooth area within the same quadrant.
2. Coverage of a per-tooth procedure shall be limited to no more than two (2) teeth within the same quadrant.

(2) Coverage of a gingivectomy or gingivoplasty procedure shall require documentation in the recipient's medical record that includes:

- (a) Pocket depth measurements;
- (b) A history of nonsurgical services; and
- (c) Prognosis.

(3) Coverage for a periodontal scaling and root planing procedure shall:

- (a) Not exceed one (1) per quadrant, per twelve (12) months, per recipient, per provider;
- (b) Require prior authorization in accordance with Section 15(2) and (4) of this administrative regulation; and

(c) Require documentation to include:

1. A periapical film or bitewing x-ray; and
2. Periodontal charting of preoperative pocket depths.

(4) Coverage of a quadrant procedure shall require a minimum of a three (3) tooth area within the same quadrant.

(5) Periodontal scaling and root planing shall not be covered if performed in conjunction with dental prophylaxis.

(6)(a) A full mouth debridement shall only be covered for a pregnant woman.

(b) Only one (1) full mouth debridement per pregnancy shall be covered.

Prosthetic Service Coverage Limitations. (1) A removable prosthetic or denture repair shall be limited to a recipient under age twenty-one (21).

(2) A denture repair in the following categories shall not exceed three (3) repairs per twelve (12) month period, per recipient:

(a) Repair resin denture base, or
(b) Repair cast framework.
(3) Coverage for the following services shall not exceed one (1) per twelve (12) month period, per recipient:

(a) Replacement of a broken tooth on a denture;
(b) Laboratory relining of:
1. Maxillary dentures; or
2. Mandibular dentures;
(c) An interim maxillary partial denture; or
(d) An interim mandibular partial denture.
(4) An interim maxillary or mandibular partial denture shall be limited to use:
(a) During a transition period from a primary dentition to a permanent dentition;
(b) For space maintenance or space management; or
(c) As interceptive or preventive orthodontics.

Maxillofacial Prosthetic Service Coverage Limitations. The following services shall be covered if provided by a board certified prosthodontist:

(1) A nasal prosthesis;
(2) An auricular prosthesis;
(3) A facial prosthesis;
(4) A mandibular resection prosthesis;
(5) A pediatric speech aid;
(6) An adult speech aid;
(7) A palatal augmentation prosthesis;
(8) A palatal lift prosthesis;
(9) An oral surgical splint; or
(10) An unspecified maxillofacial prosthetic.

Oral and Maxillofacial Service Coverage Limitations. (1) The simple use of a dental elevator shall not constitute a surgical extraction.

(2) Root removal shall not be covered on the same date of service as the extraction of the same tooth.
(3) Coverage of surgical access of an unerupted tooth shall:
(a) Be limited to exposure of the tooth for orthodontic treatment; and
(b) Require prepayment review.
(4) Coverage of alveoplasty shall:
(a) Be limited to one (1) per quadrant, per lifetime, per recipient, and
(b) Require a minimum of a three (3) tooth area within the same quadrant.
(5) An occlusal orthotic device shall:
(a) Be covered for temporomandibular joint therapy;
(b) Require prior authorization in accordance with Section 15(2) and (5) of this administrative regulation;
(c) Be limited to a recipient under age twenty-one (21); and
(d) Be limited to one (1) per lifetime, per recipient.
(6) Frenulectomy shall be limited to one (1) per date of service.

(7) Coverage shall be limited to one (1) per lifetime, per recipient, for removal of the following:

- (a) Torus palatinus (maxillary arch);
- (b) Torus mandibularis (lower left quadrant), or
- (c) Torus mandibularis (lower right quadrant).

(8) Except as specified in subsection (9) of this section, a service provided by an oral surgeon shall be covered in accordance with 907 KAR 3:005.

(9) If performed by an oral surgeon, coverage of a service identified in CDT shall be limited to:

- (a) Extractions;
- (b) Impactions; and
- (c) Surgical access of an unerupted tooth.

Orthodontic Service Coverage Limitations. (1) Coverage of an orthodontic service shall:

- (a) Be limited to a recipient under age twenty-one (21); and
- (b) Require prior authorization.

(2) The combination of space maintainers and appliance therapy shall be limited to two (2) per twelve (12) month period, per recipient.

(3) Space maintainers and appliance therapy shall not be covered in conjunction with comprehensive orthodontics.

(4) The department shall only cover new orthodontic brackets or appliances.

(5) An appliance for minor tooth guidance shall not be covered for the control of harmful habits.

(6) In addition to the limitations specified in subsection (1) of this section, a comprehensive orthodontic service shall:

- (a) Require a referral by a dentist; and
- (b) Be limited to:

- 1. The correction of a disabling malocclusion; or
- 2. Transitional or full permanent dentition unless for treatment of a cleft palate or severe facial anomaly.

(7) A disabling malocclusion shall exist if a patient:

(a) Has a deep impinging overbite that shows palatal impingement of the majority of the lower incisors;

(b) Has a true anterior open bite that does not include:

- 1. One (1) or two (2) teeth slightly out of occlusion; or
- 2. Where the incisors have not fully erupted.

(c) Demonstrates a significant antero-posterior discrepancy (Class II or III malocclusion that is comparable to at least one (1) full tooth Class II or III, dental or skeletal);

(d) Has an anterior crossbite that involves:

- 1. More than two (2) teeth in crossbite;
- 2. Obvious gingival stripping; or
- 3. Recession related to the crossbite;

(e) Demonstrates handicapping posterior transverse discrepancies which

- 1. May include several teeth, one (1) of which shall be a molar; and
- 2. Is handicapping in a function fashion as follows:

- a. Functional shift;
- b. Facial asymmetry.

- c. Complete buccal or lingual crossbite; or
 - d. Speech concern;
 - (f) Has a significant posterior open bite that does not involve:
 1. Partially erupted teeth; or
 2. One (1) or two (2) teeth slightly out of occlusion;
 - (g) Except for third molars, has impacted teeth that will not erupt into the arches without orthodontic or surgical intervention;
 - (h) Has extreme overjet in excess of eight (8) to nine (9) millimeters and one (1) of the skeletal conditions specified in paragraphs (a) through (g) of this subsection;
 - (i) Has trauma or injury resulting in severe misalignment of the teeth or alveolar structures, and does not include simple loss of teeth with no other affects;
 - (j) Has a congenital or developmental disorder giving rise to a handicapping malocclusion;
 - (k) Has a significant facial discrepancy requiring a combined orthodontic and orthognathic surgery treatment approach; or
 - (l) Has developmental anodontia in which several congenitally missing teeth result in a handicapping malocclusion or arch deformation.
 - (8) Coverage of comprehensive orthodontic treatment shall not be inclusive of orthognathic surgery.
 - (9) If comprehensive orthodontic treatment is discontinued prior to completion, the provider shall submit to the department:
 - (a) A referral form, if applicable; and
 - (b) A letter detailing:
 1. Treatment provided, including dates of service;
 2. Current treatment status of the patient; and
 3. Charges for the treatment provided.
 - (10) Remaining portions of comprehensive orthodontic treatment may be authorized for prorated coverage upon submission of the prior authorization requirements specified in Section 15(2) and (7) of this administrative regulation if treatment:
 - (a) Is transferred to another provider; or
 - (b) Began prior to Medicaid eligibility.
- Adjunctive General Service Coverage Limitations. (1)(a) Coverage of palliative treatment for dental pain shall be limited to one (1) per date of service, per recipient, per provider.
- (b) Palliative treatment for dental pain shall not be covered in conjunction with another service except radiographs.
- (2)(a) Coverage of a hospital call shall be limited to one (1) per date of service, per recipient, per provider.
- (b) A hospital call shall not be covered in conjunction with:
 1. Limited oral evaluation;
 2. Comprehensive oral evaluation; or
 3. Treatment of dental pain.
- (3)(a) Coverage of intravenous sedation shall be limited to a recipient under age twenty-one (21).
- (b) Intravenous sedation shall not be covered for local anesthesia or nitrous oxide.

6.2.18. Inpatient substance abuse treatment services and residential substance abuse

treatment services (Section 2110(a)(18))

Inpatient psychiatric hospital services, including treatment for substance use disorders, 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. Residential services for substance use disorders is residential treatment (24 hour/day) that may be short-term or long-term for the purposes of providing intensive treatment and skills building, in a structured and supportive environment, to assist individuals (children and adults) to obtain abstinence and enter into alcohol/drug addiction recovery. This service is provided in a 24-hour live-in facility that offers a planned and structured regimen of care that aims to treat persons with addictions or substance use disorders and assists them in making the necessary changes in their lives that will enable them to live drug or alcohol free lives.

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Individuals must have been assessed and meet criteria for approval of residential services, utilizing a nationally recognized assessment tool (e.g., American Society of Addiction Medicine (ASAM)) as approved by the Kentucky Department of Behavioral Health, Development and Intellectual Disabilities (DBH/DI).

Services should have less than or equal to 16 patient beds, if provided to individuals between the ages of 22 and 64, be under the medical direction of a physician, and provide continuous nursing services.

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.

Residential treatment services shall be based on individual need and may include:

- Screening
- Assessment
- Service Planning
- Individual Therapy
- Group Therapy

- Family Therapy
- Peer Support

There are two levels of residential treatment:

- Short term –length of stay less than 30 days
- Long term- length of stay 30- 90 days

Short Term

Short term services should have a duration of less than thirty (30) days, but can be exceeded based on medical necessity. 24 hour staff as required by licensing regulations.

Short term services should have planned clinical program activities constituting at least 15 hours per week of structured professionally directed treatment services to stabilize and maintain a person's substance use disorder and to help him to develop and apply recovery skills.

Long Term

Long term services should have 24 hour staff as required by licensing regulations, as well as planned clinical program activities constituting 40 hours per week of structured professionally directed treatment services to stabilize and maintain a person's substance use and or substance use and mental health disorder and to help him or her to develop and apply recovery skills.

Residential SUD treatment programs do not include, and Federal Financial Participation (FFP) is not available for, room and board services; educational, vocational and job training services; habilitation services; services to inmates in public institutions as defined in 42 CFR §435.1010; services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010; recreational and social activities; and services that must be covered elsewhere in the state Medicaid plan. Services for individuals between 22 and 64 must be provided in a residential unit with 16 or fewer beds or, if provided within multiple units operating as one unified facility, 16 or fewer aggregated beds. ———

6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))

Substance Abuse Services. The following services shall be covered in accordance with this administrative regulation.

(1) Assessment.

(a) An assessment shall:

1. Be completed by a qualified substance abuse treatment professional; and
2. Be provided for an individual prior to receiving a substance abuse treatment service or an indicated prevention service.

(b) For an individual receiving an assessment, the assessment shall include an interview on the:

1. Current level of substance intoxication or withdrawal;
2. Current pattern of substance use including quantity, frequency, and personal use history;
3. Identification of household members and significant others in the individual's life who use alcohol and other drugs;
4. Family history of alcohol and drug abuse;
5. History of emotional, sexual and physical abuse including current needs for safety.

6. History of mental health problems and diagnoses; and

7. Utilization of prenatal care and pediatric care for newborns.

(c) For an individual assessed as showing current substance use or giving evidence of risk for substance abuse based on any of the items in paragraph (b) of this subsection, the assessment shall include the following additional information:

1. Psychosocial history including:

a. Presenting need;

b. Current living arrangements;

c. Marital and family history;

d. History of involvement with child and adult protective services;

e. Current custody status of an individual's children;

f. Legal, employment, military, educational, and vocational history;

g. Peer group relationships;

h. Religious background and practices;

i. Ethnic and cultural background;

j. Leisure and recreational activities; and

k. Individual strengths and limitations;

2. Current physical health status; and

3. Completion of a mental status screening.

(d) For an individual assessed in accordance with paragraphs (b) and (c) of this subsection, an integrated written summary shall be developed that documents an individual's need for services and includes:

1. Pregnancy or postpartum status; and

a. A primary diagnosis of a substance-related disorder requiring treatment services; or

b. The need for substance abuse prevention services; and

2. The individual's need for:

a. Prenatal care;

b. A screening for health care problems for a postpartum woman;

c. Pediatric care;

d. Mental health, intellectual disability or developmental disability services; or

e. Community services to meet immediate needs for safety, food, clothing, shelter or medical care.

(e) Development of an initial plan of care shall include the following:

1. The presenting need or problem; and

2. Substance abuse services needed by the individual as established by the assessment findings and the service placement criteria in Section 6 of this administrative regulation to include:

a. An explanation of how this individual meets the admission criteria for this service;

b. The name of the provider to whom the individual as established by the assessment fin individual is being referred for this service; and

c. The determination of the immediacy of the individual's need to receive the services based on the following criteria and in accordance with the access requirements established in Section 5 of this administrative regulation:

(i) Emergency need. Emergency need shall indicate a substance-related condition that may result in serious jeopardy to the life or health of an individual or a fetus, harm to another person by an individual, or inability of an individual to seek food or shelter;

(ii) Urgent need. Urgent need shall indicate a clinical condition that does not pose an immediate risk of harm to self or another person but requires a rapid clinical response in order to prevent onset of an emergency condition.

(iii) Routine need. A routine need shall pose no immediate risk of harm to self or another person but requires a clinical response.

(iv) Universal, selective, and indicated prevention services. A provider agency shall provide access to a substance abuse universal, selective or indicated prevention service within a thirty (30) day period of a request for a service for an individual.

(f) The completed assessment and initial plan of care shall be forwarded to the substance abuse treatment or prevention provider within five (5) working days.

(2) Prevention services.

(a) General requirements for universal, selective, and indicated prevention services. A prevention service shall:

1. Be delivered as an individual or group service;

2. Utilize a protocol approved by the division for a period of two (2) years and reevaluated at the end of that time by the Protocol Review Panel to determine its continued use; and

3. Be delivered as a face-to-face contact between an individual and a qualified preventionist who meets the requirements in Section 7(1) of this administrative regulation.

(b) Universal prevention services:

1. Shall consist of a protocol for reducing harm to the fetus that:

a. Is designed to reduce the risk that an individual will use alcohol, tobacco or another drug during pregnancy or the postpartum period, thus protecting the child from subsequent risk for harm;

b. Identifies specific risks associated with alcohol, tobacco or another drug use during pregnancy and lactation, including risks to a fetus, such as low birth weight and fetal alcohol spectrum disorder;

c. Identifies signs of postpartum depression and addresses the risk for substance abuse following pregnancy; and

d. Reduces the shame and stigma attached to addressing alcohol and drug issues to encourage an individual to pursue additional needed substance abuse prevention and treatment services.

2. May include a process for the identification of an individual needing a referral for a selective prevention service or a substance abuse assessment completed in accordance with subsection (1)(b) and (c) of this section; and

3. Shall have reimbursement limited to no more than two (2) hours during a single pregnancy and postpartum period.

(c) Selective prevention services:

1. Shall consist of a therapeutic risk reduction protocol that is designed to reduce the risk that an individual will use alcohol, tobacco, or another drug during pregnancy, thus protecting the child from subsequent risk for harm.

a. The therapeutic risk reduction protocol shall:

(i) Increase the perception of personal risk for harm due to high-risk alcohol and drug use throughout life;

(ii) Identify the levels of alcohol and drug use that increase risk for problems during pregnancy and throughout life;

(iii) Address health and social consequences of high-risk drinking or drug choices; and

(iv) Address biological, psychological, and social factors that may increase risk for alcohol and other

drug use during pregnancy and lactation and alcohol and other drug abuse throughout life; and

b. While not mandatory, it is desirable that the therapeutic risk reduction protocol also include information to help the individual:

- (i) Change perceptions of normative alcohol and other drug behaviors;
- (ii) Develop skills for making and maintaining behavioral changes in alcohol and drug use and in developing social and psychological supports for these changes throughout life; or
- (iii) Address parental influences on alcohol and drug choices of children, family management issues, and the establishment of successful expectations and consequences;

2. May include a process for the identification of an individual needing a referral for a substance abuse assessment completed in accordance with subsection (1) of this section;

3. Reimbursement shall be limited to:

- a. During a single pregnancy and postpartum period; and
- b. A maximum of seventeen (17) hours for a therapeutic risk reduction protocol targeted at preventing alcohol and drug problems throughout the life of the individual.

(d) Indicated prevention service:

1. Shall consist of a therapeutic risk reduction protocol which is designed to reduce the risk that certain individuals may experience alcohol and other drug related health problems, including substance dependency or experience alcohol and other drug related impairments throughout life:

a. A therapeutic risk reduction protocol shall:

- (i) Address the health and social consequences of high-risk drinking or drug choices, including consequences to a fetus in the case of any alcohol or drug use during pregnancy;
- (ii) Increase the perception of personal risk for harm due to high-risk alcohol and drug use;
- (iii) Identify the existence of biological, psychological, and social risk factors; and
- (iv) Identify levels of alcohol and other drug use that increase risk for problems; and

b. A therapeutic risk reduction protocol for an indicated prevention service may include:

- (i) Changing perceptions of normative alcohol and drug use behaviors;
- (ii) Developing skills for making and maintaining behavioral changes, including changes in alcohol and drug use, and developing social and psychological supports to maintain the changes throughout life; and

(iii) Addressing parental influences on the alcohol and drug choices of children, family management issues, and the establishment of successful expectations and consequences; and

2. Reimbursement shall be limited to:

- a. During a single pregnancy and postpartum period; and
- b. A maximum of twenty-five (25) hours for a protocol targeted at prevention of alcohol and drug problems throughout the life of the individual.

(3) Outpatient services.

(a) An outpatient service shall be an ambulatory care service that:

1. Is a face-to-face therapeutic interaction between an individual and a qualified substance abuse treatment professional; and

2. Is for the purpose of reducing or eliminating a substance abuse problem and shall include the following services:

- a. Treatment planning;
- b. Referrals for other needed health and social services;
- c. Information on substance abuse and its effects on health and fetal development;

- d. Orientation to substance abuse related self-help groups; and
- e. Participation in one (1) or more of the following modalities of outpatient treatment:
 - (i) Individual therapy;
 - (ii) Group therapy;
 - (iii) Family therapy. This modality shall be provided to an individual and one (1) or more persons with whom an individual has a family relationship;
 - (iv) Psychiatric evaluation provided by a psychiatrist or advanced registered nurse practitioner (ARNP);
 - (v) Psychological testing provided by a licensed psychologist who holds the designation of health service provider, certified psychologist with autonomous functioning, certified psychologist, licensed psychological practitioner, or licensed psychological associate;
 - (vi) Medication management provided by a physician or an advanced registered nurse practitioner;or
 - (vii) Collateral care. This modality shall provide face-to-face consultation or counseling to a person who is in a position of custodial control or supervision of an individual under age twenty-one (21), in accordance with an individual's treatment plan.
- (b) Service limitations.
 - 1. Group therapy.
 - a. There shall be no more than twelve (12) persons in a group therapy session.
 - b. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse and other self-help groups.
 - 2. Collateral care shall be limited to individuals under age twenty-one (21).
 - 3. Psychiatric evaluations or psychological testing that do not result in an individual receiving substance abuse treatment shall not be reimbursable through this benefit.
 - 4. No more than eight (8) hours of outpatient services shall be reimbursed during a one (1) week period.
- (4) Intensive outpatient services.
 - (a) An intensive outpatient service shall be an ambulatory care service for the purpose of reducing or eliminating an individual's substance abuse problem.
 - (b) The following components shall be provided in an intensive outpatient service as a face-to-face therapeutic interaction between an individual and a qualified substance abuse treatment professional:
 - 1. Treatment planning;
 - 2. A structured program of information on substance abuse and its effects on health, fetal development and family relationships which shall be provided either to an individual or an individual and one (1) or more persons with whom an individual has a close association; and
 - 3. Individual, group and family therapy.
 - (c) The following components may be provided in an intensive outpatient service as a face-to-face activity between an individual and a qualified substance abuse treatment professional or a member of the therapeutic team, supervised by a qualified substance abuse treatment professional:
 - 1. Independent living skills training;
 - 2. Parenting skill development;
 - 3. Orientation to substance abuse and other self-help programs; or
 - 4. Staff support to activities led by the individual.
- (d) Service limitations.

1. Group therapy.

- a. There shall be no more than twelve (12) persons in a group therapy session.
- b. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse or other self-help groups.

2. Reimbursement for an intensive outpatient service shall be limited to no more than seven (7) hours per day not to exceed forty (40) hours per week.

(5) Day rehabilitation services.

(a) A day rehabilitation service shall be provided in a residential facility for the purpose of reducing or eliminating an individual's substance abuse problem.

(b) The following components shall be provided in a day rehabilitation service as a face-to-face therapeutic interaction between an individual and a qualified substance abuse treatment professional:

- 1. Treatment planning;
- 2. A structured program of information on substance abuse and its effects on health, fetal development and family relationships which shall be provided to either an individual or an individual and one (1) or more persons with whom an individual has a close association; and
- 3. Individual, group and family therapy.

(c) The following components may be provided in a day rehabilitation service but shall be provided as a face-to-face activity between an individual and a qualified substance abuse treatment professional or a member of the therapeutic team, supervised by a qualified substance abuse treatment professional:

- 1. Independent living skills training;
- 2. Parenting skill development;
- 3. Orientation to substance abuse and other self-help programs; or
- 4. Staff support to activities led by the individual.

(d) Service limitations.

1. In accordance with 42 U.S.C. 1396d(a) and 1396d(i), payment shall not be made for care or services for any individual who is a patient in an institution of more than sixteen (16) beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.

2. Group therapy.

- a. There shall be no more than twelve (12) persons in a group therapy session.
- b. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse or other self-help groups.

3. Reimbursement for a day rehabilitation service shall be limited to no more than eight (8) hours per day not to exceed forty-five (45) hours per week.

4. Room and board costs shall not be covered under this benefit.

(6) Case-management services.

(a) Case management shall be an ambulatory care service that:

1. Shall be a minimum of four (4) face-to-face or telephone contacts per month between or on behalf of an individual and a qualified substance abuse treatment professional, of which:

a. At least two (2) of the contacts shall be face to face with the individual; and

b. The remaining contacts shall be by phone or face to face with or on behalf of the individual; and

2. Is for the purpose of reducing or eliminating an individual's substance abuse problem by assisting an individual in gaining access to needed medical, social, educational and other support services.

(b) Case-management services shall include:

- 1. An assessment of an individual's case-management needs;

2. Development of a service plan that identifies an individual's case management projected outcomes; and

3. Activities that support the implementation of an individual's service plan.

(c) Case-management services shall not be connected with a specific type of substance abuse treatment but shall follow an individual across the array of substance abuse treatment services identified in the individual's treatment plan.

(d) Service limitations. The following activities shall not be reimbursed by this Medicaid benefit:

1. An outreach or case-finding activity to secure a potential individual for services;
2. Administrative activities associated with Medicaid or eligibility determinations;
3. Transportation services solely for the purpose of transporting the individual; and
4. The actual provision of a service other than a case-management service.

(7) Community-support services.

(a) A community-support service shall be an ambulatory care service that shall be provided if the service is identified as a need in the individual's case-management service plan.

(b) A community-support service shall be a face-to-face or telephone contact between an individual and a qualified community-support provider, who meets the requirements in Section 7(4) of this administrative regulation.

(c) A community-support service shall include:

1. Assisting the individual in remaining engaged with substance abuse treatment or community self-help groups;

2. Assisting the individual in resolving a crisis in the individual's natural environment; and

3. Coaching the individual in her natural environment to:

a. Access services arranged by a case manager; and

b. Apply substance abuse treatment gains, parent training and independent living skills to the individual's personal living situation.

(d) A community-support provider shall coordinate the provision of community-support services with the individual's primary provider of case-management services.

(e) Service limitation. Transportation services solely for the purpose of transporting an individual shall not be reimbursed through this Medicaid benefit.

(8) Service limitation for all substance abuse services. Reimbursement for a substance abuse service shall not be payable for an individual who is a resident in a Medicaid-reimbursed inpatient facility. ———

6.2.20. ☒ Case management services (Section 2110(a)(20))

Case Management Services. The following services shall be covered as case management services when provided by a qualified case manager to Medicaid eligible recipients in the target group:

(1) A written comprehensive assessment of the child's needs;

(2) Arranging for the delivery of the needed services as identified in the assessment;

(3) Assisting the child and his family in accessing needed services;

(4) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing needs;

(5) Performing advocacy activities on behalf of the child and his family;

(6) Preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;

(7) Providing case consultation (i.e., consulting with the service providers/collateral's in determining child's status and progress), and

(8) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services).

Excluded Activities. The following activities shall not be considered case management activities:

(1) The actual provision of mental health or other Medicaid covered services or treatments;

(2) Outreach to potential recipients;

(3) Administrative activities related to Medicaid eligibility determinations; and

(4) Institutional discharge planning. _____

6.2.21. Care coordination services (Section 2110(a)(21))

6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

The department shall reimburse for a speech pathology service if:

(a) The service:

1. Is provided:

a. By a speech-language pathologist who meets the requirements in Section 1(1) of this administrative regulation, and

b. To a recipient;

2. Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for:

a. Maximum reduction of a physical or intellectual disability; or

b. Restoration of a recipient to the recipient's best possible functioning level;

3. Is prior authorized; and

4. Is medically necessary; and

(b) A specific amount of visits is requested for the recipient by a speech-language pathologist, physician, physician assistant, or an advanced practice registered nurse.

(2)(a) There shall be an annual limit of twenty (20) speech pathology service visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each speech pathology service that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

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

(2) For example, if a recipient is receiving a speech pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for the speech pathology service provided to the same recipient

during the same time period via the home health program

The department shall reimburse for physical therapy if:

(a) The therapy:

1. Is provided;

a. By a:

(i) Physical therapist who meets the requirements in Section 1(1) of this administrative regulation; or

(ii) Physical therapist assistant who works under the direct supervision of a physical therapist who meets the requirements in Section 1(1) of this administrative regulation; and

b. To a recipient;

2. Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for;

a. Maximum reduction of a physical or intellectual disability; or

b. Restoration of a recipient to the recipient's best possible functioning level;

3. Is prior authorized; and

4. Is medically necessary; and

(b) A specific amount of visits is requested for the recipient by a physical therapist, physician, physician assistant, or an advanced practice registered nurse.

(2)(a) There shall be an annual limit of twenty (20) physical therapy visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department, if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled, if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each therapy visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

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

(2) For example, if a recipient is receiving physical therapy from a physical therapist enrolled with the Medicaid Program, the department shall not reimburse for physical therapy provided to the same recipient during the same time period via the home health program.

The department shall reimburse for an occupational therapy service if:

(a) The service:

1. Is provided;

a. By an:

(i) Occupational therapist who meets the requirements in Section 1(1) of this administrative regulation; or

(ii) Occupational therapy assistant who works under the direct supervision of an occupational therapist who meets the requirements in Section 1(1) of this administrative regulation; and

- b. To a recipient;
- 2. Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for:
 - a. Maximum reduction of a physical or intellectual disability; or
 - b. Restoration of a recipient to the recipient's best possible functioning level;
 - 3. Is prior authorized; and
 - 4. Is medically necessary; and
- (b) A specific amount of visits is requested for the recipient by an occupational therapist, physician, physician assistant, or an advanced practice registered nurse.
- (2)(a) There shall be an annual limit of twenty (20) occupational therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection.
- (b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:
 - 1. Department, if the recipient is not enrolled with a managed care organization; or
 - 2. Managed care organization in which the enrollee is enrolled, if the recipient is an enrollee.
- (c) Prior authorization by the department shall be required for each service visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

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

- (2) For example, if a recipient is receiving an occupational therapy service from an occupational therapist enrolled with the Medicaid Program, the department shall not reimburse for the same occupational therapy service provided to the same recipient during the same time period via the home health program. ———

6.2.23. ☒ Hospice care (Section 2110(a)(23))

KCHIP covers hospice services for terminally ill recipients. Hospice care provides palliative care, relief of pain and other symptoms, for persons in the last phase of an incurable disease so that they can live as fully and comfortably as possible. Hospice also provides supportive services to terminally ill persons and assistance to their families in adjusting to the patient's illness and death.

Hospice services are available to recipients with a terminal diagnosis that have been certified by a physician to have a life expectancy of six months or less.

Covered Hospice services are available to recipients in their Home, Nursing Facility or ICF/MR setting. Hospice services are reasonable and necessary for the palliation or management of the terminal illness as well as related conditions as detailed in the Hospice regulations and Hospice Services Manual.

In order to receive Hospice services, the recipient must elect Hospice coverage using the MAP-374 - Election of Medicaid Hospice Benefit Form.

Recipients that elect Hospice will receive treatment for conditions related to their terminal illness by their Hospice provider.

Recipients under the age of twenty-one (21) eligible for Hospice benefits are eligible to receive curative treatment in relation to their terminal illness concurrently with Hospice

services.

~~Hospice benefits shall consist of two (2) ninety (90) day periods.~~

~~Additional 60 day extension of Hospice benefits periods are covered until revocation or termination for other reasons such as ineligibility or death. Recertification is required for each 60 day extension benefit period. —~~

~~Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.~~

6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.26. Medical transportation (Section 2110(a)(26))

~~—Emergency Ambulance Services. (1) An emergency ambulance service shall be covered to and from a hospital emergency room in the medical service area if the:~~

~~(a) Service is medically necessary; and
(b) Documentation is maintained for postpayment review to indicate immediate emergency medical attention was provided in the emergency room.~~

~~(2) An emergency ambulance service to an appropriate medical facility or provider other than a hospital emergency room shall require documentation from the attending physician of:~~

~~(a) Medical necessity;
(b) Absence of a hospital emergency room in the medical service area; and
(c) Delivery of emergency care to the patient.~~

~~Nonemergency Ambulance Services. (1) A nonemergency ambulance service to a provider within the medical service area shall be covered if:~~

~~(a) The recipient's medical condition warrants transport by stretcher;
(b) The recipient is traveling to or from a Medicaid-covered service, exclusive of a pharmacy service; and
(c) The service is the least expensive available transportation for the recipient's needs.~~

~~(2) A nonemergency ambulance service provided outside the medical service area shall be covered if:~~

~~(a) The criteria specified in subsection (1) of this section are satisfied;
(b) The medical service required by the recipient is not available in the medical service area; and
(c) The recipient is referred by a physician.~~

~~Non-emergency medical transportation is not covered.~~

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.27. Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.2.28. Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC **State Specific Dental Benefit Package.** The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC **Periodicity Schedule.** The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific
- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

6.2.2-DC **Benchmark coverage;** (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.3. The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

- 6.3.1. The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
- 6.3.2. The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical

conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

6.4. Additional Purchase Options- If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. Cost Effective Coverage- Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

- 6.4.1.3. The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

Guidance: Check 6.4.2 if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

- 6.4.2. **Purchase of Family Coverage-** Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

- 6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

6.4.2.2. The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The State assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

- Yes
 No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan.

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA Purchasing Pool- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

- Yes
 No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant

woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA **Notice of Availability of Premium Assistance-** Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

Section 7. Quality and Appropriateness of Care

Guidance: Methods for Evaluating and Monitoring Quality- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision

of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

- 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 8.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCOA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

- 7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

7.1.1. Quality standards

7.1.2. Performance measurement

7.1.2 (a) CHIPRA Quality Core Set

7.1.2 (b) Other

7.1.3. Information strategies

7.1.4. Quality improvement strategies

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

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7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

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7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

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Section 8. Cost-Sharing and Payment

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 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. Yes

8.1.2. No, skip to question 8.8.

8.1.1-PW Yes

8.1.2-PW No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. Premiums:

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

— Acute inpatient hospital admission \$50 copayment

Outpatient hospital or ambulatory surgical center visit \$4 copayment

Generic prescription drug \$1 copayment

Preferred brand name drug \$4 copayment

Non preferred brand name drug \$8 copayment

Non emergency use of emergency room \$8 copayment

DME \$4 copayment

Podiatry office visit \$3 copayment

Chiropractic office visit \$3 copayment
Dental office visit \$3 copayment
Optometry office visit \$3 copayment
General Ophthalmological Office visit \$3 copayment
Physician office visit \$3 copayment
Office visit for care by a physician assistant, advanced practice registered nurse, certified pediatric and family nurse practitioner or or a nurse midwife \$3
Office visit for care by a behavioral health professional \$3
Rural Health Clinic visit \$3
Federally Qualified Health Care visit \$3
Primary Care Center visit \$3
Physical, Speech, or Occupational Therapy visit \$3
Laboratory, diagnostic or radiological service \$3 copayment

As KCHIP children are enrolled in one of five MCOs across the state, specific cost sharing may vary by MCO. MCOs may waive cost sharing but may not charge above the limits established by Medicaid. Only children above 150% of the FPL are subject to copayments.

8.2.4. Other:

8.2-DS **Supplemental Dental (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.**

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))
Public notice regarding cost sharing amounts were published in all major newspapers within the state prior to implementation. The announcement included information related to the cumulative maximum. In addition, information regarding cost

sharing amounts is posted on the Medicaid website and inserted into member handbooks.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

- 8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)
- 8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)
- 8.4.3. No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

—The Medicaid information system contains an indicator for each individual subject to cost sharing. The State tracks cost sharing amounts on a daily basis and compares the cumulative cost sharing amount in the system to the family's reported quarterly income. If the aggregate cost sharing amount reaches 5% of the family's income in a quarter, the indicator in Medicaid's information system is changed to indicate that cost sharing is no longer applicable. Cost sharing information and indicators is also shared with each MCO on a daily basis to ensure individuals that have reached the 5% maximum amount are no longer assessed a copayment.

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

Kentucky will rely on self-reporting to ensure American Indian and Alaskan Native children are excluded from cost sharing. During the application process in the local DCBS office the worker asks the recipient their race/ethnicity. The computer system automatically generates the medical card for American Indians or Alaska Natives without an indicator requiring co-pays. The eligibility on-line system automatically exempts anyone identifying herself or himself, as American Indian or Alaskan Native. Cards for all American Indians and Alaskan Natives that were active members at the time the policy went into effect were also automatically generated without the indicator requiring the co-payment.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

—There is no consequence for an enrollee or applicant who does not pay a charge. Providers cannot refuse to provide services to any enrollee who is unable to pay the copayment. Providers can seek to collect the cost sharing amounts owed through appropriate channels.

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title

XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

- 8.7.1.1. State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
——No premiums, coinsurance or deductibles are assessed. Providers cannot refuse to provide services to enrollees who cannot or do not pay the applicable cost sharing amount. No enrollee is disenrolled for failure to pay copayments.
- 8.7.1.2. The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
——Enrollees are not disenrolled for failure to pay copayments.
- 8.7.1.3. In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
——Not applicable. Enrollees are not disenrolled for failure to pay copayments.
- 8.7.1.4 The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))
Not applicable. Enrollees are not disenrolled for failure to pay copayments.

copayments.——

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

- 8.8.1. No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2. No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)
- 8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

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- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

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It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakdowns by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

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Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. Immunizations
 - 9.3.7.2. Well childcare
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, list:
- 9.3.8. Performance measures for special targeted populations.

9.4. The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

9.6. The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

Kentucky has no registered Indian Tribes or recognized American Indian/Alaskan Native groups or organizations. Therefore, no interactive process has been developed. If Kentucky gains a recognized tribe, group or organization an interactive process will be developed.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

Provisions regarding cost sharing was announced in major newspapers within the state in September and December of 2013. In addition, applicants receive information about cost sharing when they apply from the eligibility determination caseworker. There are educational materials available in

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the local Department for Community Based Services offices where applicants go to apply for services that explain co-pays.

Providers also receive a letter at least ten (10) days prior to implementation explaining the co-payment policies. This information is also included on the Department for Medicaid Services and KCHIP web sites, which providers routinely use to review current information.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

Kentucky has no registered Indian Tribes or recognized American Indian/Alaskan Native groups or organizations. Therefore, no interactive process has been developed. If Kentucky gains a recognized tribe, group or organization an interactive process will be developed.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- **Planned use of funds, including:**
 - **Projected amount to be spent on health services;**
 - **Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and**
 - **Assumptions on which the budget is based, including cost per child and expected enrollment.**
 - **Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.**
 - **All cost sharing, benefit, payment, eligibility need to be reflected in the budget.**

- **Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.**
- **Include a separate budget line to indicate the cost of providing coverage to pregnant women.**
- **States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.**
- **Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.**
- **Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.**
- **Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:**
 - **Total 1-year cost of adding prenatal coverage**
 - **Estimate of unborn children covered in year 1**

CHIP Budget

STATE: — Kentucky	FFY Budget
Federal Fiscal Year	— 2014
State's enhanced FMAP rate	— 78.88
Benefit Costs	
Insurance payments	
Managed care	— 130,239,272
per member/per month rate	— 215.67
Fee for Service	— 37,468,578
Total Benefit Costs	— 167,707,850
(Offsetting beneficiary cost sharing payments)	— *
Net Benefit Costs	— 167,707,850
Cost of Proposed SPA Changes – Benefit	— 140,000
Administration Costs	
Personnel	— 280,200
General administration	— 2,756,300
Contractors/Brokers	— 210,300
Claims Processing	— included in general admin
Outreach/marketing costs	— included in general admin
Health Services Initiatives	
Other	— 8,859
Total Administration Costs	— 3,255,659
10% Administrative Cap	— 18,634,206
Cost of Proposed SPA Changes	— 170,963,509
Federal Share	— 134,856,015
State Share	— 36,107,494
Total Costs of Approved CHIP Plan	— 170,963,509

NOTE: Include the costs associated with the current SPA.

— Beneficiary cost sharing is in the form of co-payments only. As all services subject to co-payments fall within the MCO contracts, beneficiary cost sharing will not reduce the per member per month capitation payment and, therefore, will not offset capitation payments. MCOs may or may not impose the co-payments outlined in this SPA.

The Source of State Share Funds: — State general fund dollars.

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at <http://www.nashp.org>. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

10.1. Annual Reports. The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

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 to Section 12.

11.1. 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. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) (The items below were moved from

section 9.8. Previously 9.8.6. - 9.8.9.)

- 11.2.1. 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. Section 1128A (relating to civil monetary penalties)
- 11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

12.1. Eligibility and Enrollment Matters- Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. Health Services Matters- Describe the review process for health services matters that complies with 42 CFR 457.1120.

12.3. Premium Assistance Programs- If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

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Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices				
CMS Regional Offices	States		Associate Regional Administrator	Regional Office Address
Region 1- Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2- New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3- Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4- Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4 th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5- Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6- Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7- Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8- Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9- San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103
Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and pre-pregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
23. Hospice care.

24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
 - a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
 - b. performed under the general supervision or at the direction of a physician, or
 - c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. **IN GENERAL-** Subject to paragraph (2), the term 'targeted low-income child' means a child--
 - a. who has been determined eligible by the State for child health assistance under the State plan;
 - b. (i) who is a low-income child, or
(ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
 - c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. **CHILDREN EXCLUDED-** Such term does not include--
 - a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
 - b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. **SPECIAL RULE-** A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. **MEDICAID APPLICABLE INCOME LEVEL-** The term 'Medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under Section 1902(1)(2) for the age of such child.
5. **TARGETED LOW-INCOME PREGNANT WOMAN.**—The term 'targeted low-income pregnant