



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L.

Alternative Benefit Plan Populations ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name:

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s).

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory.

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Voluntary Benefit Package Selection Assurances: Eligibility Goals under Section 1902(a)(10)(A) (Y)(II) of the Act **ABP2a**

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

Kentucky has reviewed the EHB's Anthem PPO and added or supplemented Medicaid benefits where necessary to at least offer the benefits for purposes of defining EHBs. The ABP that is subject to section 1937 requirements and the Medicaid State Plan are fully aligned.

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Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3

Select one of the following:

- The state/territory is amending one existing benefit package for the population defined in Section 1.
- The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package:

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- Secretary-Approved Coverage.
 - The state/territory offers benefits based on the approved state plan.
 - The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
 - The state/territory offers the benefits provided in the approved state plan.
 - Benefits include all those provided in the approved state plan plus additional benefits.
 - Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
 - The state/territory offers only a partial list of benefits provided in the approved state plan.
 - The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Selection of Base Benchmark Plan

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The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- Any of the largest three state employee health benefit plans by enrollment.
- Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- Largest insured commercial non-Medicaid HMO.

Plan name:

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The State assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
The State assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

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Alternative Benefit Plan Cost-Sharing	ABP4
<input checked="" type="checkbox"/> Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.	
Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.	
The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.	<input type="checkbox"/> No
Other Information Related to Cost Sharing Requirements (optional):	
<div style="border: 1px solid black; height: 40px;"></div>	

PRA Disclosure Statement

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Benefits Description **ABP5**

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

The state/territory is proposing "Secretary-Approved Coverage" as its section 1937 coverage option. Yes

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

The state/territory must provide a benefit by benefit comparison of the benefits in its proposed Secretary-Approved Alternative Benefit Plan with the benefits provided by one of the section 1937 Benchmark Benefit Packages or the standard full Medicaid state plan under Title XIX of the Act. Submit a document indicating which of these benefit packages will be used to make the comparison and include a chart comparing each benefit in the proposed Secretary-Approved benefit package with the same or similar benefit in the comparison benefit package, including any limitations on amount, duration and scope pertaining to the benefits in each benefit package.

An attachment is submitted.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Anthem PPO

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved



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<input checked="" type="checkbox"/> Essential Health Benefit 1: Ambulatory patient services		Collapse All <input type="checkbox"/>
Benefit Provided: Physician Services	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents Physician services.		
Benefit Provided: Outpatient Hospital Services	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization is required for some services. See State Plan for complete listing.		
Benefit Provided: Clinic Services	Source: State Plan 1905(a)	
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		

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Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		<input type="button" value="Remove"/>
<input type="text"/>		
Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Certified Pediatric or Family Nurse Practitioner"/>	<input type="text" value="State Plan 1905(a)"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Full State Plan Service Title: Certified pediatric or family Nurse Practitioner services"/>		
Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Family Planning Services and Supplies for Individu"/>	<input type="text" value="State Plan 1905(a)"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="Limited to individuals of child-bearing age"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Full State Plan Service Title: Family Planning Services and Supplies for Individuals of Child-bearing Age"/>		
Benefit Provided:	Source:	
<input type="text" value="Hospice Care"/>	<input type="text" value="State Plan 1905(a)"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="Prior Authorization"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	

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Scope Limit: Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services		Remove
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: Private duty nursing	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 2000 hours / year	Duration Limit: None	
Scope Limit: Services in an inpatient setting excluded		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: Medical care & any other type of remedial:podiatry	Source: State Plan 1905(a)	
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Limited to non-routine foot care; routine foot care excluded		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Full State Plan Service Title: Medical care and any other type of remedial care provided by licensed practitioners: Podiatry		
KY State Plan Title: Medical care and any other type of remedial care		
Podiatry exclusions include: treatment of flatfoot; treatments undertaken for the sole purpose of correcting a subluxated structure as an isolated entity within the foot; routine footcare, except when the patient has a systemic disease of sufficient severity that unskilled performance of such procedures would be hazardous; specified methods of plethysmography. Orthopedic shoes and other supportive devices for the feet are not covered under this program element. Additional detail explanations of these exclusions are included in		



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the State Plan.		
This represents podiatry services		<input type="button" value="Remove"/>
Benefit Provided:	Source:	
Medical care & any other type of remedial: Other	State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Full State Plan Service Title: Medical care and any other type of remedial care provided by licensed practitioners: Other practitioner's services		
KY State Plan Title: Medical care and any other type of remedial care		
This represents services provided by other practitioners listed in the State Plan		
		<input type="button" value="Add"/>

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<input checked="" type="checkbox"/> Essential Health Benefit 2: Emergency services		Collapse All <input type="checkbox"/>
Benefit Provided: Outpatient Hospital: Emergency Department	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 		
Benefit Provided: Any other medical care: emergency transportation	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary This represents emergency transportation/ambulance		
		Add



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<input checked="" type="checkbox"/> Essential Health Benefit 3: Hospitalization		Collapse All <input type="checkbox"/>
Benefit Provided: Inpatient Hospital Services	Source: State Plan 1905(a)	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Authorization is done through prior, concurrent, and retroactive authorization, depending on the type of hospital and service.		
Benefit Provided: Physician: Inpatient Services	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents Inpatient Physician Services		
		Add

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<input checked="" type="checkbox"/> Essential Health Benefit 4: Maternity and newborn care		Collapse All <input type="checkbox"/>
Benefit Provided: Nurse-midwife Services	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 		
Benefit Provided: Inpatient Hospital Services: Maternity	Source: State Plan 1905(a)	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Authorization is done through prior, concurrent, and retroactive authorization, depending on the type of hospital and service. Services such as physician or inpatient hospital found in other EHBs are applicable here too		
Benefit Provided: Physician services: Maternity	Source: State Plan 1905(a)	
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		



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Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This benefit is a duplicate of "outpatient surgery physician/surgical" in the base benchmark.

Remove

Add

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<input checked="" type="checkbox"/> Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment		Collapse All <input type="checkbox"/>
Benefit Provided: Inpatient Hospital Services: IP Mental Health	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: IP Mental Health in an IMD is not available to individuals between the ages of 21 to 64.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents Inpatient Mental Health services. These facilities are not IMDs.		
Benefit Provided: Rehabilitative services: OP Mental Health	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan This represents Outpatient Mental Health services.		
Benefit Provided: Inpatient Hospital Services: IP Substance Use	Source: State Plan 1905(a)	
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	



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Scope Limit:	
<input type="text" value="None"/>	<input type="button" value="Remove"/>
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	
<input type="text" value="This represents IP Substance Use Disorder Services
These facilities are not IMDs."/>	
Benefit Provided:	Source:
<input type="text" value="Rehabilitative services: OP Substance Use"/>	<input type="text" value="State Plan 1905(a)"/>
	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>
Amount Limit:	Duration Limit:
<input type="text" value="None"/>	<input type="text" value="None"/>
Scope Limit:	
<input type="text" value="None"/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	
<input type="text" value="Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan
This represents OP Substance Use Disorder Services"/>	
<input type="button" value="Add"/>	



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<input checked="" type="checkbox"/> Essential Health Benefit 6: Prescription drugs
Benefit Provided:
Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.
Prescription Drug Limits (Check all that apply.):
<input type="checkbox"/> Limit on days supply
<input type="checkbox"/> Limit on number of prescriptions
<input type="checkbox"/> Limit on brand drugs
<input type="checkbox"/> Other coverage limits
<input checked="" type="checkbox"/> Preferred drug list
Authorization: Yes <input type="text"/>
Provider Qualifications: State licensed <input type="text"/>
Coverage that exceeds the minimum requirements or other:
The Commonwealth of Kentucky's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.



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<input checked="" type="checkbox"/> Essential Health Benefit 7: Rehabilitative and habilitative services and devices		Collapse All <input type="checkbox"/>
Benefit Provided: Physical therapy & related svcs: PT	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 20 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: Physical therapy and related services 20 visits per year for physical therapy; benefit limits are aggregated between habilitation and rehabilitation services.		
Benefit Provided: Home Health: Medical supplies, equipment, and appl	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Specific restrictions and exclusions are found in the fee schedule		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Home Health: Medical supplies, equipment, and appliances suitable for use in the home KY State Plan Title: Home Health: Medical supplies suitable for use in the home Prior authorization is required for items of equipment or repairs greater than \$500 and certain other specified items.		
Benefit Provided: Prosthetics	Source: State Plan 1905(a)	
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	



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Amount Limit: None	Duration Limit: None	Remove
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization is required for items of equipment or repairs greater than \$500 and certain other specified items.		
Benefit Provided: Nursing Facility Services (21 and older)	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Meets level of care		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This is a nursing facility for rehabilitative purposes. The base benchmark limits the number of days in a nursing facility to 90 day.		
Benefit Provided: Medical and other types of remedial care: chiropra	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 26 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents chiropractic services		
Benefit Provided: Physical therapy & related svcs: OT	Source: State Plan 1905(a)	

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Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	Remove
Amount Limit: 20 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: Physical therapy and related services 20 visits per year for occupational therapy; benefit limits are aggregated between habilitation and rehabilitation services.		
Benefit Provided: Physical therapy & related svcs: ST	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 20 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: Physical therapy and related services 20 visits per year for speech therapy; benefit limits are aggregated between habilitation and rehabilitation services.		
Benefit Provided: Home health services: nursing, aide, and therapy	Source: State Plan 1905(a)	
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: PT/OT/ST: 20 visits each per calendar year	Duration Limit: None	
Scope Limit: None		

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<p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p> <p>This represents the home health visit, including PT/OT/SLT (if applicable) 20 visits each per calendar year for physical, occupational, and speech therapy; benefit rehabilitation services</p>	<p>Remove</p>
	<p>Add</p>

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<input checked="" type="checkbox"/> Essential Health Benefit 8: Laboratory services		Collapse All <input type="checkbox"/>
Benefit Provided:	Source:	
Other Laboratory and x-Ray Services	State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Some imaging services require a prior authorization. See State Plan for complete listing.		
		<input type="button" value="Add"/>

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Essential Health Benefit 9: Preventive and wellness services and chronic disease management Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventive services	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Supplements existing benefits with any additions to comply with USPSTF, ACIP, IOM, and Bright Futures.		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan This benefit includes preventive services		

Benefit Provided: Physician services: allergy	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: 		

Add



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<input checked="" type="checkbox"/> Essential Health Benefit 10: Pediatric services including oral and vision care		Collapse All <input type="checkbox"/>
Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: State Plan 1905(a)	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: EPSDT Prior Auth required for orthodontia		
Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Limited to children under 21 years of age		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Inpatient psychiatric facility services for individuals under 21 years of age These services are not in an IMD		
		Add



Alternative Benefit Plan

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Other Covered Benefits from Base Benchmark

Collapse All



Alternative Benefit Plan

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<input checked="" type="checkbox"/> Base Benchmark Benefits Not Covered due to Substitution or Duplication		Collapse All <input type="checkbox"/>
Base Benchmark Benefit that was Substituted:	Source:	
Primary Care Visit	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Patient Services.		
Base Benchmark Benefit that was Substituted:	Source:	
Specialist Visit	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Patient Services.		
Base Benchmark Benefit that was Substituted:	Source:	
Outpatient facility fee	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Clinic Services and Outpatient Hospital Services, under the EHB Ambulatory Patient Services.		
Base Benchmark Benefit that was Substituted:	Source:	
Hospice	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Hospice care, under the EHB Ambulatory services		
Base Benchmark Benefit that was Substituted:	Source:	
Home health care services	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Home Health Services, under the EHBs Ambulatory Patient Services & Rehabilitative and habilitative services and devices		
Base Benchmark Benefit that was Substituted:	Source:	
ER Services	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
Duplication: This benefit was replaced with Outpatient Hospital Services, as well as Outpatient Hospital:		



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Emergency Department, under the EHB Emergency Services. Emergency hospital services are covered as outpatient hospital services in Medicaid.		Remove
Base Benchmark Benefit that was Substituted: Emergency Transportation / Ambulance	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary, under the EHB Emergency Services .		
Base Benchmark Benefit that was Substituted: Inpatient Hospital Services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Inpatient Hospital Services, under the EHB Hospitalization.		
Base Benchmark Benefit that was Substituted: Inpatient physician and surgical services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Physician Services, under the EHB Hospitalization.		
Base Benchmark Benefit that was Substituted: Skilled nursing facility	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Nursing Facility Services (21 and older) under the EHBs Rehabilitative and Habilitative Services and Devices. This benefit is limited to 90 days.		
Base Benchmark Benefit that was Substituted: Delivery and all inpatient services for maternity	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Inpatient hospital services: maternity, under the EHB Maternity and Newborn Care.		
Base Benchmark Benefit that was Substituted: Mental/behavioral health outpatient services	Source: Base Benchmark	



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<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health</p>		Remove
<p>Base Benchmark Benefit that was Substituted:</p> <p>Mental/behavioral health inpatient services</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Inpatient Hospital Services: IP Substance Use, and Inpatient psychiatric facility services for individuals under 21 years of age, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health, and the EPSDT EHB, respectively</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Substance Abuse Disorder Outpatient Services</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services & Rehabilitative services for pregnant women: SU, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Substance Abuse Disorder Inpatient Services</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Inpatient Hospital Services: IP Mental Health, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Generic Drugs</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Prescription drugs, Dentures, Prosthetic Devices, and Eyeglasses under the EHB Prescription Drugs</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Preferred Brand Drugs</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs</p>		

TN No: 13-020
Kentucky

Approval Date: 12/20/13
ABPS-23

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Base Benchmark Benefit that was Substituted: Non-Preferred Brand Drugs	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs		
Base Benchmark Benefit that was Substituted: Specialty Drugs	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs		
Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Physical Therapy and related Services, under the EHB Rehabilitative and Habilitative Services and Devices		
Base Benchmark Benefit that was Substituted: Habilitation Services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Physical Therapy and related Services, under the EHB Rehabilitative and Habilitative Services and Devices		
Base Benchmark Benefit that was Substituted: Chiropractic Care	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Medical care and any other type of remedial care, under the Rehabilitative and Habilitative Services and Devices. This benefit is limited to 12 visits per year in the base benchmark plan.		
Base Benchmark Benefit that was Substituted: Durable Medical Equipment	Source: Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Family Planning Services and Supplies for Individuals of Child-bearing Age under the EHB for Ambulatory Services, and Home Health: Medical supplies,		



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equipment, and appliances suitable for use in the home, as well as Prosthetics, under the EHB Rehabilitative and Habilitative Services and Devices		Remove
Base Benchmark Benefit that was Substituted: Hearing Aides	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with EPSDT & Home Health: Medical supplies, equipment, and appliances suitable for use in the home, under the EHB Rehabilitative and Habilitative Services and Devices		
Base Benchmark Benefit that was Substituted: Diagnostic Tests (x-rays and lab work)	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Other Laboratory and X-Ray Services, under the EHB Laboratory Services		
Base Benchmark Benefit that was Substituted: Imaging (CT/PET/MRI)	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Other Laboratory and X-Ray Services, under the EHB Laboratory Services		
Base Benchmark Benefit that was Substituted: Preventive care / screening / immunization	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services, under the EHB Preventive and wellness Services and Chronic Disease Management		
Base Benchmark Benefit that was Substituted: Routine Eye Exam for Children	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care		
Base Benchmark Benefit that was Substituted: Eye glasses for children	Source: Base Benchmark	



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<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with EPSDT & Prescribed drugs, dentures, prosthetic devices, and eyeglasses, under EHB Pediatric services, including oral and vision care</p>		Remove
<p>Base Benchmark Benefit that was Substituted:</p> <p>Dental check-up for children</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Allergy treatment</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Physician Services, under the EHB Preventive and wellness services and chronic disease management</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Injectable drugs and other drugs administered in a</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>(Full benchmark benefit: Injectable drugs and other drugs administer in a providers' office or other OP setting) Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Services</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Medical supplies, equipment, and education for dia</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>(Full benchmark benefit: Medical supplies, equipment, and education for diabetes care for all diabetics) Duplication: This benefit was replaced with Prescription drugs, under the EHB Prescription drugs and Physician Services under EHB Ambulatory Services. The medical supplies and equipment for diabetes care maps to the Prescription Drugs, while the education for diabetics maps to Physician Services under Ambulatory.</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Dental services for accidental injury and other re</p>	<p>Source:</p> <p>Base Benchmark</p>	
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>(Full benchmark benefit: Dental services for accidental injury and other related medical services)</p>		



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<p>Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services</p>		Remove
<p>Base Benchmark Benefit that was Substituted:</p> <p>Human organ and tissue transplant transplant servi</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Inpatient hospital services and Physician Services, under the EHB Hospitalization</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Human organ and tissue transplant services - trans</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Inpatient hospital services and Physician Services, under the EHB Hospitalization</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Human organ and tissue transplant services - unrel</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>(Full benchmark benefit: Human organ and tissue transplant services - unrelated donor search)</p> <p>Duplication: This benefit was replaced with Inpatient Hospital Services</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Autism Services for children</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Radiation therapy</p>	<p>Source:</p> <p>Base Benchmark</p>	Remove
<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services</p>		
<p>Base Benchmark Benefit that was Substituted:</p> <p>Chemotherapy</p>	<p>Source:</p> <p>Base Benchmark</p>	



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<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Infusion Therapy"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Renal dialysis/hemodialysis"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Vision correction after surgery or accident"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>This benefit was replaced with Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory patient services</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Other practitioner office visit"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Certified pediatric or family Nurse Practitioner services, under the EHB Ambulatory services</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Private duty nursing"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Private Duty Nursing, under the EHB Ambulatory Care.</p> <p>The base benchmark has a 2,000 hour limit.</p>	<p>Remove</p>



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Base Benchmark Benefit that was Substituted: Urgent Care Centers	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced by Clinic Services, under the EHB Ambulatory patient services		
Base Benchmark Benefit that was Substituted: Outpatient surgery physician / surgical	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced by Physician Services, under the EHB Ambulatory patient services and Physician Services: Maternity under the Maternity and newborn care EHB.		
Base Benchmark Benefit that was Substituted: Podiatry services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Medical care and any other type of remedial care provided by licensed practitioners: Podiatry, under the EHB Ambulatory Patient Services		
Base Benchmark Benefit that was Substituted: Other practitioner's services	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Medical care and any other type of remedial care provided by licensed practitioners: Other practitioner's services, under the EHB Ambulatory Patient Services		
Base Benchmark Benefit that was Substituted: Certified Nurse Midwife	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Nurse-midwife Services, under the EHB Maternity and Newborn Care		
Base Benchmark Benefit that was Substituted: Prescription Drug Benefits	Source: Base Benchmark	Remove
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs under the EHB Prescription drugs and Family Planning Services and Supplies under the EHB Ambulatory services.		



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<input type="button" value="Add"/>



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<input checked="" type="checkbox"/> Other Base Benchmark Benefits Not Covered		Collapse All <input type="checkbox"/>
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Non-emergency care when traveling outside the US"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="This is not permissible under federal Medicaid rules."/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Prenatal and postnatal care"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="KY pays for newborns separately from their mothers, so this benefit is not applicable for the new adult group"/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Routine eye exam"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="This benefit is not a an EHB for adults."/>		
		<input type="button" value="Add"/>



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Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All

Other 1937 Benefit Provided: Services in an ICF-IID	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Medicaid individuals who meet ICF-IDD patient status criteria		
Other: 		

Other 1937 Benefit Provided: Dental Services	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: 1 cleaning and 1 x-ray per year	Duration Limit: None	
Scope Limit: Dental services for adults 21 years of age or older		
Other: No authorization required		

Other 1937 Benefit Provided: Routine eye exam	Source: Section 1937 Coverage Option Benchmark Benefit Package	
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other: No authorization required		



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<input type="text"/>		<input type="button" value="Remove"/>
Other 1937 Benefit Provided: <input type="text" value="Family planning services and supplies"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Include counseling services, medical services and supplies"/>		
Other: <input type="text" value="In-vitro fertilization, artificial insemination, sterilization reversals, sperm banking and related services, hysterectomies, and abortions shall not be considered family planning services"/> <input type="text" value="Full State Plan Service Title: Family Planning Services and Supplies for Individuals of Child-bearing Age"/> <input type="text" value="No authorization required"/>		
Other 1937 Benefit Provided: <input type="text" value="Case management services"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Some case management services are limited to specific groups of individuals. Please see State Plan for complete listing."/>		
Other: <input type="text" value="Some case management services are limited to specific groups of individuals. Populations included:
• Children meeting the eligibility criteria of the Commission for Handicapped Children (CHC) and persons of all ages with hemophilia meeting the CHC eligibility criteria.
• Children in the custody of or at risk of being in the custody of the State; children under the supervision of the state; and adults in need of protective services.
• Children birth to three participating in the Kentucky Early Intervention Program.
• Pregnant women who are under age 20 and first time parents; and pregnant women age 20 or older who are first time parents and screen as high risk for the Health Access Nurturing Development Services (HANDS) program.
• Pregnant women, including post partum women for the 60 days after the pregnancy ends, who are receiving substance use services."/>		



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<ul style="list-style-type: none">• Individuals with a moderate or severe substance use disorder diagnosis, or co-occurring substance use and mental health disorders; with need for assistance in accessing community or recovery supports or with multi-agency involvement.• Individuals with a severe emotional disability or a serious mental illness; who are at risk of out-of-home placement or institutional care.• Individuals with at least two of the following types of co-occurring disorders, which interact to complicate treatment: (1) mental health, (2) substance use, and (3) chronic or complex physical health conditions.		<input type="button" value="Remove"/>
Other 1937 Benefit Provided: Face-to-face Tobacco Cessation for Pregnant Women	Source: Section 1937 Coverage Option Benchmark Benefit Package	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: 4 face-to-face sessions per quit attempt	Duration Limit: None	
Scope Limit: None		
Other: Full amount limit: 4 face-to-face sessions per quit attempt with a minimum of 2 quit attempts No authorization required.		
Other 1937 Benefit Provided: Nursing Facility Services for Long Term Care	Source: Section 1937 Coverage Option Benchmark Benefit Package	<input type="button" value="Remove"/>
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Meets level of care		
Other: 		
Other 1937 Benefit Provided: Ambulatory prenatal care for pregnant women furni	Source: Section 1937 Coverage Option Benchmark Benefit Package	
Authorization: Other	Provider Qualifications: Medicaid State Plan	



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Amount Limit: None	Duration Limit: None	Remove
Scope Limit: None		
Other: Full State Plan Service Title: Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period No prior authorization is required.		
		Add



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<input type="checkbox"/> Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)	Collapse All <input type="checkbox"/>
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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130808



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

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ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age.

Yes

The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

Through an Alternative Benefit Plan.

Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

State/territory provides additional EPSDT benefits through fee-for-service.

State/territory contracts with a provider for additional EPSDT services.

Please specify payment method (select one):

Risk-based capitation

Administrative services contract

Other

Other Information regarding how EPSDT benefits will be provided to participants under 21 years of age (optional):

EPSDT benefits will be administered through the prior authorization process.

MCOs have been informed that they should not deny services for children because a benefit is not covered, but may deny a service if it is not medically necessary. KY regularly monitors complaints and claim denials to verify MCO compliance.

KY provides educational materials to members about EPSDT benefits

Prescription Drug Coverage Assurances

The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

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- The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.
- The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.
- The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

- The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

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Service Delivery Systems ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- Managed care.
 - Managed Care Organizations (MCO).
 - Prepaid Inpatient Health Plans (PIHP).
 - Prepaid Ambulatory Health Plans (PAHP).
 - Primary Care Case Management (PCCM).
- Fee-for-service.
- Other service delivery system.

Managed Care Options

Managed Care Assurance

- The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The following documents the steps that the Kentucky Department for Medicaid Services (DMS) is planning to take, or is taking, to implement managed care for the Alternative Benefit Plan (ABP), including member, stakeholder, and provider outreach efforts.

General

- Actuarial Analysis – Perform cost analysis for the new benefits package.
- Increased Administrative Tasks – Request additional staff for DMS.

MCO Specific Plans

- New MCO Contract for Expansion Population – Contract with a new MCO. DMS intends to contract with a new MCO in order to better serve the expanded population. The RFP for this new contractor was issued on 7/22/2013. The contract for this new vendor was negotiated and signed on 9/13/2013.
- Additional MCO Onboarding – Inform new MCO of DMS operations. DMS will need to educate providers on the new MCO's credentialing and enrollment process. Complete
- Contract with MCOs for Expansion Population – Renegotiate with existing MCOs. DMS is also re-negotiating contracts with existing MCOs. These contracts have been signed.
- DMS MCO Relations – Train DMS staff on MCO relations. DMS staff will need to be informed of the contractual requirements for each MCO. This task is complete.
- Benefits Package Communication – Inform all MCOs of new Benefit package. The new benefits package will affect all MCOs. Details of the new benefits package were finalized on 9/27/2013. DMS then sent details of the benefits package to all MCOs. DMS has answered questions for the MCOs.
- Expanding the Provider Network – Integrate the new provider network into MCOs. DMS will support the implementation of new

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- provider networks into all MCO systems. This began on 9/16/2013 and will be ongoing as new providers are contracted.
- MCO Member Outreach – Coordinate approval of materials and plans. DMS expects MCOs to conduct their own member outreach. Materials will need to be approved by DMS before they can be disbursed at schools, faith-based organizations, community, and health fairs. DMS began approving materials for the new MCO starting 10/1/2013.
 - MCO Call Center – Update call center with Expansion-related changes. The call center staff and scripts have been updated based on changes related to Medicaid expansion.
 - Monthly Meetings – Schedule monthly and quarterly meetings with other state agencies.
 - MCO Operations – Verify functionality of day-to-day operations for all MCOs.

Member Communication

- Member Handbook – Update and distribute member handbook. DMS is updating the member handbook with information regarding benefits coverage, cost sharing changes, and special policies and procedures by 12/15/2013. This will be posted on DMS' website.
- Member Print Materials – Create and distribute print materials. DMS is coordinating with Kentucky Health Benefit Exchange (KHBE) to produce informational cards, brochures, and fact sheets regarding Medicaid Expansion. Completed 10/1/2013. Informational Cards will be two-sided and include Medicaid-only information. Brochures will include a section on Medicaid expansion, in addition to KHBE information. A Medicaid-only fact sheet has been created. In addition, Medicaid related information will be included on other facts sheets produced by KHBE as well. All fact sheets will be available on the KHBE website (<http://healthbenefitexchange.ky.gov>) and the kynect website (<http://kynect.ky.gov>).
- Member Media and Online Materials – Coordinate media and online materials. DMS is coordinating with KHBE to include Medicaid information on television advertisements and marketing outreach efforts. These efforts were completed on 8/27/2013. In addition, DMS has added a page to its website to provide an overview of Medicaid Expansion, with links to additional information (<http://chfs.ky.gov/dms/medicaid+expansion.htm>). This was completed 9/18/2013. DMS also include information on its website regarding the new benefit plan.

Stakeholder Communication

- Stakeholder Meetings – Schedule meetings with stakeholders. DMS scheduled meetings starting 9/23/2013 with key external stakeholders to discuss the MCO implementation and Medicaid expansion. Advocates for various external groups, public health departments and other state employees will be invited to these meetings. DMS is also conducting outreach and awareness sessions for its own staff. DMS held an informational session on the ACA and Expansion for its employees on 9/19/2013. DMS has begun communications with other vendors who are affected by the new benefits plan and expansion. The DMS staff is working closely with HP (the MMIS contractor), OATS (Kentucky's Office of Administrative Technology and Services), Kentucky Health Benefit Exchange, and other state government agencies to proactively communicate and implement the coming changes.

Provider Communication

- Provider Services Training – Update scripts and train provider services staff.
- o Provider services staff (the call center for providers within DMS) will need to be updated with new information regarding the expansion and the benefits package. This training will be completed by November 2013.
- Provider Training Sessions – Coordinate and hold provider training sessions via HP (vendor).
- o DMS is offering provider training to communicate ACA and Medicaid Expansion changes to the providers. To do so, it has sent providers e-mail and written communication on 9/16/2013 to notify them of upcoming dates for provider training.
- o The materials for training, including the benefit plan changes, were completed.
- o Trainings are being offered in each of the 8 Medicaid Regions (4 sessions in each Medicaid Region) throughout the fall.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

No

- The Alternative Benefit Plan will be provided through a managed care organization (MCO) consistent with applicable managed care requirements (42 CFR Part 438, and sections 1903(m), 1932 and 1937 of the Social Security Act).

MCO Procurement or Selection Method

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Indicate the method used to select MCOs:

Competitive procurement method (RFP, RFA).

Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization.

Yes

List the benefits or services that will be provided apart from the MCO, and explain how they will be provided. Add as many rows as needed.

	Benefit/service	Description of how the benefit/service will be provided	
+	Intermediate care facility for individuals with an intellectual disability	Service is provided through the Commonwealth's fee-for-service program	X
+	Hospice services provided to a recipient in an institution	Service is provided through the Commonwealth's fee-for-service program	X
+	Nonemergency transportation services	Service is provided through PAHP waiver	X
+	School-based health services	Service is provided through the Commonwealth's fee-for-service program	X
+	Health access nurturing development services	Service is provided through the Commonwealth's fee-for-service program	X
+	Early intervention program service	Service is provided through the Commonwealth's fee-for-service program	X
+	Nursing facility service for an enrollee	Service is provided through the Commonwealth's fee-for-service program	X

MCO service delivery is provided on less than a statewide basis.

No

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan:

No

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

Mandatory participation.

Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Members will select a MCO and enroll through Kentucky's Health Benefit Exchange - kynect. Member MCO selection, choice, and flexibility is in accordance with federal regulation.

Choose MCO through kynect



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If don't choose, auto assigned
90 day period to select new MCO
Auto assignment: under what circumstances; wher

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program.

No

The Alternative Benefit Plan will be provided through a prepaid ambulatory health plan (PAHP) consistent with applicable managed care requirements (42 CFR Part 438, and section 1937 of the Social Security Act).

PAHPs are paid on a risk basis.

PAHPs are paid on a non-risk basis.

PAHP Procurement or Selection Method

Indicate the method used to select PAHPs:

Competitive procurement method (RFP, RFA).

Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PAHPs:

Other PAHP-Based Service Delivery System Characteristics

List the benefits or services that will be provided apart from the PAHP, and explain how they will be provided. Add as many rows as needed.

	Benefit/service	Description of how the benefit/service will be provided	
+			X

PAHP service delivery is provided on less than a statewide basis.

PAHP Participation Exclusions

Individuals are excluded from PAHP participation in the Alternative Benefit Plan:

General PAHP Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

Mandatory participation.

Voluntary participation. Indicate the method for effectuating enrollment:

Additional Information: PAHP (Optional)

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Provide any additional details regarding this service delivery system (optional):

Non-Emergency Transportation Services - provides transportation to Medicaid Recipients who otherwise do not have a way to get to medical appointments.

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OMB Expiration date: 10/31/2014

Employer Sponsored Insurance	ABPO
<p>The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.</p>	<input type="checkbox"/> Yes
<p>Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:</p>	
<p>This program is called the Health Insurance Premium Payment (HIPP) is available to all Medicaid recipients. The program will pay the cost of the premium for any Medicaid recipient that is working and has access to employer sponsored insurance and still eligible for Medicaid provided said payments would be cost effective for Medicaid. All information is entered in our MMIS system to make determination of cost effectiveness. The system looks at their age, premium cost, and claims cost to determine cost effectiveness. The benefit information is not determinable for this SPA as it varies depending on the employer insurance and insurance company. However, any services not covered by the employer sponsored insurance Medicaid does provide wrap around coverage and would pay for additional services for the eligible Medicaid recipient.</p>	
<p>The state/territory otherwise provides for payment of premiums.</p>	<input type="checkbox"/> No
<p>Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:</p>	
<p>The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.</p>	

PRA Disclosure Statement

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General Assurances	ABP10
Economy and Efficiency of Plans	
<input checked="" type="checkbox"/> The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.	
Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.	<input type="checkbox"/> Yes
Compliance with the Law	
<input checked="" type="checkbox"/> The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.	
<input checked="" type="checkbox"/> The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).	
<input checked="" type="checkbox"/> The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.	

PRA Disclosure Statement

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Alternative Benefit Plans - Payment Methodologies

Alternative Benefit Plans - Payment Methodologies

- The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

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Alternative Benefit Plan Populations ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name:

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Parents and Other Caretaker Relatives	Voluntary	X
+	Transitional Medical Assistance	Voluntary	X
+	Pregnant Women	Voluntary	X
+	Deemed Newborns	Mandatory	X
+	Infants and Children under Age 19	Mandatory	X
+	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Voluntary	X
+	SSI Beneficiaries	Voluntary	X
+	Individuals Receiving Mandatory State Supplements	Voluntary	X
+	Individuals Who Are Essential Spouses	Mandatory	X
+	Institutionalized Individuals Continuously Eligible Since 1973	Voluntary	X
+	Blind or Disabled Individuals Eligible in 1973	Voluntary	X
+	Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	Voluntary	X
+	Individuals Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Voluntary	X
+	Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	Voluntary	X
+	Working Disabled under 1619(b)	Voluntary	X
+	Disabled Adult Children	Voluntary	X
+	Reasonable Classifications of Individuals under Age 21	Voluntary	X
+	Children with Non-IV-E Adoption Assistance	Voluntary	X



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	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Optional Targeted Low Income Children	Mandatory	X
+	Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	Voluntary	X
+	Individuals Eligible for Cash except for Institutionalization	Voluntary	X
+	Individuals Receiving Home and Community Based Services under Institutional Rules	Voluntary	X
+	Optional State Supplement - 1634 States and SSI Criteria States with 1616 Agreements	Voluntary	X
+	Institutionalized Individuals Eligible under a Special Income Level	Voluntary	X
+	Individuals Receiving Hospice Care	Voluntary	X
+	Poverty Level Aged or Disabled	Voluntary	X
+	Medically Needy Pregnant Women	Voluntary	X
+	Medically Needy Children under Age 18	Voluntary	X
+	Medically Needy Aged, Blind or Disabled	Voluntary	X
+	Former Foster Care Children	Voluntary	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

Should the State Plan and ABP not be aligned in the future, the State will counsel exempt individuals on the option to select the State Plan.

PRA Disclosure Statement

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Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under section 1902(a)(10)(A)(i)(VIII) of the Act ABP2b

These assurances must be made by the state/territory if the ABP Population includes any eligibility groups other than or in addition to the Adult eligibility group.

When offering voluntary enrollment in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent), prior to enrollment:

- The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.
- The state/territory assures it will effectively inform individuals who voluntary enroll of the following:
 - a) Enrollment is voluntary;
 - b) The individual may disenroll from the Alternative Benefit Plan at any time and regain immediate access to full standard state/territory plan coverage;
 - c) What the process is for disenrolling.
- The state/territory assures it will inform the individual of:
 - a) The benefits available under the Alternative Benefit Plan; and
 - b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan differs from the approved Medicaid state/territory plan.

How will the state/territory inform individuals about voluntary enrollment? (Check all that apply.)

- Letter
- Email
- Other:

Describe:

All Medicaid beneficiaries, regardless of eligibility group, will be notified in writing within 30 days of enrollment that all Kentucky Medicaid beneficiaries receive the same benefit package, whether in the ABP or State Plan, along with a brief description of that benefit package. This notification will advise beneficiaries to contact the Department for Medicaid Services (DMS) and/or their selected Managed Care Organization (MCO) if they have questions about their benefit package or specific services. A toll free telephone number will be provided in the notification. If a member requests to be moved back into the regular state plan, members will be able to do so.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about voluntary enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Within 30 days of enrollment



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13P

Please describe the state/territory's process for allowing voluntarily enrolled individuals to disenroll.

Upon notification to DMS or the MCO

The state/territory assures it will document in the exempt individual's eligibility file that the individual:

- a) Was informed in accordance with this section prior to enrollment;
- b) Was given ample time to arrive at an informed choice; and
- c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.

Where will the information be documented? (Check all that apply.)

- In the eligibility system.
- In the hard copy of the case record.
- Other:

Describe:

The ABP is fully aligned with Kentucky's State Plan benefit package. Since the notification described above will be a universal notification to all Medicaid beneficiaries upon enrollment, documentation will be centralized.

What documentation will be maintained in the eligibility file? (Check all that apply.)

- Copy of correspondence sent to the individual.
- Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- Other:

Describe:

The universal notification along with a description of the procedure specifying how it is to be provided to all beneficiaries.

The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in an Alternative Benefit Plan and the total number who have disenrolled.

Other Information Related to Enrollment Assurance for Voluntary Participants (optional):

As indicated KY has aligned its ABP with its State Plan. In ABP1, KY stated "Should the State Plan and ABP not be aligned in the future, the State will counsel exempt individuals on the option to select the State Plan."

PRA Disclosure Statement

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Enrollment Assurances - Mandatory Participants

ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

- The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

- Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Kentucky's eligibility system identifies these individuals based on eligibility criteria.

- Self-identification

- Other

- The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.
- The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

- Review of claims data
- Self-identification
- Review at the time of eligibility redetermination
- Provider identification
- Change in eligibility group
- Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?



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- Monthly
- Quarterly
- Annually
- Ad hoc basis
- Other

- The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

The ABP and State Plan benefits are exactly equivalent, therefore, exemption processes are not applicable.

Should the State Plan and ABP not be aligned in the future, the State will counsel exempt individuals on the option to select the State Plan. The State will verify the request for exemption using the same process used for normal eligibility determination and redetermination.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

All Medicaid beneficiaries, regardless of eligibility group, will be notified in writing within 30 days of enrollment that all Kentucky Medicaid beneficiaries receive the same benefit package, whether in the ABP or State Plan, along with a brief description of that benefit package. This notification will advise beneficiaries to contact the Department for Medicaid Services (DMS) and/or their selected Managed Care Organization (MCO) if they have questions about their benefit package or specific services. A toll free telephone number will be provided in the notification. If a member requests to be moved back into the regular state plan, members will be able to do so.

Should the State Plan and ABP not be aligned in the future, the State will counsel exempt individuals on the option to select the State Plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807



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OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3

Select one of the following:

- The state/territory is amending one existing benefit package for the population defined in Section 1.
- The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package:

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- Secretary-Approved Coverage.
 - The state/territory offers benefits based on the approved state plan.
 - The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
 - The state/territory offers the benefits provided in the approved state plan.
 - Benefits include all those provided in the approved state plan plus additional benefits.
 - Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
 - The state/territory offers only a partial list of benefits provided in the approved state plan.
 - The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Selection of Base Benchmark Plan



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The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option.

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- Any of the largest three state employee health benefit plans by enrollment.
- Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- Largest insured commercial non-Medicaid HMO.

Plan name:

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The State assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
The State assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130801



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OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing

ABP4

Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807



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Benefits Description	ABP5
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The state/territory proposes a "Benchmark-Equivalent" benefit package. No

The state/territory is proposing "Secretary-Approved Coverage" as its section 1937 coverage option. Yes

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

The state/territory must provide a benefit by benefit comparison of the benefits in its proposed Secretary-Approved Alternative Benefit Plan with the benefits provided by one of the section 1937 Benchmark Benefit Packages or the standard full Medicaid state plan under Title XIX of the Act. Submit a document indicating which of these benefit packages will be used to make the comparison and include a chart comparing each benefit in the proposed Secretary-Approved benefit package with the same or similar benefit in the comparison benefit package, including any limitations on amount, duration and scope pertaining to the benefits in each benefit package.

An attachment is submitted.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Anthem PPO

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved



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Essential Health Benefit 1: Ambulatory patient services

Collapse All

Benefit Provided:

Physician Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This represents Physician services.

Benefit Provided:

Outpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is required for some services. See State Plan for complete listing

Benefit Provided:

Clinic Services

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



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Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		<input type="text"/>	<input type="button" value="Remove"/>
Benefit Provided:	Source:	<input type="text"/>	<input type="button" value="Remove"/>
<input type="text" value="Certified Pediatric or Family Nurse Practitioner"/>	<input type="text" value="State Plan 1905(a)"/>		
Authorization:	Provider Qualifications:	<input type="text"/>	
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>		
Amount Limit:	Duration Limit:	<input type="text"/>	
<input type="text" value="None"/>	<input type="text" value="None"/>		
Scope Limit:	<input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:			
<input type="text" value="Full State Plan Service Title: Certified pediatric or family Nurse Practitioner services"/>			
Benefit Provided:	Source:	<input type="text"/>	<input type="button" value="Remove"/>
<input type="text" value="Hospice Care"/>	<input type="text" value="State Plan 1905(a)"/>		
Authorization:	Provider Qualifications:	<input type="text"/>	
<input type="text" value="Prior Authorization"/>	<input type="text" value="Medicaid State Plan"/>		
Amount Limit:	Duration Limit:	<input type="text"/>	
<input type="text" value="None"/>	<input type="text" value="None"/>		
Scope Limit:	<input type="text" value="Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:			
<input type="text"/>			
Benefit Provided:	Source:	<input type="text"/>	
<input type="text" value="Private duty nursing"/>	<input type="text" value="State Plan 1905(a)"/>		
Authorization:	Provider Qualifications:	<input type="text"/>	
<input type="text" value="Prior Authorization"/>	<input type="text" value="Medicaid State Plan"/>		
Amount Limit:	Duration Limit:	<input type="text"/>	
<input type="text" value="2000 hours / year"/>	<input type="text" value="None"/>		



Alternative Benefit Plan

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Scope Limit: <input type="text" value="Services in an inpatient setting excluded"/>		<input type="button" value="Remove"/>
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: <input type="text" value="Medical care & any other type of remedial:podiatry"/>	Source: <input type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Limited to non-routine foot care; routine foot care excluded"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="Full State Plan Service Title: Medical care and any other type of remedial care provided by licensed practitioners: Podiatry"/> <input type="text" value="KY State Plan Title: Medical care and any other type of remedial care"/> <input type="text" value="Podiatry exclusions include: treatment of flatfoot; treatments undertaken for the sole purpose of correcting a subluxated structure as an isolated entity within the foot; routine footcare, except when the patient has a systemic disease of sufficient severity that unskilled performance of such procedures would be hazardous; specified methods of plethysmography. Orthopedic shoes and other supportive devices for the feet are not covered under this program element. Additional detailed explanations of these exclusions are included in the State Plan."/> <input type="text" value="This represents podiatry services"/>		
Benefit Provided: <input type="text" value="Medical care & any other type of remedial: Other"/>	Source: <input type="text" value="State Plan 1905(a)"/>	
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		



Alternative Benefit Plan

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Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		<input type="button" value="Remove"/>
Full State Plan Service Title: Medical care and any other type of remedial care provided by licensed practitioners: Other practitioner's services		
KY State Plan Title: Medical care and any other type of remedial care		
This represents services provided by other practitioners listed in the State Plan		
Benefit Provided:	Source:	<input type="button" value="Remove"/>
Family Planning Services and Supplies for Individu	State Plan 1905(a)	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
Limited to individuals of child-bearing age		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Full State Plan Service Title: Family Planning Services and Supplies for Individuals of Child-bearing Age		
		<input type="button" value="Add"/>



Alternative Benefit Plan

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<input checked="" type="checkbox"/> Essential Health Benefit 2: Emergency services		Collapse All <input type="checkbox"/>
Benefit Provided: Outpatient Hospital: Emergency department	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: Any other medical care: emergency transportation	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary This represents emergency transportation/ambulance		
		Add



Alternative Benefit Plan

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<input checked="" type="checkbox"/> Essential Health Benefit 3: Hospitalization		Collapse All <input type="checkbox"/>
Benefit Provided: Inpatient Hospital Services	Source: State Plan 1905(a)	Remove
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Authorization is done through prior, concurrent, and retroactive authorization, depending on the type of hospital and service.		
Benefit Provided: Physician: Inpatient Services	Source: State Plan 1905(a)	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents Inpatient Physician Services		
		Add



Alternative Benefit Plan

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<input checked="" type="checkbox"/> Essential Health Benefit 4: Maternity and newborn care		Collapse All <input type="checkbox"/>															
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Other diagnostic, screening, preventive, and rehab"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;"><p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p><input style="width: 95%;" type="text" value="Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitation services"/> <input style="width: 95%;" type="text" value="This benefit incorporates prenatal and postnatal care."/></td></tr></table>			Benefit Provided: <input style="width: 95%;" type="text" value="Other diagnostic, screening, preventive, and rehab"/>	Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			<p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p> <input style="width: 95%;" type="text" value="Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitation services"/> <input style="width: 95%;" type="text" value="This benefit incorporates prenatal and postnatal care."/>		
Benefit Provided: <input style="width: 95%;" type="text" value="Other diagnostic, screening, preventive, and rehab"/>	Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>															
Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>																
Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>																
Scope Limit: <input style="width: 95%;" type="text" value="None"/>																	
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<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Nurse-midwife Services"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;"><p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p><input style="width: 95%;" type="text"/></td></tr></table>			Benefit Provided: <input style="width: 95%;" type="text" value="Nurse-midwife Services"/>	Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			<p>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</p> <input style="width: 95%;" type="text"/>		
Benefit Provided: <input style="width: 95%;" type="text" value="Nurse-midwife Services"/>	Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>															
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Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>																
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<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Inpatient Hospital Services: Maternity"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/></td><td style="width: 10%; border: none;"></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="Other"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr></table>			Benefit Provided: <input style="width: 95%;" type="text" value="Inpatient Hospital Services: Maternity"/>	Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/>		Authorization: <input style="width: 95%;" type="text" value="Other"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>					
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Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>																
Scope Limit: <input style="width: 95%;" type="text" value="None"/>																	



Alternative Benefit Plan

Attachment 3.1-L

<input checked="" type="checkbox"/> Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment	Collapse All <input type="checkbox"/>															
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Inpatient Hospital Services: IP Mental Health"/></td><td style="width: 50%; border: none;">Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/></td><td style="width: 5%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="Prior Authorization"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="IP Mental Health in an IMD is not available to individuals between the ages of 21 to 64."/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%;" type="text" value="This represents Inpatient Mental Health services. These facilities are not IMDs."/></td></tr></table>		Benefit Provided: <input style="width: 95%;" type="text" value="Inpatient Hospital Services: IP Mental Health"/>	Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="Prior Authorization"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="IP Mental Health in an IMD is not available to individuals between the ages of 21 to 64."/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%;" type="text" value="This represents Inpatient Mental Health services. These facilities are not IMDs."/>		
Benefit Provided: <input style="width: 95%;" type="text" value="Inpatient Hospital Services: IP Mental Health"/>	Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>														
Authorization: <input style="width: 95%;" type="text" value="Prior Authorization"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>															
Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>															
Scope Limit: <input style="width: 95%;" type="text" value="IP Mental Health in an IMD is not available to individuals between the ages of 21 to 64."/>																
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<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Rehabilitative services: OP Mental Health"/></td><td style="width: 50%; border: none;">Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/></td><td style="width: 5%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%;" type="text" value="Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan. This represents Outpatient Mental Health services."/></td></tr></table>		Benefit Provided: <input style="width: 95%;" type="text" value="Rehabilitative services: OP Mental Health"/>	Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%;" type="text" value="Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan. This represents Outpatient Mental Health services."/>		
Benefit Provided: <input style="width: 95%;" type="text" value="Rehabilitative services: OP Mental Health"/>	Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>														
Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>															
Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>															
Scope Limit: <input style="width: 95%;" type="text" value="None"/>																
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<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Inpatient Hospital Services: IP Substance Use"/></td><td style="width: 50%; border: none;">Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/></td><td style="width: 5%; border: none;"></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="Prior Authorization"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr></table>		Benefit Provided: <input style="width: 95%;" type="text" value="Inpatient Hospital Services: IP Substance Use"/>	Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/>		Authorization: <input style="width: 95%;" type="text" value="Prior Authorization"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>							
Benefit Provided: <input style="width: 95%;" type="text" value="Inpatient Hospital Services: IP Substance Use"/>	Source: <input style="width: 95%;" type="text" value="State Plan 1905(a)"/>															
Authorization: <input style="width: 95%;" type="text" value="Prior Authorization"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>															
Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>															



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Scope Limit:		
<input type="text" value="None"/>		<input type="button" value="Remove"/>
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="This represents IP Substance Use Disorder Services
These facilities are not IMDs"/>		
Benefit Provided:	Source:	
<input type="text" value="Rehabilitative services: OP Substance Use"/>	<input type="text" value="State Plan 1905(a)"/>	<input type="button" value="Remove"/>
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan
This represents OP Substance Use Disorder Services"/>		
		<input type="button" value="Add"/>



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Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

The Commonwealth of Kentucky's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.



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Essential Health Benefit 7: Rehabilitative and habilitative services and devices Collapse All

Benefit Provided:

Physical therapy & related svcs: PT

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

20 visits per calendar year

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

State Plan Service Title: Physical therapy and related services

20 visits per year for physical therapy; benefit limits are aggregated between habilitation and rehabilitation services.

Benefit Provided:

Home Health: Medical supplies, equipment, and appl

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Specific restrictions and exclusions are found in the fee schedule

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Full State Plan Service Title: Home Health: Medical supplies, equipment, and appliances suitable for use in the home

KY State Plan Title: Home Health: Medical supplies suitable for use in the home

Prior authorization is required for items of equipment or repairs greater than \$500 and certain other specified items.

Benefit Provided:

Prosthetics

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan



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Amount Limit: None	Duration Limit: None	Remove
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization is required for items of equipment or repairs greater than \$500 and certain other specified items.		
Benefit Provided: Nursing Facility Services (21 and older)	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Meets level of care		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This is a nursing facility for rehabilitative purposes. The base benchmark limits the number of days in a nursing facility to 90 day.		
Benefit Provided: Medical and other types of remedial care: chiropra	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 26 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents chiropractic services		
Benefit Provided: Nursing Facility Services (for individuals age 65	Source: State Plan 1905(a)	



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Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	Remove
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plant Service Title: Nursing Facility Services (for individuals age 65 or older in an IMD)		
Benefit Provided: Physical therapy & related svcs: OT	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 20 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: Physical therapy and related services 20 visits per year for occupational therapy; benefit limits are aggregated between habilitation and rehabilitation services.		
Benefit Provided: Physical therapy & related svcs: ST	Source: State Plan 1905(a)	
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: 20 visits per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: Physical therapy and related services		



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20 visits per year for speech therapy; benefit limits are aggregated between habilitation and rehabilitation services.		Remove
Benefit Provided: Home health services; nursing, aide, and therapy	Source: State Plan 1905(a)	Remove
Authorization: Prior Authorization	Provider Qualifications: Medicaid State Plan	
Amount Limit: PT/OT/ST: 20 visits each per calendar year	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: This represents the home health visit, including PT/OT/SLT (if applicable) 20 visits each per calendar year for physical, occupational, and speech therapy; benefit home health services		
		Add



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<input checked="" type="checkbox"/> Essential Health Benefit 8: Laboratory services		Collapse All <input type="checkbox"/>
Benefit Provided: Other Laboratory and x-Ray Services	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Some imaging services require a prior authorization. See State Plan for complete listing.		
		<input type="button" value="Add"/>



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Essential Health Benefit 9: Preventive and wellness services and chronic disease management Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Preventive Services"/>	<input type="text" value="State Plan 1905(a)"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:	<input type="text" value="Supplements existing benefits with any additions to comply with USPSTF, ACIP, IOM, and Bright Futures."/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Full State Plan Service Title: Other diagnostic, screening, preventive, and rehabilitative services, i.e. other than those provided elsewhere in this plan"/>		
<input type="text" value="This benefit includes preventive services"/>		

Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Physician services: allergy"/>	<input type="text" value="State Plan 1905(a)"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Medicaid State Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:	<input type="text" value="None"/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text"/>		



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<input checked="" type="checkbox"/> Essential Health Benefit 10: Pediatric services including oral and vision care		Collapse All <input type="checkbox"/>
Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: State Plan Service Title: EPSDT Prior Auth required for orthodontia		
Benefit Provided: Medicaid State Plan EPSDT Benefits	Source: State Plan 1905(a)	<input type="button" value="Remove"/>
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: Limited to children under 21 years of age		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Full State Plan Service Title: Inpatient psychiatric facility services for individuals under 21 years of age These services are not in an IMD		
		<input type="button" value="Add"/>



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Other Covered Benefits from Base Benchmark

Collapse All



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<input checked="" type="checkbox"/> Base Benchmark Benefits Not Covered due to Substitution or Duplication		Collapse All <input type="checkbox"/>
Base Benchmark Benefit that was Substituted: <input type="text" value="Primary Care Visit"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Patient Services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Specialist Visit"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Patient Services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Outpatient facility fee"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Clinic Services and Outpatient Hospital Services, under the EHB Ambulatory Patient Services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Hospice"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Hospice care, under the EHB Ambulatory services"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Home health care services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Home Health Services, under the EHBs Ambulatory Patient Services & Rehabilitative and habilitative services and devices"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="ER Services"/>	Source: Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Outpatient Hospital Services, as well as Outpatient Hospital:"/>		



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Emergency department, under the EHB Emergency Services. Emergency hospital services are covered as outpatient hospital services in Medicaid.		<input type="button" value="Remove"/>
Base Benchmark Benefit that was Substituted: <input type="text" value="Emergency Transportation / Ambulance"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary, under the EHB Emergency Services ."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Inpatient Hospital Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Inpatient Hospital Services, under the EHB Hospitalization."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Inpatient physician and surgical services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physician Services, under the EHB Hospitalization."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Skilled nursing facility"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Nursing Facility Services (for individuals age 65 or older in an IMD) & Nursing Facility Services (21 and older) , under the EHBs Rehabilitative and Habilitative Services and Devices"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Prenatal and postnatal care"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services, under the EHB Maternity and Newborn Care."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Delivery and all inpatient services for maternity"/>	Source: Base Benchmark	



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<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Inpatient hospital services: Maternity, under the EHB Maternity and Newborn Care.</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Mental/behavioral health outpatient services"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services & EPSDT, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Mental/behavioral health inpatient services"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Inpatient Hospital Services: IP Substance Use, and Inpatient psychiatric facility services for individuals under 21 years of age, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health, and the EPSDT EHB, respectively</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Substance Abuse Disorder Outpatient Services"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services & Extended services to pregnant women, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Substance Abuse Disorder Inpatient Services"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Inpatient Hospital Services, under the EHB Mental Health and Substance Use Disorder Services, including Behavioral Health</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Generic Drugs"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Prescription drugs, Dentures, Prosthetic Devices, and Eyeglasses under the EHB Prescription Drugs</p>	<p>Remove</p>



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Base Benchmark Benefit that was Substituted: <input type="text" value="Preferred Brand Drugs"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Non-Preferred Brand Drugs"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Specialty Drugs"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Outpatient Rehabilitation Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physical Therapy and related Services, under the EHB Rehabilitative and Habilitative Services and Devices"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Habilitation Services"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physical Therapy and related Services, under the EHB Rehabilitative and Habilitative Services and Devices"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Chiropractic Care"/>	Source: Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Medical care and any other type of remedial care, under the Rehabilitative and Habilitative Services and Devices. This benefit is limited to 12 visits per year in the base"/>		



Alternative Benefit Plan

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<input type="text" value="benchmark plan."/>		<input type="button" value="Remove"/>
Base Benchmark Benefit that was Substituted: <input type="text" value="Durable Medical Equipment"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Family Planning Services and Supplies for Individuals of Child-bearing Age under the EHB for Ambulatory Services, and Home Health: Medical supplies, equipment, and appliances suitable for use in the home, as well as Prosthetics, under the EHB Rehabilitative and Habilitative Services and Devices."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Hearing Aides"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with EPSDT & Home Health: Medical supplies, equipment, and appliances suitable for use in the home, under the EHB Rehabilitative and Habilitative Services and Devices."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Diagnostic Tests (x-rays and lab work)"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Other Laboratory and X-Ray Services, under the EHB Laboratory Services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Imaging (CT/PET/MRI)"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Other Laboratory and X-Ray Services, under the EHB Laboratory Services."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Preventive care / screening / immunization"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Other diagnostic, screening, preventive, and rehabilitation services, under the EHB Preventive and wellness Services and Chronic Disease Management."/>		



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Base Benchmark Benefit that was Substituted: <input type="text" value="Routine Eye Exam for Children"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Eye glasses for children"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with EPSDT & Prescribed drugs, dentures, prosthetic devices, and eyeglasses, under EHB Pediatric services, including oral and vision care"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Dental check-up for children"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Allergy treatment"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="Duplication: This benefit was replaced with Physician Services, under the EHB Preventive and wellness services and chronic disease management"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Injectable drugs and other drugs administered in a"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="(Full benchmark benefit: Injectable drugs and other drugs administer in a providers' office or other OP setting)"/> <input type="text" value="Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory Services"/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Medical supplies, equipment, and education for dia"/>	Source: Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: <input type="text" value="(Full benchmark benefit: Medical supplies, equipment, and education for diabetes care for all diabetics)"/> <input type="text" value="Duplication: This benefit was replaced with Prescription drugs, under the EHB Prescription drugs and"/>		



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<p>Physician Services under EHB Ambulatory Services. The medical supplies and equipment for diabetes care maps to the Prescription Drugs, while the education for diabetics maps to Physician Services under Ambulatory.</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Dental services for accidental injury and other re</p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: (Full benchmark benefit: Dental services for accidental injury and other related medical services) Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Human organ and tissue transplant transplant servi</p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Inpatient hospital services and Physician Services, under the EHB Hospitalization</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Human organ and tissue transplant services - trans</p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with Inpatient hospital services and Physician Services, under the EHB Hospitalization</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Human organ and tissue transplant services - unrel</p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: (Full benchmark benefit: Human organ and tissue transplant services - unrelated donor search) Duplication: This benefit was replaced with Inpatient Hospital Services</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Autism Services for children</p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Duplication: This benefit was replaced with EPSDT, under the EHB Pediatric services, including oral and vision care</p>	<p>Remove</p>
<p>Base Benchmark Benefit that was Substituted: Radiation therapy</p> <p>Source: Base Benchmark</p>	



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Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Chemotherapy"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Infusion Therapy"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Renal dialysis/hemodialysis"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: This benefit was replaced with Outpatient hospital services, under the EHB Ambulatory patient services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Vision correction after surgery or accident"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="This benefit was replaced with Duplication: This benefit was replaced with Physician Services, under the EHB Ambulatory patient services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Other practitioner office visit"/>	Base Benchmark	
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		<input type="button" value="Remove"/>
<input type="text" value="Duplication: This benefit was replaced with Certified pediatric or family Nurse Practitioner services, under the EHB Ambulatory services"/>		
Base Benchmark Benefit that was Substituted:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Private duty nursing"/>	Base Benchmark	



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<p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Private Duty Nursing, under the EHB Ambulatory Care</p> <p>The base benchmark has a 2,000 hour limit.</p>	<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Urgent Care Centers"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced by Clinic Services, under the EHB Ambulatory patient services</p>	<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Outpatient surgery physician / surgical"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced by Physician Services, under the EHB Ambulatory patient services and Physician Services: Maternity under the Maternity and newborn care EHB.</p>	<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Podiatry services"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Medical care and any other type of remedial care provided by licensed practitioners: Podiatry, under the EHB Ambulatory Patient Services</p>	<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Other practitioner's services"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Medical care and any other type of remedial care provided by licensed practitioners: Other practitioner's services, under the EHB Ambulatory Patient Services</p>	<input type="button" value="Remove"/>
<p>Base Benchmark Benefit that was Substituted: <input type="text" value="Certified Nurse Midwife"/></p> <p>Source: Base Benchmark</p> <p>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</p> <p>Duplication: This benefit was replaced with Nurse-midwife Services, under the EHB Maternity and Newborn Care</p>	<input type="button" value="Remove"/>



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Base Benchmark Benefit that was Substituted:	Source:	
<input type="text" value="Prescription Drug Benefits"/>	Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input type="text" value="Duplication: This benefit was replaced with Prescribed drugs, Dentures, Prosthetic devices, and eyeglasses, under the EHB Prescription Drugs under the EHB Prescription drugs and Family Planning Services and Supplies under the EHB Ambulatory services."/>		
		<input type="button" value="Add"/>



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<input checked="" type="checkbox"/> Other Base Benchmark Benefits Not Covered		Collapse All <input type="checkbox"/>
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Non-emergency care when traveling outside the US"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="This is not permissible under federal Medicaid rules."/>		
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark	<input type="button" value="Remove"/>
<input type="text" value="Routine eye exam"/>		
Explain why the state/territory chose not to include this benefit:		
<input type="text" value="This benefit is not a an EHB for adults."/>		
		<input type="button" value="Add"/>



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<input checked="" type="checkbox"/> Other 1937 Covered Benefits that are not Essential Health Benefits		Collapse All <input type="checkbox"/>
<p>Other 1937 Benefit Provided: <input type="text" value="Services in an ICF-IID"/></p> <p>Authorization: <input type="text" value="Prior Authorization"/></p> <p>Amount Limit: <input type="text" value="None"/></p> <p>Scope Limit: <input type="text" value="Medicaid individuals who meet ICF-IDD patient status criteria"/></p> <p>Other: <input type="text"/></p>	<p>Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/></p> <p>Provider Qualifications: <input type="text" value="Medicaid State Plan"/></p> <p>Duration Limit: <input type="text" value="None"/></p>	<input type="button" value="Remove"/>
<p>Other 1937 Benefit Provided: <input type="text" value="Dental Services"/></p> <p>Authorization: <input type="text" value="Other"/></p> <p>Amount Limit: <input type="text" value="1 cleaning and 1 x-ray per year"/></p> <p>Scope Limit: <input type="text" value="Dental services for adults 21 years of age or older"/></p> <p>Other: <input type="text" value="No authorization required"/></p>	<p>Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/></p> <p>Provider Qualifications: <input type="text" value="Medicaid State Plan"/></p> <p>Duration Limit: <input type="text" value="None"/></p>	<input type="button" value="Remove"/>
<p>Other 1937 Benefit Provided: <input type="text" value="Routine eye exam"/></p> <p>Authorization: <input type="text" value="Other"/></p> <p>Amount Limit: <input type="text" value="None"/></p> <p>Scope Limit: <input type="text" value="None"/></p> <p>Other: <input type="text" value="No authorization required"/></p>	<p>Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/></p> <p>Provider Qualifications: <input type="text" value="Medicaid State Plan"/></p> <p>Duration Limit: <input type="text" value="None"/></p>	<input type="button" value="Remove"/>



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<input type="text"/>		<input type="button" value="Remove"/>
Other 1937 Benefit Provided: <input type="text" value="Case management services"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Some case management services are limited to specific groups of individuals. Please see State Plan for complete listing."/>		
Other: <input type="text" value="Some case management services are limited to specific groups of individuals. Populations included:
• Children meeting the eligibility criteria of the Commission for Handicapped Children (CHC) and persons of all ages with hemophilia meeting the CHC eligibility criteria.• Children in the custody of or at risk of being in the custody of the State; children under the supervision of the state; and adults in need of protective services.• Children birth to three participating in the Kentucky Early Intervention Program.• Pregnant women who are under age 20 and first time parents; and pregnant women age 20 or older who are first time parents and screen as high risk for the Health Access Nurturing Development Services (HANDS) program.• Pregnant women, including post partum women for the 60 days after the pregnancy ends, who are receiving substance use services.• Individuals with a moderate or severe substance use disorder diagnosis, or co-occurring substance use and mental health disorders; with need for assistance in accessing community or recovery supports or with multi-agency involvement.• Individuals with a severe emotional disability or a serious mental illness; who are at risk of out-of-home placement or institutional care.• Individuals with at least two of the following types of co-occurring disorders, which interact to complicate treatment: (1) mental health, (2) substance use, and (3) chronic or complex physical health conditions."/>		
Other 1937 Benefit Provided: <input type="text" value="Face-to-face Tobacco Cessation for Pregnant Women"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	
Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	
Amount Limit: <input type="text" value="4 face-to-face sessions per quit attempt"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		



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Other:	
Full amount limit: 4 face-to-face sessions per quit attempt with a minimum of 2 quit attempts	<input type="button" value="Remove"/>
No authorization required	
<hr/>	
Other 1937 Benefit Provided:	Source:
Nursing Facility Services for Long Term Care	Section 1937 Coverage Option Benchmark Benefit Package
<input type="button" value="Remove"/>	
Authorization:	Provider Qualifications:
Prior Authorization	Medicaid State Plan
Amount Limit:	Duration Limit:
None	None
Scope Limit:	
Meets level of care	
Other:	
<input type="text"/>	
<hr/>	
Other 1937 Benefit Provided:	Source:
Ambulatory prenatal care for pregnant women furni	Section 1937 Coverage Option Benchmark Benefit Package
<input type="button" value="Remove"/>	
Authorization:	Provider Qualifications:
Other	Medicaid State Plan
Amount Limit:	Duration Limit:
None	None
Scope Limit:	
None	
Other:	
Full State Plan Service Title: Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period	
No prior authorization is required.	
<input type="button" value="Add"/>	



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<input type="checkbox"/> Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)	Collapse All <input type="checkbox"/>
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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20130808



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

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Benefits Assurances

ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

- Through an Alternative Benefit Plan.
- Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

- State/territory provides additional EPSDT benefits through fee-for-service.
- State/territory contracts with a provider for additional EPSDT services.

Please specify payment method (select one):

- Risk-based capitation
- Administrative services contract
- Other

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

EPSDT benefits will be administered through the prior authorization process.

MCOs have been informed that they should not deny services for children because a benefit is not covered, but may deny a service if it is not medically necessary. KY regularly monitors complaints and claim denials to verify MCO compliance.

KY provides educational materials to members about EPSDT benefits

Prescription Drug Coverage Assurances

The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.



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- The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.
- The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.
- The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

- The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



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V.20130807

TN No: 13-021
Kentucky

Approval Date: 12/20/13
ABP7-3

Effective Date: 01/01/14



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OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

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Service Delivery Systems

ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- Managed care.
 - Managed Care Organizations (MCO).
 - Prepaid Inpatient Health Plans (PIHP).
 - Prepaid Ambulatory Health Plans (PAHP).
 - Primary Care Case Management (PCCM).

Fee-for-service.

Other service delivery system.

Managed Care Options

Managed Care Assurance

- The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

As authorized in the existing 1915(b) waiver KY-07.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

Yes

The managed care program is operating under (select one):

- Section 1915(a) voluntary managed care program.
- Section 1915(b) managed care waiver.
- Section 1932(a) mandatory managed care state plan amendment.
- Section 1115 demonstration.
- Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:

Dec 28, 2012



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Describe program below:

KY-07 allows for mandatory enrollment for Medicaid beneficiaries into managed care. Beneficiaries have the choice of two to four managed care organizations depending on the region of state in which they reside.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program.

Yes

The managed care program is operating under (select one):

- Section 1915(a) voluntary managed care program.
- Section 1915(b) managed care waiver.
- Section 1115 demonstration.
- Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS:

Sep 25, 2013

Describe program below:

Non-Emergency Transportation Services: KY-06 provides transportation under a capitated arrangement with regional transportation brokers for eligible Medicaid members requiring transportation to and from approved non-emergency medical services.

Additional Information: PAHP (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130718



Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums

ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

Yes

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

This program is called the Health Insurance Premium Payment (HIPP) is available to all Medicaid recipients. The program will pay the cost of the premium for any Medicaid recipient that is working and has access to employer sponsored insurance and still eligible for Medicaid provided said payments would be cost effective for Medicaid. All information is entered in our MMIS system to make determination of cost effectiveness. The system looks at their age, premium cost, and claims cost to determine cost effectiveness. The benefit information is not determinable for this SPA as it varies depending on the employer insurance and insurance company. However, any services not covered by the employer sponsored insurance Medicaid does provide wrap around coverage and would pay for additional services for the eligible Medicaid recipient.

The state/territory otherwise provides for payment of premiums.

No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

General Assurances

ABP10

Economy and Efficiency of Plans

- The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.

Yes

Compliance with the Law

- The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.
- The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).
- The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20130807

TN No: 13-021
Kentucky

Approval Date: 12/20/13
ABP10-1

Effective Date: 01/01/14



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-L

Payment Methodology

ABP11

Alternative Benefit Plans - Payment Methodologies

- The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Kentucky

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

Yes No

2. Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

Yes No

3. All individuals eligible under the State's approved title XIX plan.

4. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. Eligible categorically needy individuals

3. Eligible medically needy individuals

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

Attachment 4.11-A
Page 14.1

STANDARDS FOR INSTITUTIONS

Standards to be utilized by state authorities for approval of institutions to participate in Title XIX of the Social Security Act are as follows:

1. Standards established for institutional certification by Title XVIII of the Social Security Act. The types and kinds of institutions in which medical care and services may be provided to eligible recipients are:
 - a. Hospitals certified to participate under Title XVIII of the Social Security Act or determined currently to meet the requirements for such participation.
 - b. State and private institutions for mental diseases which meet the requirements for a psychiatric hospital under Title XVIII, Section 1861 (f) of the Social Security Act.
 - c. State institutions for tuberculosis which meet the requirements for a tuberculosis hospital under Title XVIII, Section 1861 (g) of the Social Security Act.
 - d. Skilled nursing facilities certified to participate under Title XVIII of the Social Security Act or determined currently to meet the requirements for such participation.
2. Standards governing Title XIX requirements of participation for intermediate care facilities are described as follows:
 - a. Meet federal, state and local laws and hold a current license as an intermediate care facility.
 - b. Have an advisory physician or a medical advisory committee composed at least one licensed physician who shall be responsible for advising the administrator on the overall medical management of the patients in the facility.
 - c. Have an administrator responsible for the written program of medical services that indicates the scope of care to be provided, the policies relating to, and procedures for implementation of the services.
 - d. Assure that each patient is under the supervision of a licensed physician;
 - e. Have a Director of Nursing Services responsible for the supervision of the organized nursing staff and the nursing services that are provided in the facility, establishing minimum qualifications for nursing personnel and participating in the development of policies related to patient care.

- f. Have procedures for administration of pharmaceutical services in accordance with accepted medical practice.
- g. Establish and maintain adequate records which shall include a medical record for each patient, financial records of personal money for each patient, and a permanent chronological patient registry indicating date of admission, discharge, or death.
- h. Have a qualified Director of Food Service who is responsible for the provision of dietary services that will maintain adequate nutrition and contribute appreciably to the patients total well—being.
- i. Have social services available to assist all residents in dealing with related social problems.
- j. Maintain administrative records to reflect expenditures related to food purchase and personnel employed by the facility.
- k. Be in compliance with Title VI of the Civil Rights Act of 1964.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State Kentucky

Attachment 4.16-A
Page 18.1

Cooperative Arrangements with State Health and State Vocational
Rehabilitation Agencies

The following is a description of the cooperative arrangements with the State health and State vocational rehabilitation agencies by means of which the services administered or supervised by those agencies will be utilized to the maximum degree and will be coordinated with the medical care and services provided by State agency under the plan:

1. The agreement with the Bureau of Rehabilitation Service, Department of Education, the state vocational rehabilitation agency, provides for fulfillment of the requirements of 42 FR 431.615. A copy of this agreement is attached. (Attachment 4.16-A.1)
2. The provisions of the agreement between the former Departments of Health and Economic Security fulfill the requirements of 42 CFR 431.615 and continue to remain in force. A copy of this agreement is attached. (Attachment 4.16-A.2)
3. The intra-cabinet memorandum of agreement with the Department for Health Services provides for preventive and remedial health care services for eligible Medicaid recipients and fulfills the requirements of 42 CFR 431.615.
4. The intra-cabinet memorandum of agreement with the Department for Mental Health and Mental Retardation Services provides for prescreening, annual resident review, and other administrative functions relating to Preadmission Screening and Annual Resident Review (PASAPR) and fulfills the requirements of 42 CFR 431.620.
5. The state agency provides for the coordination of the operations under Title XIX with the states operations under the special supplemental food program for Women, Infants, and Children under Section 17 of the Child Nutrition Act of 1966 by notifying all Medicaid recipients of the availability of WIC benefits and referring such potential WIC eligible to the WIC Program.
6. The interagency memorandum of agreement with the Commission for Handicapped Children provides for Title V Grantee services and fulfills the requirements of 42 CFR 431.615.

TN No. 92-10
Supersedes
TN No. 90-29

Approval Date 5/12/92

Effective Date 4-1-1992

7. The intra-cabinet memorandum of agreement with the Department for Public Health, the Department for Community Based Services and the Department for Mental Health and Mental Retardation Services provides for targeted case management services for Medicaid eligible recipients including children in the custody of or at risk of being in the custody of the state, and children under the supervision of the state, and adults who may require protective services from the state, and fulfills the requirements of 42 CFR 431.615.
8. The intra-cabinet memorandum of agreement with the Department for Public Health, the Department for Community Based Services and the Department for Mental Health and Mental Retardation Services provides for rehabilitative services for children in the custody of or at risk of being in the custody of the state, and for children under the supervision of the state, and fulfills the requirements of 42 CFR 431 .615.

9. The interagency agreements with the Commission for Children with Special Health Care Needs and the Department for Public Health provide for targeted case management, and diagnostic, preventive, and rehabilitative early intervention services for Medicaid eligible recipients participating in the Kentucky Early Intervention Program for infants and toddlers, and fulfills the requirements of 42 CFR 431-615.

10. The Title V interagency agreement with the Department for Public Health provides for targeted case management to first time parenting pregnant women and their infants and toddlers up to three (3) years of age. Eligible recipients are those women and their infants that screen positive on the screening tool adopted for use in the Health Access Nurturing Development Services (HANDS) program.

A G R E E M E N T

This Agreement is for the purpose of clarifying the relationship between a program of rehabilitation services administered through the Bureau of Rehabilitation Services of the Kentucky Department of Education and a program of medical assistance administered by the Department of Economic Security, in cooperation with the State Department of Health, under Title XIX of the Social Security Act. The Agreement also serves to formalize procedures and practices that are presently in force between the Department and the Bureau. A cooperative relationship has long existed between the two Agencies in the matter of services to and referral of mutual clients.

The Department and Bureau agrees to use the facilities of each Agency for rehabilitating applicants and recipients of medical and financial assistance. This includes sharing of information between agencies on mutual clients and to respect the confidential nature of information made available by either Agency.

In recognition of the fact that a very large number of individuals who receive services from the Bureau will be eligible for medical care benefits administered by the Department, staff of the Bureau will be alert to referral to the Department of individuals who may qualify for such benefits. Staff of the Department will refer to the Bureau those recipients who are in need of rehabilitation services.

Title XIX funds will be used to pay for medical services, within the scope of the Department's program, which are a part of the plan of treatment and rehabilitation of individuals eligible under Title XIX. The Bureau will thus be enabled to broaden the benefits of its program to individuals in need of service who are not eligible for Title XIX benefits, or to provide additional supplementary benefits. Except, Bureau funds will be used in the event of necessity to maintain quality of care.

Policies of either Agency known to effect the cooperative work of the agencies will be jointly evaluated. Plans to effect policy changes needed to achieve joint, goals will be joint efforts.

The Bureau and the Department hereby agree to direct all other of their activities toward using the resources of the two Agencies to the best advantage of clients served jointly.

/s/ Ben F. Coffman
Ben F. Coffman
Assistant Superintendent
Bureau of Rehabilitation Service
Department of Education

/s/ C. Leslie Dawson
Leslie Dawson
Commissioner
Department of Economic Security

6/14/66
Date

6/14/66
Date

CONTRACT

This agreement entered into this 27th day of December, 1960, between the Department of Economic Security, party of the first part, and the State Department of Health, party of the second part, is made pursuant and subject to the provisions of Sections 205.510 to 206.610, 205.991 and 211.106 of the Kentucky Revised Statutes:

WITNESSETH:

WHEREAS, the 1960 General Assembly of the commonwealth of Kentucky by the enactment of Sections 205.510 – 205.610, 205.991 and 211.106 of the Kentucky Revised Statutes, has recognized and declared that it is an essential function, duty and responsibility of the Commonwealth of Kentucky to provide medical care to its indigent citizenry; and

WHEREAS, the General Assembly has directed that the Department of Economic Security shall contract with the State Department of Health for the purpose of carrying out the medical aspects of the Medical Care Program for Indigent Persons in accordance with the intent of said Sections 205.510 – 206.610, 205.991 and 211.106 of the Kentucky Revised Statutes;

NOW, THEREFORE, in consideration of the covenants and premises hereinafter set out, the parties hereto, in order to implement, carry out and fulfill the duties and responsibilities placed upon the parties by the enactment into law of the Medical Care Program for Indigent Persons do agree as follows:

1. The party of the first part will provide funds to the party of the second part, within limitations to be hereafter agreed to from time to time by the parties, giving consideration to existing budgetary conditions for the actual, necessary expenses which second party incurs in carrying out the duties and responsibilities outline herein.
2. The party of the second part shall carry out the medical care aspects of the Program and in doing so will among other things:
 - a. Certify that services rendered are in accordance with quantity and quality standards as established;
 - b. Certify to the Department of Economic Security that medical services have been rendered by qualified vendors;
 - c. Develop and maintain manuals of policies, procedures, and instructions for the operation of the medical aspects of the Program;
 - d. Develop bases of payment for medical care and any alterations therein; and certify vendor billings for compliance with bases of payment as established;

- e. evaluate the medical aspects of the Program, and assist in the. evaluation of the total Program, and in preparing recommendations for alterations therein;
 - f. establish and maintain separately or jointly with first party statistical procedures and methods for the accumulation of accurate records on utilization of the Program; and for use as a control technique in the enforcement of quality and quantity standards; and for use in the evaluation of the Program and recommendations for alterations therein;
 - g. prepare periodic program reports and other reports and materials;
 - h. provide staff assistance to the Advisory Council for Medical Assistance;
 - i. work with the technical advisory committees and county medical review committees as they carry out their functions;
 - j. develop and recommend rules and regulations pertaining to quality and quantity standards for medical aspects of the Program;
 - k. jointly with the first party establish and maintain effective channels for the dissemination of information regarding the Program to professional organizations involved and to the public;
 - l. assist local health departments in working with community groups and organizations interested in the Medical Care Program;
 - m. perform all other duties required of said second party by law or regulations promulgated thereunder, and all other duties agreed to by the parties.
3. In the event the appropriate funds become insufficient to provide medical services on a uniform basis pursuant to this contract, the Department of Health shall consult with and advise the Department of Economic Security as to the best method of expenditure reduction and upon the manner and method of reduction of medical services for the duration of such insufficiency of funds. In like manner, in the event that, appropriated funds are over and above the amount necessary to provide medical services in accordance with established regulations, the Department of Health shall consult with and advise the Department of Economic Security as to the method of expanding services provided and upon the manner and method of expansion of medical services for the duration of such surplus of funds.

4. The parties hereto further agree that second party will maintain adequate records of administrative expenditures and should a Federal audit exception be taken to an administrative expenditure made by second party, and said exception later sustained, then second party shall refund to first party the amount of the excepted expenditure.

This Agreement shall continue in full force and effect until terminated in writing by both parties or cancelled by either party upon written notice to the other party given at least sixty (60) days prior to the designated termination date, at which time both parties shall enter into a new contract.

IN TESTIMONY WHEREOF, the party of the first part has caused this instrument to be executed by Jo M. Ferguson, its Commissioner, and the party of the second party by Russell E. Teague, M.D., its Commissioner, the day and date first above written.

Approved: /s/ William L. Brooks DEPARTMENT OF ECONOMIC SECURITY
Party of the First Part
Asst. Attorney General
Department of Finance

Approved: /s/ Maurice F. Carpenter By /s/ Jo M. Ferguson
Director of Purchases . Jo M. Ferguson
Commissioner

Approved: /s/ Robert Matthews, Jr. STATE DEPARTMENT OF HEALTH
Party of the Second Part
Commissioner of Finance

By /s/ Russell E. Teague, M.D.
Russell E. Teague, M. D.
Commissioner

Liens and Adjustments or Recoveries

- A. The Medicaid agency uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home as specified under regulations at 42 CFR 433.36(d):

Kentucky does not impose liens against property, therefore the specified determination is not applicable.

- B. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR 433.36(f):

Kentucky does not impose liens against property, therefore the specified criteria is not applicable.

- C. The Medicaid agency uses the following definitions:

Aged institutionalized individual - a recipient age fifty five (55) or older who received Nursing Facility (NF) services, Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (ICF/MRIDD) services, Home and Community Based Services (HCBS) or Supports for Community Living (SCL) services with payment for these services made, wholly or in part, by the Medicaid Program.

Estate - all real and personal property or other assets in which the deceased recipient had a legal title or interest, to the extent of his or her interest, as defined for purposes of state probate law. In addition, it shall include all other assets in which the deceased individual had legal title or interest at the time of death, to the extent of his or her interest. Examples include assets conveyed to a survivor, heir or assign of the deceased recipient through joint tenancy, tenancy in common survivorship, life estate, living trust or other arrangement.

Estate representative - the court appointed fiduciary or the fiduciary's attorney, the recipient family member or other interested party who represents to the Medicaid agency in writing that he or she is the representative for the deceased Medicaid recipient's estate.

Period of institutionalization - the period of time an aged institutionalized or permanently institutionalized individual received Medicaid services.

Liens and Adjustments or Recoveries (continued)

Permanently institutionalized — a Medicaid recipient residing in a nursing facility or intermediate care facility for the mentally retarded or developmentally disabled for six (6) months or more.

Recipient family member - the surviving spouse, child or sibling of a deceased Medicaid recipient.

Surviving child — a Medicaid recipient's living child under age 21, or a child who is blind or disabled as defined in 42 USC 1 382c.

Undue hardship - The Medicaid agency determines that an undue hardship exists when an asset subject to recovery is the sole income-producing asset, family farm or business, conveyed to the surviving recipient family member. A sole income-producing asset shall not include residential real property producing income through a lease or rental arrangement.

- D. The Medicaid agency uses the following procedure to provide general notice to the Medicaid recipient or the recipient's representative at the time of application or reapplication for institutionalized services:

The Medicaid agency provides a written general notice to the recipient or the recipient's representative that explains the provisions of the estate recovery program. The general notice contains information regarding when an estate is subject to recovery, the type of charges that will be included in an estate recovery claim, how the executor or estate representative will be notified, and information about exemptions and limitations to estate recovery.

- E. The Medicaid agency uses the following collection procedures:

1. Upon the death of an institutionalized recipient, the institutional provider is required to notify the eligibility office within ten (10) days of the death. The eligibility office then notifies the Medicaid agency of the death.
2. The Medicaid agency calculates the total estate recovery claim by totaling the claims paid on behalf of a deceased recipient for any period of institutionalization. The amount of the claim includes the following:
 - a. Where applicable, the expenditures for Nursing Facility (NF) services, Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (ICF/MRIDD) services; Home and Community Based Services (HCBS); or Supports for Community Living (SCL) services;
 - b. Costs of related prescription drugs, hospital services, related physician services, Medicare cost-sharing, or Medicare premiums; and

Liens and Adjustments or Recoveries (continued)

- c. Any capitation payment made by the Medicaid agency to a managed care organization on behalf of the deceased recipient.
 - 3. The amount recovered shall not exceed the amount paid by the Medicaid agency on behalf of the deceased recipient for services received during periods of institutionalization.
- F. The Medicaid agency uses the following procedure to file its claim and provide notice of intent to recovery to the estate representative, family member or heir of the deceased Medicaid recipient:
- 1. The agency provides written notice to the estate representative, family member or heir of the deceased Medicaid recipient if the agency has such information. If no estate representative exists, notice shall be provided to the family members or heirs if the recipient has provided the agency with this information through the eligibility application process. The estate representative is responsible for notifying individuals who are affected by the proposed recovery.
 - 2. The notice includes the action the agency intends to initiate, the reason for the action, the amount of Medicaid's claim, exemptions and limitations to estate recovery, the address to contact the Medicaid agency and advises the representative to contact the Medicaid agency if more information is needed regarding Medicaid's claim. The notice advises the representative to respond to Medicaid's claim within 60 days.
 - 3. Included with the written notice is the general notice, as provided at the time of eligibility or recertification, advising the representative of the exemptions and the conditions that are considered when requesting an undue hardship exemption. The notice also contains a listing of the documentation the Medicaid agency will accept in proof of the request for an exemption.
- G. Estate recovery may be waived if either of the following two criteria is met:
- 1. The administrative cost of recovering from the estate is more than the total date- of-death value of the estate subject to recovery.
 - a. The administrative cost shall be comprised of the estimated financial equivalent of agency staff time and resources required to recover the full claim in any individual case.

Liens and Adjustments or Recoveries (continued)

- b. This administrative cost shall be compared to actual date of death value, less any exemptions or limitations to recovery known at the time the estimate is made, including any payments made to contractors who may perform the recovery function. If the cost is equal or greater to the value subject to recovery, it shall be determined not cost effective to pursue recovery.
 - c. Based upon a review of historical data regarding the average value of cases, including extrapolated estimates of the expanded value of the estate under current rules, and the staff time and resources involved in securing recovery, the agency has determined that it is not cost effective to recover when the total date-of-death value of the estate is \$10,000 or less.
2. An undue hardship exists.
- a. The estate representative shall apply for an undue hardship exemption by making a written request to the Medicaid agency within 30 days of receipt of Medicaid's notice of the claim, and must also provide documentation to substantiate an undue hardship exists.
 - b. Medicaid will issue a decision on the exemption request within 30 days of receipt of the request and all supporting documentation. If a hardship exemption is denied, an estate representative's may request an appeal within 30 days of the denial, and an administrative hearing shall be conducted.
 - c. An undue hardship shall not exist if the deceased recipient created the hardship by resorting to estate planning methods under which the recipient illegally divested assets to avoid estate recovery.
- H. The Medicaid agency may grant an exemption of the recovery provisions on a case-by- case basis to the extent of the anticipated cost of continuing education or health care needs of an estate heir. The estate representative shall submit to the Medicaid agency a written request for an exemption and provide verification of the cost of such exemption to the satisfaction of the Medicaid agency.
- I. A deceased recipient's estate shall be subject to recovery of Medicaid expenditures if it is adjudicated through a final administrative appeal process or court action that the recipient qualified for Medicaid fraudulently. If the recipient qualified for Medicaid benefits fraudulently, the exemptions or limitations established by administrative regulation shall not apply.
- J. The Division of Program Integrity, Recovery Operations Branch or its designee is responsible for collecting the payments, considering requests for exemptions, processing hearing requests and depositing funds in the appropriate Medicaid account.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

- A. Cost Sharing Provisions Under the KyHealth Choices Benefit Plan: The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act. Cost sharing is being imposed under 1916 of the Social Security Act.

Service	Co-pay	Amount and Basis for Determination
Prescription Drugs	X	\$1 for each preferred and non-preferred generic drug or atypical antipsychotic drug that does not have a generic equivalent; \$4 for each preferred brand name drug that does not have a generic equivalent and is available under the supplemental rebate program; or \$8 for each non-preferred brand name drug. The Department for Medicaid Services (DMS) shall reduce a pharmacy provider's reimbursement by the applicable co-pay outlined above.
Audiology		\$0.00
Chiropractor	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Dental	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Hearing Aid Dealer		A co-payment will not be imposed on hearing aids.
Podiatry	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Optometry*	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
General ophthalmological services*	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Eyewear		A co-payment will not be imposed on eyewear.
Office visit for care by a physician,** physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, or nurse midwife or behavioral health professional	X	\$3.00 per each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Physician Service	X	\$3.00 per each service. DMS shall reduce a provider's reimbursement by \$3.00.

*CPT codes 92002, 92004, 92012, and 92014

**CPT codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214

- B. Preventive Health Services, including "A" and "B" services recommended by the United State Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program project; and additional preventive services for women recommended by the Institute of Medicine (IOM) shall not be subject to co-pays.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Cost Sharing Provisions Under the KyHealth Choices Benefit Plan, continued:

Service	Co-pay	Amount and Basis for Determination
Visit to a rural health clinic, primary care center, or federally qualified health center	X	\$3.00 per each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Outpatient hospital service	X	\$4.00 for each visit. DMS shall reduce a provider's reimbursement by \$4.00.
Emergency room visit for a non-emergency service	X	\$8 for each visit. DMS shall reduce a provider's reimbursement by \$8.
Inpatient hospital admission	X	\$50.00 per admission. DMS shall reduce a provider's reimbursement by \$50.00.
Physical Therapy, Speech Pathology Services, Speech/Hearing/Language Therapy Services and Occupational Therapy	X	\$3.00 per each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Durable Medical Equipment	X	\$4 per date of service. DMS shall reduce a provider's reimbursement by \$4.00.
Ambulatory Surgical Center	X	\$4.00 for each visit. DMS shall reduce a provider's reimbursement by \$4.00.
Laboratory, diagnostic, or x-ray service	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.

- C. The following shall not be subject to a copayment, with the exception of the \$8 co-pay for non-preferred brand drugs:
- (a) Individuals excluded in accordance 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act.
 - (b) A service provided to a recipient who has reached his or her 18th birthday.
 - (c) A service provided to a recipient in an optional group, such as foster care who remains on Medicaid, who has reached his or her 18th birthday but has not turned 19.
 - (d) Individuals who are pregnant.
 - (e) Individuals receiving hospice service.
- D. Services included and related to established age and periodicity screenings pursuant to Centers for Disease Control guidelines shall not be subject to co-pays.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

- E. The maximum amount of total cost-sharing shall not exceed 5% of a family's total income for a quarter. Kentucky has a program called copayment tracking within the MMIS system that will track the member's co-pays to ensure that they are not charged more than the 5% during a quarter. Information regarding the quarterly amount of household income for each case is stored in the MMIS and is updated on a quarterly basis. As claims are processed, the billed services evaluated to determine if a copayment should have been assessed. If the service was subject to co-payment based on service and member category, the system calculates the amount of the copayment and maintains that amount in the system. If 5% of the stored income is reached, the copayment indicator for the member or household is turned off in the system and providers can see the copayment is no longer applicable. Additionally, Members will be notified through mail when they have incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current quarterly cap period. Current methodology assumes that all copayments are paid by the member. This will be coordinated with the pharmacy benefit manager (PBM) as well.
- F. Definition of non-emergency care is defined as any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is **not** required. Hospitals will operationalize this process by performing the required EMTALA screening on the patient and if they determine the condition non-emergent (determined by medical professional at the hospital), the ER staff (either a nurse, doctor or intake staff) will advise the recipient that it is not a condition that requires emergency treatment, and that they (the hospital) will assist them in locating another facility (late night clinic, etc.), call their primary care physician when they are open, or go to urgent care clinic that may be available. If the individual still opts to be treated at the ER, they will be required to pay the \$8 co-pay.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

B. The method used to collect cost sharing charges for categorically needy individuals:

- Providers are responsible for collecting the cost sharing charges from individuals.
- The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Federal limits on the services for which copayment applies restrict the maximum copayment charges. The State's scope of services is broad and eligible recipients have low, if any, out-of-pocket medical expenses; therefore, the state believes that all recipients within the class that are subject to copayments should be able to pay the required copayment.

Should a recipient claim to be unable to pay the required copayment, the provider may not deny service, but may arrange for the recipient to pay the copayment at a later date. Any uncollected amount is considered a debt to providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.56(a) are described below:

KY has a "Y/N" indicator switch in the MMIS system. At the time of enrollment and renewal, if the recipient is exempt from cost sharing the indicator switch is set to indicate that they are exempt from any cost sharing. MMIS has been programmed not to deduct copayments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act. MMIS will identify the exempt recipients by age for children under age 18 (or 19 for optional groups), by aid category and recipient status for pregnant women and institutionalized individuals. Recipients outside the exempt status will have a copayment due and printed on the Medicaid cards they received each month. Providers will use the Medicaid card to identify those recipients who should pay a copayment.

If an individual notifies us that they are an American Indians/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State, we will use the same "Y/N" indicator switch in the MMIS system and set that individual to be exempt from cost-sharing.

KY imposes cost-sharing for non-preferred drugs to individuals otherwise exempt from cost-sharing.

- E. Cumulative maximums on charges:

- State policy does not provide for cumulative maximums.
 Cumulative maximums have been established as described below:

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

A. Cost Sharing Provisions Under the Ky Health Choices Benefit Plan: The following charges are imposed on the medically needy for services. Cost sharing is being imposed under 1916 of the Social Security Act.

Service	Type of Charge Co-pay	Amount and Basis for Determination
Prescription Drugs	X	\$1 for each preferred and non-preferred generic drug or atypical antipsychotic drug that does not have a generic equivalent; \$4 for each preferred brand name drug that does not have a generic equivalent and is available under the supplemental rebate program; or \$8 for each non-preferred brand name drug. The Department for Medicaid Services (DMS) shall reduce a pharmacy provider's reimbursement by the applicable co-pay/co-insurance outlined above.
Audiology		\$0.00
Chiropractor	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Dental	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Hearing Aid Dealer		A co-payment will not be imposed on hearing aids.
Podiatry	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Optometry*	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
General ophthalmological services*	X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Eyewear		A co-payment will not be imposed on eyewear.
Office visit for care by a physician,** physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, or nurse midwife or behavioral health practitioner	X	\$3.00 per visit. DMS shall reduce a provider's reimbursement by \$3.00.

*CPT codes 92002, 92004, 92012, and 92014

**CPT codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. Cost Sharing Provisions Under the KyHealth Choices Benefit Plan, continued:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Co-pay	
Physician Service			X	\$3.00 per each service. DMS shall reduce a provider's reimbursement by \$3.00.
Visit to a rural health clinic, primary care center, or federally qualified health center			X	\$3.00 per visit. DMS shall reduce a provider's reimbursement by \$3.00.
Outpatient hospital service			X	\$4.00 for each visit. DMS shall reduce a provider's reimbursement by \$4.00.
Emergency room visit for a non-emergency service			X	\$8 for each visit. DMS shall reduce a provider's reimbursement by \$8.
Inpatient hospital admission			X	\$50.00 per admission. DMS shall reduce a provider's reimbursement by \$50.00.
Physical Therapy, Speech, hearing, language therapy and occupational therapy			X	\$3.00 per each visit. DMS shall reduce a provider's reimbursement by \$3.00.
Durable Medical Equipment			X	\$4.00 per date of service. DMS shall reduce a provider's reimbursement by \$4.00.
Ambulatory Surgical Center			X	\$4.00 for each visit. DMS shall reduce a provider's reimbursement by \$4.00.
Laboratory, diagnostic, or x-ray service			X	\$3.00 for each visit. DMS shall reduce a provider's reimbursement by \$3.00.

- B. The following shall not be subject to a copayment with the exception of the \$8 co-pay for non-preferred drugs:
- (a) Individuals excluded in accordance 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act.
 - (b) A service provided to any recipient who has reached his or her 18th birthday.
 - (c) A service provided to a recipient in an optional group, such as foster care who remains on Medicaid, who has reached his or her 18th birthday but has not turned 19.
 - (d) Individuals who are pregnant.
 - (e) Individuals receiving hospice service.
- C. Services included and related to established age and periodicity screenings pursuant to Centers for Disease Control guidelines shall not be subject to co-pays.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

- D. The maximum amount of total cost sharing shall not exceed 5% of a family's total income for a quarter. Kentucky has a program called copayment tracking within the MMIS system that will track the member's co-pays to ensure that they are not charged more than the 5% during a quarter. Information regarding the quarterly amount of household income for each case is stored in the MMIS and is updated on a quarterly basis. As claims are processed, the billed services evaluated to determine if a copayment should have been assessed. If the service was subject to co-payment based on service and member category, the system calculates the amount of the copayment and maintains that amount in the system. If 5% of the stored income is reached, the copayment indicator for the member or household is turned off in the system and providers can see the copayment is no longer applicable. Additionally, Members will be notified through mail when they have incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current quarterly cap period. Current methodology assumes that all copayments are paid by the member. This will be coordinated with the PBM as well.
- F. Definition of non-emergency care is defined as any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is **not** required. Hospitals will operationalize this process by performing the required EMTALA screening on the patient and if they determine the condition non-emergent (determined by medical professional at the hospital), the ER staff (either a nurse, doctor or intake staff) will advise the recipient that it is not a condition that requires emergency treatment, and that they (the hospital) will assist them in locating another facility (late night clinic, etc.), call their primary care physician when they are open, or go to urgent care clinic that may be available. If the individual still opts to be treated at the ER, they will be required to pay the \$8 co-pay.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

B. The method used to collect cost sharing charges for categorically needy individuals:

- Providers are responsible for collecting the cost sharing charges from individuals.
- The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Federal limits on the services for which copayment applies restrict the maximum copayment charges. The State's scope of services is broad and eligible recipients have low, if any, out-of-pocket medical expenses; therefore, the state believes that all recipients within the class that are subject to copayments should be able to pay the required copayment.

Should a recipient claim to be unable to pay the required copayment, the provider may not deny him service, but may arrange for the recipient to pay the copayment at a later date. Any uncollected amount is considered a debt to providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.56(a) are described below:

KY has a "Y/N" indicator switch in the MMIS system. At the time of enrollment and renewal, if the recipient is exempt from cost sharing the indicator switch is set to indicate that they are exempt from any cost sharing. MMIS has been programmed not to deduct copayments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act. MMIS will identify the exempt recipients by age for children under age 18 (or 19 for optional groups), by aid category and recipient status for pregnant women and institutionalized individuals. Recipients outside the exempt status will have a copayment due and printed on the Medicaid cards they received each month. Providers will use the Medicaid card to identify those recipients who should pay a copayment.

If an individual notifies us that they are an American Indians/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State, we will use the same "Y/N" indicator switch in the MMIS system and set that individual to be exempt from cost-sharing.

KY imposes cost-sharing for non-preferred drugs to individuals otherwise exempt from cost-sharing.

- E. Cumulative maximums on charges:

- State policy does not provide for cumulative maximums.
 Cumulative maximums have been established as described below:

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Premiums Imposed on Low Income Pregnant Women and Infants

- A The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

Not Applicable

- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

Not Applicable

*Description provided on attachment.

TN No. 92-01
Supersede:
TN No. None

Approval Date NOV 14 1994

Effective Date 1-1-92
HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

C. State or local funds under other programs are used to pay for premiums:

Yes No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

Not applicable

*Description provided on attachment.

TN No. 92-01
Supersedes
TN No. None

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

- A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

Not applicable

- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment:

Not applicable

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

C. State or local funds under other programs are used to pay for premiums:

Yes No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

Not applicable

*Description provided on attachment.

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14, 1994

Effective Date 1-1-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Premiums Imposed on Families Receiving Extended Benefits
During a Second Six-Month Period

- A. The following method is used to determine the premium imposed during each premium payment period on families receiving extended benefits (Transitional Medicaid or TMA) during the second six-month period under section 1902(a)(52) and section 1925 of the Act:

The premium amount for months seven through twelve is \$30 per family per month for families who remain eligible for TMA. We calculated this premium amount by taking three percent of the 100 percent federal poverty level (FPL) guideline for a family of two in 2003 and rounding down to the nearest whole dollar.

1. If a family pays the premium as a quarterly or semi-annual payment, they will get a ten percent discount.
2. The premium will never exceed three percent of the family's average gross monthly earnings, less the average monthly cost of child care that is necessary for the employment of the caretaker relative.
3. A family is exempt from the premium requirement if average gross monthly earnings less work-related child care is equal to or less than 100 percent FPL for the family size.

- B. A description of the billing method used is as follows (include due date for premium payment and notification of the consequences of nonpayment):

1. Bills are issued on the 7th working day before the end of each month, with payment due the fifth of the next month.
2. Payments must be made in advance, by the fifth of the month for the following month.
3. Families who do not pay by the fifth of the month are sent a reminder that premium payments are past due,
4. If the family fails to make the second monthly premium payment, medical coverage stops at the end of the second month for which the family has not paid the premium.

Premiums Imposed on Families Receiving Extended Benefits
During a Second Six-Month Period (continued)

5. All bills and reminder notices inform families that they will lose their health care benefits if premiums are not paid.
 6. The department will do the following before stopping benefits due to premium non-payment:
 - a. Give notice of the past due premiums;
 - b. Provide an opportunity to pay past due premiums; and
 - c. Give families an opportunity to prove that income has decreased and the family should be exempt from premium payment.
 7. If TMA is discontinued due to non-payment and the recipients are eligible for benefits in another Medicaid or SCHIP group, their coverage will be automatically continued in the appropriate category.
- A. The criteria for determining good cause for failure to pay such premium on a timely basis are described below.
- Reasons for good cause include:
1. An immediate family member living in the home was institutionalized or died during the payment month;
 2. The family was victim of a natural disaster including flood, storm, earthquake, or serious fire;
 3. The specified relative was out of town for the payment month; or
 4. The family moved and reported the move timely, but the move resulted in:
 - a. A delay in receiving the billing notice; or
 - b. Failure to receive the billing notice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Kentucky

It should be noted that States can select one or more options in imposing cost sharing (including co-payments, co-insurance, and deductibles) and premiums.

- A. For groups of individuals with family income above 100 percent but below 150 percent of the F1)1.4
1. Cost sharing
 - a. No cost sharing is imposed.
 - b. Cost sharing is imposed under section 1916A of the Act as follows (specify the amounts by group and services (see below)):
 - In Family Choices cost sharing amounts are placed on the KCHIP Medicaid Expansion Children (101-150 percent of the poverty line) under 1916A(a) and 1916A(b)(1)-(2) of the Act. The cost sharing amounts for Family Choices can be found on Attachment 3.1-C pages 10.17-10.20.
 - The methodology to determine family income does not differ from the methodology for determining eligibility. Net income is used to determine eligibility.
 - b. Limitations:

The total aggregate amount of cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent oldie family income of the family involved, as applied on a monthly and quarterly basis as specified by the State above. Under state regulation, there is a \$225 cost sharing limit for medical services and an additional cost sharing limit of \$225 for pharmacy services on an annual basis. The state will enforce the cap that is the least of each family's total income.

 - Cost sharing with respect to any item or service may not exceed 10 percent of the cost of such item or service.
 - c. No cost sharing will be imposed for the following services:
 - Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid and assistance is made available under part B of the title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
 - Preventive services (such as well baby and well child care and immunizations) provided to children
 - under 18 years of age, regardless of family income;
 - Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
 - Services furnished to a terminally individual who is receiving hospice care, (as defined in section I 905(o) of the Act);
 - Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
 - Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
 - Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
 - Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(11)(XVIII) and 1902(aa) of the Act.

TN No. 06-012
Supersedes
TN No: None

Approval Date: 01/22/09

Effective Date: 7/1/06

- Services provided to individuals with income not exceeding 100 percent of the poverty line. Except for those that apply to prescription drugs and Hospital Non-emergency services as defined in 1916A(c) and 1916A(e).
- d. Enforcement
1. Pharmacist are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.
 2. Providers permitted to reduce or waive cost sharing on a case-by-case basis.
 3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.
 4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.
2. Premiums
- No premiums may be imposed for individuals with family income above 100 percent but below 150 percent of the FPL.
- B. For groups of individuals with family income above 150 percent of the FPL: 1. Cost sharing amounts
- a. No cost sharing is imposed.
 - b. X / Cost sharing is imposed under section 19 16A of the Act as follows (specify amounts by groups and services (see below)):\
- b. Limitations:
- The total aggregate amount of cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly and quarterly basis as specified by the State above.
 - Cost sharing with respect to any item or service may not exceed 20 percent of the cost of such item or service.
- c. No cost sharing will be imposed for the following services;
- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(1), and including services furnished to individuals with respect to whom aid and assistance is made available under part s of the title IV to children in foster care and individuals with respect to whom, adoption or foster care assistance is made available under part E of such title, without regard to age;
 - Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age, regardless of family income;
 - Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
 - Services furnished to a terminally individual who is receiving hospice care, (as defined in section I 905(o) of the Act);
 - Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
 - Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
 - Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
 - Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

- d. Enforcement
1. Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.
 2. Providers permitted to reduce or waive cost sharing on a case-by-case basis.
 3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing if noted as such in Attachment 3.I-C pages 10.17-10;24, Attachment 4.18-A pages I, 1(a), and Attachment 4.18-C pages 1, 1(a).
 4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.
2. Premiums
- a. No premiums are imposed.
 - b. Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.
- b. Limitations:
- The total aggregate amount of cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly and quarterly basis as specified by the State above.
- c. Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals furnished to individuals with respect to whom aid and assistance is made available under part B of the title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Pregnant women;
 - Any terminally ill-individual receiving hospice care, as defined in section 1905(o);
 - Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs; and
 - Women who are receiving Medicaid by virtue of the applications of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.
- d. Enforcement
1. Prepayment required for the following groups of individuals who are applying for Medicaid:
 2. Eligibility terminated after failure to pay for 60 days for the following groups of individuals who are receiving Medicaid:
 3. Payment will be waived on a case-by-case basis for undue hardship.
- C. Period of determining aggregate 5 percent cap
- Specify the period for which the 5 percent maximum would be applied.

- Quarterly
 Monthly

D. Method for tracking cost sharing amounts

Describe the State process used for tracking cost sharing and informing beneficiaries and providers of their beneficiary's liability and informing providers when an individual has reached his/her maximum so further costs are no longer charged.

The Department tracks cost-sharing based on claims submissions. All cost sharing outlined in the state plan and regulations is calculated on an individual member basis and aggregated by case.

Providers can determine if a member is subject to cost sharing one of two, ways:

1. Providers can access the member benefit plan and cost sharing obligations via a web-based program, KY Health Net; or
2. Providers can access member cost sharing obligations by calling the toll free voice response line.

Both options allow the provider to see/hear the poverty level indicator of the Member, out of pocket maximum amount, and an indicator that informs them if the out of pocket maximum amount of cost sharing has been met for the quarter.

Individual members have an out of pocket cost sharing amount of \$225 for pharmacy services and a \$225 maximum for medical services. Therefore, individual cost sharing cannot exceed \$450 per calendar year. However, aggregate cost sharing per case cannot exceed 5% of the family's income for the quarter. Once members reach the out-of-pocket maximum amount per quarter, their cost sharing indicator is changed to "N" and providers do not collect co-payments for the remainder of the quarter. Likewise, when the out of pocket maximum is reached per member, the cost sharing indicator is changed to "N" and providers do not collect co-payments for the remainder of the year.

Members can call the toll free line to check the amount of cost sharing they have paid per quarter and per year to determine if their out of pocket amount has been met

Also describe the State process for informing beneficiaries and providers of the allowable cost sharing amounts.

Cost sharing amounts are outlined in our Member Handbook. When enrolled, the beneficiaries are informed of the toll free Member Services number and that the Member handbook will be provided to them upon request.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: KENTUCKY

- A. In accordance with section 1916A of the Social Security Act (the Act), alternative cost sharing will be implemented for non-preferred drugs to encourage the use of less costly effective drugs. For individuals otherwise not subject to cost sharing as a result of section 1916A(b)(3)(B) of the Act the cost sharing charge for non-preferred drugs will not exceed a nominal amount as specified under section 1916. For individuals whose family income is at or below 150 percent of the Federal poverty level (FPL), cost sharing may not exceed a nominal amount as defined in section 1916. For individuals whose family income is above 150 percent of the FPL, cost sharing charges may not exceed 20 percent of the cost of the drug. Cost sharing for non-preferred drugs counts toward the 5 percent aggregate cap.
- B. In case of a drug that is not a preferred drug, the cost sharing amount for the preferred drug will be charged for a non-preferred drug if the prescribing physician determines that the preferred drug would be less effective or would have adverse effects for the individual or both. These overrides will meet the State criteria for prior authorization and will be approved through the State prior authorization process before the preferred drug cost sharing is applied to the non-preferred drug.
- C. States may exclude specified drugs or classes of drugs from the non-preferred or preferred drug class.
- D. Cost sharing is implemented for non-preferred drugs for the following groups of beneficiaries as indicated below:
- Members of Global Choices non-preferred drug copay is listed on Attachment 4.18-A, page 1 and Attachment 4.18-C, page 1, and eligibility (up to 250 percent of the federal poverty level) or population covered for Global Choices can be found on Attachment 4.18-A page 1(b)-1(d) and Attachment 4.18-C page 1(b)-1(d);
 - Members of Family Choices non-preferred drug copay is listed on Attachment 3.1-C, page 10.19. In Family Choices cost sharing amounts are placed on the KCHIP Medicaid Expansion Children (101-150 percent of the federal poverty level) under 1916A(a) and 1916A(b)(1)-(2) of the Act; and
 - Members of Comprehensive or Optimum Choices non-preferred drug copay is listed on Attachment 3.1-C page 10.23, and eligibility (up to 300 percent of the federal poverty level) or population covered for Comprehensive and Optimum Choices can be found on Attachment 3.1-C pages 10.1-10.2.
- E. Cost sharing for non-preferred drugs may be waived or reduced below nominal for the following populations or services:
- Individuals under 18 years of age with mandatory coverage and Title IV-B and Title IV-E children;
 - Preventive services;
 - Pregnant women;
 - Terminally ill individuals receiving hospice care;
 - Individuals who are inpatients in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
 - Emergency services;
 - Family planning services and supplies; and ,
 - Services under the breast and cervical cancer program.

Cost sharing will not be waived or reduced for any population except as provided in section F.

- F. Cost sharing for preferred drugs may not be charged for the following populations or services:

TN No: 06-012
Supersedes
TN No: None

Approval Date: 01/22/09

Effective Date: 7/01/2006

- Individuals under 18 years of age with mandatory coverage and Title IV-B and Title IV-E children;
- Preventive Services;
- Pregnant women;
- Terminally ill individuals receiving hospice care;
- Individuals who are inpatients in a hospital nursing facility, intermediated care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
- Emergency Services;
- Family Planning services and supplies; and,
- Services under the breast and cervical cancer program.

G. Cost sharing payment requirements:

- Providers are permitted to require, as a condition for the provision of prescriptions, the payment of cost sharing.

H. Availability of Information

- States must make available to the public and to beneficiaries the schedule of the cost sharing/premium amounts for specific items and the various eligibility groups.

(1) General Overview

- A. Beginning October 15, 2007, the Department will pay for inpatient hospital services in general acute care hospitals under a revised DRG-based methodology. The methodology is similar to the Medicare Prospective Payment System. The revised system will have hospital specific operating and capital base rates, and Kentucky specific relative weights. Hospital services not paid for using the DRG-based methodology will be paid for using per diem rates unless otherwise stated in this plan.

The following will be excluded from the DRG methodology:

1. Services provided in Critical access hospitals;
2. Services provided in Free-standing rehabilitation hospitals;
3. Services provided in Long-term acute care hospitals;
4. Psychiatric services in Acute care hospitals;
5. Services provided in Free-standing psychiatric hospitals;
6. Rehabilitation services in Acute care hospitals; and
7. Transplant services, other than kidney, pancreas, and cornea.

- B. Appeals and Review Process. Hospitals will be able to utilize the dispute resolution and appeals process described in 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative process, and sanctions. (Revised effective 12-19-2001).

1. An appeal shall comply with the review and appeal provisions established in 907 KAR 1:671, as previously cited.
2. An appeal shall not be allowable unless compliant with the terms and conditions shown in 907 KAR 1:671, as previously cited.
3. An administrative review shall specifically not be available for the following; this listing of exclusions is not to be considered exhaustive or complete:
 - a. A determination of the requirement, or the proportional amount, of a budget neutrality adjustment in the prospective payment rate; or
 - b. The establishment of:
 - 1) Diagnostic related groups;
 - 2) The methodology for the classification of an inpatient discharge within a DRG; or
 - 3) An appropriate weighting factor which reflects the relative hospital resources used with respect to a discharge within a DRG.

C. Adjustment of rates.

1. Final rates are not adjusted except for correction of errors, to make changes resulting from the dispute resolution or appeals process if the decision determines that rates were not established in accordance with the approved State Plan, Attachment 4.19-A (attachment), or to make changes resulting from Federal Court orders including to the extent necessary action to expand the effect of a Federal Court order to similarly situated facilities.
2. New rates may be set for each universal rate year, and at any point in the rate year when necessitated by a change in the applicable statute or regulation subject to a state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS).

D. Use of a Universal Rate Year

1. A universal rate year shall be established as July 1 through June 30 of the following year to coincide with the state fiscal year.
2. A hospital shall not be required to change its fiscal year to conform with a universal rate year.

E. Cost Reporting Requirements. The department follows the Medicare Principles of reimbursement found in 42 CFR 413 and the CMS Publication 15 to determine allowable cost. Additional cost report requirements are as follows:

1. An in-state hospital participating in the Medicaid program shall submit to the department a copy of a Medicare cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1 and the Supplemental Medicaid Schedule KMAP-4 as follows:
 - a. A cost report shall be submitted:
 - 1) For the fiscal year used by the hospital; and
 - 2) Within five (5) months after the close of the hospital's fiscal year; and
 - b. Except as follows, the department shall not grant a cost report submittal extension:
 - 1) If an extension has been granted by Medicare, the cost report shall be submitted simultaneously with the submittal of the Medicare cost report; or
 - 2) If a catastrophic circumstance exists, for example flood, fire, or other equivalent occurrence, the department shall grant a thirty (30) day extension.
2. If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a complete cost report is received.
3. A cost report submitted by a hospital to the department shall be subject to audit and review.
4. An in-state hospital shall submit to the department a final Medicare-audited cost report upon completion by the Medicare intermediary along with an electronic cost report file (ECR).

F. Unallowable Costs

1. The following shall not be allowable cost for Medicaid reimbursement unless otherwise noted:
 - a. A cost associated with a political contribution;
 - b. The allowability of legal fees is determined in accordance with the following:
 - 1) A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet for Health and Family Services is not allowable;
 - 2) A legal fee relating to a lawsuit against the Cabinet for Health and Family Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and
 - c. Cost associated with travel and related expenses must take into consideration the following:
 - 1) A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity is not allowable.
 - 2) A cost for a training or educational purpose outside the Commonwealth of Kentucky shall be allowable.
 - 3) If a meeting is not solely educational, the cost, excluding transportation, shall be allowable if an educational or training component is included.
2. A hospital shall identify an unallowable cost on the Supplemental Medicaid Schedule KMAP-1.
3. The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report.

G. Trending of an In-state Hospital's Cost Report Used for Non-DRG Rate Setting Purposes.

1. An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the department, either audited or un-audited, shall be trended from the midpoint of the cost report year to the beginning of the universal rate year to update an in-state hospital's Medicaid cost. This methodology applies for all rate setting throughout this attachment.
2. The trending factor to be used shall be the inflation factor prepared by GII (Global Insight, Incorporated, a market basket data indexing and forecasting firm referred to as GII) for the period being trended.

H. Indexing for Inflation of an In-state Hospital's Cost Report Used for Rate Setting Purposes.

1. After an allowable Medicaid cost has been trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost to the midpoint in the universal rate year. This methodology applies for all rate setting throughout this attachment.

2. The department shall use the inflation factor prepared by GII (Global Insight, Incorporated) as the indexing factor for the universal rate year.

I. Cost Basis.

1. An allowable Medicaid cost shall:
 - a. Be a cost allowed after a Medicaid or Medicare audit;
 - b. Be in accordance with 42 C.F.R. Part 413;
 - c. Include an in-state hospital's provider tax; and
 - d. Not include a cost in the Unallowable Costs listed in Section (1)F of this attachment.
2. A prospective rate shall include both routine and ancillary costs.
3. A prospective rate shall not be subject to retroactive adjustment, except for:
 - a. A critical access hospital; or
 - b. A facility with a rate based on un-audited data.
4. An overpayment shall be recouped by the department as follows:
 - a. A provider owing an overpayment shall submit the amount of the overpayment to the department; or
 - b. The department shall withhold the overpayment amount from a future Medicaid payment due the provider.

J. Access to Subcontractor's Records. If a hospital has a contract with a subcontractor for services costing or valued at \$10,000 or more over a twelve (12) month period:

1. The contract shall contain a provision granting the department access:
 - a. To the subcontractor's financial information; and
 - b. In accordance with 907 KAR 1:672, published on January 4, 2008, Provider enrollment, disclosure, and documentation for Medicaid participation; and
2. Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

K. New Provider, Change of Owner or Merged Facility

1. A new provider.
 - a. Until a fiscal year end cost report is available, a newly constructed or newly participating hospital shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification.
 - b. During the projected rate year, the budget shall be adjusted if indicated and justified by the submittal of additional information.

2. If a hospital undergoes a change of ownership, the new owner shall be reimbursed at the rate in place at the time of the ownership change.
 3. A merged facility of two or more entities.
 4. a. The merger of two per diem facilities shall:
 - 1.) Merge the latest available data used for rate setting.
 - 2.) Combine bed utilization statistics, creating a new occupancy ratio.
 - 3.) Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs.
 - 4.) If one (1) of the entities merging has disproportionate status and the other does not, retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid.
 - 5.) Recognize an appeal of the merged per diem rate in accordance with the state regulation on Conditions of Medicaid provider participation, withholding overpayments, administrative appeal process, and sanctions.
 - b. In the merger of two DRG facilities, the rate of the purchasing facility shall be applicable to the merged entity.
 - c. In the merger of a per diem facility and a DRG facility, the facility shall elect either a per diem style of reimbursement or a DRG style of reimbursement. Upon determination of the style, the rate shall be set in accordance with either Item a. or Item b. of this subsection.
 5. Cost report submission
 - a. Require each provider to submit a Medicaid cost report for the period ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end.
 - b. A Medicaid cost report for the period starting with the day of the merger and ending on the fiscal year end for the merged entity shall also be filed with the department in accordance with this attachment.
- L. Payment Not to Exceed Charges or the Upper Payment Limits.
1. The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges plus disproportionate share payments, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges, the state will recoup payments in excess of allowable charges plus disproportionate share payments.
 2. The state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement. Medicare upper payment limits as required by 42 CFR 447.272 will be determined in advance of the fiscal year from cost report and other applicable data from the most recent rate setting as compared to reimbursement for the same period. Cost data and reimbursement shall be trended forward to reflect current year upper payment limits. See Exhibit A for detail description and formula for UPL demonstration.

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- M. Public Process for Determining Rates for Inpatient Hospitals. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.
- N. The Hospital Provider Tax is described in Kentucky Revised Statute 142.303, revised June 26, 2007.
- P. As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Department for Medicaid Services will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Beginning with Medicaid State Plan year 2011, DSH payments made to hospitals may be adjusted based on the results of the federally-mandated DSH audits as follows:

1. DSH payments found in the DSH audit process that exceed the hospital specific DSH limits will be recouped from hospitals to reduce their payments to their limit. Any payments that are recouped from hospitals as a result of the DSH audit will be redistributed to hospitals that are shown to have been paid less than their hospital-specific DSH limits. Redistribution of DSH payments will first be made to hospitals in the same ownership class (state owned, non-state government owned, and privately owned hospitals). These redistributions will occur proportionately to the original distribution of DSH funds not to exceed each hospital's specific DSH limit. If DSH funds cannot be fully redistributed within the same ownership class, due to the hospital specific limits, the excess funds will be redistributed to the other ownership class in proportion to the original DSH payments made by the state.
2. If the Medicaid program's original DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment will be retroactively paid to hospitals that are under their hospital-specific DSH limit are reflecting the potential redistributions in #1 above. These additional DSH payments will be made in proportion to the original DSH payments, and will be limited to each hospital's specific DSH limit.

(2) Acute Care Hospital Services

A. DRG-Based Methodology

1. An in-state acute care hospital shall be paid for an inpatient acute care service on a fully-prospective per discharge basis.
2. For an inpatient acute care service in an in-state acute care hospital, the total hospital-specific per discharge payment shall be the sum of:
 - a. A DRG base payment;
 - b. If applicable, a high volume per diem payment; and
 - c. If applicable, a cost outlier payment amount.

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3. For a rate effective on or after January 5, 2009, the department shall assign to the base year claims data as described in Item 5(c), DRG classifications from Medicare grouper version twenty-four (24) effective in the Medicare inpatient prospective payment system as of October 1, 2006.
 4. A DRG base payment shall be calculated for a discharge by multiplying the hospital specific base rate by the DRG relative weight.
 5. Calculating base rates.
 - a. The department shall determine a base rate by calculating hospital cost per discharge, adjusted for hospital case mix, outlier payments medical education costs and budget neutrality as described in subsections (5) through (11) of this section.
 - b. A hospital specific cost per discharge used to calculate a base rate shall be based on base year inpatient paid claims data.
 - c. For rates effective on or after January 5, 2009, the base year claims data for calculating a hospital specific cost per discharge shall be calculated using state fiscal year 2006 inpatient Medicaid paid claims data.
 6. Calculating cost to charge ratios.
 - a. The department shall calculate hospital-specific cost to charge ratios for the fifteen (15) cost centers displayed in Table 1 below.
 - b. If a hospital lacks cost-to-charge information for a given cost center or if the hospital's cost-to-charge ratio is above or below three (3) standard deviations from the mean of a log distribution of cost-to-charge ratios, the department shall use the statewide geometric mean cost-to-charge ratio for the given cost center.
 - c. The department shall base cost center specific cost-to-charge ratios on cost and charge data extracted from the most recently submitted CMS Form 2552 Medicare cost report.

The costs used in the cost-to-charge ratios, which include operating and capital costs and exclude direct medical education costs, are extracted from Worksheet C, Part I, Column 5. The charges used in the cost-to-charge ratios are extracted from Worksheet C, Part I, Column 8.

Table 1. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk

<u>Table 1. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk</u>		
<u>Kentucky Medicaid Cost Center</u>	<u>Kentucky Medicaid Cost Center Description</u>	<u>Medicare Cost Report Standard Cost Center</u>
<u>1</u>	<u>Routine Days</u>	<u>25</u>
<u>2</u>	<u>Intensive Days</u>	<u>26, 27, 28, 29, 30</u>
<u>3</u>	<u>Drugs</u>	<u>48, 56</u>
<u>4</u>	<u>Supplies or equipment</u>	<u>55, 66, 67</u>
<u>5</u>	<u>Therapy services excluding inhalation therapy</u>	<u>50, 51, 52</u>
<u>6</u>	<u>Inhalation therapy</u>	<u>49</u>
<u>7</u>	<u>Operating room</u>	<u>37, 38</u>
<u>8</u>	<u>Labor and delivery</u>	<u>39</u>
<u>9</u>	<u>Anesthesia</u>	<u>40</u>
<u>10</u>	<u>Cardiology</u>	<u>53, 54</u>
<u>11</u>	<u>Laboratory</u>	<u>44, 45</u>
<u>12</u>	<u>Radiology</u>	<u>41, 42</u>
<u>13</u>	<u>Other services</u>	<u>43, 46, 47, 57, 58, 59, 60, 61, 62, 63, 63.5, 64, 65, 68</u>
<u>14</u>	<u>Nursery</u>	<u>33</u>
<u>15</u>	<u>Neonatal intensive days</u>	<u>30</u>

7. For hospitals with interns and residents cost-reported on Medicare cost report Worksheet B, Part I, Columns 22 and 23, the department shall multiply each of the hospital's cost-to-charge ratios by its indirect medical education adjustment factor. A hospital's indirect medical education adjustment factor shall be calculated as follows:

- a. Compute the costs of interns and residents before the allocation of overhead costs to the patient service cost centers in Medicare cost report Worksheet B, Part I by summing the costs found in Column 0, Lines 22 and 23; and
 - b. Compute the costs of interns and residents after the allocation of overhead costs to the patient service cost centers in Medicare cost report Worksheet B, Part I by summing the costs found in Columns 22 and 23, Line 103; and
 - c. Compute the difference in costs of interns and residents after the allocation of overhead costs to the patient service cost centers in the Medicare cost report Worksheet B, Part I (as determined in (b) of this subsection) and before the allocation (as determined in (a) of this subsection); and
 - d. Divide the difference calculated in (c) of this subsection by total costs after allocation, found in Medicare cost report Worksheet B, Part I, Column 27, Line 103.
8. For an in-state acute care hospital, the department shall compile the number of patient discharges, patient days, and total charges by revenue code from the base year paid claims data. The department shall exclude from the rate calculation:
- a. Claims paid under a managed care program;
 - b. Claims for rehabilitation and psychiatric discharges reimbursed on a per diem basis;
 - c. Claims in hospital-based skilled nursing facilities or long-term care units;
 - d. Transplant claims other than kidney, pancreas, and cornea; and
 - e. Revenue codes not covered by the Medicaid Program; and
 - f. Claims with charges equal to zero (0).
9. Calculating the Cost of a base year claim.
- a. The department shall calculate the Medicaid cost of a base year claim by multiplying the charges from each Medicaid covered revenue code by the corresponding cost center specific cost-to-charge ratio.
 - b. The department shall base cost center specific cost-to-charge ratios on data extracted from the most recently, as of June 1, finalized cost report.
 - c. Only an inpatient revenue code recognized by the department shall be included in the calculation of estimated costs.
10. Using the base year Medicaid claims referenced in subsection (8) of this Section, the department shall compute an average hospital specific cost per discharge by dividing a hospital's Medicaid costs as determined in subsection 9 by its number of Medicaid discharges.
11. The department shall determine an in-state acute care hospital's DRG base payment rate by adjusting the hospital's average cost per discharge by the hospital's case mix index, expected outlier payments and budget neutrality factors.
- a. Case mix calculations.
 - 1) A hospital's case mix adjusted cost per discharge shall be calculated by dividing the

-
- hospital's average cost per discharge by its case mix index; and
- 2) The hospital's case mix index shall be equal to the average of its DRG relative weights for acute care services for base year Medicaid discharges referenced in subsection 8 above.
- b. Case mix adjustments.
- 1) A hospital's case mix adjusted cost per discharge shall be multiplied by an initial budget neutrality factor.
 - 2) The initial budget neutrality factor for rates effective January 5, 2009 shall be 0.7065 for all hospitals.
 - 3) When rates are rebased, the initial budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted to eliminate changes in patient volume and wage index as published by CMS in the Federal Register.
- c. Consideration of outliers.
- 1) Each hospital's case mix and initial budget neutrality adjusted cost per discharge shall be multiplied by a hospital-specific outlier payment factor.
 - 2) A hospital-specific outlier payment factor shall be calculated using the following formula: $((\text{expected DRG non-outlier payments}) - (\text{expected proposed DRG outlier payments})) / (\text{expected DRG non-outlier payments})$.
- d. Consideration of budget neutrality.
- 1) A hospital's case mix, initial budget neutrality and outlier payment adjusted cost per discharge shall be multiplied by a secondary budget neutrality factor.
 - 2) The secondary budget neutrality factor for rates effective January 5, 2009, shall be 1.0562.
 - 3) When rates are rebased, the secondary budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted for changes in patient volume and case mix.
12. High volume adjustments as of October 15, 2007.
- a. The department shall make a high volume per diem payment to an in-state acute care hospital for the rate year beginning October 15, 2007 in addition to the DRG base payment rate.
 - b. To qualify for high volume per diem payments, a hospital must meet either the Kentucky Medicaid patient days criteria or the Kentucky Medicaid utilization percentage as shown in Table 2.
 - c. A high volume per diem payment shall be equal to the applicable high volume per diem amount multiplied by the DRG's statewide arithmetic mean length-of-stay.
 - d. The DRG statewide arithmetic mean length of stay shall be calculated using the base year claims described in section (2)A.5.c.

- e. The department shall pay the greater of the high volume per diem payment for estimated Kentucky Medicaid inpatient days or Kentucky Medicaid inpatient days utilization criteria established in Table 2 below:

Kentucky Medicaid Inpatient Days		Kentucky Medicaid Inpatient Days Utilization	
Days Range	Per Diem Payment	Medicaid Utilization Range	Per Diem Payment
3,000 – 4,200 days	\$40 per day	19.3% - 20%	\$50 per day
4,200 – 5,600 days	\$60 per day	20.1% - 27.2%	\$115 per day
5,600 – 9,000 days	\$100 per day	27.3% - above	\$125 per day
9,000 – 20,000 days	\$125 per day		
20,000 and above days	\$205 per day		

- f. Base year classification.
- 1) The department shall use base year claims data referenced in section (2)A.5.c to determine if a hospital qualifies for a high volume per diem add-on payment.
 - 2) As of October 15, 2007, the department shall determine Kentucky Medicaid inpatient days for a hospital by multiplying the DRG classification for each base year claim by the corresponding Kentucky DRG average length of stay.
- g. The department shall only change a hospital's classification regarding a high volume add-on payment or per diem amount during a rebasing year.
13. High volume adjustments as of November 15, 2007.
- a. The department shall make a high volume per diem payment to an in-state acute care hospital beginning November 15, 2007 in addition to the DRG base payment rate.
 - b. To qualify for high volume per diem payments, a hospital must meet either the Kentucky Medicaid patient days criteria or the Kentucky Medicaid utilization percentage as shown in Table 3.
 - c. A high volume per diem payment shall be equal to the applicable high volume per diem amount multiplied by the DRG's statewide arithmetic mean length-of-stay.
 - d. The DRG statewide arithmetic mean length of stay shall be calculated using the base year claims referenced in section (2)A.5.c.
 - e. The department shall pay the greater of the high volume per diem payment for covered Kentucky Medicaid inpatient days criteria or Kentucky Medicaid inpatient days utilization percent criteria established in Table 3 below:

<u>Table 3 – High Volume Adjustment Eligibility Criteria</u> <u>as of November 15, 2007</u>			
<u>Kentucky Medicaid Inpatient Days</u>		<u>Kentucky Medicaid Inpatient Days Utilization</u>	
<u>Days Range</u>	<u>Per Diem Payment</u>	<u>Medicaid Utilization Range</u>	<u>Per Diem Payment</u>
<u>0 – 3,499 days</u>	<u>\$0 per day</u>	<u>0.0% - 13.2%</u>	<u>\$0.00 per day</u>
<u>3,500 – 4,499 days</u>	<u>\$22.50 per day</u>	<u>13.3% - 16.1%</u>	<u>\$22.50 per day</u>
<u>4,500 – 7,399 days</u>	<u>\$45.00 per day</u>	<u>16.2% - 21.6%</u>	<u>\$45.00 per day</u>
<u>7,400 – 10,999 days</u>	<u>\$129.00 per day</u>	<u>21.7% - 27.2%</u>	<u>\$81.00 per day</u>
<u>11,000 – 19,999 days</u>	<u>\$172.00 per day</u>	<u>27.3% - 100.00%</u>	<u>\$92.75 per day</u>
<u>20,000 and above days</u>	<u>\$306.00 per day</u>		

- f. The department shall use base year claims data referenced in Item (2)A.5.c to determine if a hospital qualifies for a high volume per diem add-on payment.
 - g. The department shall only change a hospital's classification regarding a high volume add-on payment or per diem amount during a rebasing year.
14. High volume adjustments as of January 5, 2009.
- a. The department shall make a high volume per diem payment, except as excluded in item h. of this list, to an in-state acute care hospital beginning January 5, 2009 in addition to the DRG base payment rate, for each diagnostic category.
 - b. To qualify for high volume per diem payments, a hospital must meet either the Kentucky Medicaid patient days criteria or the Kentucky Medicaid utilization percentage as shown in Table 4.
 - c. A high volume per diem payment shall be made in the form of a per diem add on amount in addition to the DRG base payment rate encompassing the DRG average length-of-stay days per discharge.
 - d. A high volume per diem payment shall be equal to the applicable high volume per diem amount multiplied by the DRG's statewide arithmetic mean length-of-stay.
 - e. The DRG statewide arithmetic mean length of stay shall be calculated using the base year claims referenced in section (2)A.5.c.
 - f. The department shall pay the greater of the high volume per diem payment for covered Kentucky Medicaid inpatient days criteria or Kentucky Medicaid inpatient days utilization percent criteria established in Table 4 below:

Table 4 – High Volume Adjustment Eligibility Criteria
as of January 5, 2009

<u>Kentucky Medicaid Inpatient Days</u>		<u>Kentucky Medicaid Inpatient Days Utilization</u>	
<u>Days Range</u>	<u>Per Diem Payment</u>	<u>Medicaid Utilization Range</u>	<u>Per Diem Payment</u>
<u>0 – 3,499 days</u>	<u>\$0 per day</u>	<u>0.0% - 13.2%</u>	<u>\$0.00 per day</u>
<u>3,500 – 4,499 days</u>	<u>\$22.50 per day</u>	<u>13.3% - 16.1%</u>	<u>\$22.50 per day</u>
<u>4,500 – 5,999 days</u>	<u>\$45.00 per day</u>	<u>16.2% - 21.6%</u>	<u>\$45.00 per day</u>
<u>6,000 – 7,399 days</u>	<u>\$80.00 per day</u>	<u>21.7% - 27.2%</u>	<u>\$81.00 per day</u>
<u>7,400 – 10,999 days</u>	<u>\$118.15 per day</u>	<u>27.3% -100%</u>	<u>\$92.75 per day</u>
<u>11,000 – 19,999 days</u>	<u>\$163.49 per day</u>		
<u>20,000 and above days</u>	<u>\$325.00 per day</u>		

- f. The department shall use base year claims data referenced in Item (2)A.5.c to determine if a hospital qualifies for a high volume per diem add-on payment.
- g. The department shall only change a hospital's classification regarding a high volume add-on payment or per diem amount during a rebasing year.
- h. The department shall not make a high volume per diem payment for a level I neonatal center, level II neonatal center, or level III neonatal center.
- i. A level I neonatal center, level II neonatal center, or level III neonatal center claim shall be included in a hospital's high volume adjustment eligibility criteria calculation.

15. Cost outlier adjustments.

- a. The department shall make an additional cost outlier payment for an approved discharge paid under the DRG-based methodology, and meeting the Medicaid criteria for a cost outlier payment.
- b. A cost outlier shall be subject to QIO (Quality Improvement Organization) review and approval.
- c. A discharge shall qualify for an additional cost outlier payment if its estimated cost exceeds the DRG's outlier threshold.
- d. Outlier calculations.
 - 1) The department shall calculate the estimated cost of a discharge, for purposes of comparing the discharge cost to the outlier threshold, by multiplying the sum of the hospital specific Medicare operating and capital-related hosp-to-charge ratios by the Medicaid allowed charges.
 - 2) A Medicare operating and capital-related cost-to-charge ratio shall be extracted from the CMS IPPS Pricer Program.
- e. Outlier thresholds.
 - 1) The department shall calculate an outlier threshold as the sum of a hospital's DRG

- base payment or transfer payment, before outlier payments and excluding Medicaid high volume per diem payments, and the fixed loss cost threshold.
- 2) The fixed loss cost threshold shall equal \$29,000.
- f. A cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.
16. The department shall calculate Kentucky Medicaid-specific DRG relative weights by:
- a. Relative weight factors.
 - 1) Selecting Kentucky base year Medicaid inpatient paid claims, excluding those described in subsection (8) of this section;
 - 2) For rates effective January 5, 2009, a hospital-specific cost per discharge shall be calculated using state fiscal year 2006 inpatient Medicaid paid claims data;
 - b. DRG Classification.
 - 1) Reassigning the DRG classification for the base year claims based on the Medicare DRG in effect in the Medicare inpatient prospective payment system at the time of rebasing; and
 - 2) For a rate effective June 16, 2008, the department shall assign to the base year claims data the Medicare grouper version 24 DRG classifications which were effective in the Medicare inpatient prospective payment system as of October 1, 2006;
 - 3) Consideration of DRG usage:
 - a) Arraying DRGs with less than twenty-five (25) cases in the base year in order by the Medicare DRG relative weight in effect in the Medicare inpatient prospective payment system for the Medicare DRG grouper version twenty-four (24), published in the Federal Register, relied upon for Kentucky DRG classifications; and
 - b) For rates effective June 16, 2008, the department shall use the Medicare DRG relative weights which were effective for the Medicare inpatient prospective payment system as of October 1, 2006;
 - 4) Grouping low volume DRGs, based on the Medicare DRG relative weight sort, into one(1) of five (5) categories resulting in each category having approximately the same number of Medicaid cases;
 - 5) Calculating DRG relative weights for each category; and
 - 6) Assigning the relative weight calculated for a category to each DRG included in the category;
 - c. Removing the following claims from the calculation:
 - 1) Claims data for a discharge reimbursed on a per diem basis including:
 - a) A psychiatric claim, defined as follows:

- (i) An acute care hospital claim with a psychiatric DRG;
 - (ii) A psychiatric distinct part unit claim; and
 - (iii) a psychiatric hospital claim;
 - b) A rehabilitation claim, defined as follows:
 - (i) An acute care hospital claim with rehabilitation DRG;
 - (ii) a rehabilitation distinct part unit claim; and
 - (iii) A rehabilitation hospital claim;
 - c) A critical access hospital claim; and
 - d) A long term acute care hospital claim;
- 2) A transplant service claim as specified in item 21 of this section;
- 3) A claim for a patient discharged from an out-of-state hospital; and
- 4) A claim with total charges equal to zero (0);
- d. Calculating relative weight values for DRGs with twenty-five (25) or more cases in the base year, by:

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- 1) General considerations.
 - a) Standardizing the labor portion of the cost of a claim for differences in Medicare wage indices and the full cost of a claim for differences in Medicare indirect medical education factors using Medicare rate components;
 - b) For rates effective January 5, 2009, base year Medicare rate components shall equal Medicare rate components effective in the Medicare inpatient prospective payment system as of October 1, 2005; and
 - c) Base year Medicare rate components used in the Kentucky inpatient prospective payment system include:
 - (i) Labor-related percentage and non-labor-related percentage;
 - (ii) Operating and capital cost-to-charge ratios;
 - (iii) Operating indirect medical education factors; and
 - (iv) Wage indices;
 - 2) Cost factors.
 - a) The department shall standardize costs using the following formula: $\text{standard cost} = [((\text{labor related percentage} \times \text{costs}) / \text{Medicare wage index}) + (\text{nonlabor related percentage} \times \text{costs})] / (1 + \text{Medicare operating indirect medical education factor})$; and
 - b) For rates effective January 5, 2009, the labor related percentage shall equal sixty-two (62) percent and the nonlabor related percentage shall equal thirty-eight (38) percent;
 - 3) Removing statistical outliers by deleting any claim that is:
 - a) Above or below three (3) standard deviations from the mean cost per discharge for each DRG; and
 - b) Above or below three (3) standard deviations from the mean cost per day for each DRG;
- e. Computing an average standardized cost for all DRGs in aggregate and for each DRG or low volume DRG category, excluding statistical outliers;
 - f. Computing DRG relative weights:
 - 1) For a DRG with twenty-five (25) claims or more in the base year by dividing the average cost per discharge for each DRG by the statewide average cost per discharge; and
 - 2) For a DRG with less than twenty-five (25) claims in the base year by dividing the average cost per discharge for each of the five (5) low volume DRG categories by the statewide average cost per discharge; and
 - g. Calculating, for the purpose of a transfer payment, Kentucky Medicaid geometric mean length of stay for each DRG and low volume DRG category based on the base year claims data used to calculate DRG relative weights.

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- h. Employing enhanced neonatal care relative weights as follows:
- 1) Excluding high intensity level II neonatal center claims and low intensity level III neonatal center claims from the neonatal care relative weight calculations; and
 - 2) Applying an adjustment factor to relative weights not referenced in paragraph 1) of this subsection to offset the level I, II, and III neonatal care relative weight increase resulting from the use of enhanced neonatal care relative weights.
 - 3) See Exhibit C of this attachment for the detailed calculations.
17. The department shall:
- a. Separately reimburse for a mother's stay and a newborn's stay based on the DRG assigned to the mother's stay and to the newborn's stay;
 - b. Establish a unique set of diagnostic categories and relative weights for in-state acute care hospitals identified by the department providing level I neonatal care, qualifying as a level II neonatal care center and level III neonatal care center, as follows:
 - 1) The department shall exclude high intensity level II neonatal center claims and low intensity level III neonatal center claims from the neonatal center relative weight calculations;
 - 2) The department shall reassign a claim that would have been assigned to a Medicare DRG 385-390 to a Kentucky-specific:
 - a) DRG 675-680 for an in-state acute care hospital with a level II neonatal center; and
 - b) DRG 685-690 for an in-state acute care hospital with a level III neonatal center;
 - 3) The department shall assign a DRG 385-390 for a neonatal claim from a hospital which does not operate a level II or III neonatal center; and
 - 4) Computations and calculations.
 - a) The department shall compute a separate relative weight for a level II or III neonatal intensive care unit (NICU) neonatal DRG;
 - b) As of October 15, 2007, the department shall use base year claims from level II neonatal centers to calculate relative weights for DRGs 675-680.
 - c) As of November 15, 2007, the department shall use base year claims from level II neonatal centers, excluding claims from any high intensity level II neonatal center, to calculate relative weights for DRGs 675-680; and
 - d) The department shall use base year claims from level III neonatal centers to calculate relative weights for DRGs 685-690.
18. The department shall:
- a. Expend in aggregate by category (level I neonatal care, level II or III neonatal center care) and not by individual facilities:

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- 1) A total expenditure for level I neonatal center care projected to equal 100% of Medicaid allowable cost for the universal rate year;
 - 2) A total expenditure for level II neonatal center care projected to equal 100% of Medicaid allowable cost for the universal rate year; or
 - 3) A total expenditure for level III neonatal center care projected to equal 100% of Medicaid allowable cost for the universal rate year.
 - 4) Medicaid allowable cost shall be determined based on the providers CMS 2552-96 Medicare cost report.
- b. Adjust neonatal care DRG relative weights to result in:
 - 1) Total expenditures for level I Neonatal care projected to equal 100% of Medicaid allowable cost for the universal rate year;
 - 2) Total expenditures for level II Neonatal care projected to equal 100% of Medicaid allowable cost for the universal rate year; or
 - 3) Total expenditures for level III Neonatal care projected to equal 100% of Medicaid allowable cost for the universal rate year; and
 - c. Not cost settle reimbursement referenced in this subsection.
19. The department shall reimburse an individual:
- a. Level I neonatal center for level I neonatal care at the average Medicaid allowable cost per DRG of all level I neonatal centers;
 - b. Level II neonatal center for level II neonatal care at the average Medicaid allowable cost per DRG of all level II neonatal centers; or
 - c. Level III neonatal center for level III neonatal care at the average Medicaid allowable cost per DRG of all level III neonatal centers.
20. The department shall adjust the non-neonatal care DRGs to result in the aggregate universal rate year reimbursement for all services (non-neonatal and neonatal) to equal the aggregate base year reimbursement for all services (non-neonatal and neonatal) inflated by the trending factor.
21. If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.
- a. For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.
 - 1) The department shall calculate an average daily rate by dividing the DRG base payment, excluding outlier payments and Medicaid high volume per diem payments, by the statewide Medicaid geometric mean length-of-stay for a patient's DRG classification.
 - 2) If a hospital qualifies for a high volume per diem add-on payment in accordance with

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- Section (2)A.12 of this attachment under the DRG-based methodology, the department shall pay the hospital the applicable per diem add-on for the DRG average length-of-stay.
- 3) Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.
- b. For a hospital receiving a transferred patient, the department shall reimburse the DRG base payment, and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.
22. The department shall treat a transfer from an acute care hospital to a qualifying post-acute care facility for selected DRGs in accordance with paragraph (b) of this subsection as a post-acute care transfer.
- a. The following shall qualify as a post-acute care setting:
- 1) A psychiatric, rehabilitation, children's hospital, long-term acute care hospital, or cancer hospital;
 - 2) A skilled nursing facility; or
 - 3) A home health agency.
- b. A DRG eligible for a post-acute care transfer payment shall be in accordance with 42 U.S.C. 1395ww(d)(4)(C)(i).
- c. The department shall pay each transferring hospital an average daily rate for each day of stay.
- 1) A payment shall not exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.
 - 2) A DRG identified by CMS as being eligible for special payment shall receive fifty (50) percent of the full DRG payment plus the average daily rate for the first day of the stay and fifty (50) percent of the average daily rate for the remaining days of the stay, up to the full DRG base payment.
 - 3) A DRG that is referenced in item 22.b. and not referenced in item 22.c.2. shall receive twice the per diem rate the first day and the per diem rate for each following day of the stay prior to the transfer.
- d. The per diem amount shall be the base DRG payment allowed divided by the statewide Medicaid geometric mean length of stay for a patient's DRG classification.
23. The department shall reimburse for an intrahospital transfer to or from an acute care bed to or from a rehabilitation or psychiatric distinct part unit:
- a. The full DRG base payment allowed; and
 - b. The facility-specific distinct part unit per diem rate for each day the patient remains in the distinct part unit.
24. Transplant services.
- a. The department shall reimburse for a kidney, cornea, pancreas, or kidney and pancreas

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- transplant on a prospective per discharge method according to the patient's DRG classification.
- b. A transplant not referenced in paragraph (a) of this subsection, shall be reimbursed in accordance with 907 KAR 1:350 published on January 5, 2007, Coverage and payments for organ transplants.
25. A preadmission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:
- a. Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and
- b. Exclude a service furnished by a home health agency, a skilled nursing facility or hospice unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.
26. Direct Graduate Medical Education Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs.
- a. If federal financial participation for direct graduate medical education costs is not provided to the department, pursuant to 42 C.F.R. 447.201(c) or other federal regulation or law, the department shall not reimburse for direct graduate medical education costs.
- b. If federal financial participation for direct graduate medical education costs is provided to the department, the department shall reimburse for the direct costs of a graduate medical education program approved by Medicare as follows
- 1) A payment shall be made:
- a) Separately from the per discharge and per diem payment methodologies; and
- b) On an annual basis; and
- 2) The department shall determine an annual payment amount for a hospital as follows:
- a) The hospital-specific and national average Medicare per intern and resident amount effective for Medicare payments on October 1 immediately preceding the universal rate year shall be provided by each approved hospital's Medicare fiscal intermediary;
- b) The higher of the average of the Medicare hospital-specific per intern and resident amount or the Medicare national average amount shall be selected;
- c) The selected per intern and resident amount shall be multiplied by the hospital's number of interns and residents used in the calculation of the indirect medical education operating adjustment factor. The resulting amount is an estimate of total approved direct graduate medical education costs;
- d) The estimated total approved direct graduate medical education costs shall be divided by the number of total inpatient days as reported in the hospital's most recently finalized cost report on Worksheet D, Part 1, to determine an average approved graduate medical education cost per day amount;

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- e) The average graduate medical education cost per day amount shall be multiplied by the number of total covered days for the hospital reported in the base year claims data, excluding services described in subsection (8), to determine the total graduate medical education costs related to the Medicaid Program; and
 - f) Medicaid Program graduate medical education costs shall then be multiplied by the budget neutrality factor.
27. Budget Neutrality Factors.
- a. When rates are rebased, estimated projected reimbursement in the universal rate year shall not exceed payments for the same services in the prior year adjusted for inflation using the inflation factor prepared by GII for the universal rate year and adjusted for changes in patient utilization and case mix.
 - b. The estimated total payments for each facility under the reimbursement methodology in effect in the year prior to the universal rate year shall be estimated from base year claims.
 - c. The estimated total payments for each facility under the reimbursement methodology in effect in the universal rate year shall be estimated from base year claims.
 - d. If the sum of all the acute care hospitals' estimated payments under the methodology used in the universal rate year exceeds the sum of all the acute care hospitals' adjusted estimated payments under the prior year's reimbursement methodology, each hospital's DRG base rate and per diem rates shall be multiplied by a uniform percentage to result in estimated total payments for the universal rate year being equal to total adjusted payments in the year prior to the universal rate year.
 - e. When rates are rebased, the budget neutrality factors shall take into consideration the high volume adjustment payments.
28. Reimbursement Updating Procedures.
- a. The department shall annually, on July 1, use the inflation factor prepared by GII for the universal rate year to inflate a hospital-specific base rate for rate years between rebasing periods.
 - b. The department shall rebase payment rates using the DRG reimbursement methodology every four (4) years. The first rebasing year under this provision shall be for the universal rate year beginning on July 1, 2012.
 - c. Except for an appeal in accordance with section (1)B. of this attachment, the department shall make no other adjustment.
29. Trending Medicaid Costs for DRG Re-basing Purposes.
- a. Estimated Medicaid costs used to calculate DRG relative weights and DRG base rates shall be trended to the midpoint of the universal rate year.
 - b. The department shall use the inflation factor prepared by GII as the trending factor for the period being trended.
 - c. On an annual basis, the DRG rates will be changed as stated in Item a. of this trending section unless it is higher than GII inflation factor found in Item b. of this section. If the

GII trending factor is lower than the trending factor calculated in Item a. of this section, the GII trending factor will be used.

30. Readmissions.

- a. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.
- b. Reimbursement for a readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.

31. Intensity Operating Allowance Inpatient Supplement Payments.

- a. Beginning October 15, 2007, a State owned or operated University Teaching Hospital, including a hospital operated by a related party organization as defined at 42 CFR 413.17, which is operated as part of an approved School of Medicine, shall be based on the upper payment limits as required by 42 CFR 447.272 and will be determined prospectively each year based on the difference between the total payments made by Medicaid, excluding DSH, and the estimated Medicare payments for the same services. The Medicare payments will be determined based on the Medicare Principles of Reimbursement in accordance with 42 CFR 412 and 413.
- b. The detailed formula to determine the supplemental payments is described in Exhibit B incorporated as part of this attachment.
- c. The prospective supplemental payments will be reconciled annually to the final cost report filed for the rate year or prospective payment period.
- d. Any payments made under subsection a of this section are subject to the payment limitations as specified in 42 CFR 447.271, whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.
- e. Payments made under this section shall be prospectively determined quarterly amounts, subject to a year-end reconciliation described in 2.a.
- f. In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Health Care Financing Administration, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.
- g. Pediatric Teaching Hospital

A state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

- 1) Calculated by determining the difference between Medicaid costs as stated on the audited cost report filed as of June 1 each year and payments received for the Medicaid recipients (i.e., Medicare, KMAP, TPL, and Medical Education); and including,
- 2) An additional quarterly payment of \$250,000 (\$1 million annually).

(Medicaid recipients shall not include recipients receiving services reimbursed through a Medicaid managed care contract.)

32. Supplemental Payments for DRG Psychiatric Access Hospitals

- a. For services provided on and after April 2, 2001 the Department shall provide supplemental payments to certain hospitals to assure access to psychiatric services for patients in rural areas of the Commonwealth. To qualify for psychiatric access payments a hospital must meet the following criteria:
- 1) The hospital is not located in a Metropolitan Statistical Area (MSA);
 - 2) The hospital provides at least 65,000 days of inpatient care as reflected in the Department's Hospital Rate data for Fiscal Year 1998-99;
 - 3) The hospital provides at least 20% of inpatient care to Medicaid eligible recipients as reflected in the Department's Hospital Rate data for State Fiscal Year 1998-99; and
 - 4) The hospital provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.
- b. Each qualifying hospital will receive a psychiatric access payment amount based on its proportion of the hospital's Medicaid psychiatric days to the total Medicaid psychiatric days for all qualifying hospitals applied to the total funds for these payments. Payments will be made on a quarterly basis in according with the following:

Medicaid patient days

$$\text{Total Medicaid patient days} \times \text{Fund} = \text{Payment}$$

- c. Total Medicaid payments to a hospital from all sources shall not exceed Medicaid charges plus disproportionate share payments. A hospital's disproportionate share payment shall not exceed the sum of the payment shortfall for Medicaid services and the costs of the uninsured. The fund shall be an amount not to exceed \$6 million annually.

33. Appalachian Regional Hospital System supplemental payments.

All DRG hospitals operating in the Commonwealth of Kentucky that belong to the Appalachian Regional Hospital System will receive an adjusted payment equal to the difference between what Medicaid pays for inpatient services and what Medicare would pay for those same services to Medicaid eligible individuals or its proportionate share of \$7.5 million, whichever is lower. The Upper Payment Limit as defined in 42 CFR 447.272 will be applied on a facility-specific basis as described in Exhibit A. These payments will be made on a quarterly basis within 30 days of the end of the quarter.

34. Supplemental DRG Payments

- a. In-state high intensity level II neonatal center.
- 1) The Department will make prospective supplemental payments to in-state hospitals for all DRGs 675 through 680 as referenced in Section (2)A.15.b.1 of this attachment to a hospital with a Level II neonatal intensive care unit that meets the following qualifications:
 - a) Is licensed for a minimum of 24 neonatal level II beds;
 - b) Has a minimum of 1,500 Medicaid neonatal level II patient days per year;
 - c) Has a gestational age lower limit of twenty-seven (27) weeks; and

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- to a hospital with a Level II neonatal intensive care unit that meets the following qualifications:
- a) Is licensed for a minimum of 24 neonatal level II beds;
 - b) Has a minimum of 1,500 Medicaid neonatal level II patient days per year;
 - c) Has a gestational age lower limit of twenty-seven (27) weeks; and
 - d) Has a full-time perinatologist on staff.
 - e) The payment will be an additional add-on per discharge for each of the above DRGs.
- 2) Before July 1, 2007, the add-on will be \$3,775;
 - 3) From July 1, 2007 through-October 14, 2007, the add-on will be \$9,853; and
 - 4) On or after October 15, 2007, the add-on will be \$2,870.
- b. The Department will pay no more in the aggregate for inpatient hospital services than the inpatient Upper Payment Limit, as set forth in 42 CFR 447.253(b)(2) and 42 CFR 447.272. The Department will determine the inpatient Upper Payment Limit by estimating what would be paid for inpatient hospital services under the Medicare principles of reimbursement. The methodology used by the Department to calculate the inpatient Upper Payment Limits can be found in Attachment 4.19-A Exhibit A.
 - c. An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility in accordance with applicable federal regulations.
 - d. For the purpose of this attachment, Medicaid patient days shall not include days for a Medicaid recipient eligible to participate in the state's Section 1115 waiver as described as the Demonstration project: Services provided through regional managed care partnerships 1115 Wavier.
 - e. A payment made under the Supplemental DRG payments shall not duplicate a payment made via Item (8) Disproportionate share hospital distributions.
 - f. Supplemental Payment for Hospitals Paid Using the DRG-Based Methodology
 - 1) Hospitals paid using the DRG payment system shall receive, subject to conditions specified in this section,, supplemental payments for the calendar quarters beginning with the calendar quarter ending March 31, 2009 and ending with the calendar quarter ending on December 31, 2010.
 - 2) The aggregate supplemental payments described herein shall not exceed \$195,000,000 less any amount set aside that would have gone to those hospitals that decline the supplemental payment and retain their appeal rights.
 - 3) Each hospital's share of the aggregate pool shall be equal to its proportionate

share of the projected historical aggregate cost gap of the DRG hospitals, defined as the difference between costs and Medicaid payments for DRG services for the period July 1, 2004 through June 30, 2007, trended to the midpoint of the January 2009 through December 2010 payment period. The hospital's payment amount shall be divided into 36 equal units and paid on a descending balance basis as follows: first quarter, 8 units; second quarter, 7 units; third quarter, 6 units; fourth quarter, 5 units; fifth quarter, 4 units; sixth quarter, 3 units; seventh quarter, 2 units; and eighth quarter, 1 unit.

- 4) Hospitals receiving the Intensity Operating Allowance Supplement as established in this attachment shall not be eligible for the supplement payments described in this section since they are already receiving a supplement payment.
- 5) Any payments made under this supplement provision are subject to the upper payment limits specified in 42 CFR Part 447. See attached Exhibit A for the detailed methodology used to calculate the upper payment limits.

B. Certified Public Expenditures

The department shall reimburse an in-state public government-owned hospital the full cost of inpatient care via a Certified Public Expenditure (CPE) contingent upon approval by CMS

C. Per Diem Methodology: Payment for Rehabilitation or Psychiatric Care in an In-State Acute Care Hospital.

1. As of October 15, 2007, the department shall reimburse for rehabilitation or psychiatric care in an in-state acute care hospital that has a Medicare-designated rehabilitation or psychiatric distinct part unit:
 - a. On a facility specific per diem basis equivalent to the per diem cost reported for Medicare distinct part unit patients on the most recently Medicare cost report received prior to the rate year; and
 - b. In accordance with Reimbursement Limits and Updating Procedures section 24 of this attachment.
2. As of October 15, 2007, the department shall reimburse for rehabilitation or psychiatric care provided in an in-state hospital that does not have a Medicare designated distinct part unit:
 - a. On a facility-specific per diem basis equivalent to its aggregate projected payments for DRG services divided by its aggregate projected Medicaid covered days; and
 - b. In accordance with the Reimbursement Limits and Updating Procedures section 24 of this attachment.
3. As of November 15, 2007, the department shall reimburse for rehabilitation or psychiatric care in an in-state acute care hospital that has a Medicare-designated rehabilitation or psychiatric distinct part unit on a per diem basis as follows:
 - a. On a facility-specific per diem basis equivalent to the per diem cost reported for Medicare distinct part unit patients on the most recently received Medicare cost report prior to the rate year.
 - b. Reimbursement for an inpatient rehabilitation or psychiatric service shall be determined by multiplying a hospital's rehabilitation or psychiatric per diem rate by the number of allowed patient days.
 - c. A rehabilitation or psychiatric per diem rate shall be the sum of a rehabilitation or psychiatric operating per diem rate and a rehabilitation or psychiatric capital per diem rate, as appropriate.

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- c. A rehabilitation or psychiatric per diem rate shall be the sum of a rehabilitation or psychiatric operating per diem rate and a rehabilitation or psychiatric capital per diem rate, as appropriate.
- 1) The rehabilitation or psychiatric operating cost-per-day amounts used to determine the rehabilitation or psychiatric operating per diem rate shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric cost basis (as appropriate), excluding capital costs and medical education costs, by the number of Medicaid rehabilitation or psychiatric patient days in the base year.
 - 2) The Medicaid rehabilitation or psychiatric cost basis and patient days shall be based on Medicaid claims for patients with a rehabilitation or psychiatric diagnosis (as appropriate) with dates of service in the base year. The rehabilitation or psychiatric operating per diem rate shall be adjusted for:
 - a) The price level increase from the midpoint of the base year to the midpoint of the universal rate year using the CMS Input Price Index; and
 - b) The change in the Medicare published wage index from the base year to the universal rate year.
- d. Computation of rates.
- 1) A rehabilitation or psychiatric capital per diem rate shall be facility-specific and shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric capital cost basis by the number of Medicaid rehabilitation or psychiatric patient days (as appropriate) in the base year.
 - 2) The Medicaid rehabilitation or psychiatric capital cost basis and patient days shall be based on Medicaid claims for patients with rehabilitation or psychiatric diagnoses (as appropriate) with dates of service in the base year.
 - 3) The rehabilitation or psychiatric capital per diem rate shall not be adjusted for inflation.
- 4 The department shall reimburse for rehabilitation or psychiatric care provided in an in-state hospital that does not have a Medicare-designated distinct part unit:
- a. On a projected payment basis using:
 - 1) A facility specific per diem basis equivalent to its aggregate projected payments for DRG services divided by its aggregate projected Medicaid paid days.
 - 2) Aggregate projected payments and projected Medicaid paid days shall be the sum of:
 - a) Aggregate projected payments and aggregate projected Medicaid paid days for non-per diem DRG services as calculated by the model established in section (2)A;
 - b) Actual prior year payments inflated by the inflation factor provided by GII; and
 - c) Per diem DRG service Medicaid days; and
 - e. In compliance with provisions for the use of a universal rate year and taking into consideration Medicaid policy with regard to unallowable costs as shown in (1)D and F of this attachment.

- (3) Payment for Long-term Acute Care Hospital Care, In-State Freestanding Psychiatric Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.
- A. The department shall reimburse for inpatient care provided to eligible Medicaid recipients in an in-state freestanding psychiatric hospital, in-state freestanding rehabilitation hospital, or LTAC hospital on a per diem basis.
- B. The department shall calculate a per diem rate by:
1. Using a hospital's fiscal year 2005 Medicare cost report, allowable cost and paid days to calculate a base cost per day for the hospital;
 2. Trending and indexing a hospital's specific cost, excluding capital cost, per day to the current state fiscal year;
 3. Calculating an average base cost per day for hospitals within similar categories, for example rehabilitation hospitals, using the indexed and trended base cost per day;
 4. Assigning no hospital a base cost per day equaling less than ninety-five (95) percent of the weighted average trended and indexed base cost per day of hospitals within the corresponding category;
 5. Applying a parity factor equivalent to aggregate cost coverage established by the DRG reimbursement methodology described in the diagnostic related group hospital reimbursement portion of the state plan; and
 6. An additional amount of three (3) million dollars will be distributed on a pro-rata basis and applied to the per diem as calculated in paragraphs 1. through 5. of this subsection.
- C. From October 15, 2007 through November 14, 2007, the department shall reimburse the inpatient care provided to an eligible Medicaid recipient in an in-state psychiatric hospital previously designated as a primary referral and service resource for a child in the custody of the Cabinet for Health and Family Services at the median per diem rate paid of all freestanding psychiatric hospitals. Effective November 15, 2007, this provision is no longer relevant.
- D. In-State Hospital Minimum Occupancy Factor.
1. If an in-state hospital's minimum occupancy is not met, allowable Medicaid capital costs shall be reduced by:
 - a. Increasing the occupancy factor to the minimum factor; and
 - b. Calculating the capital costs using the calculated minimum occupancy factor.
 2. The following minimum occupancy factors shall apply:
 - a. A sixty (60) percent minimum occupancy factor shall apply to a hospital with 100 or fewer total licensed beds;
 - b. A seventy-five (75) percent minimum occupancy factor shall apply to a hospital with 101 or more total licensed beds; and
 - c. A newly-constructed in-state hospital shall be allowed one (1) full universal rate year before a minimum occupancy factor shall be applied.

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- E. Reduced Depreciation Allowance. The allowable amount for depreciation on a hospital building and fixtures, excluding major movable equipment, shall be sixty-five (65) percent of the reported depreciation amount as shown in the hospital's cost reports.
- F. Payment to a Newly-participating In-State Freestanding Psychiatric Hospital, Freestanding Rehabilitation Hospital or a Long Term Acute Care Hospital.
1. The department shall reimburse a newly-participating in-state freestanding psychiatric hospital, freestanding rehabilitation hospital or long term acute care hospital the minimum per diem rate paid to hospitals in their category until the first fiscal year cost report submitted by the hospital has been finalized.
 2. Upon finalization of the first fiscal year cost report for a facility, the department shall reimburse the facility a per diem rate in accordance with Section (3)B of this attachment.
- (4) Payment for Critical Access Hospital Care.
- A. The department shall pay a per diem rate to a critical access hospital equal to the hospital's Medicare rate.
- B. A critical access hospital's final reimbursement for a fiscal year shall reflect any adjustment made by CMS.
- C. Cost Report Requirements.
- a. A critical access hospital shall comply with the cost reporting requirements established in Section (1)E of this attachment in the In-State Hospital Cost Reporting Requirements section.
 - b. A cost report submitted by a critical access hospital to the department shall be subject to audit and review.
- D. An out-of-state critical access hospital shall be reimbursed under the same methodology as an in-state critical access hospital.
- E. The department shall reimburse for care in a federally defined swing bed in a critical access hospital at the same rate as established by the Centers for Medicare and Medicaid Services for Medicare.
- F. Reimbursement Limit. Total reimbursement to a hospital, other than to a critical access hospital, shall be subject to the limitation established in 42 C.F.R. 447.271.
- (5) In-State Psychiatric, Rehabilitation, and Long-term Acute Care Hospitals Reimbursement Updating Procedures.
- A. The department shall adjust an in-state hospital's per diem rate annually according to the following:
- 1) The Healthcare Cost Review, a publication prepared by Global Insight (GI) is used to obtain to update trending and indexing factors. The most recently received first-quarter publication is used for rate-setting. For trending and indexing factors the Total %MOVAVG line from Table 6.1CY, Hospital Prospective Reimbursement Market Basket, is used. The second quarter column of the respective year being trended/indexed to is used.

- 2) A capital per diem rate shall not be adjusted for inflation.
- B. The department shall, except for a critical access hospital, rebase an in-state hospital's per diem rate every four (4) years.
- C. Except for an adjustment resulting from an audited cost report, the department shall make no other adjustment, except for correction of error, as a result of a change resulting from a dispute resolution or appeal to the extent rates were not set in accordance with the State Plan or Federal Court decision; or as a result of a properly promulgated policy change and approved by CMS through a State Plan amendment.
- (6) Reimbursement for Out-of-state Hospitals for Critical Access Care, Long Term Acute Care, Rehabilitation Care and Psychiatric Care.
- A. For inpatient psychiatric or rehabilitation care provided by an acute out-of-state hospital, the department shall reimburse a per diem rate comprised of an operating per diem rate and a capital per diem rate.
1. As of October 15, 2007, the psychiatric or rehabilitation operating per diem rate shall be the median operating cost, excluding graduate medical education cost or any provider tax cost, per day for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 2. As of November 15, 2007, the psychiatric or rehabilitation operating per diem rate shall be the median psychiatric or rehabilitation operating per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 3. As of October 15, 2007, the psychiatric or rehabilitation capital per diem rate shall be the median psychiatric capital per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 4. As of November 15, 2007, the psychiatric or rehabilitation capital per diem rate shall be the median psychiatric or rehabilitation capital per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 5. An out-of-state hospital's per diem rate shall not include:
 - a. A provider tax adjustment; or
 - b. Graduate medical education costs.
- B. For care provided by an out-of-state freestanding long term acute care, critical access, or freestanding psychiatric hospital, the department shall reimburse a per diem rate comprised of an operating per diem rate and a capital per diem rate for each type of facility as appropriate.
1. The long term acute care, critical access, or psychiatric operating per diem rate shall equal the median operating cost, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding hospitals of the same type.
 2. The long term acute care, critical access, or psychiatric capital per diem rate shall be the median capital per diem rate for all in-state freestanding hospitals of the same type.
 3. An out-of-state hospital's per diem rate shall not include:
 - a. A provider tax adjustment; or

b. Graduate medical education costs.

C. For care in an out-of-state rehabilitation hospital, the department shall reimburse a per diem rate equal to the median rehabilitation per diem rate for all in-state rehabilitation hospitals except that an out-of-state hospital's per diem rate shall not include:

1. A provider tax adjustment; or
2. Graduate medical education costs.

D. The department shall apply the requirements of 42 C.F.R. 447.271 to payments made pursuant to the plan provisions shown in this section of this attachment.

(7) Supplemental Payments for a Free-standing In-state Rehabilitation Hospital:

A state designated rehabilitation teaching hospital that is not state-owned or operated shall receive an annual rehabilitation teaching supplement payment, determined on a per diem basis, in an amount calculated by determining the difference between Medicaid costs as stated on the cost settled audited cost report each year, and payments received for the Medicaid patients (i.e., Medicare, KMAP, TPL, and Medical Education.)

(8) Disproportionate Share Hospital Provisions

A. Definition. A disproportionate share hospital or DSH means an in-state hospital that:

1. Has an inpatient Medicaid utilization rate of one (1) percent or higher; and
2. Meets the criteria established in 42 U.S.C. 1396r-4(d).
3. Has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.
4. Meets the requirements established in section 1923(d) of the Act.

B. Disproportionate Share Hospital Distribution General Provisions. A DSH distribution shall:

1. Be made to a qualified hospital;
2. Be based upon a hospital's proportion of inpatient and outpatient indigent care from the preceding state fiscal year;
3. Be a prospective amount. For example, a DSH distribution made to a hospital in October 2007 shall cover the state fiscal year beginning July 1, 2007 and ending June 30, 2008;
4. Not be subject to settlement or revision based on a change in utilization during the year to which it applies;
5. Be made on an annual basis;
6. Be made from a hospital's share of the allocated pool or total disproportionate share funds with the following allocation into three (3) pools: forty-three and ninety-two hundredths percent (43.92%) allocated to acute care hospitals; thirty-seven percent (37%) allocated to university hospitals; and nineteen and eight hundredths percent (19.08%) allocated to private psychiatric hospitals and state mental hospitals, or the maximum dollar cap from the annual federal allotment;

7. "Type I hospital" means an in-state disproportionate share hospital with 100 beds or less that participates in the Medicaid Program;
8. "Type II hospital" means an in-state disproportionate share hospital with 101 beds or more that participates in the Medicaid Program, except for a hospital that meets the criteria established in this administrative regulation for a Type III or Type IV hospital;
9. "Type III hospital" means an in-state disproportionate share state university teaching hospital, owned or operated by either the University of Kentucky or the University of Louisville Medical School; and
10. "Type IV hospital" means an in-state disproportionate share hospital participating in the Medicaid Program that is a state-owned psychiatric hospital.

C. Disproportionate Share Hospital Distribution to a DRG-Reimbursed Acute Care Hospital. The department shall determine a DSH distribution to a DRG-reimbursed acute care hospital by:

1. Determining a hospital's average reimbursement per discharge;
2. Dividing the hospital's average reimbursement per discharge by Medicaid days per discharge;
3. Multiplying the amount established in paragraph b by the hospital's total number of inpatient indigent care days for the most recently completed state fiscal year to establish the hospital's inpatient indigent care cost;
4. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report;
5. Combining the inpatient indigent care cost established in paragraph (c) with the outpatient indigent care cost established in paragraph (d) to establish a hospital's indigent care cost total; and
6. Comparing the total indigent care cost for each DRG-reimbursed hospital to the indigent care costs of all hospitals receiving DSH distributions under the acute care pool pursuant to the following procedure to establish a DSH distribution on a pro rata basis:
 - a. The department shall calculate an indigent care factor for each hospital annually. The indigent care factor shall be determined by calculating the percentage of each hospital's annual indigent care costs toward the sum of the total annual indigent care cost for all hospitals within each respective pool. For purposes of this paragraph, "indigent care costs" means the hospital's inpatient and outpatient care as reported to the department multiplied by the hospital's Medicaid rate, or at a rate determined by the department in administrative regulation that, when multiplied by the hospital's reported indigent care, is equivalent to the amount that would be payable by the department under the fee-for-service Medicaid program for the hospital's total reported indigent care; and
 - b. Each hospital's annual distribution shall be calculated by multiplying the hospital's indigent care factor by the total fund allocated to the acute care pool, university hospital pool, and the private psychiatric pool.

D. Disproportionate Share Hospital Distribution to a Critical Access Hospital, Rehabilitation

Hospital or Long Term Acute Care Hospital. The department shall determine a DSH distribution to a critical access hospital, rehabilitation hospital, or long term acute care hospital:

1. For the period beginning state fiscal year beginning July 1, 2007 and ending June 30, 2008 by:
 - a. Multiplying the hospital's per diem rate in effect as of June 30, 2007 by its total number of inpatient indigent care days for the preceding state fiscal year (July 1, 2006 - June 30, 2007) to establish the hospital's inpatient indigent care cost;
 - b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report;
 - c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and
 - d. Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to state regulations related to establishing a hospital's DSH distribution on a pro rata basis; and
 2. For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:
 - a. Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection (2) of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and
 - b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report;
 - c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and
 - d. Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to state statute establishing a hospital's DSH distribution on a pro rata basis.
- E. Disproportionate Share Hospital Distribution to a Private Psychiatric Hospital. The department shall determine a DSH distribution to a private psychiatric hospital:
1. For the period beginning state fiscal year beginning July 1, 2007 and ending June 30, 2008 by:
 - a. Multiplying the hospital's per diem rate in effect as of June 30, 2007 by its total number of inpatient indigent care days for the preceding state fiscal year (July 1, 2006 - June 30, 2007) to establish the hospital's inpatient indigent care cost;

- b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report hospital fee schedule or by establishing an inpatient equivalency;
 - c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and
 - d. Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis; and
 2. For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:
 - a. Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection 2 of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and
 - b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge from the Medicare Cost Report fee schedule or by establishing an inpatient equivalency;
 - c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and
 - d. Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis.
- F. Disproportionate Share Hospital Distribution to a State Mental Hospital. The Department shall determine a DSH distribution to a state mental hospital by:
 1. Comparing each state mental hospital's costs of services provided to individuals meeting the indigent eligibility criteria established in subsections H and I of this Section, minus any payment made by or on behalf of the individual to the hospital; and
 2. Using the DSH funding allocated to state mental hospitals to establish a state mental hospital's DSH distribution on a pro rata basis.
- G. Disproportionate Share Hospital Distribution to a University Hospital. The department's DSH distribution to a university hospital shall be based on the hospital's historical proportion of the costs of services to Medicaid recipients, minus reimbursement paid according to the regulation related to Diagnostic related group (DRG) inpatient hospital reimbursement, or the nondiagnostic related group inpatient hospital reimbursement and supplemental or IOA payments, plus the costs of services to indigent and uninsured patients minus any distributions made on behalf of indigent and uninsured patients; and
- H. Indigent Care Eligibility.
 1. Prior to billing a patient and prior to submitting the cost of a hospital service to the

department as uncompensated, a hospital shall use the indigent care eligibility form, DSH-001, Application for Disproportionate Share Hospital Program, to assess a patient's financial situation to determine if:

- a. Medicaid or Kentucky Children's Health Insurance Program (KCHIP) may cover hospital expenses; or
 - b. A patient meets the indigent care eligibility criteria.
2. An individual referred to Medicaid or KCHIP by a hospital shall apply for the referred assistance, Medicaid or KCHIP, within thirty (30) days of completing the DSH-001, Application for Disproportionate Share Hospital Program, at the hospital.

I. Indigent Care Eligibility Criteria.

1. A hospital shall receive disproportionate share hospital funding for an inpatient or outpatient medical service provided to an indigent patient under the provisions of this attachment if the following apply:
 - a. The patient is a resident of Kentucky;
 - b. The patient is not eligible for Medicaid or KCHIP;
 - c. The patient is not covered by a third-party payor;
 - d. The patient is not in the custody of a unit of government that is responsible for coverage of the acute care needs of the individual;
 - e. The hospital shall consider all income and countable resources of the patient's family unit and the family unit shall include:
 - 1) The patient;
 - 2) The patient's spouse;
 - 3) The minor's parent or parents living in the home; and
 - 4) Any minor living in the home;
 - f. A household member who does not fall in one (1) of the groups listed in paragraph (e) of this subsection shall be considered a separate family unit;
 - g. Countable resources of a family unit shall not exceed:
 - 1) \$2,000 for an individual;
 - 2) \$4,000 for a family unit size of two (2); and
 - 3) Fifty (50) dollars for each additional family unit member;
 - h. Countable resources shall be reduced by unpaid medical expenses of the family unit to establish eligibility; and
 - i. The patient or family unit's gross income shall not exceed the federal poverty limits published annually in the Federal Register and in accordance with KRS 205.640.
2. Except as provided in subsection (3) of this section, total annual gross income shall be the lessor of:
 - a. Income received during the twelve (12) months preceding the month of receiving a service; or

- b. The amount determined by multiplying the patient's or family unit's income, as applicable, for the three (3) months preceding the date the service was provided by four (4).
3. A work expense for a self-employed patient shall be deducted from gross income if:
 - a. The work expense is directly related to producing a good or service; and
 - b. Without it the good or service could not be produced.
4. A hospital shall notify the patient or responsible party of his eligibility for indigent care.
5. If indigent care eligibility is established for a patient, the patient shall remain eligible for a period not to exceed six (6) months without another determination.

J. Indigent Care Eligibility Determination Fair Hearing Process.

1. If a hospital determines that a patient does not meet indigent care eligibility criteria as established in subsections H and I of this Section, the patient or responsible party may request a fair hearing regarding the determination within thirty (30) days of receiving the determination.
2. If a hospital receives a request for a fair hearing regarding an indigent care eligibility determination, impartial hospital staff not involved in the initial determination shall conduct the hearing within thirty (30) days of receiving the hearing request.
3. A fair hearing regarding a patient's indigent care eligibility determination shall allow the individual to:
 - a. Review evidence regarding the indigent care eligibility determination;
 - b. Cross-examine witnesses regarding the indigent care eligibility determination;
 - c. Present evidence regarding the indigent care eligibility determination; and
 - d. Be represented by counsel.
4. A hospital shall render a fair hearing decision within fourteen (14) days of the hearing and shall provide a copy of its decision to:
 - a. The patient or responsible party who requested the fair hearing; and
 - b. The department.
5. A fair hearing process shall be terminated if a hospital reverses its earlier decision and notifies, prior to the hearing, the patient or responsible party who requested the hearing.
6. A patient or responsible party may appeal a fair hearing decision to a court of competent jurisdiction in accordance with state statute on judicial review of final order.

K. Indigent Care Reporting Requirements.

1. On a quarterly basis, a hospital shall collect and report to the department indigent care patient and cost data.
2. If a patient meeting hospital indigent care eligibility criteria is later determined to be Medicaid or KCHIP eligible or has other third-party payor coverage, a hospital shall adjust its indigent care report previously submitted to the department in a future reporting period.

L. Merged Facility. If two (2) separate entities merge into one (1) organization and one (1) of the merging entities has disproportionate status and the other does not, the department shall retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid.

M. Payment Limits: Limit on Amount of Disproportionate Share Payment to a Hospital.

1. Payments made under these provisions do not exceed the OBRA '93 limits described in 1923 (g) of the Social Security Act. This limit is the sum of the following two measurements that determine uncompensated costs: (a) Medicaid shortfall; and (b) costs of services to uninsured patients less any payments received. Medicaid shortfall is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the non-disproportionate share hospital payment method under this state plan. The cost of services to the uninsured includes inpatient and outpatient services. Costs shall be determined by multiplying a hospital's cost to charge ratio by its uncompensated charges. Uninsured patients are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.
2. Funds not distributed under the above provisions due to the limit in 1. may be redistributed to public hospitals who are located in the state's managed care region based on the following:

Medicaid Days

Total Medicaid Days X Remaining Funds = DSH Payment

Funds available for redistribution will be allocated to state teaching hospitals (Type III) to cover their uncompensated costs and then to public non-state providers (Type I and Type II). Medicaid days shall be based on the number of inpatient Medicaid days reported on the most recently completed cost report. Medicaid days shall include days provided under FFS and through a managed care entity.

3. Limit on Amount of Disproportionate Share Payment to a Hospital
 - a. A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for Medicaid recipient services and the costs of uninsured patients. (Section 1923(g) of the Social Security Act.)
 - b. Payment Shortfall for Medicaid Recipient Services. The payment shortfall for Medicaid recipient services is the amount by which the costs of inpatient and outpatient services provided Medicaid recipients exceed the payments made to the hospital for those services excluding disproportionate share payments.
 - c. Unrecovered Cost of Uninsured/indigent Patients. The unrecovered cost of uninsured/indigent patients is the amount by which the costs of inpatient and outpatient services provided to uninsured/indigent patients exceed any cash payments made by or on behalf of them. An uninsured/indigent patient is an individual who has no health insurance and meets income standards established in state law.
4. The disproportionate share hospital payment shall be an amount that is reasonably related

to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(9) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

- A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A
- B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

Level I PRTF

- 1 The department shall reimburse for Level I PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of \$274.01; or the usual and customary charge
- 2 The per diem rate shall be increased each biennium by 2.22 percent.
- 3 The per diem or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:
 - (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be:
 - 1. Reimbursed via the department's pharmacy program in accordance with 907 KAR 1:018.

Level 2 PRTF

- 1 The department shall reimburse a per diem rate as follows for Level II PRTF services and costs for a recipient not enrolled in a managed care organization:
 - (a) \$345 for Level II PRTF services to a recipient who meets the rate group one (1) criteria described below;
 - (b) \$365 for Level II PRTF services to a recipient who meets the rate group two (2) criteria described below;
 - (c) \$385 for Level II PRTF services to a recipient who meets the rate group three (3) criteria described below; or
 - (d) \$405 for Level II PRTF services to a recipient who meets the rate group four (4) criteria described below.

2 Rate Groups

- (a) Rate group one (1) criteria shall be for a recipient who:
1. Is twelve (12) years of age or younger;
 2. Is male or female; and
 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have mental retardation or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (b) Rate group two (2) criteria shall be for a recipient who:
1. Is twelve (12) years of age or younger;
 2. Is male or female; and
 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have mental retardation or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (c) Rate group three (3) criteria shall be for a recipient who:
1. Is thirteen (13) years of age or older;
 2. Is male or female; and
 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have mental retardation or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (d) Rate group four (4) criteria shall be for a recipient who:
1. Is thirteen (13) years of age or older;
 2. Is male or female; and
 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have mental retardation or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (e) Rate group four (4) criteria also includes the following for a recipient who:
1. Is under twenty-two (22) years of age;
 2. Is male or female; and
 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Has mental retardation or a developmental disability; and
 - (iii) Has an intelligence quotient lower than seventy (70).

- C. The per diem rates referenced in subsection (2) of this section, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:
- (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program:

- D. The department shall annually evaluate each per diem rate for Level II PRTF services and costs by reviewing the most recent, reliable claims data and cost report data to analyze treatment patterns, technology, and other factors that may alter the cost of efficiently providing Level II PRTF services.
- E. The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.

(10) Reimbursement for Out-of-state Hospitals.

- A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.
 - 1. The all-inclusive DRG payment amount:
 - a. Shall be based on the patients diagnostic category; and
 - b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
 - 2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:

- 1) An adjustment for provider; and
 - 2) Graduate medical education.
3. The out-of-state hospital DRG base rate shall be determined as follows:
- a. For an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, the DRG base rate shall equal the average DRG all-inclusive base rate paid to in-state children's hospitals. Children's hospitals shall be defined as hospitals designated as Children's hospitals by CMS under the Medicare inpatient prospective payment system.
 - b. For an out-of-state rural hospital, the DRG base rate shall equal the bottom quartile DRG all-inclusive base rate paid to in-state rural hospitals. Rural hospitals shall be defined as hospitals located in rural areas as designated by CMS in the Medicare inpatient prospective payment system.
 - c. For an out-of-state urban hospital, the DRG base rate shall equal the bottom quartile DRG all-inclusive base rate paid to in-state urban hospitals. Urban hospitals shall be defined as hospitals located in urban areas as designated by CMS in the Medicare inpatient prospective payment system.
3. An out-of-state provider shall not be eligible to receive high volume per diem add-on payments, indirect medical education reimbursement or disproportionate share hospital payments.
4. The department shall make a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to Quality Improvement Organization review and approval.
- a. The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim.
 - b. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.
 - c. The department shall use the Medicare operating the capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.
 - d. The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.
- B. As of November 15, 2007, the department shall reimburse an acute care out-of-state hospital, except for a children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and a bordering state, for inpatient care:
1. On a fully-prospective per discharge basis based on the patient's diagnostic category; and
 2. An all-inclusive rate.

- C. As of November 15, 2007, the all-inclusive rate referenced in subsection B.2 of this section shall:
1. Equal the facility-specific Medicare base rate multiplied by the Kentucky-specific DRG relative weights, except that the DRG relative weights shall exclude any provider tax adjustment for in-state hospitals;
 2. Exclude:
 - a. Medicare indirect medical education cost or reimbursement
 - b. Direct graduate medical education cost payment amounts;
 - c. High volume per diem add-on reimbursement;
 - d. Disproportionate share hospital distributions;
 - e. Any adjustment mandated for in-state hospitals; and
 - f. Graduate medical education costs; and
 3. Include a cost outlier payment if the associated discharge meets the cost outlier criteria;
 - a. The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim;
 - b. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges;
 - c. The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year; and
 - d. The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.
- D. As of November 15, 2007, the department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, a DRG base rate equal to the average DRG base rate paid to in-state children's hospitals.
- E. As of January 5, 2009, the department shall reimburse an acute care out-of-state hospital, except for a children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and bordering state, and except for Vanderbilt Medical Center, for inpatient care:
1. On a fully-prospective per discharge basis based on the patient's diagnostic category; and
 2. An all-inclusive rate.
 - a. The all-inclusive rate referenced in subsection (10)E.2. of this section shall:
 - 1) Equal the facility specific Medicare base rate multiplied by:

-
- a) 0.7065; and
 - b) The Kentucky-specific DRG relative weights after the relative weights have been reduced by twenty (20) percent;
- 2) Exclude:
- a) Medicare indirect medical education cost or reimbursement;
 - b) High volume per diem add-on reimbursement;
 - c) Disproportionate share hospital distributions; and
 - d) An adjustment for the provider tax; and
- 3) Include a cost outlier payment if the associated discharge meets the cost outlier criteria established in item (2)A.15 of this attachment.
- a) The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim;
 - b) The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges;
 - c) The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year; and
 - d) The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.
- b. The department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, and except for Vanderbilt Medical Center, and all-inclusive rate equal to the average all-inclusive base rate paid to in-state children's hospitals.
- c. The department shall reimburse for inpatient care provided by Vanderbilt Medical Center at the Medicare operating and capital-related cost-to-charge, extracted from the CMS IPPS Pricer Program in effect at the time the care was provided, multiplied by eighty-five (85) percent. For example, if care was provided on September 13, 2008, the cost-to-charge ratio used shall be the cost-to-charge ratio extracted from the CMS IPPS Pricer Program in effect on September 13, 2008.
- d. An out-of-state provider shall not be eligible to receive high volume per diem add-on payments, indirect medical education reimbursement or disproportionate share hospital payments.
- e. The department shall make a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to Quality Improvement Organization review and approval.

- 1) The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim.
- 2) The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.
- 3) The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.
- 4) The outlier payment amount shall equal eighty (80) percent for the amount which estimated costs exceed the discharge's outlier threshold.

G. The department shall make a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to Quality Improvement Organization review and approval.

1. The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim.
2. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.
3. The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.
4. The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.

(11) Hospital Acquired Conditions and Never Events

For dates of service July 1, 2010 and after, for all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Medicare identified hospital acquired conditions, not present on admission, will not be considered by the Peer Review Organization (PRO) and are not reimbursable. This policy applies to all Medicaid reimbursement provisions contained in Section 4.19A, including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments.

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

This describes the methodology for calculating the Commonwealth of Kentucky's ("Commonwealth") inpatient hospital upper payment limits ("UPLs"). The Department's UPL methodology is in accordance with UPL guidance set forth by the Centers for Medicare and Medicaid Services ("CMS").

Overview of the Upper Payment Limit Methodology

The Commonwealth estimated the inpatient UPLs for the most recent state fiscal year by calculating a reasonable estimate of what would have been paid for Medicaid services using Medicare payment principles, by provider class. If the Medicaid payments for those services were equal to or less than the reasonable estimate of what would have been paid using Medicare payment principles, the Commonwealth met the UPL test.

For the inpatient hospital UPL analysis, the Commonwealth used various approaches to estimate what hospitals would have been paid using Medicare payment principles. These approaches are summarized as follows:

- *Private and non-state governmental owned acute hospitals:* Estimated payments under the Medicare Inpatient Prospective Payment System ("IPPS") payment methodology for the Federal Fiscal Year ("FFY") that most closely matches the UPL time period
- *Privately-owned psychiatric and rehabilitation distinct part units ("DPU"):* Estimated costs using the Medicare TEFRA approach (same approach as the outpatient analysis)
- *State-owned or operated inpatient hospitals:* Comparison of case-mix adjusted payment per discharge between Medicare and Medicaid for the UPL time period. These calculations have been made separately and are not included in this narrative.

Overview of Data Used for Analysis

The following data sources were used in the UPL calculations:

- Fee-for-service ("FFS") inpatient Medicaid claims data from the Medicaid Management Information System ("MMIS") for with dates of service that are within the UPL time period
- Most recently available Form CMS 2552 ("Medicare cost report") data extracted from the Healthcare Cost Report Information System ("HCRIS") dataset
- Supplemental Medicaid payment data from the Commonwealth as calculated in accordance with sections found in Attachment 4.19-A.

Development of UPL Analysis

The following summarizes the steps involved in the development of the UPL amounts for inpatient hospital services.

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- Step 1: Assigned Providers Into Provider Classes
Step 2: Calculated Reasonable Estimate of What Would Have Been Paid Under Medicare Payment Principles
Step 3: Determined Total Payments for Medicaid Services
Step 4: Compared Medicare Payments to Medicaid Payments for Each Provider Class

Each step is described in detail below.

Step 1: Assigned Providers Into Provider Classes

Per Federal UPL regulations, hospitals were placed into three provider classes:

- State-owned or operated
- Non-state government-owned or operated
- Privately-owned or operated

These provider class designations were determined via correspondence with staff from the Kentucky Office of the Inspector General, Division of Health Care Facilities and Services.

Kentucky Medicaid reimburses critical access hospitals, freestanding psychiatric hospitals and freestanding rehabilitation hospitals on a price basis using Medicare cost apportionment methodologies. As such, these providers have not been included in the UPL calculations.

Step 2: Calculated Reasonable Estimate of What Would Have Been Paid Under Medicare Payment Principles

Inpatient UPL analysis

There are several approaches to estimating Medicare payments for inpatient services, depending on the type of facility. These approaches are described as follows.

A. *Non-state governmental and Privately-Owned Acute Hospitals*

Kentucky Medicaid reimburses FFS acute inpatient hospital claims on a prospective basis using the Medicare Diagnosis Related Group ("DRG") Grouper. As such, it was reasonable to estimate what

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

payments would have been under the Medicare Inpatient Prospective Payment System ("IPPS") methodology for the same services paid by Medicaid during the UPL time period. The steps to estimating the Medicare IPPS payments are described as follows:

- 1) Medicare Rate Data: Medicare IPPS rate components were extracted from following sources (shown in Table 1):

Table 1: Medicare IPPS Rate Components

Medicare IPPS Rate Component	Source
<ul style="list-style-type: none"> • National Adjusted Operating Standardized Amounts, broken out by Labor and Non-Labor Components • Capital Standard Federal Payment Rates • Diagnosis Related ("DRG") Classifications, Relative Weights and Geometric Mean Average Length of Stay ("GLOS") • Post Acute Transfer DRGs 	"Final Rule" Federal Register
<ul style="list-style-type: none"> • Wage indices • Geographic Adjustment Factors ("GAF") • Large Urban Add-ons (if applicable) • Intern-to-Bed Ratios • Full-time Residents to Average Daily Census Ratios • Total Hospital Beds • Supplemental Security Income ("SSI") Ratios • Medicaid Ratios • Other Hospital ("HSP") Factors • Medicare Hospital Aggregate Operating and Capital CCRs 	CMS IPPS Program for an admit date of 10/land a discharge date of 10/2
<ul style="list-style-type: none"> • Medicare Approved Per Intern and Resident Amounts • Intern and Resident Full-Time Equivalents ("FTEs") 	Hospital Fiscal Intermediaries Data Request for amounts
<ul style="list-style-type: none"> • Quarterly Price Index Levels 	CMS PPS Hospital Input Price Index Levels, published by GLOBAL INSIGHT

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- 2) Medicare IPPS Rates: Medicare payment rates were determined as follows:
- a) Acute Base Rates: Operating and capital acute base rates were calculated for each hospital. For operating, the labor portion of the National Adjusted Operating Standardized Amount was adjusted by facility wage index. For capital, the full Capital Standard Federal Payment Rate was adjusted by facility GAF and Large Urban Add-on (if applicable).
 - b) Indirect Medical Education ("IME") Factors: operating and capital IME factors were calculated for each teaching hospital. Operating IME factors were calculated using the Intern-to-Bed Ratio, while capital IME factors were calculated using the full-time residents to average daily census ratio.
 - c) Disproportionate Share Hospital ("DSH") Factors: operating and capital IME factors were calculated for each qualifying hospital. DSH factors were determined for each hospital based on the hospital DSH percentage and number of beds. The DSH percentage was calculated by adding the SSI ratio and the Medicaid ratio.
 - d) Hospital-Specific ("HSP") Factor: Operating HSP factors were extracted from the CMS IPPS PRICER Program for qualifying Sole Community Hospitals.
 - e) Hospital Outlier Thresholds: Operating and capital outlier thresholds were calculated for each hospital. Thresholds were calculated by splitting the outlier-fixed loss threshold into operating and capital based on hospital CCRs. For operating, the labor portion was adjusted by wage index. For capital, the full amount was adjusted by facility GAF and Large Urban Add-on (if applicable).
- 3) Development of Inpatient Paid Claims Database: Payments under the FFY 2006 IPPS methodology were calculated using Medicaid inpatient claims. Payments were calculated based on the assigned DRG classification, discharge status, submitted charges and length of stay from the claims data.
- a) Non-transfer claims: For claims where the patient was not discharged to another hospital, DRG payments were estimated by multiplying the DRG relative weight by the operating and capital base rates. For qualifying hospitals, IME, DSH and HSP payments were estimated by multiplying the respective factors by the operating and capital DRG payments.
 - b) Normal Transfer Claims: For claims where the patient was discharged to another hospital and the DRG was not designated as special post-acute transfer, payments were estimated based on the transfer adjustment.
 - i. The transfer adjustment was calculated as follows:
$$(\text{Length of stay} + 1) / (\text{DRG GLOS})$$

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- ii. If the transfer adjustment was less than 1.0, payments were estimated by multiplying the total payment under the non-transfer claim methodology by the transfer adjustment
 - iii. If the transfer adjustment was greater than or equal to 1.0, payments were estimated using the non-transfer claim methodology
- c) Special Post-Acute Transfer Claims: For claims where the patient was discharged to another hospital and the DRG was designated as a special post-acute transfer, payments were estimated based on the special transfer adjustment:
- i. The special transfer adjustment was calculated as follows: $05 + [((\text{Length of stay} + 1) * 0.5) / (\text{DRG GLOS})]$
 - ii. If the special transfer adjustment was less than 1.0, payments were estimated by multiplying the total payment under the non-transfer claim methodology by the special transfer adjustment
 - iii. If the special transfer adjustment was greater than or equal to 1.0, payments were estimated using the non-transfer claim methodology
- d) Outlier Claims: Outlier payments were calculated for all qualifying claims a claim qualified for an outlier payment if the total costs, estimated by multiplying Medicare hospital aggregate CCRs by submitted charges, exceeded the total outlier threshold. The total outlier threshold equaled the sum of the operating and capital hospital outlier thresholds and the full DRG payment, including IME and DSH payments. For transfer claims, the outlier thresholds were multiplied by the transfer adjustment.

If a claim qualified for an outlier payment, separate operating and capital outlier payments were calculated as follows:

- i. Operating outlier payment:
 $[(\text{Operating Cost}) - (\text{Operating Outlier Threshold})] * (\text{Marginal Cost Factor})$
 - ii. Capital outlier payment:
 $[(\text{Capital Cost}) - (\text{Capital Outlier Threshold})] * (\text{Marginal Cost Factor})$
 - iii. Marginal cost factor: 90% for DRGs with an MDC of 22 (Bum) and 80% for all other DRGs
- e) Medicare payments were determined for every inpatient claim, resulting in an inpatient paid claims database

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- f) Using the inpatient paid claims database, Medicare payments by provider were determined.
- 4) Medicare IPPS Direct GME payments: Medicare reimburses teaching hospitals for the Direct GME costs related to the Medicare program. Medicare direct GME payments were estimated by determining the direct GME cost related to the Medicaid program. Direct GME payments were calculated as follows:
- a) Total provider direct medical education costs were estimated by multiplying the Medicare Approved Per Intern and Resident Amounts by intern and resident FTEs
 - b) The Medicaid portion of the direct GME costs was estimated by multiplying the total direct medical education costs by the ratio of Medicaid days to total hospital days. Medicaid days were determined from the cost claims database and total hospital days were extracted from Medicare cost reports.

B. Psychiatric and Rehabilitation DPUs

Kentucky Medicaid reimburses all claims from psychiatric and rehabilitation DPUs on a per diem payment basis. As such, it was not reasonable to estimate payments under Medicare's Inpatient Psychiatric Facility Prospective Payment System ("IPF PPS") or Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS") Methodologies. In lieu of replicating Medicare's payment methodologies, the Commonwealth used estimated TEFRA costs as a reasonable proxy for Medicare payments for hospital DPU claims.

Inpatient services include both routine and ancillary costs. Routine costs were estimated by applying cost per diems to Medicaid claim routine revenue code patient days, while ancillary costs were estimated by applying cost-to-charge ratios to Medicaid claim ancillary revenue code charges.

- 1) Medicare Cost Report Data: Each psychiatric and rehabilitation DPU reported its routine costs in a subprovider cost center in the Medicare cost report. Subprovider routine costs and patient days and ancillary costs and charges were extracted from the most recently available Medicare cost report, as follows:
- a) Worksheet B, Part I, Column 27: Total subprovider routine and ancillary costs were extracted from lines 31 through 68
 - b) Worksheet C, Part I, Column 5: Total hospital ancillary costs were extracted from the non-distinct part observation beds cost center (line 62)
 - c) Worksheet C, Part I, Column 6 and 7: Total hospital ancillary charges were extracted for each ancillary cost center.

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- d) Worksheet S-3, Part I, Column 6: Total hospital subprovider routine patient days were extracted from lines 14 and 14.01
 - e) Worksheet S-2, Line 20: Subprovider type (psychiatric or rehabilitation) was extracted for each subprovider cost center
- 2) Routine Cost Per Diems: Cost per diems were calculated for each DPU as follows:
- a) Each DPU's reported routine subprovider cost center from the HCRIS dataset was aligned into a standardized DPU cost center (Psych or Rehab) based on Medicare cost report Worksheet S-2
 - b) Costs and patient days were summed by provider, for each DPU
 - c) Cost per diems were calculated for each DPU by dividing costs by patient days
- 3) Cost-to-charge ratios ("CCRs"): CCRs were calculated for each ancillary cost center as follows:
- a) Each provider's reported ancillary cost centers from the HCRIS dataset were aligned into standardized cost centers. CMS includes documentation with the HCRIS dataset that crosswalks between reported cost centers and the standardized cost centers. This process involved aligning sub-scripted cost centers into standard cost centers (for example, aligned reported cost center 41.01 to 41 - Radiology/Diagnostic).
 - b) Costs and charges, by provider, were summed for each standardized Medicare cost center.
 - c) Cost-center specific CCRs were calculated for each provider by dividing costs by charges for each standardized cost center. Aggregate ancillary CCRs were calculated for each hospital by summing the costs and charges for all ancillary cost centers, and then dividing total ancillary costs by total ancillary charges. These aggregate ancillary CCRs were used when a cost-center specific CCR was not available.
- 4) Inflation Factors: inflation factors were developed for each hospital to inflate routine cost per diems to the UPL time period
- a) Price index levels were extracted from the CMS Prospective Payment System Hospital Input Price Index
 - b) The midpoint of each hospital Medicare cost report fiscal year was determined
 - c) Inflation factors were calculated based on the percentage change in Price Index Levels from the midpoint of each hospital's Medicare cost report to the midpoint of the UPL time period

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- 5) Development of DPU Inpatient Costed Paid Claims Database: DPU reasonable costs were estimated for inpatient claims
- a) Revenue codes from inpatient claims detail were crosswalked to a standardized cost center, except for non-covered revenue codes, which were excluded.
 - b) Routine costs at the claims detail level were estimated by multiplying the claims data variable "UNITS_OF_SERVICE" (which represents patient days) by the corresponding hospital cost center-specific routine cost per diem. Then multiply the result by 1.000 plus the corresponding routine inflation factor.
 - c) Ancillary costs were estimated at the claims' detail level by multiplying the claims' field "LI SUBMITTED CHARGE" (which represents ancillary service line item charges) by corresponding hospital cost center-specific CCR for the appropriate revenue code. If a cost center-specific CCR was not available, the hospital aggregate ancillary CCR was used as a proxy.
 - d) Estimated costs at the claims detail level were combined at the claims header level and added to the inpatient costed paid claims database
 - e) Using the DPU inpatient costed claims database, inpatient costs by DPU were determined.

Step 3: Determined Total Payments for Medicaid Services

For the inpatient hospital analyses, Medicaid FFS payments for each hospital were determined based on amounts reported in the MMIS for each claim in the FFS claims data. Other supplemental Medicaid payments amounts received from the Commonwealth were included in the inpatient UPL analysis. The Medicaid payments included in the UPL analysis are described detail below:

- A. FFS Medicaid Payments: Using the inpatient paid claims databases from the MMIS, total FFS Medicaid inpatient payments were calculated by summing the "REIMBURSEMENT_AMOUNT" and "THIRD_PARTY_PMT_AMT" fields for each hospital.
- B. Other Supplemental Inpatient Medicaid Payments:
 - 1) Settlement Payments: Based on lump sum Medicaid settlement payments to hospitals
 - 2) Direct GME Payments: Based on Medicaid direct graduate medical education payments.
 - 3) Intensity Operating Allowance ("IOA") Payments: Based on Medicaid IOA payments to teaching hospitals.
 - 4) Level II Neonatal Payment: Based on Medicaid Level II Neonatal payments to Central Baptist
 - 5) All other payments that may be made determined on a year by year basis.

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

Step 4: Compared Medicare Payments to Medicaid Payments for Each Provider Class

After calculating Medicaid payments and a reasonable estimate of Medicare payments for each hospital, subtotals were calculated for each provider class. The remaining limit for each provider class was determined by subtracting total Medicaid payments from total estimated Medicare payments. If the difference was positive, there was remaining limit, and the provider class passed the UPL test. If the difference was negative, there was no remaining limit, and the provider class did not pass the UPL test.

University of Louisville Hospital and University of Kentucky Hospital
Upper Payment Limits Demonstration Calculations
FYE (Providers Fiscal Year End)**Step 1: Find Medicare per case rate with case mix removed**

1.	Portions of Medicare Payments for (Fiscal Year End) Subject to Case Mix Index		
a.	Other than Outlier payments (base rate)		
b.	IME Adjustment (MCR Wksht E Part A Line 3.24)		
c.	DSH Adjustment (MCR Wksht E Part A Line 4.04)		
d.	Capital Adjustment (MCR Wksht. E Part A Line 9)		
e.	Total Medicare Payments Subject to Case Mix Index (total lines 1a through 1d)	\$	
2.	Adjustment for Case Mix Index		
a.	Medicare Case Mix Index-From Medicare annual PS&R Reports		
b.	Case Mix Adjusted Total Payments (In 3e/In 2a)		#DIV/o!
3.	Medicare Payments for (Fiscal Year End) not subject to case mix index		
a.	Outlier Adjustment (MCR Wksht E Part A Line 2.01)		
b.	GME adjustment (MCR Wksht E-3 Pt IV Line 23.01) – Excluding Medicare Part B		
c.	PPS Exempt Psych Unit (MCR Wksht E-3 Part 1 Ln 4)	\$	
d.	New Technology & Organ Acquisition pass-thru (MCR Wksht E Part A Line 11.02 & 12)	\$	
e.	Routine service pass-thru (Wksht E Part A Line 14)		
f.	Other ancillary other pass-thru (Wksht E Part A Lines 15 and E Part B Ln 1.07)		
g.	Total Medicare Payments Not Subject to Case Mix Index (total lines 3a through 3f)	\$	
4.	Total Medicare Payment		#DIV/0!
5.	Medicare Discharges (MCR Wksht. S-3 Part 1 Line 12)-Reconciled to Medicare annual PS&R Reports		

Step 2: Find Medicaid per case rate with case mix removed

6.	Medicaid Payments for (Fiscal Year End) Subject to Case Mix Index		
a.	Medicaid Inpatient Payments subject to CMI-Reconciled to the annual Medicaid Paid Claims Listing		
7.	Adjustment for Case Mix		
a.	Medicaid Case Mix Index Using Medicare Weights (Internal Report)-Reconciled to the Medicaid MMIS.		
b.	Case Mix Adjusted Total Payments (In 6a/In7a)		*DIV/0!
8.	Medicaid Payments not subject to case mix index-Reconciled to the annual Medicaid paid claims listing.		

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a.	Outlier adjustment		
b.	GME adjustment (Annual Payment)		
c.	PPS Exempt Psych Unit Payments		
d.	Transplants (Internal Reports Match to Medicaid Remittance)-reconciled to the Medicaid MMIS		
e.	Total Medicaid Payments Not Subject to Case Mix Index (total lines 8a thru 8d)	\$	
9.	Total Medicaid payment with case mix removed (Ln 7b + Ln 8e)		#DIV/0!
10.	Calculate Per Case Payment		
a.	Medicaid Discharges-Reconciled to the Medicaid MMIS.		
b.	Per case Medicaid rate with case mix removed (Ln 9/Ln 10a)		#DIV/0!

Step 3: Calculate UPL Gap

11.	Per Case Differential from Medicare payments subject to case mix (Ln 2b/Ln 5) – (Ln 7b/Ln 10a)		#DIV/0!
12.	Per Case Differential adjusted for Medicaid case mix using Medicare weights (Ln 11 x Ln 7a)		#DIV/0!
13.	Available Gap Under Case Mix Portion of UPL for UPL Payment (Ln 12 x Ln 10a)		#DIV/0!
13.1	Per Case Differential from Medicare Payments, Not Subject to Case Mix (Ln 3g/Ln 5a) – (Ln 8e/Ln10a)		#DIV/0!
13.2	Available Gap Under Non-case Mix Portion of UPL for UPL Payment (Ln 13.1 X Ln 10a)		#DIV/0!
13.3	Available UPL Gap for U PL Payment (Ln 13 + Ln 13.2)		#DIV/0!

Step 4: Inpatient Charges

14.	Total Medicaid Inpatient Charges-Reconciled to the Medicaid MMIS.	\$	
15.	Medicaid Inpatient Payments-Reconciled to the Medicaid MMIS.		
16.	Medicaid Charge Gap (Ln 14 – Ln 15)	\$	

Step 5: UPL Gap Available

17.	Less of Charge Gap (Ln 16) or UPL Gap (Ln 13.3)		#DIV/0!
Step 6: Calculate Federal Payment Available			
18.	Federal Matching Percentage	\$	
19.	Federal Incremental Payment (Ln 17 x Ln 18)		#DIV/0!
20.	State Match (Line 17 – Ln 19)		#DIV/0!

NOTE:

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Supersedes

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1. This worksheet shall include all Medicare & Medicaid payments EXCEPT Medicaid DSH
2. All MCR reference are to the CMS 2552-96 cost report forms. In the event the cost report report forms are revised all data will be from the applicable forms of the new cost report.
3. Medicaid discharges shall include 0 paid discharges.
4. Medicaid Management Information System

OS Notification

State/Title/Plan Number: KY 07-010
Type of Action: SPA Approval
Required Date for State Notification:
Fiscal Impact: FY 2008 \$ 14,020,000 Federal Share
FY 2009 \$ 14,020,000 Federal Share

Number of Services Provided by Enhanced Coverage, Benefits or Retained
Enrollment: 0
Number of Potential Newly Eligible People: 0
Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0 Reduces Benefits: No

Detail:

Effective October 15, 2007 this amendment modifies the State's reimbursement methodology for setting payment rates for inpatient hospital services. Specifically, the amendment provides for a rebasing of the diagnosis-related groups base rates and relative weight, adds a high volume per diem payment methodology based on Medicaid utilization and deletes obsolete language.

Other Considerations: This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

We do not recommend the Secretary contact the governor.

CMS Contact: Stanley Fields, NIRT 502-223-5332
Venesa Day, NIRT 410-786-8281

Certified Public Expenditures incurred in providing services to Medicaid and individuals with no source of third party insurance.

The Kentucky Medicaid Agency uses the CMS Form 2552 cost report for its Medicaid program and all acute care hospitals must submit this report each year. The Agency will utilize Worksheet Series S, B, C and D to determine the cost of services provided to Medicaid recipients and services to individuals with no source of third party insurance to be certified as public expenditures (CPE) from the CMS Form 2552 for inpatient services provided by hospitals. The Agency will use the protocol as described below.

Interim Payment

Interim payments will be made through the state Medicaid Management Information System (MMIS) and paid based on the approved Diagnosis Related Grouper (DRG) payment, per diem payments, fee schedule payments and/or dedicated on-demand payments through the state eMARS system.

Cost of Medicaid

1. **Interim Reconciliation of Interim Medicaid Inpatient Hospital Payment rate Post Reporting Year:** Upon completion of the State fiscal year, each hospital's interim payments and supplemental payments will be reconciled to its CMS Form 2552 cost report as filed to the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period. For hospitals that have a cost reporting period that differs from the State fiscal year end date of June 30th, the cost reports that overlap the State fiscal year will be used for the calculation. The reconciliation will occur upon receipt of the electronic CMS Form 2552 cost report that includes the June 30th fiscal year end of the State.

The State will apply the cost per diems calculated on the Medicare Worksheet D-1 Part II lines 38 and 42-47 to the respective routine days from Worksheet S-3, Part 1, Medicaid column, to determine Medicaid routine service cost for acute services. The cost per diem calculated on Medicare Worksheet D-1, Part II, line 38 for each subprovider will be applied to the respective days on worksheet S-3, Part 1, Medicaid column. Cost to charge ratios calculated on the Medicare Worksheet D-4 or D-3 will be applied to the Medicaid inpatient ancillary charges related to CMS ancillary service cost centers to determine Medicaid inpatient ancillary service cost. A calculation will be made to add back the cost of graduate medical education to the cost per diems and cost to charge ratios, if removed as a step-down adjustment on Worksheet B, Part I columns 22 and 23. The Medicaid days and charges are reconciled to MMIS paid claims data.

In addition to the cost calculated through application of cost per diems to routine service days and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures.

The Worksheet D-6 or D-4 series with the inclusion of medical education cost as stated above for each organ will be used to determine organ acquisition cost. The total amount of Medicaid organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 or D-4 Part III Line 53 or 61 divided by Total usable organs per Worksheet D-6 or 0-4 Part III Line 54 or 62 times number of Medicaid organs (fee for service) transplanted during the year.

Total Medicaid inpatient cost therefore will be the sum of routine service cost, ancillary service cost, graduate medical education cost, and organ acquisition cost. Any Medicaid payments (other than the interim payments provided in this protocol) and third party and client responsibility payments are deducted from the total Medicaid inpatient cost to determine the certifiable amount. The State will compare the interim payments made to the interim Medicaid cost computed here for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

2. Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate Post Reporting Year: Upon issuance of a Notice of Program Reimbursement for CMS Form 2552 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period(s). For hospitals that have a cost reporting period that differs from the State fiscal year end date of June 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

The State will apply the cost per diems calculated on the Medicare Worksheet D-1 Part II lines 38 and 42-47 to the respective routine days from Worksheet S-3, Part 1, Medicaid column to determine Medicaid routine service cost for acute services. The cost per diem calculated on Medicare Worksheet D-1, Part II, line 38 for each subprovider will be applied to the respective days on Worksheet S-3, Part 1, Medicaid column. Cost to charge ratios calculated on the Medicare Worksheet 0-4 or D-3 will be applied to the Medicaid inpatient ancillary charges related to CMS ancillary service cost centers to determine Medicaid inpatient ancillary service cost. A calculation will be made to add back the cost of graduate medical education to the cost per diems and cost to charge ratios, if removed as a step-down adjustment on Worksheet B, Part I columns 22 and 23. The Medicaid days and charges are reconciled to MMIS paid claims data.

In addition to the cost calculated through application of cost per diems to routine service and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures. The Worksheet D-6 or D-4 series with the inclusion of medical education cost as stated above for each organ will be used to determine organ acquisition cost. The total amount of Medicaid organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 or D-4 Part III Line 53 or 61 divided by Total usable

organs per Worksheet D-6 or D-4 Part 111 Line 54 or 62 times the number of Medicaid organs (fee for service) transplanted during the year.

Total Medicaid inpatient cost therefore will be the sum of routine service cost, ancillary service cost, graduate medical education cost, and organ acquisition cost. Any Medicaid payments other than the interim payments provided in this protocol and third party and client responsibility payments are deducted from the total Medicaid inpatient cost to determine the certifiable amount. The State will compare the final reconciliation to the interim reconciliation for each hospital. Any difference to the Medicaid cost will be recorded as an adjustment on the CMS 64 report.

Cost of the Uninsured - Interim

3. Calculation of Cost of Uninsured - Interim

The Department for Medicaid Services will utilize the computations noted below for costs to be certified for public expenditure.

A. Non State-Government Owned Acute Care Hospitals

- a. Providers will submit the DSH Data Collections form quarterly based on the state fiscal year to report data to be used in the indigent cost calculation. The provider will report inpatient days and charges.
- b. The inpatient indigent days submitted for each quarter are totaled and then multiplied by an inpatient average reimbursement per discharge rate to calculate the cost of the uncompensated services. The inpatient average reimbursement per discharge rate is calculated by dividing the hospitals average reimbursement per discharge by the Medicaid days per discharge based on a data bi-query from the MMIS claims system.
 1. For a critical access hospital, rehabilitation, or long term acute care hospital the Medicaid inpatient per diem rate paid as of August 1st in the SFY period for which the DSH payment is made will be multiplied by inpatient indigent care days to calculate inpatient indigent costs.

4. Interim Reconciliation: Upon completion of the State fiscal year, each hospital's interim rate and supplemental payments will be reconciled to its CMS Form 2552 cost report as filed to the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period. For hospitals that have a cost reporting period that differs from the State fiscal year end date of June 30th, the cost reports that overlap the State fiscal year will be used for the calculation. The reconciliation will occur upon receipt of the electronic CMS Form 2552 cost report that includes the June 30th fiscal year end of the State.

Each hospital will supply the State with detailed uninsured inpatient routine days and ancillary charges information for services provided to uninsured individuals.

The State will apply the cost per diems calculated on the Medicare Worksheet D-1 Part II lines 38 and 42-47 to the respective routine uninsured days submitted by the provider to determine uninsured routine service cost for acute services. The cost per diem calculated on Medicare Worksheet D-1, Part II, line 38 for each subprovider will be applied to the respective uninsured days submitted by the provider. Cost to charge ratios calculated on the Medicare Worksheet D-4 or D-3 will be applied to the inpatient uninsured ancillary service charges submitted by the provider to determine uninsured inpatient ancillary service cost. A calculation will be made to add back the cost of graduate medical education to the cost per diems and cost to charge ratios, if removed as a step-down adjustment on Worksheet B, Part I columns 22 and 23. The uninsured inpatient days and charges are reconciled to the provider submitted uninsured data.

In addition to the cost calculated through application of cost per diems to routine service days and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures.

The Worksheet D-6 or D-4 series with the inclusion of medical education cost as stated above for each organ will be used to determine organ acquisition cost. The total amount of uninsured organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 or D-4 Part III Line 53 or 61 divided by Total usable organs per Worksheet D-6 or D-4 Part III Line 54 or 62 times number of uninsured organs (fee for service) transplanted during the year.

Total uninsured inpatient cost therefore will be the sum of routine service cost, ancillary service cost, graduate medical education costs, and organ acquisition cost. Uninsured payments related to the charges submitted are deducted from the total uninsured inpatient cost to determine the certifiable amount. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of services for individuals with no source of third party insurance. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

5. Cost of the Uninsured - Final

Upon issuance of a Notice of Program Reimbursement for CMS Form 2552 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period(s). For hospitals that have a cost reporting

period that differs from the State fiscal year end date of June 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

If necessary, each hospital will supply the State with updated detailed inpatient routine days and ancillary charges information for services provided to uninsured individuals.

The State will apply the cost per diems calculated on the Medicare Worksheet D-1 Part II lines 38 and 42-47 to the respective routine uninsured days submitted by the provider to determine uninsured routine service cost for acute services. The cost per diem calculated on Medicare Worksheet D-1, Part II, line 38 for each subprovider will be applied to the respective uninsured days submitted by the provider. Cost to charge ratios calculated on the Medicare Worksheet D-4 or D-3 will be applied to the inpatient uninsured ancillary service charges submitted by the provider to determine uninsured inpatient ancillary service cost. A calculation will be made to add back the cost of graduate medical education to the cost per diems and cost to charge ratios, if removed as a step-down adjustment on Worksheet B, Part I columns 22 and 23. The uninsured inpatient days and charges are reconciled to the provider submitted uninsured data.

In addition to the cost calculated through application of cost per diems to routine service and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures. The Worksheet D-6 or D-4 series with the inclusion of medical education cost as stated above for each organ will be used to determine organ acquisition cost. The total amount of organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 or D-4 Part III Line 53 or 61 divided by Total usable organs per Worksheet D-6 or D-4 Part III Line 54 or 62 times the number of organs (fee for service) transplanted during the year

Total uninsured inpatient cost therefore will be the sum of routine service cost, ancillary service cost, graduate medical education costs, and organ acquisition cost. Uninsured payments related to the charges submitted are deducted from the total uninsured inpatient cost to determine the certifiable amount. Any Medicaid payments made in excess of Medicaid cost will be used to offset uncompensated care of services for individuals with no source of third party coverage. . Any difference to the cost will be recorded as an adjustment on the CMS 64 report.

Methods and Standards for Establishing Payment Rates — Other Types of Care

I. Drugs

A. Reimbursement

1. Participating pharmacies are reimbursed for the cost of the drug plus a dispensing fee. Payments shall not exceed the federal upper limits specified in 42 CFR 447.331 through 447.334.
2. Participating dispensing physicians are reimbursed for the cost of the drug only.
3. Providers will be reimbursed only for drugs supplied from pharmaceutical manufacturers who have signed a rebate agreement with CMS.

B. Payment Limits — Payment for the cost of drugs shall be the lesser of:

1. The Federal Upper Limit (FUL) means the maximum federal financial participation available toward reimbursement for a given drug dispensed to a Medicaid recipient.
2. The State Maximum Allowable Cost (SMAC). A SMAC may be established for any drug for which two or more A-rated therapeutically equivalent, multi- source, non-innovator drugs with a significant cost difference exist. The SMAC will be determined taking into account drug price status (non-rebatable, rebatable), marketplace status (obsolete, regional availability), equivalency rating (A-rated), and relative comparable pricing. Other factors considered are clinical indications of generic substitution, utilization and availability in the marketplace. The source of comparable drug prices will be nationally recognized comprehensive data files maintained by a vendor under contract with the Department for Medicaid Services. Resources accessed to determine SMAC include Wholesale Acquisition Cost (WAC), and Direct Price (to retail pharmacies) with weights applied based on the distribution of the volume purchased.
 - a. Multiple drug pricing resources are utilized to determine the estimated acquisition cost for the generic drugs. These resources include pharmacy providers, wholesalers, drug file vendors such as First Data Bank (FDB), and pharmaceutical manufacturers;

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- b. The Estimated Acquisition Cost (EAC) for each product is maintained in a WAC pricing file database;
 - c. Products are then sorted into drug groups by Generic Code Number (GCN), which denotes the same generic name, strength, and dosage form;
 - d. A filter is applied to remove all drug products that are obsolete, are not therapeutically equivalent, or are not available in the marketplace;
 - e. The acquisition cost for the remaining drug products are analyzed to produce the estimated acquisition cost for the drug group giving due consideration (which consists of utilization and availability in the marketplace) to the lower cost products;
 - f. The resulting estimated acquisition cost is used to produce a SMAC rate. The resulting SMAC is always greater than the pharmacy provider actual acquisition cost and is designed to provide the pharmacy with an appropriate profit margin;
 - g. The SMAC rate will then be applied to all brand and generic drug products in that specific GCN;
 - h. The SMAC file is updated monthly. Kentucky's MAC list may be downloaded from the following website: <http://www.chfs.ky.gov/dms>.
 - i. A pharmacy provider may appeal a SMAC price;
3. Effective October 1, 2011, the Estimated Acquisition Cost (EAC) for a generic drug shall equal the Wholesale Acquisition Cost (WAC) plus 3.2% and for a brand drug shall equal the WAC plus 2%; or
 4. If WAC pricing is not available, the provider will be required to contact the manufacturer for WAC or produce an invoice price or
 5. The provider's Usual and Customary charge (U&C).

6. The department shall reimburse for drugs at the lesser of:
 - Branded Drugs: WAC + 2% (plus dispensing fee) OR
 - Generic Drugs: WAC + 3.2 % (plus dispensing fee) OR
 - FUL + dispense fee OR
 - MAC + dispense fee OR
 - Usual & Customary (U & C)

7. For nursing facility residents meeting Medicaid patient status, an incentive of two (2) cents per unit dose shall be paid to long term care, personal care, and supports for community living pharmacists for repackaging a non-unit dose drug in unit dose form.

Methods and Standards for Establishing Payment Rates - Other Types of Care

C. Dispensing Fee

1. Effective February 23, 2005, the dispensing fee for a generic drug prescription is \$5.00 and for a brand name drug prescription is \$4.50. The dispensing fee is applied to any drug reimbursed through the pharmacy benefit program at the point of sale.

II. Physician Services**A. Definitions**

- (1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.
- (2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.
- (3) "Medical School Faculty Physician" is a physician who is employed by a state-supported school of medicine (for teaching and clinical responsibilities), receives their earnings statement (W-2) from the state-supported school of medicine for their teaching and clinical responsibilities, and they are part of a university health care system that includes:
 - (a) a teaching hospital; and
 - (b) a state-owned pediatric teaching hospital; or
 - (c) an affiliation agreement with a pediatric teaching hospital.
- (4) Reimbursement for an anesthesia service shall include:
 - (a) Preoperative and postoperative visits;
 - (b) Administration of the anesthetic;
 - (c) Administration of fluids and blood incidental to the anesthesia or surgery;
 - (d) Postoperative pain management;
 - (e) Preoperative, intraoperative, and postoperative monitoring services; and
 - (f) Insertion of arterial and venous catheters.

B. Reimbursement

- (1) Payment for covered physicians' services shall be based on the lesser of the physicians' usual and customary actual billed charges or the fixed upper limit per procedure established by the Department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS).
- (2) If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit by reimbursing 45% of billed charges. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

- (3) The flat rate for a service shall be established by multiplying the dollar conversion factor by the sum of the RVU units plus the number of units spent on that specified procedure. RBRVS units shall be multiplied by a dollar conversion factor to arrive at the fixed upper limit. The dollar conversion factors are as follows:

<u>Types of Service</u>	<u>Kentucky Conversion Factor</u>
Deliveries	Not applicable
Non-delivery Related Anesthesia	\$15.20
Non-anesthesia Related Services	\$29.67

- (4) The fixed upper limit for a covered anesthesia service shall not exceed the upper limit that was in effect on June 1, 2006 by more than twenty (20) percent. The reimbursement shall not decrease below the upper payment limit in effect on June 1, 2006.

C. Reimbursement Exceptions

- (1) Physicians will only be reimbursed for the administration of specified immunizations obtained free from the Department for Public Health through the Vaccines for Children Program to provide immunizations for Medicaid recipients under the age of nineteen (19). Vaccine costs will not be reimbursed.

- (2) Payments for obstetrical delivery services provided on or after September 15, 1995 shall be reimbursed the lesser of the actual billed charge or at the standard fixed fee paid by type of procedure. The obstetrical services and fixed fees are:

Delivery only	\$870.00
Vaginal delivery including postpartum care	\$900.00
Cesarean delivery only	\$870.00
Cesarean delivery including postpartum care	\$900.00

- (3) For delivery-related anesthesia services provided on or after July 1, 2006, a physician shall be reimbursed the lesser of the actual billed charge or a standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Vaginal delivery	\$215.00
Cesarean section	\$335.00
Neuroxial labor anesthesia for a vaginal delivery or cesarean section	\$350.00
Additional anesthesia for cesarean delivery following neuroxial labor anesthesia for Vaginal delivery	\$25.00
Additional anesthesia for cesarean hysterectomy following neuroxial labor Anesthesia	\$25.00

- (4) Payment for individuals eligible for coverage under Medicare part B is made, in accordance with Sections A and B and items (1) through

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- (5) For services provided on or after July 1, 1990, family practice physicians practicing in geographic areas with no more than one (1) primary care physician per 5,000 population, as reported by the United States Department of Health and Human Services, shall be reimbursed at the lesser of the physicians' usual and customary actual billed charges or 125 percent of the fixed upper limit per procedure established by the Department.
 - (6) For services provided on or after July 1, 1990, physician laboratory services shall be reimbursed based on the Medicare allowable payment rates. For laboratory services with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges.
 - (7) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the physician's office are subject to outpatient limits if provided at alternative sites and shall be paid adjusted rates to take into account the change in usual site of services.
 - (8) Payments for the injection procedure for chemonucleolysis of intervertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or at a fixed upper limit of \$793.50 as established by the Department.
 - (9) Specified family planning procedures performed in the physician office setting shall be reimbursed at the lesser of the actual billed charge or the established RBRVS fee plus actual cost of the supply minus ten percent.
 - (10) Certain injectable antibiotics and antineoplastics, and contraceptives shall be reimbursed at the lesser of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent.
 - (11) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).
 - (12) For practice related service provided by a physician assistant, the participating physician shall be reimbursed at the lesser of the usual and customary actual billed charge or the fixed upper limit per procedure established by the Department for Medicaid Services at seventy-five (75) percent of the physician's fixed upper limit per procedure.
 - (13) Any physician participating in the lock-in program will be paid a \$10.00 per month lock-in fee for provision of patient management services for each recipient locked in to that physician.

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- (14) Supplemental payments will be made for services provided by medical school faculty physicians either directly or as supervisors of residents. These payments are in addition to payments otherwise provided under the state plan to physicians that qualify for such payments under the criteria outlined below in Part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in Parts (b) and (c) of this section.
- a. To qualify for a supplemental payment under this section, physicians must meet the following criteria:
1. Be Kentucky licensed physicians;
 2. Be enrolled as Kentucky Medicaid providers; and
 3. Be Medical School Faculty Physicians as defined in Att 4.19-B, page 20.3, with an agreement to assign their payments to the state-owned academic medical center in accordance with 42 CFR 447.10.
- b. For physicians qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between payments otherwise made to these physicians and the average rate paid for the services by commercial insurers. The payment amounts are determined by:
1. Annually calculating an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the providers' contracted rates with commercial insurers for each procedure code from an actual year's data, beginning with CY 2006;
 2. Multiplying the total number of Medicaid claims paid per procedure code by the average commercial payment rate for each procedure code to establish the estimated commercial payments to be made for these services; and
 3. Subtracting the initial fee-for-service Medicaid payments, all Medicare payments, and all Third Party Liability payments already made for these services to establish the supplemental payment amount. Effective January 1, 2007 all claims where Medicare is the primary provider will be excluded from the supplemental payment methodology.
 4. The supplemental payments will be calculated annually after the end of each CY using actual data from the most recent completed CY. Claims data will only be used for physicians meeting the criteria in Part (a) above. If a physician did not meet the criteria for the whole calendar year, then only the claims data that coincides with their dates of eligibility will be used in the calculation. The supplemental payments will not be increased with any trending or inflationary indexes.
- c. Initial fee-for-service payments under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made as four (4) equal quarterly payments.
- (15) A second anesthesia service provided by a provider to a recipient on the same date of service shall be reimbursed at the Medicaid Physician Fee Schedule amount established by the Department.
- (16) A bilateral procedure shall be reimbursed at one hundred fifty (150) percent of the amount established by the Department.
- (17) A fixed rate of twenty-five (25) dollars for anesthesia add-on services provided to a recipient under age one (1) or over age seventy (70).
- (18) Physicians will only be reimbursed for the administration of immunizations, to include the influenza vaccine, to a Medicaid recipient of any age. Vaccine costs will not be reimbursed.
- (19) The department shall reimburse a flat rate of seventy-two (72) dollars per office visit for an office visit beginning after 5:00pm Monday through Friday or beginning after 12:00pm on Saturday through the remainder of the weekend.
- (20) Deep sedation of general anesthesia relating to oral surgery performed by an oral surgeon shall have a fixed rate of \$150.
- (21) For an evaluation and management service with a corresponding CPT of 99214 or 99215 exceeding the limit outlined in Att. 3.1-A p. 7.2.1 & Att. 3.1-B p. 21, DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.
- (22) The evaluation and management services with a corresponding CPT of 99201-99205 and 99211-99215 have been enhanced from approximately fifty-seven (57) percent of Medicare allowable to eighty-seven and one half (87.5) percent of Medicare allowable

(23) For an evaluation and assessment service with a corresponding CPT of 99407 for tobacco cessation, the Department will pay a fixed fee of \$52.03 for a physician. For the same services performed by a physician assistant or an APRN, the Department will pay 75% of the physician fee.

D. Assurances. The State hereby assures that payment for physician services are consistent with efficiency, economy, and quality of care and payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances.

Reimbursement Template -Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

- The rates reflect all Medicare site of service and locality adjustments.
- The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting. Kentucky only has one Medicare Geographic Practice Cost Index. Kentucky is using the Deloitte fee schedule and will not make changes to rates throughout the year.
- The rates reflect all Medicare geographic/locality adjustments.
- The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.
The following formula was used to determine the mean rate over all counties for each code:

Method of Payment

- The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.
- The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.
Supplemental payment is made: monthly quarterly

The Department for Medicaid Services will track the codes and eligible providers, which you must do regardless of the method of payment. DMS will calculate the supplemental payment based on actual services rendered. DMS will then make the supplemental payments to the provider.

Primary Care Services Affected by this Payment Methodology

- This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

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(Primary Care Services Affected by this Payment Methodology – continued)

- The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

Code	Code
99339	99402
99340	99403
99358	99404
99359	99406
99360	99408
99363	99409
99364	99411
99366	99412
99367	99420
99368	99441
99374	99442
99375	99443
99377	99444
99378	99450
99379	99455
99380	99456
99401	99481 Thru 99499

- The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

99224, 99225, 99226, 99407, added in 2011 and 99307 added in 2012

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at <http://chfs.ky.gov/dms/fee.htm>.

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Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

- Medicare Physician Fee Schedule rate
- State regional maximum administration fee set by the Vaccines for Children program
- Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

- The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:_____.
- A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: \$3.30.
- Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

Physician Services – Vaccine Administration (continued)

Note: This section contains a description of the state’s methodology and specifies the affected billing codes.

Ky DMS Proc. Code	Vaccine Name	CMS Code
90632	HEP A-AD (HEPATITIS A/ADULT/IM)	90460
90633	Hep A (HEPATITIS A/PED/ADOL/2 DOSE/IM)	90460
90634	HEP A VACC PED/ADOL/3 DOSE	90460
90636	HEP AB18 (HEP A & HEP B VACCINE/ADULT/IM)	90460
90645	HIB(HEMOPHILUS INFLUENZA B VACCINE/ HBOC CONJUGATE/4 DOSE/IM)	90460
90646	HIB /HEMOPHILUS INFLUENZA B VACCINE(HIB) PRP-D CONJUGATE/BOOSTER/HIGH RISK	90460
90647	HIB/HEMOPHILUS INFLUENZA B VACCINE(HIB) PRP-OMP CONJUGATE/3 DOSE/IM	90460
90648	HIB/HEMOPHILUS INFLUENZA B VACCINE(HIB) PRP-T CONJUGATE/4 DOSE/IM	90460
90649	HPV/ HUMAN PAPILOMA VIRUS /TYPES 6, 11,16 &18/ QUADRIVALENT/3 DOSE/IM	90460
90655	FLU VACCINE/NO PRESER/6-35 MONTHS/IM	90460
90656	FLU VACCINE/NO PRESER/3 YEARS >/IM	90460
90658	FLU(Fluvirin) 3 yrs> IM	90460
90660	FLUMIST (FLU VACCINE, NASAL)	90460
90669	PNU 7	90460
90670	PNEUMOCOCCAL VACC, PED<5 (PNE 7)	90460
90680	ROTA (3dose)	90460
90681	TORARIX	90460
90696	KINRIX DTAP-IPV VACCINE 4-6 YR IM	90460
90698	PENTACEL DTAP-HIB-IP VACCINE, IM	90460
90700	DTAP <7 YRS, IM	90460
90702	DT VACCINE < IM	90460
90707	MMR VACCINE, SC	90460
90710	MMR-V VACCINE, SC	90460
90713	EIPV POLIOVIRUS, IPV, SC/IM	90460
90714	TD VACCINE, NO PRESERVATIBE>/=7IM	90460
90715	TDAP VACCINE > 7 IM	90460
90716	VAR CHICKEN POX VACCINE, SC	90460
90718	TD VACCINE >7, IM	90460
90723	DTAP-HEPB-IPV VACCINE	90460
90732	PNEUMOCOCCAL VACCINE	90460
90733	MPSV	90460
90734	MCV4-MENINGOCOCCAL VACCINE, IM	90460
90744	HEP B-PF PED/ADOL 3 DOSE IM	90460
90746	HEP B-A	90460
90748	HEPB-HIB	90460

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Physician Services – Vaccine Administration (continued)

Effective Date of Payment

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at <http://chfs.ky.gov/dms/fee.htm>.

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III. Dental Services

A. Definitions.

For purposes of determination of payment usual and customary actual billed charge refers to the uniform amount the individual dentist charges in the majority of cases for a specific dental procedure or service.

“Dental School Faculty Dentist” is a dentist who is employed by a state-supported school of dentistry.

B. Reimbursement for Outpatient and Inpatient Services.

- (1) The department shall reimburse participating dentists for covered services provided to eligible Medicaid recipients at the dentist’s actual billed charge not to exceed the fixed upper limit per procedure established by the department.
- (2) With the exceptions specified in section (3), (4), (5), and (8) the upper payment limit per procedure shall be established by increasing the limit in effect on 9/30/00 by 32.78%, rounded to the nearest dollar. This rate of increase is based upon an allocation of funds by the 2000 Kentucky General Assembly and a comparison to rates of other states based upon a survey of Dental Fees by the American Dental Association. The DMS fee schedule rate was set as of October 31, 2008 and is effective for services provided on or after that date. All rates are published on the DMS website <http://www.chfs.ky.gov/dms/fee.htm>.
- (3) If an upper payment limit is not established for a covered dental service in accordance with (2) above, the department shall establish an upper limit by the following:
 - a. The state will obtain no less than three (3) rates from other sources such as Medicare, Workmen’s Compensation, private insurers or three (3) high volume Medicaid providers:
 - b. An average limit based upon these rates will be calculated; and
 - c. The calculated limit will be compared to rates for similar procedures to assure consistency with reimbursement for comparable services.
- (4) The following reimbursement shall apply:
 - a. Orthodontic Consultation, \$112.00, except that a fixed fee of \$56.00 shall be paid if:
 1. The provider is referring a recipient to a medical specialist;
 2. The prior authorization for orthodontic services is not approved; or
 3. A request for prior authorization for orthodontic services is not made.
 - b. Prior authorized early phase orthodontic services for moderately severe disabling malocclusions, \$1,367 for orthodontists and \$1,234 for general dentists..
 - c. Prior authorized orthodontic services for moderately severe disabling malocclusions, \$1,825 for orthodontists and \$1,649 for general dentists.

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- d. Prior authorized orthodontic services for severe disabling malocclusions, \$2,754 for orthodontists and \$2,455 for general dentists.
 - e. Prior authorized services for Temporomandibular Joint (TMJ) therapy, an assessed rate per service not to exceed \$424.
- (5) This reimbursement methodology does not apply to oral surgeons' services that are included within the scope of their licenses. Those services are reimbursed in accordance with the reimbursement methodology for physician services.
- (6) Medicaid reimbursement shall be made for medically necessary dental services provided in an inpatient or outpatient setting if:
- a. The recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if provided in a dentist's office; and
 - b. In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in an inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.
- (7) Supplemental payments will be made in addition to payments otherwise provided under the state plan to practice plans whose dentists qualify for such payments under the criteria outlined below in Part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in Parts (b) and (c) of this section.
- a. To qualify for a supplemental payment under this section, dentists in the practice plan must meet the following criteria:
 - i. Be Kentucky licensed dentists;
 - ii. Be enrolled as Kentucky Medicaid providers; and
 - iii. Be members of a practice plan under contract to provide professional services at a state-owned academic medical center as determined by the Department.
 - b. For practice plans qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between Medicaid payments otherwise made to these practice plans and the average rate paid for the services by commercial insurers. The average commercial rates are determined by:
 - i. Calculating a commercial payment to charge ratio for all services paid to the eligible providers by commercial insurers using the providers' claims-specific data from the most currently available fiscal year;
 - ii. Multiplying the Medicaid charges by the commercial payment to charge ratio to establish the estimated commercial payments to be made for these services; and
 - iii. Subtracting the interim Medicaid payments already made for these services to establish the supplemental payment amount.
 - c. Practice plans eligible under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made on a quarterly basis or as determined by the Department.
- (8) The upper payment limit per procedure for a recipient under age twenty-one (21) shall be established by increasing the limit in effect on 9/30/07 by 30%, rounded to the nearest dollar. The 30% limit increase applied to all dental procedure codes, except dental procedure codes D2951, D0150, D0140, D0330, D1520, D1525, shall not be adjusted from the limit in effect on 9/30/07. The DMS fee schedule rate was set as of October 31, 2008 and is effective for services provided on or after that date. All rates are published on the DMS website <http://www.chfs.ky.gov/dms/fee.htm>

IV. Vision Care Services**A. Definitions.**

For purposes of determination of payment, “usual and customary actually billed charge” refers to the uniform amount the individual optometrist or ophthalmic dispenser charges in the majority of cases for a specific procedure or service.

B. Reimbursement for Covered Procedures and Materials for Optometrists.

- (1) Reimbursement for covered services, within the optometrist’s scope of licensure, except materials and laboratory services shall be based on the lesser of the optometrists’ usual and customary actual billed charges or the fixed upper limit per procedure established by the department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS) with a conversion factor of \$29.67.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Optometry. The agency’s fee schedule rate was set as of January 1, 2011 and is effective for services provided on or after that date. The agency’s fee schedules are reviewed annually and updated as necessary. All rates are published on the Department for Medicaid Services web site at <http://chfs.ky.gov/dms/fee.htm>.

- (2) With the exception of rates paid for dispensing services, fixed upper limits for vision services shall be calculated using the same RBRVS units as those used in the physicians services program, with the units multiplied by the “all other services” conversion factor to arrive at the fixed upper limit for each procedure.
- (3) Reimbursement for materials (eyeglasses or part of eyeglasses) shall be made at the lesser of the optical laboratory cost of the materials or the upper limits for materials as set by the department. An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient’s medical records for post-payment review. The agency upper limits for materials are set based on the agency’s best estimate or reasonable and economical rates at which the materials are widely and

consistently available, taking into consideration statewide billing practices, amounts paid by Medicaid programs in selected comparable states, and consultation with the optometry Technical Advisory Committee of the Medical Assistance Advisory Council as to the reasonableness of the proposed upper limits.

- (4) Laboratory services shall be reimbursed at the lesser of the actual billed amount or the Medicare allowable reimbursement rates. If there is no established Medicare allowable reimbursement rate, the payment shall be sixty-five (65) percent of usual and customary actual billed charges.

C. Maximum Reimbursement for Covered Procedures and Materials for Ophthalmic Dispensers

Reimbursement for a covered service within the ophthalmic dispenser's scope of licensure shall be as described in Section B (above).

D Effect of Third Party Liability

When payment for a covered service is due and payable from a third party source, such as private insurance, or some other third party with a legal obligation to pay, the amount payable by the department shall be reduced by the amount of the third party payment.

- F. Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

V. Hearing Services

- A. The State Agency shall reimburse a participating audiologist at usual and customary actual billed charges up to the fixed upper limit per procedure established by the Kentucky Medicaid Fee Schedule with a conversion factor of \$29.67.

Audiologists shall be entitled to the same dispensing fee for hearing aids as shown in Section B.

B. Hearing Aid Dealers.

1. If a manufacturer's invoice price is submitted for a hearing instrument billed to the department, the department shall reimburse the lesser of:
 - a) The manufacturer's invoice price plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date: or
 - b) The actual hearing instrument specialist's cost plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date: or
 - c) The suggested retail price submitted by the manufacturer for the hearing instrument.
2. If the manufacturer's invoice price of a hearing instrument billed to the department does not match the manufacturer's submitted price schedule which includes the manufacturer's invoice price for the hearing instrument, the department shall reimburse the participating specialist in hearing instruments at the less of:
 - a) The lowest price submitted for a comparable hearing instrument plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date: or
 - b) The actual specialist in hearing instruments' cost plus a professional fee of:
 - 1) \$150 for the first (one (1) ear) hearing instrument; and
 - 2) Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date: or
 - c) The lowest suggested retail price submitted by the manufacturer for a comparable instrument.

- C. Replacement Cord Reimbursement. The department shall reimburse for a replacement cord at the hearing instrument specialist's cost plus a professional fee set at \$21.50.

- D. Hearing Instrument Repair Reimbursement. The department shall reimburse a hearing instrument specialist in hearing instruments for a hearing instrument repair:
1. On the basis of the manufacturer's charge for repair or replacement of parts;
 2. Plus the hearing instrument specialist's cost for postage and insurance relative to the repair
 3. Plus a professional fee of \$21.50; and
 4. Not to exceed the price of a new hearing instrument.

State: Kentucky

2. If the manufacturer of the hearing aid billed to the program has not submitted a dealer price schedule which includes that hearing aid, the State Agency shall reimburse that participating hearing aid dealer at the lessers of:
 - a) The lowest dealer price submitted for a comparable hearing aid plus a professional fee of seventy-five (75) dollars or at the actual dealer cost plus a professional fee of seventy-five (75) dollars or twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date;
 - b) The actual dealer cost plus a professional fee of seventy-five (75) dollars for the first aid and twenty-five (25) dollars for the second aid when two hearing aids are dispensed on the same date; or
 - c) The lowest suggested retail price submitted for a comparable aid. A comparable aid is defined as an aid falling within the general classification of fitting type, i.e., body, behind-the-ear, in-the-ear, eyeglasses.
- C. Cords. The State Agency shall make payment for a replacement cord at the dealer's cost, plus professional fee set at the fixed upper limit.
- D. Hearing Aid Repairs. The State Agency shall reimburse a hearing aid dealer for a hearing aid repair on the basis of the manufacturer's charge for repair or replacement of parts, plus the dealer's cost for postage and insurance relative to the repair, plus a professional fee set at the fixed upper limit.

VI. Screening Services

- A. The state agency shall reimburse providers for screening services in accordance with their usual payment procedures outlined in this state plan.
- B. The state agency shall reimburse screening clinics or agencies with the lesser of the payment procedure for physician's services described in Attachment 4.19-B, page 20.3, or the usual and customary charge of the provider for the service.

VI-A. Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

- (1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services) the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:
 - (a) 1905(a)(1), inpatient hospital services;
 - (b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
 - (c) 1905(a)(3), other laboratory and X-ray services;
 - (d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
 - (e) 1905(a)(5)(A), physicians services; 1905(a)(5)(B), medical and surgical services furnished by a dentist;
 - (f) 1905(a)(6), medical care by other licensed practitioners;
 - (g) 1905(a)(7), home health care services;
 - (h) 1905(a)(9), clinic services;
 - (i) 1905(a)(10), dental services;
 - (j) 1905(a)(11), physical therapy and related services;
 - (k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
 - (l) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
 - (m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
 - (n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
 - (o) 1905(a)(17), nurse—midwife services;
 - (p) 1906(a)(18), hospice care;
 - (q) 1905(a)(19), case management services; and
 - (r) 1905(a)(22), other medical and remedial care specified by the Secretary.
- (2) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21 the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100% of usual and customary charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:

- (a) Any service described in 1, above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
- (b) 1905(a)(8), private duty nursing services;
- (c) 1905(a)(20), respiratory care services;
- (d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under 1905(a)(6); and
- (e) 1905(a)(24), other medical or remedial care recognized by the Secretary but which are not covered in the plan including services of Christian Science nurses, care and services provided in Christian Science sanitoriums, and personal care services in a recipient's home.

VII: Transportation Services**A. Ambulance Services**

- (1) The department shall reimburse an ambulance service at the lesser of the provider's usual and customary charge or an upper limit established by the department for the service. Payment for an ambulance service shall be contingent upon a statement of medical necessity.
- (2) The upper limit for air ambulance transportation shall be set at \$3,500 per one (1) way trip.
- (3) The upper limit for an ambulance service (other than air ambulance transportation) shall be calculated by adding a base rate, mileage allowance, and flat rate fee as follows:
 - (a) The base rate for Advanced Life Support (ALS) emergency ambulance transportation to the emergency room of a hospital shall be set at \$110 per one (1) way trip; the mileage allowance for trips shall be four (4) dollars per mile for mileage from mile one (1); a flat rate of twenty-five (25) dollars shall be set for each additional recipient with no additional allowance for mileage.
 - (b) The base rate for Basic Life Support (BLS) emergency ambulance transportation to the emergency room of a hospital shall be set at eighty-two dollars and fifty cents (82.50) per one (1) way trip; the mileage allowance for trips shall be three (3) dollars per mile for mileage from mile one (1); a flat rate of twenty (20) dollars shall be set for each additional recipient with no additional allowance for mileage.
 - (c) The base rate for any ALS or BLS providing emergency ambulance transportation to an appropriate medical facility or provider other than the emergency room of a hospital shall be set at sixty (60) dollars per one (1) way trip; the mileage allowance for trips shall be two (2) dollars and fifty (50) cents per mile for mileage from mile one (1); a flat rate of fifteen (15) dollars shall be set for each additional recipient with no additional rate for mileage.
 - (d) The base rate for BLS emergency ambulance transportation to the emergency room of a hospital during which the services of an ALS Medical First Response provider is required to stabilize the patient shall be \$110; the mileage allowance shall be four (4) dollars per mile from mile one (1); a flat rate of twenty-five (25) dollars shall be set for each additional recipient with no additional rate for mileage.

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- (e) The base rate for BLS emergency ambulance transportation to a medical facility or provider other than the emergency room of a hospital during which the services of an ALS Medical First Response provider are required shall be sixty (60) dollars; the mileage allowance shall be two (2) dollars and fifty (50) cents per mile from mile one (1); a flat rate of fifteen (15) dollars shall be set for each additional recipient with no additional rate for mileage.
 - (f) The base rate for non-emergency ambulance transportation during which the recipient requires no medical care during transport shall be fifty-five (55) dollars and the mileage allowance shall be two (2) dollars per mile from mile one (1).
 - (g) The cost of other itemized supplies for ALS or BLS emergency transportation services shall be the actual cost as reflected on the transportation provider's invoice which shall be maintained in the provider's files and shall be produced upon request by the department. Each quarter, the department shall review a random sample of invoices to verify reported costs.
- (4) In addition to the rates described in paragraph (3) above, administration of oxygen during an ambulance transportation service (other than air ambulance transportation) shall be reimbursed at a flat rate of ten (10) dollars per one (1) way trip when medically necessary.
 - (5) Reimbursement for an ambulance service shall not be made if a recipient receives transportation free as the result of a local subscription fee or tax.

B. Commercial Transportation Carriers

When a broker has been terminated, the department shall reimburse participating commercial transportation carriers at usual commercial rates on an interim basis (pending selection of a new broker) with limitations as follows:

- (1) For taxi services provided in regulated areas the provider shall be reimbursed the normal passenger rate charged to the general public for a one (1) way trip regardless of the number of Medicaid eligible recipients transported when the trip is within the medical service area. The taxi shall be paid the single passenger rate regardless of the number of additional passengers.
- (2) For taxi services in those areas of the state where taxi rates are not regulated by the appropriate local rate setting authority, and for taxi services in regulated areas when they go outside the medical service area, the provider shall be reimbursed the normal passenger rate charged the general public for a single passenger (without payment for additional passengers, if any) up to the upper limit; reimbursement for transport of a parent or attendant shall be considered included within the upper limit allowed for the trip. The upper limit for a taxi transporting a recipient shall be:

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- (a) The usual and customary charge up to a maximum of six (6) dollars for trips of five (5) miles or less, one (1) way, loaded miles.
 - (b) The usual and customary charge up to a maximum of twelve (12) dollars for trips of six (6) to ten (10) miles, one (1) way, loaded miles.
 - (c) The usual and customary charge up to a maximum of twenty (20) dollars for trips of eleven (11) to twenty-five (25) miles, one (1) way, loaded miles.
 - (d) The usual and customary charge up to a maximum of thirty (30) dollars for trips of twenty-six (26) miles to fifty (50) miles, one (1) way, loaded miles.
 - (e) For trips of fifty-one (51) miles or above shall be the lesser of the usual and customary charge or an amount derived by multiplying one (1) dollar by the actual number of miles, not to exceed a maximum of seventy-five (75) dollars per trip, one (1) way, loaded miles.

C. Private Automobile Carriers.

- (1) The department shall reimburse private automobile carriers at the basic rate of twenty-two (22) cents per mile plus a flat fee of four (4) dollars per recipient if waiting time is required. For round trips of less than five (5) miles the rate shall be computed on the basis of a maximum allowable fee of six (6) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. Private automobile carriers shall have a signed participation agreement with the Department for Medicaid Services prior to furnishing reimbursable medical transportation services.
- (2) For round trips of five (5) to twenty-five (25) miles the rate for private automobile carriers shall be computed on the basis of maximum allowable fee of ten (10) dollars for the first recipient plus four (4) dollars each for waiting time for additional recipients. The maximum allowable fee rates shall not be utilized in situations where mileage is paid.

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- (3) Even though the maximum allowable fee rate when computed on the basis of twenty- two (22) cents per mile plus four (4) dollars for waiting time would not equal the six (6) dollars or ten (10) dollars allowable amounts, the higher amount is paid to encourage private automobile carriers to provide necessary medical transportation. Additionally, nothing in this section requires the department to pay the amounts specified if the private automobile carrier expresses a preference for reimbursement in a lesser amount, then the lesser amount shall be paid. Toll charges shall be reimbursable when presented with a receipt.
 - (4) Waiting time shall be a reimbursable component of the private automobile carrier transportation fee only if waiting time occurs. If waiting time occurs due to admittance of the recipient into the medical institution, the private automobile carrier may be reimbursed for the return trip to the point of recipient pick-up as though the recipient were in the vehicle; that is, the total reimbursable amount shall be computed on the basis of the maximum allowable fee or mileage rate plus waiting time. Waiting time shall not be paid for the attendant or caretaker relative (e.g., mother, father) who is accompanying the recipient and not personally being transported for Medicaid covered service.
 - (5) If a private automobile carrier is transporting more than one (1) recipient, only one (1) mileage payment shall be allowed. Mileage shall be computed on the basis of the distance between the most remote recipient and the most remote medical service utilized; and will include any necessary additional mileage to pickup and discharge the additional recipients.

D. Non-Commercial Group Carriers.

- (1) The department shall reimburse participating non-commercial group carriers based on actual reasonable, allowable cost to the provider based on cost data submitted to the department by the provider.
- (2) The minimum rate shall be twenty (20) cents per recipient per mile transported and the rate upper limit shall be fifty (50) cents per recipient per mile transported.
- (3) Payment for a parent or other attendant shall be at the usual recipient rate.

E. Specialty Carriers.

- (1) Participating specialty carriers shall be reimbursed at the lesser of the following rates:

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- (a) The actual charge for the service; or
 - (b) The usual and customary charge for that service by the carrier, as shown in the schedule of usual and customary charges submitted by the carrier to the department or
 - (c) The program maximum established for the service.
- (2) Program maximums shall be:
- (a) For nonambulatory recipients who require the use of a wheelchair, the upper limit shall be twenty-five (25) dollars for the first recipient plus four (4) dollars for each additional nonambulatory recipient transported on the same trip, for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollar and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and certified; mileage charges shall not be allowed for additional recipients.
 - (b) For ambulatory recipients who are disoriented, the upper limit shall be twelve (12) dollars and fifty (50) cents for the first recipient plus four (4) dollars for each additional disoriented recipient transported on the same trip for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollars and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and verified; mileage charges shall not be allowed for additional recipients.
 - (c) For both paragraphs (a) and (b) of this section, empty vehicle miles shall not be included when computing allowable reimbursement for mileage.
- (3) Reimbursement shall be made at specialty carrier rates for the following types of recipients only:
- (a) Nonambulatory recipients who need to be transported by wheelchair, but shall not include recipients who need to be transported as stretcher patients; and
 - (b) Ambulatory recipients who are disoriented.

(4) The specialty carrier shall obtain a statement from the recipient's physician (or, if the recipient is in a nursing facility, from the director of nursing, charge nurse, or medical director in lieu of physician) to verify that transportation by the specialty carrier is medically necessary due to the recipient's nonambulatory or disoriented condition. Claims for payment which are submitted without the required statement of verification shall not be paid.

F. Specially authorized transportation services authorized in unforeseen circumstances may be paid for at a rate adequate to secure the necessary service; the amount allowed shall not exceed the usual and customary charge of the provider. The Department for Medicaid Services shall review and approve or disapprove requests for specially authorized transportation services based on medical necessity.

G. Use of flat rates.

Transportation payment shall not exceed the lesser of six (6) dollars per trip, one (1) way (or twelve (12) dollars for a round trip), or the usual fee for the participating transportation provider computed in the usual manner if:

- (1) The recipient chooses to use a medical provider outside the medical service area; and
- (2) The medical service is available in the recipient's medical service area; and
- (3) The recipient has not been appropriately referred by the medical provider within his medical service area.

H. Meals and Lodging.

The flat rate for meals and lodgings for recipients and attendants when preauthorized (or post-authorized if appropriate) by the department shall be as follows:

- (1) Standard Area:
 - (a) Meals: breakfast-\$4 per day; lunch-\$5 per day; dinner-\$11 per day; and
 - (b) Lodgings: \$40 per day
- (2) High Rate Area:
 - (a) Meals: breakfast-\$5 per day; lunch-\$6 per day; dinner-\$15 per day; and
 - (b) Lodgings: \$55 per day.

I. Limitations.

- (1) Any reimbursement for medical transportation shall be contingent upon the recipient receiving the appropriate preauthorization or postauthorization for medical transportation as required by the Department for Medicaid Services.
- (2)
 - (a) Authorization shall not be granted for recipients transported for purposes other than to take the recipient to or from covered Medicaid services being provided to that recipient, except in the instance of one (1) parent accompanying a child to or from covered medical services being provided to the child or if one (1) attendant is authorized for a recipient traveling to or from covered medical services based on medical condition of the recipient.
 - (b) Reimbursement shall be limited to transportation services and shall not include the services, salary or time of the attendant or parent.
- (3) An individual who owns a taxi company and who uses the taxi as his personal vehicle shall be reimbursed at the private auto rate when transporting household family members.
- (4) Mileage for reimbursement purposes shall be computed by the most direct accessible route from point of pickup to point of delivery.

VIII. Outpatient Hospital Services

A. In-State Outpatient Hospital Service Reimbursement.

1.
 - a. Except for critical access hospital services, and an individual in the Lock-In program, the department shall reimburse on an interim basis for in-state outpatient hospital services at a facility specific outpatient cost-to-charge ratio based on the facility's most recently filed Medicaid cost report.
 - b. An outpatient cost-to-charge ratio shall be expressed as a percent of the hospital's charges.
2. A facility specific outpatient cost-to-charge ratio paid during the course of a hospital's fiscal year shall be designed to result in reimbursement, at the hospital's fiscal year end, equaling ninety-five (95) percent of a facility's total allowable Medicaid outpatient costs incurred during the hospital's fiscal year.
3. Except as established in item 4. of the In-State Outpatient Hospital Services section:
 - a. Upon reviewing an in-state outpatient hospital's as submitted Medicaid cost report for the hospital's fiscal year, the department shall preliminarily settle reimbursement to the facility equal to ninety-five (95) percent of the facility's allowable Medicaid outpatient costs incurred in the corresponding fiscal year; and
 - b. Upon receiving and reviewing an in-state outpatient hospital's finalized Medicaid cost report for the hospital's fiscal year, the department shall settle final reimbursement to the facility equal to ninety-five (95) percent of the facility's total allowable Medicaid outpatient costs incurred in the corresponding fiscal year.
4.
 - a. Under no circumstances shall the department's total reimbursement for outpatient hospital services exceed the aggregate limit established in 42 C.F.R. 447.321.
 - b. If projections indicate for a given state fiscal year that reimbursing for outpatient hospital services at ninety-five (95) percent of allowable Medicaid costs would result in the department's total outpatient hospital service reimbursement exceeding the aggregate limit established in 42 CFR 447.321, the department shall proportionately reduce final outpatient hospital service reimbursement for each hospital to equal a percent of costs which shall result in total outpatient hospital reimbursement equaling the aggregate limit established in 42 CFR 447.321.
5. A service in a hospital emergency room that is determined to be non-emergency for a Lock-In recipient shall be reimbursed at \$25.00.
6. In accordance with 42 USC 1396r-8(a)(7), a hospital shall include the corresponding National Drug Code (NDC) when billing a physician administered drug in the outpatient hospital setting.
7. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 6 will be bundled with the fixed rate payment and not reimbursed separately.

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6. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 5 will be bundled with the fixed rate payment and not reimbursed separately.
- B. Out-of-State Outpatient Hospital Service Reimbursement. Excluding services provided in a critical access hospital and laboratory services, reimbursement for an outpatient hospital service provided by an out-of-state hospital shall be ninety-five (95) percent of the average in-state outpatient hospital cost-to-charge ratio times the Medicaid covered charges billed by the out-of-state hospital.
- C. Critical Access Hospital Outpatient Service Reimbursement.
1. The department shall reimburse for outpatient hospital services in a critical access hospital as established in 42 CFR 413.70(b) through (d).
 2. A critical access hospital shall comply with the cost reporting requirements established in subsection E of the Outpatient Reimbursement section of the state plan.
 3. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 5 will be bundled with the fixed rate payment and not reimbursed separately.
- D. Outpatient Hospital Laboratory Service Reimbursement.
1. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 5 will be bundled with the fixed rate payment and not reimbursed separately.
 2. Laboratory service reimbursement, in accordance with item 1 in the Outpatient Hospital Laboratory Service Reimbursement section, shall be:
 - a. Final; and
 - b. Not settled to cost.
 3. An outpatient hospital laboratory service shall be reimbursed in accordance with item D.2 of the Outpatient reimbursement section of the state plan regardless of whether the service is performed in an emergency room setting or in a non-emergency room setting.

E. Cost Reporting Requirements.

1. Claims for services provided prior to January 5, 2009, will be reimbursed per State Plan Amendment 03-015 pages 20.12(f)-20.12(f)(3) effective August 1, 2003.
2. To assure that the Upper Payment Limit is not exceeded in SFY 2008-2009 (July 1, 2008 through June 30, 2009), two analyses will be performed :
 - a. An analysis of the cost of providing outpatient services and the reimbursement projected for the rate year (using both payment methodologies during partial years) beginning July 1, 2008 and ending June 30, 2009.
 - b. An analysis of the cost of providing outpatient services (based on the relative charges applied) for the period of January 5, 2009 and June 30, 2009; and the reimbursement projected based on the payment methodology in effect during this period.
3. As of January 5, 2009, an in-state outpatient hospital participating in the Medicaid program shall submit to the department a copy of the Medicare cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1, the Supplemental Medicaid Schedule KMAP-4 and the Supplemental Medicaid Schedule KMAP-6 as follows:
 - a. A cost report shall be submitted:
 - (1) For the fiscal year used by the hospital; and
 - (2) Within five (5) months after the close of the hospital's fiscal year; and
 - b. Except as follows, the department shall not grant a cost report submittal extension:
 - (1) The department shall grant an extension if an extension has been granted by Medicare. If an extension has been granted by Medicare, when the facility submits its cost report to Medicare it shall simultaneously submit a copy of the cost report to the department; or
 - (2) If a catastrophic circumstance exists, as determined by the department (for example flood, fire, or other equivalent occurrence), the department shall grant a thirty (30) day extension.
4. If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a completed cost report is received.
5. If a cost report indicates payment is due by a hospital to the department, the hospital shall submit the amount due or submit a payment plan request with the cost report.
6. If a cost report indicates a payment is due by a hospital to the department and the hospital fails to remit the amount due or request a payment plan, the department shall suspend future payment to the hospital until the hospital remits the payment or submits a request for a payment plan.

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- 7 An estimated payment shall not be considered payment-in-full until a final determination of cost has been made by the department.
 - 8 A cost report submitted by a hospital to the department shall be subject to departmental audit and review.
 - 9 Within seventy (70) days of receipt from the Medicare intermediary, a hospital shall submit to the department a printed copy of the final Medicare-audited cost report including adjustments.
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 - a. If it is determined that an additional payment is due by a hospital after a final determination of cost has been made by the department, the additional payment shall be due to the department within sixty (60) days after notification.
 - b. If a hospital does not submit the additional payment within sixty (60) days, the department shall withhold future payment to the hospital until the department has collected in full the amount owed by the hospital to the department.

F. Supplemental Payments to Non-state Government-owned or Operated Hospitals.

1. The Department provides quarterly supplemental payments to non-state government-owned or operated hospitals for outpatient services provided to Medicaid recipients. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321.
2. To qualify for a supplemental payment, a hospital must be a non-state government-owned or operated hospital that has entered into an Intergovernmental Transfer Agreement with the Commonwealth. The payment amount for a qualifying hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's payments for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all qualifying hospitals for the same fiscal year.

G. Emergency Room Services

1. Effective for services provided on and after September 1, 2002, the Department will reimburse for emergency room services at a flat rate per visit based upon the level of service provided. In addition, diagnostic and radiological procedures will be paid at specific rates.
2. There shall be rates for three (3) levels of service and an assessment fee:
 - Level I shall be those services billed using CPT codes 99281 and 99282, reimbursed at \$82.00.
 - Level II shall be those services billed using CPT codes 99283 and 99284, reimbursed at \$164.00.
 - Level III shall be those services billed using CPT codes 99285, reimbursed at \$264.00
 - An assessment, or triage, shall be payable at \$20.00

Included in the flat rate are pharmacy (except for thrombolytic agents), medical supplies, radiology (except as described in 4 below), laboratory, physical and respiratory therapy, electrocardiogram, and electroencephalogram.
3. The flat rates per visit were calculated in accordance with the following:

The Level II rate was calculated by multiplying the average costs for Level II services in state fiscal years 2000 and 2001 (adjusted by the moving average of Data Resources, Inc. for the Hospital Market Basket) by .75.

The Level I rate is established at 50% of the Level II rate.
The Level III rate is established at \$100 higher than the Level II rate.
4. Separate rates were established for the following:

The rates for treatment procedures including cardiac catheterization and lithotripsy are calculated at 150% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

The rates for diagnostic procedures including CT scans, ultra sounds, and magnetic reasoning imaging are calculated at 100% of the average adjusted costs for the procedure in state fiscal years 2000 and 2001.

The rate for observation are calculated at 100% of the average adjusted costs for state fiscal years 2000 and 2001.
5. Thrombolytic agents shall be reimbursed at acquisition costs.

X. Home Health Agency Services

- (1) The following home health services are paid in accordance with a fee schedule established by the state Medicaid agency, not to exceed billed charges:

Skilled Nursing
Home Health Aide
Medical Social Service
Physical, Occupational and Speech Therapy

- (2) Enteral nutritional products and disposable medical supplies shall be reimbursed based on costs as submitted on an annual cost report. Providers shall be paid an interim rate determined by multiplying a provider's facility-specific cost to charge ratio by its billed charges. Interim payments shall not exceed submitted charges and will be settled back to actual cost at the end of the home health agency's fiscal year, subject to lower of costs or charges. Interim payments will be settled back to allowable cost within 18 months following the end of the agency's fiscal year. Allowable costs will be based on audited or desk reviewed cost reports and determined in accordance with Medicare reimbursement principles. Cost reports for each of the home health agencies described in sections (3), (4), and (5) must be received by the Department within five (5) months of the close of the agency's fiscal year (May 31).

Public providers will not be subject to the lower of cost or charges and will be reimbursed their total allowable cost for enteral nutritional and disposable medical supplies.

- (3) Payment to a new home health agency for the services described in (1) will be in accordance with the methodology described in (1). New home health agencies will be paid for enteral nutritional products and disposable medical supplies on an interim basis by multiplying their billed charges for these products by seventy (70) percent. A new home health agency will be held to the seventy (70) percent threshold until a cost report is received by the state Medicaid agency. A home health agency that did not participate under the current ownership or a previous ownership in the prior year will be considered a new home health agency. A new home health agency will be reimbursed as described above until a cost report is received by the department, no later than May 31 prior to the rate year beginning July 1.
- (4) Payment to an out of state home health agency for the services described in (1) will be in accordance with the methodology described in (1). Out of state agencies will be paid for enteral nutritional products and disposable medical supplies by multiplying billed charges by eighty (80) percent.

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- (5) For home health services provided by licensed county health department home health agencies, a supplemental payment which represents the difference between the estimated costs of home health services for the eight month period beginning November 1, 2002 and ending June 30, 2003 and the amount of payments made by the Department for these services under the flat fee reimbursement as describe in (1) will be made.

Using cost reports filed with the Department, the Department will calculate the unit cost for a service listed under (1) and compare the unit cost to the rate per unit as described in (1). The supplemental payment will equal the difference between the cost per unit of service multiplied by the number of units of service provided during the period. In this way, the Department shall assure public providers reimbursement for their total allowable costs.

If a provider's costs as estimated from the annual cost report are less than the estimated payments, the Department will recoup any excess payments.

- (6) Services provided by County Health Department Home Health Agencies. For the fiscal period beginning July 1, 2003 and for subsequent periods beginning July 1, supplemental payments will be made on a quarterly basis. The supplemental payments will be compared to the provider's annual cost report and adjustments made as described in (5) above.

8. Private Duty Nursing Services

DMS will reimburse for private duty nursing services at a rate of nine dollars per fifteen minutes. DMS will not reimburse for more than ninety-six units per recipient per twenty-four hour period or 8,000 units per twelve-consecutive month period per recipient.

XI. Laboratory Services

Eff. 7/1/88 The State Agency will reimburse participating independent laboratories, outpatient surgical clinics, renal dialysis centers, and outpatient hospital clinics for covered laboratory services rendered on the basis of the allowable payment rates set by Medicare.

XII (Deleted)

XIII Family Planning Clinics

Eff. 7/1/87 The State Agency will reimburse participating family planning 7-1-87 agencies for covered services in accordance with 42 CFR Section 447.321; payments shall not exceed applicable Title XVIII upper limits. Payments to physicians and Advanced Registered Nurse Practitioners (ARNP) for individual services shall not exceed the following amounts:

	Physicians	ARNP
Initial Clinic Visit	\$50.00	\$37.75
Annual Clinic Visit	\$60.00	\$45.00
Follow-up Visit with Pelvic Examination	\$25.00	\$18.75
Follow-up Visit without Pelvic Examination	\$20.00	\$15.00
Counseling Visit	\$13.00	\$13.00
Counseling Visit w/3 months contraceptive supply	\$17.00	\$17.00
Counseling Visit w/6 months contraceptive supply	\$20.00	\$20.00
Supply Only Visit – Actual acquisition cost of contraceptive supplies dispensed		

 TN# 90-20

Supersedes

 Approval Date: June 4, 1993

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 TN# None

XIV. Durable Medical Equipment, Supp. Prosthetics and Orthotics

1. General DME Items

For DME items that have an HCPC code (except for customized items) reimbursement shall be based on the Medicaid fee schedule, not to exceed the supplier's usual and customary charge.

2. Manual Pricing of DME Items

- a. Customized items with a miscellaneous HCPC code of K0108 will require prior-authorization and will be reimbursed at invoice minus twenty- two (22) percent, not to exceed the supplier's usual and customary charge.
- b. Customized components that do not have a HCPC code, and all other miscellaneous codes will require prior-authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary change.
- c. DME items that do not have HCPC codes and have been determined by the department to be covered will require prior authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary charge.
- d. Specialized wheelchair bases with codes of K0009 and K0014 will require prior authorization and will be reimbursed at manufacturers suggested retail price minus fifteen (1 5) percent, not to exceed the supplier's usual and customary charge.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Other diagnostic, screening, preventive and rehabilitative services provided by licensed community mental health centers, and other mental health and substance use providers shall be reimbursed as outlined below:

1. Community Mental Health Centers (CMHCs) are paid CMHC-specific cost-based rates per service based on the type of practitioner rendering the service. For the period beginning January 1, 2014, the rates are those in existence for the practitioners in CY 2013. Separate rates are set for the following practitioners:
 - Licensed Psychologist (LP)
 - Licensed Psychological Practitioner (LPP)
 - Licensed Clinical Social Worker (LCSW)
 - A psychiatric social worker with a master's degree from an accredited school
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Marriage and Family Therapist (LMFT)
 - Psychiatrist
 - Physician
 - A psychiatric nurse licensed in the state of Kentucky with one of the following combination of education and experience:
 - i. Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.
 - ii. Bachelor of Science in Nursing and 1 year of experience in a mental health setting.
 - iii. A graduate of a three-year educational program with 2 years of experience in a mental health setting.
 - iv. A graduate of a two-year educational program (Associate degree) with 3 years of experience in a mental health setting.
 - A professional equivalent, through education in a mental health field and experience in a mental health setting, qualified to provide mental health services.
 - The following professionals under the appropriate supervision:
 - i. A mental health associate with a minimum of a Bachelors degree in psychology, sociology, social work, or human services under supervision of one of the above professionals;
 - ii. A licensed psychological associate working under the supervision of a licensed psychologist;
 - iii. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor;
 - iv. A certified social worker, Master Level working under the supervision of a licensed clinical social worker;
 - v. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist;

XVI. Other diagnostic, screening, preventive and rehabilitative services.

- vi. A physician assistant working under the supervision of a physician;
- vii. A peer support specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a regional community mental health center;
- vii. A certified alcohol and drug counselor (CADC) working under the supervision of a CADC who has at least two (2) years of post-certificate experience and who provides supervision to not more than twelve (12) applicants in an individual or group setting at any one (1) time, and whose certificate is currently in good standing with the (CADC) board;
- ix. A community support associate who is working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a regional community mental health center, or professional equivalent.

Reimbursement for services provided in CMHCs will end on December 31, 2014.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. All other mental health and substance use providers

The reimbursement described below is applicable to the following mental health and substance use disorder services.

- Screening
- Assessment
- Psychological Testing
- Crisis Intervention
- Residential Crisis Stabilization
- Day Treatment
- Peer Support
- Parent/Family Peer Support
- Individual Outpatient Therapy
- Group Outpatient Therapy
- Family Outpatient Therapy
- Collateral Outpatient Therapy
- Partial Hospitalization
- Service Planning
- SBIRT – Screening, Brief Intervention and Referral to Treatment (Substance use only)
- Medication Assisted Treatment (Substance use only)
- Comprehensive Community Support Services (Mental health & Co-occurring only)
- Therapeutic Rehabilitation Program (TRP) (Mental health only)

Reimbursement for the services listed above are based on the Kentucky specific Medicaid fee schedule, which can be found at <http://chfs.ky.gov/dms/fee.htm> and is effective beginning on January 1, 2014. The Medicaid fee schedule is based on the following methodology:

1. Physician Base Fee is calculated based on the following (in descending order of applicability):
 - (a) If a current Kentucky-specific Medicare rate exists for the service, physicians will be reimbursed at 75% of the current Kentucky-specific Medicare rate, as published by CMS on an annual basis, using 15 minute increments. This is calculated using the following methodology:
 - i The Mental Health and Substance Abuse rates start with the current standard Kentucky specific Non-Facility Medicare rate for a 60 minute service.
 - ii The 60 minute elapsed time rate is converted to a 15 minute rate to correspond to the Kentucky Medicaid reimbursement methodology of 15 minute units for traditional Medicaid and Mental Health providers.
 - iii The Kentucky Medicaid rate for physicians/psychiatrists is 75% of the current Kentucky-specific Medicare rate.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. All other mental health and substance use providers

- (b) If a current Kentucky-specific Medicare rate does not exist, physicians will be reimbursed for the service based on the state's payment rates for similar services in other Kentucky Medicaid reimbursement programs (with similar degrees of complexity). Kentucky has developed, based on Resource Based Relative Value Scale weighting where possible, and absent RBRVS metrics, a weighted average based comparison of charges, so that a service that Medicare has not priced generates a Medicaid rate to a physician that is "similar" to a rate for either a similar RVRBS metric or a similar percent of charges metric.
- (c) If a current Kentucky-specific Medicare rate does not exist and the service is not similar to other Kentucky Medicaid reimbursed services, physicians will be reimbursed for the service based on the state's payment rates for similar services in other Kentucky programs that are not Medicaid reimbursed (i.e., funded only through State General Funds).

XVI. Other diagnostic, screening, preventive and rehabilitative services.

2. Other practitioners providing the service (listed in a, b, c, d, and e below) will be reimbursed based on a step down methodology calculated as a percentage of the physician rate (75% of the current Kentucky-specific Medicare rate, or the established Medicaid rate if a current Kentucky-specific Medicare rate does not exist). The step down includes:
 - (a) 85% - Advanced Practice Registered Nurse (APRN), Licensed Psychologist (LP)
 - (b) 80% - Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Psychological Practitioner (LPP), Licensed Marriage and Family Therapist (LMFT)
 - (c) 70% - Licensed Psychological Associate (LPA) working under the supervision of a LP if the LP is the billing provider for the service, Licensed Marriage and Family Therapist Associate (LMFTA) working under the supervision of a LMFT if the LMFT is the billing provider for the service, Licensed Professional Clinical Counselor Associate (LPCA) working under the supervision of a LPCC if the LPCC is the billing provider for the service, Certified Social Worker, Masters Level (CSW) working under the supervision of a LCSW if the LCSW is the billing provider for the service, Physician Assistant (PA) working under the supervision of a physician if the physician is the billing provider for the service
 - (d) 50% - Professional equivalents (only at CMHCs), Bachelors-level providers
 - (e) 40% - Other non-bachelors-level providers

Partial hospitalization will be reimbursed a rate of \$194.10 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.
2. The partial hospitalization rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

3. Per 42 CFR 431.107, each provider or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

Residential Services for Substance Use Disorders will be reimbursed a rate of \$230 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year. This per diem was calculated by using Kentucky's EPSDT rate for similar facility services.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.
2. The residential services for substance use disorders rate is based on rates currently set for state plan services - Kentucky's EPSDT rate for similar services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.
3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Residential Services for Substance Use Disorders will be reimbursed a rate of \$230 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year. This per diem was calculated by using Kentucky's EPSDT rate for similar facility services.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.
2. The residential services for substance use disorders rate is based on rates currently set for state plan services - Kentucky's EPSDT rate for similar facility services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.
3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Intensive outpatient program will be reimbursed a rate of \$58.26 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year. This per diem was calculated by using Kentucky's existing rate for rehabilitative children in the custody of or at risk of being in the custody of the state or for children under the supervision of the state and converting it to a per diem for the same service.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.
2. The intensive outpatient program rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.
3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Assertive Community Treatment will be reimbursed a rate of \$750 per month for a four (4) person team, and \$1,000 per month for a ten (10) person team. In order to be reimbursed this rate, at least one service must be provided during the period. These rates will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.
2. The ACT rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.
3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

- B. Effective for services provided on and after July 2, 2001, primary care centers will be reimbursed in accordance with the prospective payment system described in Attachment 4.19-B, page 20.16 for FQHCs and RHCs.

For drugs for specified immunizations provided free from the Health Department to primary care centers for immunizations for Medicaid recipients, the cost of the drugs are paid to the Health Department. The specified immunizations are: diphtheria and tetanus toxoids and pertuisis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any type) (OPV); and hemophilus B conjugate vaccine (HBCV).

Effective January 1, 1989, the cost for these immunizations will not be allowed as a part of the primary care center cost base so long as these drugs are available free from the Health Department.

TN No.: 89-30
Supersedes
TN No.: None

Approval
Date: Oct 16, 1989

Effective
Date: 7-1-1989

For the period 10/01/02 through 6/30/04, adjusted payments will be made to Community Mental Health Centers to recognize and support their continued commitment to the provision of mental health services. These payments will be made on a quarterly basis and will reflect the difference in the costs used to determine current rates and Medicaid Costs determined as follows:

1. Using audited cost reports ending June 30, 2000, costs for the covered mental health rehabilitation services described in Attachment 3.1- A, page 7.6.1(a) and Attachment 3.1-B, page 31.5(a) will be allocated to the following cost centers: therapeutic rehabilitation, outpatient individual, outpatient group, outpatient psychiatry, outpatient/personal care home, outpatient/in-home setting, and hospital psychiatric (professional services provided in an inpatient setting).
2. The Medicaid percentage for each cost center will be determined by dividing Medicaid units of service by total units of service by cost center.
3. Medicaid costs per cost center will be determined by multiplying costs by the Medicaid percentage per cost center.
4. Medicaid costs per cost center will be inflated to the mid-point of the rate year using the Home Health Market Basket Index.
5. The increased Medicaid capital will be determined by multiplying any capital increase from the base year to the rate year by the aggregate Medicaid percentage. The aggregate Medicaid percentage is determined by dividing total Medicaid costs by total costs.
6. The difference between the base year Medicaid costs and the inflated Medicaid costs will be added to the increased Medicaid capital.
7. Costs shall be determined in accordance with cost principles outlined in the Provider Manual. Only Medicaid recognized costs will be included in the calculation.
8. These adjusted payments will expire on July 1, 2004.

Payment methodology for rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and that are provided through an agreement with the State Health or Title V agency.

A. Rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rates for rehabilitative services are negotiated rates between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of each service.

The payment rate for rehabilitative services that are authorized after June 30, 2002, are uniform rates, determined by 98% of the weighted median of claims for each service for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

B. Rehabilitative services for children under the supervision of the state and that are provided through an agreement with the State Health or Title V agency.

Payments for rehabilitative services covered in Attachment 3.1-A, page 7.6.1 and Attachment 3.1B, page 31.5 for the target populations are per service. They are based upon one or more documented rehabilitative services provided to each client. The rates for the rehabilitative services are based upon the actual direct and indirect costs to the providers. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing rehabilitative services based on financial information submitted by the provider.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: identification, by recipient and worker, of each individual service provided, a showing of all direct costs for rehabilitative services; and a showing of all indirect costs for rehabilitative services appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principle if necessary.

Rehabilitative service providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

XVII. FQHC/RHC Services

Reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) shall be made in accordance with section 1902 of the Social Security Act as amended by section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA).

For the period of January 1, 2001 through June 30, 2001, the state will implement an alternative reimbursement methodology that is agreed to by the state and the individual center/clinic and results in a payment rate to the center/clinic that is at least equal to the Medicaid PPS rate. The alternative methodology shall be in accordance with the state plan in effect on December 31, 2000.

All FQHCs and RHCs are reimbursed on a prospective payment system beginning with State Fiscal Year 2002 with respect to services furnished on or after July 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the clinic/centers reasonable cost for the clinic/center's fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during the clinic/center's fiscal year 2001 and increased by an appropriate medical index. These costs are divided by the number of visits/encounters for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for state fiscal year 2002. For each state fiscal year thereafter, each clinic/center will be paid the amount (on a per visit basis) equal to the amount paid in the previous state fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic during that state fiscal year. The clinic/center must supply a budgeted cost report of the change in service to justify scope of service adjustments.

For newly qualified FQHCs/RHCs after State Fiscal Year 2001, initial payments are established by cost reporting methods. A newly qualified clinic/center shall submit a budgeted cost report from which an interim rate shall be established. After completion of a clinic/center fiscal year, a final PPS rate will be established. After the initial year, payment is set using the MEI methods used by other clinics/centers, with adjustments for increases or decreases in the scope of service furnished by the clinic/center during that fiscal year.

In the case of a FQHC or RHC that contracts with a Medicaid managed care organization, supplemental payments will be made quarterly to the center or clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the center or clinic is entitled under the PPS.

Until a prospective payment methodology is established, the state will reimburse FQHCs/RHCs based on the rate in effect on June 30, 2001. This rate is based on the State Plan in effect on June 30, 2001. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.

XVIII. Outpatient Surgical Centers

The Department shall utilize the 1996 Medicare ambulatory surgical center group rates for the federal Cincinnati, Ohio-Kentucky region to reimburse for an outpatient surgical center service. Following is a chart which states the reimbursement rate for each corresponding surgical group:

ASC Group	Reimbursement Rate
Group 1	\$307.38
Group 2	\$412.79
Group 3	\$471.90
Group 4	\$582.25
Group 5	\$664.02
Group 6	\$775.59
Group 7	\$921.15
Group 8	\$911.55

Procedures that are not included in one (1) of the eight (8) Medicare surgical groups, reimbursement shall be on the basis of forty-five (45) percent of the center's usual and customary charge for the procedure performed. Payment rates shall not exceed the provider's usual and customary charge to the general public. Hospital based outpatient surgical centers shall be reimbursed in the same manner as hospital outpatient services.

XIX Nurse-Midwife Services

Participating nurse-midwife providers shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of the nurse-midwife.

For services provided on or after July 1, 1990, payments to nurse-midwives shall be at usual and customary actual billed charges on a procedure-by-procedure basis, with reimbursement for each procedure to be the lesser of the actual billed charge or at seventy—five (75) percent of the fixed upper limit per procedure for physicians.

XX Nurse Anesthetist services

Reimbursement will be made at the rate of seventy—five (75) percent of the anesthesiologist's allowable charge for the same procedure under the same conditions, or at actual billed charges if less.

Exception:

For inpatient delivery—related anesthesia services provided on or after December 1, 1988, a nurse anesthetist will be reimbursed the lesser of the actual billed charge or the standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Normal Delivery	\$150.00
Low Cervical C-Section	\$202.50
Classic C-Section	\$240.00
Epidural Single	\$236.25
Epidural Continuous	\$251.25
C-Section with Hysterectomy, subtotal	\$240.00
C-Section with Hysterectomy, total	\$240.00
Extra peritoneal C-Section	\$240.00

XXI. Podiatry Services

The cabinet shall reimburse licensed, participating podiatrists for covered podiatry services rendered to eligible Medical Assistance recipients at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the cabinet at 65 percent of the median billed charge for outpatient services and 50 percent of the median billed charge for inpatient services using 1989 calendar year billed charges. If there is no median available for a procedure, or the cabinet determines that available data relating to the median for a procedure is unreliable, the cabinet shall set a reasonable fixed upper limit for the procedure consistent with the general array of upper limits for the type of service. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

XXII. Hospice Care**A. General Reimbursement**

Reimbursement for hospice care will be made at one of four predetermined rates for each day in which a recipient is under the care of the hospice. The daily rate is applicable to the type and intensity of services furnished to the recipient for that day. There are four levels of care into which each day of care is classified:

1. Routine Homecare
2. Continuous Homecare
3. Inpatient Respite Care
4. General Inpatient Care

The Medicaid hospice rates are set prospectively by Centers for Medicare and Medicaid Services, based on the methodology used in setting Medicare hospice rates and adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register.

B. Reimbursement for Room and Board

Hospice is reimbursed a per diem amount to cover room and board, for those recipients who reside in a nursing facility. The state shall reimburse ninety five percent (95%) of the nursing facility's Medicaid per diem to the hospice provider, to cover the expenses of the room and board provided to the hospice patient who occupies a Medicaid certified bed in a nursing facility.

The hospice provider shall have a contract with the nursing facility stipulating that:

1. Room and board shall be provided by the nursing facility for the hospice resident;
2. The rate the nursing facility will charge the hospice provider for room and board furnished to the Medicaid hospice resident; and
3. The hospice is fully responsible for the professional management of the Medicaid hospice patient's care.

C. Limitation on Payments for Inpatient Care

1. The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicaid patients not exceed twenty percent (20%) of the total days for which these patients have elected hospice.
2. At the end of the cap period, Medicaid will calculate a limitation on payment for inpatient care (general or respite) to ensure payment is not made in excess of twenty percent (20%) of the total number of days of hospice care furnished to Medicaid patients.
3. If the number of days of inpatient care furnished to Medicaid patients is equal to or less than twenty percent (20%) of the total days of hospice care to Medicaid patients, no adjustment is necessary. Overall payments to a hospice are subject to the cap amount.

D. Monitoring of Reimbursement

The Department for Medicaid Services will perform a desk audit on each hospice provider once a year following the end of the cap period in order to compute and apply the cap amount and audit payments made for inpatient services.

XXIII. Case Management Services

A. Targeted case management services for severely emotionally disturbed children and adults with chronic mental illness.

The Department will pay for a unit of targeted case management up to allowable reasonable cost per unit, not to exceed 130% of the median cost per unit of all providers. Reasonable costs shall be determined from the latest prior year audited cost reports. Total payments will not exceed provider's actual costs.

"Unit" is defined as a month. A unit consists of a minimum of four service contacts, for a child two of the contacts must be face-to-face, at least one with the child and the other with a parent or family member. The other contacts may be by telephone or face-to-face and may be with or on behalf of the child. For adults, four service contacts must also be made, two are required to be face-to-face.

The unit cost is based on audited prior fiscal year cost reports. Adult TCM and child TCM are separate cost centers. Cost per unit is determined by dividing the overall costs for the service by the number of units of service provided.

XXV. Advanced Registered Nurse Practitioner Services

(1) Reimbursement

- a. Participating licensed advanced registered nurse practitioners (ARNP) shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of a licensed ARNP.
- b. Except as specified in subsection c of this section or Section 2 below, reimbursement for a procedure provided by an ARNP shall be at the lesser of the following:
 1. The ARNP's actual billed charge for the service; or
 2. Seventy-five (75) percent of the amount reimbursable to a Medicaid participating physician for the same service.
- c. An ARNP employed by a primary care center, federally qualified health center, hospital, or comprehensive care center shall not be reimbursed directly for services provide in that setting while operating as an employee.

(2) Reimbursement Limitations.

- a. The fee for administration of a vaccine to a Medicaid recipient under the age of twenty-one (21) by an ARNP shall be three (3) dollars and thirty (30) cents up to three (3) administrations per ARNP, per recipient, per date of service.
- b. The cost of a vaccine available free through the Vaccines for Children Program shall not be reimbursed.
- c. Injectable antibiotics, antineoplastic chemotherapy, and contraceptives shall be reimbursed at the lesser of:
 1. The actual billed charge; or
 2. The average wholesale price of the medication supply minus ten (10) percent.

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- d. Reimbursement for an anesthesia service provided during a procedure shall be inclusive of the following elements:
1. Preoperative and post-operative visits;
 2. Administration of the anesthetic;
 3. Administration of intravenous fluids and blood or blood products incidental to the anesthesia or surgery;
 4. Post-operative pain management; and
 5. Monitoring services.
- e. Reimbursement of a psychiatric service provided by an ARNP shall be limited to four (4) psychiatric services per ARNP, per recipient, per twelve (12) months.
- f. Reimbursement for a laboratory service provided in an office setting shall be inclusive of:
1. The fee for collecting and analyzing the specimen; and
 2. Should the test require an arterial puncture or venipuncture, the fee for the puncture.
- g. Reimbursement shall be limited to one (1) of the following evaluation and management services performed by an ARNP per recipient, per date of service:
1. A consultation service;
 2. A critical care service;
 3. An emergency department evaluation and management service;
 4. A home evaluation and management service;
 5. A hospital inpatient evaluation and management service;
 6. A nursing facility service;
 7. An office or other outpatient evaluation and management service;
 8. A preventive medicine service; or
 9. A psychiatric or other psychotherapy service.

XXVI: Federally Qualified Health Center Services

Enrolled Federally Qualified Health Center providers shall be paid full reasonable cost determined in the same manner as for primary care centers except that cost shall not include an incentive payment.

XXVIII. Public Health Clinics

- A. This methodology applies to services described on Attachments 3.1-A, pages 7.6.1, 7.6.1(c) – (e), and 3.1-B, pages 31.5, 31.5(c) – (e).
- B. Reimbursement
 - 1. Covered services shall be paid based on Medicare RVU adjusted by the current Medicare conversion factor for Kentucky, multiplied by non-facility relative value unit weight for the procedure code. These factors will be adjusted each January as adjusted by Medicare.
 - 2. If a copayment applies to the service, the reimbursement rate shall be reduced by the amount of the copayment.

TN No.: 03-021
Supersedes
TN No.: None

Approval Date: 05/11/07
Effective Date: 07/01/03

XXIX Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

- (1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services), the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:
 - (a) 1905(a)(1), inpatient hospital services;
 - (b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
 - (c) 1905(a)(3), other laboratory and X-ray services;
 - (d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
 - (e) 1905(a)(5)(A), physicians services; 1905(a)(5)(B), medical and surgical services furnished by a dentist;
 - (f) 1905(a)(6), medical care by other licensed practitioners;
 - (g) 1905(a)(7), home health care services;
 - (h) 1905(a)(9), clinic services;
 - (i) 1905(a)(10), dental services;
 - (j) 1905(a)(11), physical therapy and related services;
 - (k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
 - (l) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
 - (m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
 - (n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
 - (o) 1905(a)(17), nurse-midwife services;
 - (p) 1905(a)(18), hospice care;
 - (q) 1905(a)(19), case management services; and
 - (r) 1905(a)(28), other medical and remedial care specified by the Secretary.
- (2) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21, the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100 percent of usual and customary charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:
 - (a) Any service described in one (1), above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
 - (b) 1905(a)(8), private duty nursing services;
 - (c) 1905(a)(20), respiratory care services;
 - (d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under 1905(a)(6); and

- 3) For medically-necessary evaluative, diagnostic, preventive, and treatment services listed in Section 1905(a) of the Social Security Act, the state shall pay in accordance with items (1) or (3), as applicable, except that for governmental providers the payment shall be a fee-for-service system designed to approximate cost in the aggregate with settlement to reconciled cost. The following describes the methodology utilized in arriving at the rates.
- (a) Medicaid providers are paid according to the Kentucky Medicaid Fee Schedule and its modifiers which are maintained by the department and paid through the fee-for-service system. "Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of covered services. The agency's current fee schedule rate was set as of January, 2010 and is effective for services provided on or after that date. All rates are published on the KY Medicaid web site at <http://chfs.ky.gov/dms/fee.htm>.
- (b) Fee for new services are established based on the fees for similar existing services. If there are no similar services the fee is established at 75% of estimated average charge.
- (c) Fees for particular services can be increased based on administrative review if it is determined that the service is essential to the health needs of Medicaid recipients, that no alternative treatment is available, and that a fee adjustment is necessary to maintain physician participation at a level adequate to meet the needs of Medicaid recipients. A fee may also be decreased based on administrative review if it is determined that the fee may exceed the Medicare allowable amount for the same or similar services, or if the fee is higher than Medicaid fees for similar services, or if the fee is too high in relation to the skills, time and other resources required to provide the particular service.
- (d) Medicaid Services Provided in Schools are services that are medically necessary and provided in schools to Medicaid recipients in accordance with an Individualized Education Program, (IEP) or an Individual Family Service Plan (IFSP). Covered services include the following as described in Attachment 3.1-A pages 7.1.7(b)-7.1.7(e):
1. Audiology
 2. Occupational Therapy
 3. Physical Therapy
 4. Behavioral Health Services
 5. Speech
 6. Nursing Services
 7. Respiratory Therapy
 8. Transportation
- The interim payment to the Local Education Agencies for services (Paragraph (d) 1-7) listed above are based on the physician fee schedule methodology as outlined in Kentucky Medicaid Fee Schedule.
- (e) Direct Medical Services Payment Methodology
Beginning with cost reporting period August 1, 2008, the Department for Medicaid Services (DMS) will begin using a cost based methodology for all Local Education Agencies (LEAs). This methodology will consist of a cost report, time study and reconciliation. If payments exceed Medicaid-allowable costs, the excess will be recouped.
- Once the first year's cost reports are received, and each subsequent year, the Department will examine the cost data for all direct medical services to determine if an interim rate change is justified.

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-eligible clients in the LEA, the following steps are performed:

1. Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services personnel listed in the descriptions of the covered Medicaid services delivered by school districts in Attachment 3.1-A pages 7.1.7(b) - 7.1.7(e).

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, direct materials, supplies and equipment.

Medical devices and equipment are only allowable for the provision of direct medical services. For items not previously approved, the LEA must use a pre-approval process to determine suitability, coverage, and reimbursement of medical supplies, material, and equipment. The following process must be followed by the schools at a minimum:

- 1) The medical device must be approved and effective (i.e., not experimental) and within the scope of the school based services shown as covered in the Medicaid state plan;
- 2) The use of the device must be determined suitable for the individual; and
- 3) The service or device must be approved by one of the covered medical professionals and reviewed by the Kentucky Department for Medicaid Services.

These direct costs are accumulated on the annual cost report, resulting in total direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

2. The net direct costs for each service is calculated by applying the direct medical services percentage from the CMS-approved time study to the direct cost in 1 above.

A time study which incorporates a CMS-approved methodology is used to determine the percentage of time medical service personnel spend on IEP-related medical services, and general and administrative time. This time study will assure that there is no duplicate claiming relative to claiming for administrative costs

3. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. Kentucky public school districts use predetermined fixed rates for indirect costs. The Department of Education (KDE) is the cognizant agency for the school districts, and approves unrestricted indirect cost rates for school districts for the US Department of Education (USDE). Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.
4. Net direct costs and indirect costs are combined.

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5. Medicaid's portion of total net costs is calculated by multiplying the results from Item 4 by the ratio of the total number of students with Medicaid Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP) receiving services to the total number of students with an IEP or an IFSP.

(f) Transportation Services Payment Methodology

Effective dates of services on or after August 1, 2008, providers will be paid on a interim cost basis. Providers will be reimbursed interim rates for School Based Health Services (SBHS) Specialized Transportation services at the lesser of the provider's billed charges or the interim rate. The interim rate will be a per mile amount determined by the Department of Education Division of School Finance based on data collected from school districts. This interim rate will be an average of each school district's actual cost per mile. On an annual basis, a cost reconciliation and cost settlement will be processed for all over and under payments.

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1. Special transportation is specifically listed in the IEP as a required service;
2. A medical service is provided on the day that specialized transportation is provided; and
3. The service billed only represents a one-way trip.

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education. The cost identified on the cost report includes the following:

1. Bus Drivers
2. Mechanics
3. Substitute Drivers
4. Fuel
5. Repairs & Maintenance
6. Rentals
7. Contract Use Cost
8. Vehicle Depreciation

The source of these costs will be audited Chart of Accounts data kept at the school district and the Department of Education level. The Chart of Accounts is uniform throughout the State of Kentucky. Costs will be reported on an accrual basis.

1. A rate will be established and applied to the total transportation cost of the school district or the Department of Education. This rate will be based on the *Total IEP Special Education Department (SPED) Students in District Receiving Specialized Transportation* divided by the *Total Students in District Receiving Transportation*. The result of this rate (%) multiplied by the *Total District or Department of Education Transportation Cost* for each of the categories listed above will be include on the cost report. It is important to note that this cost will be further discounted by the ratio of *Medicaid Eligible SPED IEP One Way Trips* divided by the total number of *SPED IEP One Way Trips*. This data will be provided from transportation logs. The process will ensure that only one way trips for Medicaid eligible Special Education children with IEP's are billed and reimbursed for.

2. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. Kentucky public school districts use predetermined fixed rates for indirect costs. The Department of Education (KDE) is the cognizant agency for the school districts, and approves unrestricted indirect cost rates for school districts for the US Department of Education (USDE). Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.
3. Net direct costs and indirect costs are combined.

(g) Certification of Funds Process

On an annual basis, each provider will certify through its cost report its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

(h) Annual Cost Report Process

For Medicaid services listed in Paragraph (d) 1-8 provided in schools during the state fiscal year, each LEA provider must complete an annual cost report. The cost report is due on or before April 1 following the reporting period.

The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology.
2. Reconcile annual interim payments to its total CMS-approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual SBHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SBHS Cost Reports are subject to desk review by Department for Medicaid Services (DMS) or its designee.

(i) The Cost Reconciliation Process

The cost reconciliation process must be completed by DMS within twenty-four months of the end of the reporting period covered by the annual SBHS Cost Report. The total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the LEA provider's Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

(j) The Cost Settlement Process

EXAMPLE: For services delivered for the period covering August 1, 2007, through July 31, 2008, the annual SBHS Cost Report is due on or before April 1, 2009, with the cost reconciliation and settlement processes completed no later than July 31, 2010.

If a provider's interim payments exceed the actual, certified costs for Medicaid services provided in schools to Medicaid clients, the provider will remit the federal share of the overpayment at the time the cost report is submitted. DMS will submit the federal share of the overpayment to CMS within 60 days of identification.

If the actual, certified costs of a LEA provider exceed the interim payments, DMS will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

The Department for Medicaid Services (DMS), Kentucky Department of Education (KDE) and individual schools wish to share in the responsibility for promoting access to health care for students in the public school system, preventing costly or long term health care problems for at risk students, and coordinating students' health care needs with other providers. Many of these activities, when performed by school staff, meet the criteria for Medicaid school-based administrative claiming and may be reimbursable. For this purpose we have produced the Kentucky School Based Time Study document to set out the method for these reimbursements.

State: Kentucky

XXX. Radiological (X-ray) Services

Payments for radiological services covered pursuant to the mandate contained in 42 CFR 440.30 shall be at usual and customary charges up to sixty (60) percent of the allowable physician fee for the same procedures where the physician is performing both the professional and technical portions of the service.

TN # 92-25
Supersedes
TN # None

Approved Date: Jan 13, 1993

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XXXI. Payment methodology for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and for adults in need of protective services.

A. Targeted case management services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rate for targeted case management is a negotiated rate between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of the service.

The payment rate for a targeted case management service that is authorized after June 30, 2002, is a uniform rate, determined by 98% of the weighted median of claims for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

The billable unit of service is one month

B. Targeted case management services for children under the supervision of the state and for adults in need of protective services.

Payments for targeted case management services for the target populations are monthly. They are based upon one or more documented targeted case management services provided to each client during that month. The monthly rate for the targeted case management services is based on the total average cost per client served by the provider. The monthly rate is established on a prospective basis based upon actual case management costs for the previous year. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing case management services based on financial information submitted by the provider.

Case management providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: directly coded worker time; identification, by recipient and worker, of each individual service provided, a showing of all direct costs for case management activities; and a showing of all indirect costs for case management activities appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principles if necessary.

XXII. Specialized Children's Services Clinics

Clinic services provided by Specialized Children's Services Clinics will be reimbursed initially at a statewide uniform all-inclusive rate per visit (encounter rate) of \$538. This rate is estimated to approximate the average statewide costs of all clinics providing the service. This rate includes the costs of professional services (physician and mental health professional), related costs of providing a sexual abuse exam, and facility costs (overhead). This rate is based on the projected cost of providing the service as submitted to the department by the providers and a consideration of rates paid to providers for similar services.

Providers will submit cost reports annually. Upon receipt of completed cost reports from all clinics, the department will establish a rate within 90 days using updated cost data.

Payments made under this provision shall not exceed the upper limit of payment as specified in 42 CFR 447.325.

XXIII. Targeted Case Management and Diagnostic, Preventive and Rehabilitative Early Intervention Services for children eligible for the Early Intervention program provided through a Title V agreement.

This payment system is for all providers, including those providing services under the Title V agreement described in Supplement 1 to Attachment 4.16-A, Item #10.

All costs shall be determined based on the methodology outlined in OMB Circular A-87. Payments for case management, diagnostic, rehabilitative, and preventive early intervention services shall be made in accordance with a fee schedule established by the Title V agency. Interim payments shall be based on the direct cost of providing the service. Payments for overhead and administrative costs associated with providing the service shall be determined with a settlement to cost at the end of the fiscal year. Providers will submit cost reports no later than 180 days after the end of the state fiscal year.

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XXXV Chiropractic Services

A. Definitions

- (1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.
- (2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.
- (3) "Covered chiropractic services" shall include the following:
 - (a) An evaluation and management service;
 - (b) Chiropractic manipulative treatment;
 - (c) Diagnostic X-rays;
 - (d) Application of a hot or cold pack to one (1) or more areas;
 - (e) Application of mechanical traction to one (1) or more areas;
 - (f) Application of electrical stimulation to one (1) or more areas; and
 - (g) Application of ultrasound to one (1) or more areas.

B. Reimbursement

- (1) Payment for covered chiropractor's services shall be based on the lesser of the chiropractor's usual and customary actual billed charges or the fixed upper limit per procedure established by the Department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS).
- (2) If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein. RBRVS units shall be multiplied by the Non-anesthesia Related Services dollar conversion factor of \$29.67 to arrive at the fixed upper limit.

C. Reimbursement Exceptions.

- (1) Payment for individuals eligible for coverage under Medicare Part B is made, in accordance with Sections A and B and items (1) through (4) and (6) of this section within the individual's Medicare deductible and coinsurance liability.
- (2) For services provided on or after July 1, 1990, chiropractors practicing in geographic areas with no more than one (1) primary care physician per 5,000 population, as reported by the United States Department of Health and Human Services, shall be reimbursed at the lesser of the chiropractors' usual and customary actual billed charges or up to 125 percent of the fixed upper limit per procedure established by the Department.

(3) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the chiropractor's office are subject to outpatient limits if provided at alternative sites and shall be paid adjusted rates to take into account the change in usual site of services.

D. Assurances. The state hereby assures that (1) payment for chiropractor services are consistent with efficiency, economy, and quality of care (42 CFR 447.200); and (2) payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances (42 CFR 447.325).

Targeted case management services for at risk parents during the prenatal period and until the child's third birthday

This payment system is for all providers, including those providing services under the Title V agreement described in Attachment 4.16-A, Item #10.

Payments shall be based on cost. Interim rates based on projected cost shall be used with a settlement to cost at the end of the state fiscal year. Case management providers who are public state agencies shall have on file an approved cost allocation plan.

Interim rates shall be established in the following manner:

- 1) The rate for the assessment shall be based on the projected cost of providing the service consistent with methodology in OMB Circular A-87. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.
- 2) The rate for the professional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.
- 3) The rate for the family service worker/paraprofessional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

Cost will be accounted for as follows:

- 1) Case management staff directly related to the targeted case management program will code all direct time using categories designated for case management functions in 15 minute increments.
- 2) Any contract costs (i.e., for contracted services) will be based on the actual cost of acquisition of the service.
- 3) Any indirect costs of any public state agency will be determined using the appropriate cost allocation plan.

Providers will submit cost reports no later than 180 days after the end of the state fiscal year. Interim payments will be adjusted to actual cost based upon review and acceptance of these cost reports in accordance with usual agency procedures.

Reimbursement for Physical, Occupational and Speech Therapy - Outpatient

Reimbursement for physical, occupational, and speech therapy services are based on the Kentucky specific Medicaid fee schedule, which can be found at <http://chfs.ky.gov/dms/fee.htm>. The Medicaid fee schedule is based on the following methodology:

- Physician Base Fee is calculated based on 75% of the Medicare rate, as published by CMS on an annual basis.
- Other practitioners will be reimbursed based on a step down methodology calculated as a percentage of the physician rate of 75% of the Medicare rate. The step down includes:
 - 85% - Physical Therapist, Occupational Therapist, Speech Language Pathologist
 - 50% - Physical Therapy Assistant working under the supervision of a Physical Therapist if the Physical Therapist is the billing provider for the service, Occupational Therapy Assistant working under the supervision of an Occupational Therapist if the Occupational Therapist is the billing provider,

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT
State: Kentucky

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Payment of Medicare Part A & Part B Deductible/Coinsurance

- A. Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:
1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a specified rate or method is set out on Page 3 in item B of this attachment (see 3.below).
 2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".
 3. Payments are up to the amount of a special rate, or according to a special method, described on page 3 in item of this attachment, for those groups and payments listed below and designated with the letters "NR".
 4. Any exceptions to the general methods used for a particular group or payment are specified on page 3 in item B of this attachment (See 3. Above)

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT
State: Kentucky

Payment of Medicare Part A and Part B Deductible/Coinsurance (cont.)

QMBs:	Part A:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance
	Part B:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance

Other Medicaid Recipients	Part A:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance
	Part B:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance

Dual Eligible (QMB Plus)	Part A:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance
	Part B:	<u>MR</u> Deductibles	<u>MR</u> Coinsurance

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT
State: Kentucky

Payment of Medicare Part A and Part B Deductible/Coinsurance (cont.)

- B. Medicaid payment for specified Medicare crossover claims will be the lower of the allowed Medicaid payment rates or the Medicare coinsurance and deductibles.
1. The specified Medicare Part A crossover claims are defined as: Inpatient Hospital and Nursing Facilities (effective 9/01/02).
 2. The specified Medicare Part B claims are defined as:
 - a. Physician services, Community Mental Health Center services, Advanced registered nurse practitioner services, podiatry services, chiropractic services, dental services, hearing and vision services, and laboratory and x-ray services (effective 2/01/03);
 - b. Durable Medical Equipment and Pharmacy (effective 4/01/03);
 - c. Emergency ambulance services (effective 6/01/03); and
 - d. Ancillary Services/Nursing Facilities (effective 11/01/03).

In the event that Medicaid does not have a price for codes included on a crossover claim the Medicare coinsurance and deductible will be paid.

PAYMENTS FOR RESERVED BEDS

Payment is made for a reserved bed in Intermediate Care Facilities for the Mentally Retarded in accordance with the following:

A. Payment for the bed reservation shall not exceed the following number of days:

A maximum of fifteen (15) days for a hospital stay for treatment of an acute condition(s), and a total of forth-five (45) days for leave(s) of absence in any given quarter (except that not more than thirty (30) days of such leave may be consecutive days).

B. Payment may ordinarily be made when the following conditions exist:

1. The individual is an eligible recipient and is authorized for Program benefits in the level of care in which he is currently residing.
2. The individual is expected to return to the same level of care, barring complications:
3. There is a likelihood that the bed would be occupied by some other patient if not reserved (facilities with a vacancy history would not be reimbursed for reserving a bed);
4. In the case of a leave of absence, the physician orders and the patient's plan of care provides for such an absence.

PAYMENTS FOR RESERVED BEDS

Payment is made for a reserved bed for price-based nursing facilities in accordance with the following:

The program will cover reserved bed days in accordance with the following specified upper limits and criteria.

- (1) Reserved bed days will be covered for a maximum of fourteen (14) days per calendar year due to hospitalization.
- (2) Reserved bed days will be covered for a maximum of ten (10) days during the calendar years for leaves of absence other than for hospitalization.
- (3) Reserved bed days will be reimbursed at seventy-five (75) percent of a facility's rate if the facility's occupancy percent is ninety-five (95) percent.
- (4) Reserved bed days will be reimbursed at fifty (50) percent of a facility's rate if the facility's occupancy percent is less than ninety-five (95) percent.
- (5) Coverage during a recipient's absence for hospitalization or leave of absence is contingent on the following conditions being met:
 - (a) The person is in Title XIX payment status in the level of care he/she is authorized to receive and has been a resident of the facility at least overnight. Persons for whom Title XIX is making Title XVIII co-insurance payments are not considered to be in Title XIX payment status for purposes of this policy;
 - (b) The person can be reasonably expected to return to the same level of care;
 - (c) Due to demand at the facility for beds at that level, there is a likelihood that the bed would be occupied by some other patient where it not reserved;
 - (d) The hospitalization is for treatment of an acute condition, and not for testing, brace-fitting, etc.: and
 - (e) In the case of leaves of absence other than for hospitalization, the patient's physician orders and plan of care provide for such leaves. Leaves of absence include visits with relatives and friends, and leaves to participate in state-approved therapeutic or rehabilitative programs.

TN No. 05-005

Supersedes

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FACILITY REIMBURSEMENT – METHODS AND PROCEDURES
FOR JANUARY 1, 2000 AND THEREAFTER

The following sections summarize the cost-based and price-based reimbursement methodologies for facilities in Kentucky.

Participation Requirements

To participate in the Medicaid Program, the facilities are required to be licensed as nursing facilities or as an intermediate care facility for the mentally retarded and developmentally disabled. Hospitals provide swing-bed hospital nursing facility care shall not be required to have the hospital beds licensed as NF beds. All nursing facilities (NFs) must participate in Medicare in order to participate in Medicaid, except for those NFs with waivers of the nursing requirements (who are prohibited by statute from participation in Medicare).

Audits

The state agency reviews all cost reports for compliance with administrative thresholds. Costs will be limited to those cost found reasonable. Overpayments found in audits under this paragraph will be accounted for in accordance with federal regulations.

Cost-Based Facilities

The following facilities shall remain in the cost-based facility methodology:

- a. A nursing facility with a certified brain injury unit;
- b. A nursing facility with a distinct part ventilator unit;

- c. A nursing facility designed as an institution for mental disease;
- d. A dually-licensed pediatric nursing facility;
- e. An intermediate care facility for the mentally retarded and developmentally disabled; and

Cost Reports for Cost-Based Facilities

Facilities shall use a uniform cost reporting form for submission at the facility's fiscal year end. The single state agency shall set a uniform rate year for cost-based NF's and ICF-MRs (July 1-June 30) by taking the latest available cost data which is available as of May 16 of each year and trending the facility costs to July 1 of the rate year.

1. If the latest available cost report period has not been audited or desk reviewed prior to rate setting, the prospective rates shall be based on cost reports which are not audited or desk reviewed subject to adjustment when the audit or desk review is completed. If desk reviews or audits are completed after May 16, but prior to universal rate setting for the next rate year, the desk review or audited data shall be used.
2. Partial year or budgeted cost data may be used if a full year's data is unavailable. Unaudited reports shall be subject to adjustment to the audited amount.
3. Facilities paid on the basis of partial year or budgeted cost reports shall have their reimbursement settled back to allowable cost.

Allowable Cost

Allowable costs are costs found necessary and reasonable by the single state agency using Medicare Title XVIII-A principles except as otherwise stated. Bad debts, charity and courtesy allowances for non-Title XIX patients are not included in allowable costs. A return on equity is not allowed.

Methods and standards for Determining Reasonable Cost-Related Payments

The methods and standards for the determination of reimbursement rates to nursing facilities and intermediate care facilities for the mentally retarded and developmentally disabled is as described in the Nursing Facility Reimbursement manual which is Attachment 4.19-D, Exhibit B.

Payments Rates resulting from Methods and Standards

1. Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.
2. The rates take into account economic trends and conditions since costs are trended to the beginning of the rate year (July 1) and then indexed for inflation for the rate year using Global Insight inflation index.
3. Interim rates are established on July 1 of each year. Interim rates will be adjusted to include the cost of staffing ratio increases, level of service increases, to accommodate changes of circumstances affecting resident patient care, to correct errors in the rates (whether due to action or inaction of the state or the facilities), or to address displacement of residents. Rates shall be adjusted to an audited cost base if an unaudited cost report has been used due to new construction or other specified reasons which requires using an unaudited cost report.
4. The Medicare Upper Payment Limit (UPL) described in Exhibit B, Section 705 of this attachment is subject to increase to take into account any costs incurred to comply with Federal requirements or a combination of Federal and State requirements that were not in effect during the Medicare UPL base year. These requirements are actions that increase costs as a result of staffing ratio increases, level of service increases, to accommodate changes of circumstances affecting patient care, or to address displacement of residents. The increase will be equal to the average per diem cost of complying with such requirements times the total number of Medicaid patient days in the Medicare UPL current year as defined in Exhibit B, Section 705.
5. The following special classes of nursing facilities are addressed in the Medicaid cost-based methodology regulation:

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- a. NF/Brain Injury Units means units recognized by the Medicaid agency as specially designated and identified NF units dedicated to, and capable of, provide care to individuals with severe head injury. Facilities providing preauthorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae means a facility appropriately accredited by a nationally recognized accrediting agency or organization. To participate in Kentucky Medicaid the facility or unit must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

The all-inclusive rate for brain injury unit is \$360 per diem, excluding drugs and physician cost. These claims are to be submitted through the pharmacy and physician's programs. For those residents with brain injury and neurobehaviorial sequelae, the per diem is a negotiated rate not to exceed usual and customary charges. This rate excludes drugs and physician costs. These claims shall be submitted through the pharmacy and physician's programs.

- b. Certified distinct part ventilator nursing facility unit means a preauthorized distinct part unit of not less than twenty (20) beds with a requirement that the facility have a ventilator patient census of at least fifteen (15) patients. The patient census shall be based upon the quarter preceding the beginning of the rate year, or upon the quarter precedent the quarter for which certification is requested if the facility did not qualify for participation as a ventilator care unit at the beginning of the rate year. The unit must have a ventilator machine owned by the facility for each certified bed with an additional backup ventilator machine required for every tent (10) beds. The facility must have an appropriate program for discharge planning and weaning from the ventilator. The fixed rate for hospital based facilities is \$460.00 per day, and the fixed rate for freestanding facilities is \$250.00 per day. The rates are to be increased based on the Data Resources Incorporated inflation index for the nursing facility services for each rate year beginning with the July 1, 1997 rate year.

6. The following special classes of nursing facilities are addressed in the Medicaid cost-based methodology regulation and are reimbursed at full reasonable and allowable cost in accordance with methodology determined by the state regulations:
 - a. NF/Institutions for Mental Diseases (IMO) means facilities identified by the Medicaid agency as providing nursing facility care primarily to the mentally ill.
 - b. NF/Dually licensed pediatric nursing facilities means facilities identified by the Medicaid agency as providing nursing facility care to residents under the age of twenty-one (21).
 - c. ICF/MRIDD-Intermediate Care Facilities for Mentally Retarded and Developmentally Disabled means facilities identified by the Medicaid agency as providing care primarily to the mentally retarded and developmentally disabled.
7. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment.
8. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program. A sufficient number of providers assures eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

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9. Participation in the program is limited to providers of service who accept, as payments in full, the amounts paid in accordance with the State Plan.
 10. Payments will be made by Medicaid for Medicare Part A and Part B coinsurance in accordance with Attachment 4.19 B, Supplement 1.

Price-Based Nursing Facilities

The following facilities are reimbursed by the price-based nursing facility methodology:

- a. A free-standing nursing facility;
- b. A hospital-based nursing facility;
- c. A nursing facility with waiver;
- d. A nursing facility with mental retardation specialty; and
- e. A hospital providing swing bed nursing facility care.

Costs Reports for Price-Based Nursing Facilities

Price-based nursing facilities must submit the latest Medicare cost report and the Medicaid supplement schedules attached to Attachment 4.19-0 Exhibit-B. The Medicaid Supplement Schedules are utilized for statistical data. The Medicare Supplemental Cost Schedules are utilized for historical data.

The Medicare cost report and Medicaid supplement schedules shall be submitted to the Department pursuant to time frames established in HCFA Provider Reimbursement Manual-Part 2 (PUB. 15-11) Section 102, 102.1, 102.3 and 104.

Methods and Standards for Determining Price-based Nursing Facility Payments

The methods and standards for the determination of reimbursement rates to price-based nursing facilities is described in the Nursing Facility Reimbursement manual which is ATTACHMENT 4.19-D, Exhibit B.

Payment Rates Resulting from Methods and Standards

1. Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.
2. The standard price is market-based using historical data, salary surveys and staffing ratios. The standard price accounts for the higher wage rates for the urban area and the slightly lower rates for wages in the rural area.
3. The rate also takes into account a facility specific capital cost component based on an appraisal of each facility and the department shall appraise a price-based Nursing Facility to determine the facility specific capital component again in 2009.
4. The standard price is re-based in 2008 and consists of two components: the "case-mix" adjustable portion and the "non-casemix" adjustable portion.
 - (1) The "case-mix" adjustable portion consists of wages for direct care personnel, cost associated with direct care, and non-personnel operation cost (supplies, etc.).

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- (2) The "non-case mix" adjustment portion consists of all other facility cost except capital cost.
6. Case-mix is based on data extracted from the Minimum Data Set 2.0 submitted to the state survey agency as required by CMS and the individual facility case-mix is calculated using the Resource Utilization Group (RUG) III version 5.12.
 7. Rates are established prospectively on July 1 of each year and adjusted for "case-mix at the beginning of each quarter during the rate year (January, April, July, and October). A "case-mix" adjustment is the only adjustment made to the rates by the Department.
 8. Other adjustments will not be made to the rates except for errors identified by the Department when computing the rate.
 9. Facilities protection period shall be in effect until June 30, 2002. No price-based nursing facility will receive a rate under the new methodology that is less than their rate that was set on July 1, 1999, adjustment for the facility's "resident acuity". However, nursing facilities may receive increase in rates as a result of the new methodology as the Medicaid budget allows.
 10. Effective January 1, 2003, county owned hospital-based nursing facilities shall not receive a rate that is less than the rate that was in effect on June 30, 2002.
 11. Payments under this methodology must not exceed \$260,997,283 for the period of January 1, 2000 to June 30, 2000.
 12. The Department remains at risk for increases in total nursing facility payments that result from higher utilization of beds by Medicaid recipients. The Department reserves the right to adjust rates, to remain within budgeted amount.

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13. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program. A sufficient number of providers assures eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.
 14. The Department shall require the submission of the most recent Medicare cost report and the Medicaid Supplemental Schedules included in the manual to be used for historical data.
 15. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.
 16. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment.
 17. Payments will be made by Medicaid for Medicare Part A and Part B coinsurance in accordance with Attachment 4.19-B, Supplement 1.

PUBLIC PROCESS FOR DETERMINING RATES FOR LONG-TERM CARE
FACILITIES

The State has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Beginning April 2, 2001 and ending June 30, 2005, subject to the availability of funds, the Department will make supplemental payments to qualifying nursing facilities on a quarterly basis. The Department will use the following methodology to determine these payments:

- 1) For each state fiscal year, the Department will calculate the maximum addition payments that it can make to non-state government-owned or operated nursing facilities as set forth at 42 CFR Section 447.272 (a)(2) and 42 CFR Section 447.272 (b).
- 2) The Department will use the latest cost report data on file with the Department as of December 31, 2000 to identify the nursing facilities eligible for supplemental payments. To be eligible for supplemental payments the nursing facility must:
 - a) Be a nursing facility owned or operated by a local unit of government;
 - b) Have at least 140 or more Medicaid certified beds; and
 - c) Have Medicaid occupancy at or above 75%.

A qualifying nursing facility is an eligible facility that is owned or operated by a local unit of government that has entered into an Intergovernmental Transfer Agreement with the Commonwealth.

- 3) The Department will determine the amount of supplemental payments it will make to qualifying nursing facilities in a manner not to exceed the upper limit amount as calculated in 1 above.
- 4) Using the cost report data on file as of December 31, 2000, the Department will identify the total Medicaid days reported by the qualifying nursing facilities as identified in 2 above.
- 5) The Department will divide the total Medicaid days for each qualifying county-owned or operated nursing facility as determined in 2 above by the total Medicaid days for all qualifying facilities to determine the payment supplementation factor.
- 6) The Department will apply each qualifying county-owned or operated nursing facility's payment supplementation factor determined in 5 above to the total supplemental payment amount identified in 3 above to determine the payment to be made to each qualifying nursing facility.

Effective for services provided on and after September 1, 2001, the Department will make pediatric supplemental payments on a quarterly basis to qualifying nursing facilities. The Department will use the following methodology to determine these payments:

1. For the period of 9/01/01 through 6/30/02 and annually thereafter (7/01 through 6/30), the Department shall establish a pool of \$550,000 to be distributed to qualified facilities based upon their pro rata share of Medicaid patient days.
2. A nursing facility qualifies for a pediatric supplemental payment if it meets the following criteria:
 - a. Is located within the Commonwealth of Kentucky;
 - b. Has a Medicaid occupancy at or above 85%;
 - c. Provides services only to children under age twenty-one (21); and
 - d. Has forty (40) or more licensed beds.

Reimbursement for SFY 2002- 2003

- A. Excluding nursing facilities with brain injury units, intermediate care facilities for the mentally retarded and developmentally disabled, and state-owned nursing facilities, rates for cost-based nursing facilities will be the rates in effect on June 30, 2002.
- B. Rates for price-based nursing facilities will be established in accordance with the methodology described in Attachment 4.19-D, Exhibit A.

KENTUCKY CASE MIX ASSESSMENT AND REIMBURSEMENT SYSTEM

RESIDENT ASSESSMENT

INTRODUCTION

The Kentucky Department for Medicaid Services is implementing a new reimbursement system for price-based nursing facilities participating in the Medicaid program. These facilities include:

1. A free-standing nursing facility;
2. A hospital-based nursing facility;
3. A nursing facility with waiver;
4. A nursing facility with mental retardation specialty; and
5. A hospital providing swing bed nursing facility care.

The new price-based reimbursement methodology will consist of a reasonable standard price set for a day of service for rural and urban facilities. This should provide an incentive to providers to manage costs efficiently and economically.

The standard price includes:

1. Standardized wage rates;
2. Staffing *ratios*;
3. Benefits and absenteeism factors; and
4. "Other cost" percentages.

The new price-based reimbursement methodology is dependent on the specific care needs of each Medicaid and dually eligible Medicare resident in a nursing facility. The new methodology will base the resident acuity using the Minimum Data Set (MDS) 2.0 as the assessment tool. The Resource Utilization Group (RUGs) is the classification tool to place resident into different case-mix groups necessary to calculate the "casemix score". This methodology is based on a snapshot of facility's acuity on a particular point in time.

This methodology entails a re-determination of a facility's mix of residents each quarter in order to establish a new facility specific nursing rate on a quarterly basis.

One of the objectives of the new case-mix system is to mirror the resident assessment process used by Medicare and therefore not require the facilities to use two case-mix assessment tools to determine resident acuity. The second objective for using the MDS 2.0 and RUGS III is to improve reimbursement for facilities providing services for residents with higher care needs in order to improve access to care for those recipients.

1. There will be two major categories for the standard price:
 - a. Case-mix adjustable portion includes wages for personnel that provide or are associated with direct care and non- personnel operation costs (supplies, etc). The case-mix adjustable portion will be separated into urban and rural designations based on Metropolitan Statistical Area definitions; and
 - b. Non case-mix adjustable portion of the standard price includes an allowance to offset provider assessment, food, non-capital facility related cost, professional supports and consultation, and administration. These costs are reflected on a per diem basis and will be based on Metropolitan Statistical Area definitions.

Effective July 1, 2004, rates are increased \$7.60 per day.
2. Each July 1 the rate will be increased by an inflation allowance using the appropriate Data Resource Incorporated (DRI) Index for inflation. The DRI will not be applied to the capital cost component.

4. Capital Cost Add-on:

Each nursing facility will be appraised by November 30, 1999 and the department shall appraise a price-based NF to determine the facility specific capital component again in 2009. The appraisal contractor will use the E. H. Boeckh Co. Evaluation System for facility depreciated replacement cost. The capital cost component add-on will consist of the following limits:

- a. Forty thousand dollars per licensed bed;
- b. Two thousand dollars per bed for equipment;
- c. Ten percent of depreciated replacement cost for land value;
- d. A rate of return will be applied, equal to the 20 year Treasury bond plus a 2% risk factor, subject to a 9% floor and 12% ceiling; and
- e. In order to determine the facility-specific per diem capital reimbursement, the department shall use the greater of actual bed days or bed days at 90%.

5. Renovations to nursing facilities in non-appraisal years:

- a. For facilities that have 60 or fewer beds, re-appraisals shall be conducted if the total renovation cost is \$75,000 or more.
- b. For facilities that have more than 60 beds, re-appraisal shall be conducted if the total renovation cost is \$150,000.

6. Facilities Protection Period:

- a. Rate Protection — Until July 1, 2002, no NF shall receive a rate under the new methodology that is less than their rate that was set in July 1, 1999 unless a facility's resident acuity changes. However, NFs may receive increases in rates as a result of the new methodology as the Medicaid budget allows.
- b. Case Mix — Until July 1, 2000, no facility will receive an average case-mix weight lower than the case-mix weight used for the January 1, 1999 rate setting. After July 1, 2000 the facility shall receive the case-mix weight as calculated by RUGs III from data extracted from MDS 2.0 information.
- c. Effective January 1, 2003, county owned hospital-based nursing facilities shall not receive a rate that is less than the rate that was in effect on June 30, 2002.

7. Case-mix Rate Adjustments. Rates will be recomputed quarterly based on revisions in the case mix assessment classification that affects the Nursing Services components.

8. Case-mix rate adjustment will be recomputed should a provider or the department find an error.

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SECTION 100. INTRODUCTION TO PRICE- BASED REIMBURSEMENT SYSTEM

- A. January 1, 2000, a price-based reimbursement system will be implemented to reimburse a nursing facility (NF), a nursing facility with waiver (NF-W), a hospital based nursing facility (NF-HB) and a nursing facility with a mental retardation specialty (N F-MRS Beginning).
- B. The price-based system is a reimbursement methodology based on a standard price set for a day of service as opposed to reimbursing facilities based on the latest submitted cost report. The standard price is based on reasonable, standardized wage rates, staffing ratios, benefits and absenteeism factors and 'other cost' percentages.
- C. A rate model was developed which resolves issues inherent in the current system reflects current reimbursement methodology trends and satisfies the needs of the Department and the Provider community. The goal of the price-based methodology was to develop a uniform, acuity adjustment rate structure that would pay a nursing facility the same reimbursement for the same type of resident served. This rate structure accounts for resource utilization and allows rates to increase annually by an appropriate inflationary factor. The rate model is market based and accounts for the higher wage rates urban facilities must pay their employees; therefore the urban average rate is slightly higher than the rural. The rate does not distinguish between hospital based and freestanding facilities.
- D. This payment method is designed to achieve three major objectives:
 - 1. To assure that needed nursing facility care is available for all eligible recipients including those with higher care needs; and,
 - 2. To provide an equitable basis for both urban and rural facilities to participate in the Program; and,
 - 3. To assure Program control and cost containment consistent with the public interest and the required level of care.
- E. The system is designed to provide a reasonable reimbursement for providers serving the same type of residents in the nursing facility and to provide for a reasonable rate of return on the provider's investment.

-
- F. The price-based model reimbursement methodology provides for a facility specific capital cost add-on calculated using the E.H. Boeckh System, a commercial valuation system that estimates the depreciated and non-depreciated replacement cost of a facility.
 - G. The Office of Inspector General has required the submission of the Minimum Data Set (MDS) since 1992 and DMS sought to use a tool familiar to the nursing facility industry in order to calculate case-mix. The case-mix portion of the rate will utilize the MDS 2.0 and the Resource Utilization Group (RUG) III to calculate the individual facility's average case-mix.
 - H. The case-mix portion of the rate will be adjusted quarterly to reflect the facility's most recent case-mix assessment and to adjust the direct care and non-personnel operation costs (supplies, etc.) portion of the standard price for the current quarter.

SECTION 110. PARTICIPATION REQUIREMENTS

- A. The facilities referenced in Section one hundred (100) shall be reimbursed using the methodology described in 907 KAR 1:065. These facilities shall be licensed by the state survey agency (Office of Inspector General) for the Commonwealth of Kentucky and certified for Medicaid participation by the Department for Medicaid Services.
- B. A nursing facility, except a nursing facility with waiver, choosing to participate in the Medicaid Program will be required to have twenty (20) percent of its Medicaid certified beds participate in the Medicare program or ten (10) of its Medicaid beds participating in the Medicare program whichever is greater. If the NF has less than ten (10) beds all of its beds shall participate in the Medicare Program.
- C. The Medicaid Program shall reimburse all Medicaid beds in a nursing facility at the same rate. The Medicaid rate established for a facility is the average rate for all Medicaid participating beds in that individual facility.

SECTION 120. PAYMENTS FOR SERVICES TO MEDICARE/MEDICAID RESIDENTS

- A. Dually eligible residents and residents eligible for both Medicare and Medicaid (non-QMB) shall be required to Exhaust any applicable benefits under Title XVIII (Part A and Part B) prior to coverage under the Medicaid Program.
- B. APPLICATION. Services received by a resident that are reimbursable by Medicare shall be billed first to the Medicare Program. Any appropriate co-insurance or deductible payment due from the Medicaid Program shall be paid outside the Cost-based facility Cost-Related Payment System in a manner prescribed by the Department for Medicaid Services. Coinsurance and deductible payments shall be based on rates set by the Medicaid Program. A day of service covered in this manner shall be considered a Medicare resident day and shall not be included as a Medicaid resident day in the facility cost report.

SECTION 130. PRICE-BASED NF REIMBURSEMENT METHODOLOGY

- A. The price-based nursing facility reimbursement methodology reflects the differential in wages, property values and cost of doing business in rural and urban designated areas This results in two standard rates, a standard rate reflecting the lower wages for the rural facilities and a slightly higher rate for the urban facilities.
- B. The rural and urban designated areas are based on the “Metropolitan Statistical Area (MSA) designating the urban population centers based on the national census and updated on a yearly basis, as published by the Federal Office of Management and Budget.
- C. In order to determine the standard rates for urban and rural facilities, the department utilized an analysis of fair-market pricing and historical cost for staffing ratios, wage rates, cost of administration, food, professional support, consultation, and non-personnel operating expenses as a percentage of total cost.
- D. The standard price is comprised of the following components and percentages of the total rate:
 - 1. Personnel 65%

-
2. Non-personnel operating 6%;
 3. Administration 13%;
 4. Food 4%;
 5. Professional supports & consultation 2%;
 6. Non-capital facility related cost 3%; and
 7. Capital rate 7%.
- E. The standard price shall be re-based in 2008 and adjusted for inflation every July 1.
- F. A portion of the standard price for both urban and rural facilities Will be adjusted each calendar quarter for "case-mix". The "case-mix" adjusted portion shall include the following:
1. The personnel cost of a:
 - (a) DON-Director of Nursing;
 - (b) RN-Registered Nurse;
 - (c) LPN-Licensed Practical Nurse;
 - (d) Nurse Aide;
 - (e) Activities worker; and
 - (f) Medical records director.
 2. The non-personnel operating cost including:
 - (a) Medical supplies; and
 - (b) Activity supplies.
- G. The "non-case-mix" portion of the standard price shall not be adjusted for case mix and includes:
1. Administration;
 2. Non-direct care personnel;
 3. Food;
 4. Non-capital related costs;
 5. Professional support;
 6. Consultation;
 7. Capital cost component; and
 8. An allowance to offset a provider assessment.

-
- H. The capital cost component shall be an “add-on” to the non case-mix” adjusted portion of the rate.
- I. Ancillaries are services for which a separate charge is submitted and include:
1. Speech Therapy;
 2. Occupational Therapy;
 3. Physical Therapy;
 4. Oxygen Services;
 5. Laboratory; and
 6. X-ray.
- J. Ancillary therapy services are reimbursed pursuant to 907 KAR 1:023.
- K. Oxygen concentrator limitations. Effective October 1, 1991, the allowable cost of oxygen concentrator rentals shall be limited as follows:
1. A facility may assign a separate concentrator to any resident who has needed oxygen during the prior or current month and for whom there is a doctor’s standing order for oxygen. For the charge by an outside supplier to be considered as an allowable cost, the charge shall be based upon actual usage. A minimum charge by an outside supplier is allowable if this charge does not exceed twenty-five (25) percent of the Medicare Part B maximum. The minimum charge is allowable if the concentrator is used less than an average of two (2) hours per day during the entire month (for example, less than 60 hours during a thirty (30) day month). The maximum allowable charge by the outside supplier shall not exceed one hundred (100) percent of the Medicare Part B maximum. For the maximum charge to a facility to be considered as the allowable cost, the concentrator shall have been used on average for a period of at least eight (8) hours per day for the entire month (for example, 240 hours during a thirty (30) day month). In those cases where the usage exceeds that necessary for the minimum charge and is less than the usage required for the maximum charge, the reimbursement shall be computed by dividing the hours of usage by

240 and then multiplying the result of this division by the Medicare Part B maximum charge. For example, if a concentrator is used less than 220 hours during a thirty (30) day month and the maximum Part B allowable charge is \$250.00; then the allowable charge is computed by dividing the 220 hours by 240 hours and then multiplying the product of this division by \$250.00 to obtain the allowable charge of \$229.17. Allowable oxygen costs outlined in this paragraph shall be considered to be ancillary costs.

2. A facility shall be limited to one (1) standby oxygen concentrator for each nurses' station. The Medicaid Services Program may grant waivers of this limit. This expense shall be considered as a routine nursing expense for any month in which there is no actual use of the equipment. The allowable cost for standby oxygen concentrators shall be limited to twenty-five (25) percent of the maximum allowable payment under Medicare Part B for in home use.

NOTE: Drugs for residents in nursing facilities shall be reimbursed through the pharmacy program.

L. The department shall adjust the Standard Price if:

1. A government entity imposes a mandatory minimum wage or staffing ratio increase and the increase was not included in the DRI; or
2. A new licensure requirement or new interpretation of an existing requirement by the state survey agency that results in changes that affect all facilities within the class. The provider shall document

that a cost increase occurred as a result of licensure requirement or policy interpretation.

3. The provider- shall submit any documentation required by the department.

SECTION 140. PRICE- BASED NF REIMBURSEMENT CALCULATION

- A. For each calendar quarter, based on the classification of urban and rural, the department shall calculate an individual NF's price-based rate to be the sum of:
 1. The case-mix adjustable portion of a NF Standard Price, adjusted by the individual NF's current average case-mix index. Except that until June 30, 2000 the average case-mix index shall be the greater of the current average case-mix index or the case-mix average calculated as a ratio of the facility's case-mix index to the statewide average case-mix index that would have been used for January 1, 2000 rate setting. After July 1, 2000 the individual NF's actual average case-mix shall be used in the rate calculation; and
 2. The non-case-mix adjustable portion of the assigned total Standard Price and the capital cost component.
- B. A capital cost component shall be calculated on an individual facility basis based on the facility appraisal completed in November 1999. Reappraisal shall be conducted and utilized to determine the facility specific capital component. The department shall appraise a price- based NF to determine the facility specific capital component again in 2009. The Department shall contract with a certified appraisal company to perform the appraisal using the E.H. Boeckh Valuation System. The appraisal is based on the depreciated replacement value of the individual facility. The same Appraisal Company shall perform any re-appraisal that may be requested by a facility within that five-year period.
- C. A facility may request a re-appraisal within five years should renovations or additions have a minimum total cost of \$150,000 for facilities with more than sixty (60) licensed beds. For facilities having sixty (60) or less licensed beds, the total renovation or addition must be a

minimum total cost of \$75,000. The individual NF shall submit written proof of construction cost to the department in order to request a reappraisal. The individual NF shall reimburse the department's contracted appraisal company for the cost of the appraisal. The department shall reimburse the facility the cost of the appraisal or re-appraisal upon receipt of a valid copy of the paid invoice from the Appraisal Company.

- D. A capital cost component shall be calculated on an individual facility basis. A capital cost component based on the results of the appraisal shall be the total of the average licensed bed value and ten (10) percent of the licensed bed value for land on which the NF is built. To this sum, add two thousand dollars per licensed bed for equipment. To determine the rate of return for capital cost, multiply the sum of the preceding paragraph by the yield on a twenty (20) year Treasury bond plus a risk factor of two (2) percent. The rate of return shall be no less than nine (9) percent or greater than twelve (12) percent per state fiscal year. The final calculation to determine the individual NF's capital cost component shall be the product of the rate of return calculation divided by the total number of NF bed days as calculated in paragraph F of this section.
- E. To determine the average licensed bed value, the depreciated replacement cost of the NF shall be divided by the total number of licensed beds in the NF with the following limitations:
1. The average bed value shall not exceed \$40,000; and
 2. Shall exclude:
 - (a) Equipment; and
 - (b) Land,
- F. NF bed days used in the capital cost rate calculation shall be based on actual bed occupancy, except that the occupancy rate shall not be less than ninety (90) percent of certified bed days.
- G. The department shall utilize a rate of return for capital costs that shall be equal to the yield on a twenty (20) year Treasury bond as of the first business day on or after May 31 of each year. Should a change of ownership occur pursuant to 42 CFR 447.253 (2)(d), the new owner shall continue to receive the capital

cost rate of the previous owner unless the NF is eligible for re-appraisal pursuant to section IV B of this manual.

SECTION 150. ON-SITE REVIEWS AND VALIDATION

- A. On a quarterly basis, beginning January 1, 2000 the department shall perform an on-site review of the NF. The review will consist of a minimum of ten (10) percent of the MDS assessments completed by the NF. The department shall validate the MDS assessments by using the Long Term Care Facility Resident Assessment Instrument User's Manual.
- B. Should the department invalidate a NF's MDS, the NF may appeal the findings of the department within seven (7) business days. The department shall receive a written request by the NF that the department reconsider the invalidation. The department shall conduct the second validation with seven (7) business days of receipt of the request and notify the provider in writing of the decision. A provider may appeal the second validation per 907 KAR 1:671, Sections 8 and 9.

SECTION 160. LIMITATION ON CHARGES TO RESIDENTS.

- A. Except for applicable deductible and coinsurance amounts, a NF that receives reimbursement for a Medicaid resident shall not charge a resident or his representative for the cost of routine or ancillary services.
- B. A NF may charge a resident or his representative for an item if the resident requests the item and the NF informs the resident in writing that there will be a charge. A NF shall not charge a resident for an item or service if Medicare or Medicaid pays for the item pursuant to 42 CFR 483.1 0(c)(8)(ii).
- C. A NF shall not require a resident or an interested party to request any item or services as a condition of admission or continued stay. A NF shall inform the resident or an interested party requesting an item or service that a charge will be made in writing that there will be a charge and the amount of the charge.
- D. A NF may charge a resident for the cost of reserving a bed if requested by resident or interested party after the fourteenth (14th) day of a temporary absence from the facility pursuant to 907 KAR 1:022.

-
- E. Durable medical equipment (DME) and supplies shall be furnished by the NF and not be billed to the department under separate DME claim pursuant to 907 KAR 1:479.

SECTION 170. REIMBURSEMENT FOR REQUIRED SERVICES UNDER TEE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR).

- A. Prior to admission of an individual, a price-based NF shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.
- B. The department shall reimburse a NF for services delivered to an individual if the NF complies with the requirements of 907 KAR 1:755.
- C. Failure to comply with 907 KAR 1:755 may be grounds for termination of the NF's participation in the Medicaid Program.

SECTION 180. NF PROTECTION PERIOD AND BUDGET CONSTRAINTS

- A. For the period of January 1, 2000 through June 30, 2002, a NF shall not receive a rate that is less than the rate that s set for the NF pursuant to 907 KAR 1:025E on July 1, 1999, including any capital cost and extenuating circumstances add-ons.
- B. The department shall monitor payments on a monthly basis to ensure that aggregate payments made to NF's do not exceed the appropriated funds in fiscal years 2000 through 2002.
- C. In order to monitor the payments, the department shall on a monthly basis notify the industry's representatives in writing the total payment amount for the preceding month.
- D. The department shall also place on the Medicaid Internet site the amount of payment in aggregate to the NF's for the preceding month and the cumulative amount paid for the current state fiscal year.

SECTION 190. ANCILLARY SERVICES

- A. The department shall reimburse for an ancillary service that meets the criteria established in 907 KAR 1:023 utilizing the corresponding outpatient procedure code rate listed in the Medicaid Physicians Resource Based Relative Value Scale fee schedule.
- B. The department shall reimburse for an oxygen therapy utilizing the durable medical equipment fee schedule.
- C. Respiratory therapy and respiratory therapy supplies shall be considered in the routine services per diem rate.
- D. The department shall calculate an add-on amount in accordance with 907 KAR 1:065, Section 12, to be in effect from November 1, 2003 through June 30, 2004, to a nursing facility's routine services per diem rate if the nursing facility incurred cost providing respiratory therapy or respiratory therapy supplies for the period July 1, 2003 through September 30, 2003.
- E. A nursing facility shall submit documentation requested by the department in order to apply for a routine services per diem add-on in accordance with 907 KAR 1:065, Section 12.

SECTION 200. REIMBURSEMENT REVIEW AND APPEAL

A NF may Appeal department decisions as to the application of this regulation as it impacts the NF's price-based reimbursement rate in accordance with 907 KAR 1:671, Section 8 and 9.

SECTION 210. COST REPORT INSTRUCTIONS FOR PRICE-BASED

All Medicaid Supplemental Schedules must be accompanied by a working trial balance and audited financial statements (if applicable).

SECTION 1. SCHEDULE NF-1 - PROVIDER INFORMATION

Enter in the appropriate information. Choose whether the cost report is in a leap year or a regular 365 day year. Note that the cost report must have an original signature by an officer or administrator of the facility.

SECTION 2. SCHEDULE NF-2 -- WAGE AND SALARY INFORMATION

This schedule records a facility's labor costs.

- A. The pay period starting date should be the first day of the first payroll period in the provider's fiscal year. Likewise, the end date shall be the final day of the last payroll period in the fiscal year.
- B. Under wage information, the hours paid includes vacation pay, sick leave, bereavement, shift differential and holidays in *addition to* time engaged in for regular business activity. Hours worked, in contrast, are only those hours that the employee spent at the facility in normal work duties. Wages paid should include all compensation paid to the employee, including time worked, time in training, vacation, and sick time.
- C. Expenses incurred with outside businesses for temporary-nursing staff should be placed under contracted services. For each nursing category, enter the hours worked by the contract employees and the amount charged by the contracting business for wages paid. Hours paid and hours worked will differ only if the contract staff engaged in training while being employed at the facility.
- D. Benefits paid by the facility for *all employees* (nursing staff, administrative, etc.) should be included under Section C: the facility's contribution for health insurance, life insurance, etc. would be listed under these categories.

SECTION 3. SCHEDULE NF- 3- STAFF INFORMATION

On an annual basis the Department for Medicaid Services shall select a seven-day period in which the facility records information regarding their staffing levels and patient days.

- A. Record the number of residents in your facility in the Resident Census section. This includes only those full-time residents in the certified nursing facility section.
- B. For each of the staff categories, record the number of staff on duty. Contract staff should be included in this category.
- C. Continue this throughout the seven-day survey period.

SECTION 4. SCHEDULE NF- 7— ALLOCATION STATISTICS

A. Section A - Ancillary Charges

1. Column 1. Enter the total charges for each type of ancillary service on Line I through 6. The sum of lines 1 through 6 are totaled on line 7.
2. Column 2. Enter the total charges for each type of ancillary service provided to KMAP patients in certified beds on lines 1 through 6. Lines 1 through 6 a summed and totaled on line 7.
3. Column 3. The Medicaid percentage in column 3 is calculated by dividing KMAP charges in column 2 by total charges in column 1. Percentages shall be carried to four decimal places (i.e., XX.XXXX%).

B. Section B - Occupancy Statistics.

Certified Nursing Facility. Use the Bed Days Available worksheet on Box C to complete lines 1, 2, and 3. For line 4, enter in the Total Patient Days provided to all certified nursing facility residents. On line 6, enter in the KMAP Patient Days.

C. Non-Certified and Other Long-Term Care

1. Lines 1 and 2. Enter the number of licensed beds at the beginning and end of the fiscal year. Temporary changes due to alterations, painting, etc., do not affect bed capacity.
2. Line 3. Total licensed bed days available shall be determined by multiplying the number of beds in the period by the number of days in the period. Take into account increases and decreases in the number of licensed beds and the number of days elapsed since the changes. If actual bed days are greater than licensed bed days available, use actual bed days.
3. Line 4. Total patient days should be entered in.

SECTION 5. SCHEDULE NF- 8- MISCELLANEOUS INFORMATION

All providers must complete section A and B.

- A. A NF shall submit a Medicare cost report and Medicaid supplement schedule pursuant to HCFA Provider Reimbursement Manual - Part 2 (Pub. 15-11) Section 102, 102.1, 102.3 and 104 included in this manual.
- B. A copy of a NF's Medicare cost report for the most recent fiscal year end.
- C. A completed copy of the Medicaid supplemental schedules included in this manual shall also be submitted with the NE's Medicare cost report.
- D. A cost reports financial data related to routine services shall be used for statistical purposes.

SCHEDULE NF-1
PROVIDER INFORMATION

PROVIDER NAME:

PROVIDER NUMBER:

Period from: _____ to _____

Leap Year 365
 366

Street
Address

P. O. Box

City

State

Zip Code _____

Phone

Fax

Officer of Facility

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medicaid Cost Report for the period ended 01/01/2000 and to the best of my knowledge and belief, they are true and accurate statements prepared from the books and records of _____ in accordance with applicable program directives, except as noted.

(Print) _____
 Officer or Administrator of Facility

(Signed) _____
 Officer or Administrator of Facility

 Title

SCHEDULE NF-2
 WAGE AND SALARY INFORMATION

PROVIDER NAME:
 PROVIDER NUMBER:

FYE: 01/01/2000

Pay period start date: _____ End date: _____

A. Wage Information			
Cost Category	Hours Paid	Hours Worked	Wages Paid
A. RN	0	0	\$0
B. LPN	0	0	\$0
C. Aides	0	0	\$0
D. Director of Nursing	0	0	\$0
E. Activities	0	0	\$0
F. Medical Records	0	0	\$0
G. Dietary	0	0	\$0
H. Housekeeping/Laundry	0	0	\$0
I. Social Services	0	0	\$0
J. Maintenance	0	0	\$0
Total	0	0	\$0

B. Contracted Services			
Cost Category	Hours Paid	Hours Worked	Wages Paid
A. RN	0	0	\$0
B. LPN	0	0	\$0
C. Aides	0	0	\$0
Total	0	0	\$0

C. Benefits Paid for by Nursing Facility	
Totals taken from FYE 01/01/2000	
Health Insurance	\$0
Life Insurance	\$0
Retirement	\$0
Workers Compensation	\$0
FICA	\$0

SCHEDULE NF-3
STAFF INFORMATION

PROVIDER NAME:
PROVIDER NUMBER

FYE: 01/01/2000

Patient Census	Number of Patient Days						
	09/13/99	09/14/99	09/15/99	09/16/99	09/17/99	09/18/99	09/19/99
	0	0	0	0	0	0	0
Staff Category	Number of Staff on Payroll						
	09/13/99	09/14/99	09/15/99	09/16/99	09/17/99	09/18/99	09/19/99
RN							
RN Staffing – Day	0	0	0	0	0	0	0
RN Staffing – Evening	0	0	0	0	0	0	0
RN Staffing – Overnight	0	0	0	0	0	0	0
LPN							
LPN Staffing - Day	0	0	0	0	0	0	0
LPN Staffing – Evening	0	0	0	0	0	0	0
LPN Staffing–Overnight	0	0	0	0	0	0	0
Aides							
Aide Staffing – Day	0	0	0	0	0	0	0
Aide Staffing – Evening	0	0	0	0	0	0	0
Aide Staffing - Overnight	0	0	0	0	0	0	0
Food Service							
Food Service Workers – Day	0	0	0	0	0	0	0
Food Service Workers – Evening	0	0	0	0	0	0	0
Support Personnel							
Housekeeping/Laundry Service Workers	0	0	0	0	0	0	0
Social Services Worker	0	0	0	0	0	0	0
Activities Worker	0	0	0	0	0	0	0
Medical Records Worker	0	0	0	0	0	0	0
Maintenance Worker							
Director of Nursing							

Effective Date 1-1-00

Approved Date Aug 10, 2001

TN No. 00-04
Supersedes
TN No. 96-10

SCHEDULE NF-7
 ALLOCATION STATISTICS

PROVIDER NAME:
 PROVIDER NUMBER:

FYE: 01/01/2000

Ancillary Charges	(1) TOTAL	(2) MEDICAID	(3) MEDICAID %
PHYSICAL THERAPY	\$0	\$0	0.0000%
X-RAY	\$0	\$0	0.0000%
LABORATORY	\$0	\$0	0.0000%
OXYGEN/RESP. THERAPY	\$0	\$0	0.0000%
SPEECH	\$0	\$0	0.0000%
OCCUPATIONAL THERAPY	\$0	\$0	0.0000%
TOTAL	\$0	\$0	

OCCUPANCY STATISTICS	(1)	(2)	(3)
LICENSED BEDS AT BEGINNING OF PERIOD	0	0	0
LICENSED BEDS AT END OF PERIOD	0	0	0
????? OCCUPANCY	0	0	0
????? PATIENT DAYS	0		
???? KMAP OCCUPANCY	0		

BED DAYS AVAILABLE – CERTIFIED NURSING FACILITY ONLY

Beginning Date	Ending Date	Days	X	Beds	=	Bed Days Available
		0	X	0	=	
		0	X	0	=	
		0	X	0	=	
		0	X	0	=	
		0	X	0	=	
		0	X	0	=	
		0	X	0	=	
				TOTAL BED DAYS AVAILABLE		0

SCHEDULE NF-8
MISCELLANEOUS INFORMATION

PROVIDER NAME:
PROVIDER NUMBER:

TFY: 07/01/2000

Current Ownership

List the current owners and the percent owned. If the facility is corporately owned, list the officers of the company and their respective title.

Name	Percent Owned
------	---------------

Has the facility had a change of ownership in the past fiscal year? Change of ownership is defined as the transfer of the assets of a facility. The sale of stock in a facility does not constitute a change in ownership.

Yes No

If yes, indicate the new owners and the percent owned. If the facility is corporately owned, list the officers of the company and their respective title.

Name	Percent Owned
------	---------------

TN # 00-04
Supersedes
TN # 96-10

Approved Date: Aug 10, 2001

Eff. Date: 1-1-00

SECTION 220. INTRODUCTION TO COST-BASED REIMBURSEMENT SYSTEM

- A. The Department for Medicaid Services has established a prospective reimbursement system for costs-based facilities. Cost based facilities include the following:
1. Institutions for Mental Diseases (IMD's);
 2. Pediatric Nursing Facilities; and
 3. Intermediate Care facilities for the Mentally Retarded and Developmentally Disabled (ICF/MRIDD).

The reimbursement methodology for the facilities listed is outlined here. Also included in this section are the facilities that are reimbursed by all-inclusive rates. The payment method is designed to achieve two major objectives: 1). To assure that needed facility care is available for all eligible recipients including those with higher care needs and, 2). To assure Department for Medicaid Services control and cost containment consistent with the public interest and the required level of care.

- B. 1. This cost-based system is designed to provide a reasonable return in relation to cost but also contains factors to encourage cost containment. Under this system, payment shall be made to state owned or operated, non-state but government owned or operated, and non-governmental ICF/MR/DDs on a prospectively determined basis for routine cost of care with no year-end adjustment required other than adjustments which result from either desk reviews or field audits.
2. Effective with the eight month period ending June 30, 2006, and continuing annually thereafter on a state fiscal year basis, a year-end cost settlement will be required for state owned or operated ICF/MR/DDs. Total reimbursement to state owned or operated ICF/MR/DDs in aggregate shall be limited to the lesser of actual costs or the amount the state reasonably estimates would have been paid under Medicare Payment Principles. The determination will be in conformance with the standards and methods as expressed in 42 CFR 447.257, 447.272, and 447.304. Cost associated with prescription drugs should be removed from the routine cost. Central Office Overhead costs for facilities that are state owned, but not state operated should be adjusted to remove costs that duplicate costs incurred by the operating entity.
- C. Ancillary services as defined, shall be reimbursed on a cost basis with a year-end retroactive settlement. As with routine cost, ancillary services are subject to both desk reviews and field audits that may result in retroactive adjustments.
- D. The basis of the prospective payment for routine care cost is the most recent annual cost report data (available as of May 16) trended to the beginning of the rate year and indexed for the prospective rate year. The routine cost is divided into two major categories: Nursing Services Cost and All Other Cost.
- E. The payment system also contains various restrictions on allowable costs that are designed to assure that Medicaid payment is limited to the cost of providing adequate resident care.

SECTION 230. PARTICIPATION REQUIREMENTS

PARTICIPATION REQUIREMENTS. Cost-based facilities participating in the Department for Medicaid program shall be required to have at least twenty (20) percent of its beds but not less than ten (10) beds; for a facility with less than ten (10) beds, all beds participate in the Medicare Program.

SECTION 240. REIMBURSEMENT FOR REQUIRED SERVICES UNDER THE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR) FOR VENTILATOR UNITS, BRAIN INJURY UNITS, IMDS, AND PEDIATRIC FACILITIES.

- A. Prior to admission of an individual, a nursing facility shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.
- B. The department shall reimburse a nursing facility for services delivered to an individual if the facility complies with the requirements of 907 KAR 1:755
- C. Failure to comply with 907 KAR 1:755 may be grounds for termination of nursing the facility participation in the Medicaid Program.

SECTION 250. LIMITATION ON CHARGES TO RESIDENTS.

- F. Except for applicable deductible and coinsurance amounts, a NF that receives reimbursement for a Medicaid resident shall not charge a resident or his representative for the cost of routine or ancillary services.
- G. A NF may charge a resident or his representative for an item if the resident requests the item, the NF informs the resident in writing that there will be a charge. A NF shall not charge a resident for an item or service if Medicare or Medicaid pays for the item pursuant to 42 CFR 483.1 0(c)(8)(ii).
- H. A NF shall not require a resident or an interested party to request any item or services as a condition of admission or continued stay. A NF shall inform the resident or an interested party requesting an item or service that a charge will be made in writing that there will be a charge and the amount of the charge.

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- I. A NF may charge a resident for the cost of reserving a bed if requested by resident or interested party after the fourteenth (14th) day of a temporary absence from the facility pursuant to 907 KAR 1:022.
 - J. Durable medical equipment (DME) and supplies shall be furnished by the NF and not be billed to the department under separate DME claim pursuant to 907 KAR 1474.

SECTION 260. ROUTINE COST

- A. Routine costs are broken down into two major categories: Nursing Service costs and All Other costs. Routine Cost includes all items and services routinely furnished to all residents.
- B. NURSING SERVICES COSTS. The direct costs associated with nursing services shall be included in the nursing service cost category. These costs include:
 - 1. Costs of equipment and supplies that are used to complement the services in the nursing services cost category;
 - 2. Costs for education or training including the cost of lodging and meals of nursing service personnel. Educational costs are limited to either meeting the requirements of laws or rules or keeping an employee's salary, status, or position or for maintaining or updating skills needed in performing the employee's present duties;
 - 3. The salaries, wages, and benefits of persons performing nursing services including salaries of the director of nursing and assistant director of nursing, supervising nurses, medical records personnel, registered professional nurses, licensed practical nurses, nurse aides, orderlies, and attendants;
 - 4. The salaries or fees of medical directors, physicians, or other Professionals performing consulting services on medical care which are not reimbursed separately; and
 - 5. The costs of travel necessary for training programs for nursing personnel required to maintain licensure, certification or professional standards.
 - 6. Nurse aide training costs billable to the program as an administrative cost are to be adjusted out of allowable cost.

- B. ALL OTHER COSTS. Costs reported in the All OTHER COST category includes three major cost centers as reported on the annual cost report:

Other Care-Related Cost, Other Operating Costs, Indirect Ancillary Costs, and Capital Costs.

1. Other Care-Related Costs. These costs shall be reported in the other care-related services cost category:
 - a. Raw food costs, not including preparation;
 - b. Direct costs of other care-related services; such as social services and resident activities;
 - c. The salaries, wages, and benefits of activities' directors and aides, social workers and aides, and other care-related personnel including salaries or fees of professionals performing consultation services in these areas which are not reimbursed separately under the Medicaid program;
 - d. The costs of training including the costs of lodging and meals to meet the requirements of laws or rules for keeping an employee's salary, status or position, or to maintain or update skills needed in performing the employee's present duties.
2. Other Operating Costs. The costs in this category shall include the supplies, purchased services, salaries, wages and benefits for:
 - a. Dietary Services
 - b. Laundry services including the laundering of personal clothing which is the normal wearing apparel in the facility. The cost of dry cleaning personal clothing, even though it is the normal wearing apparel in the facility, is excluded as an allowable cost. Providers shall launder institutional gowns, robes and personal clothing which is the normal wearing apparel in the facility without charge to recipients. The recipient or responsible party may at their discretion makes other arrangements for the laundering of personal clothing.
 - c. Housekeeping
 - d. Plant Operation and Maintenance
 - e. General and Administrative Services
3. Capital Costs. The costs in this category shall include:

- a. Depreciation on building and fixtures
 - b. Depreciation on equipment
 - c. Capital related interest expense
 - d. Rent
4. Indirect Ancillary Costs. Indirect ancillary costs are those costs associated with ancillary departments (including fringe benefits).

SECTION 270. ANCILLARY SERVICES

A. Ancillaries are services for which a separate charge is submitted and include:

1. Respiratory Therapy
2. Speech Therapy
3. Occupational Therapy
4. Physical Therapy
5. Oxygen Service
6. Laboratory
7. X-ray

B. Ancillary therapy services are reimbursed pursuant to 907 KAR 1:023.

C. Psychological and psychiatric services shall be billed as an ancillary service by an ICF- MR/DD.

NOTE: Effective October 1, 1990 drugs for residents in Cost-Based Facilities shall be reimbursed through the pharmacy program.

D. Oxygen concentrator limitations. Effective October 1, 1991, the allowable cost of oxygen concentrator rentals shall be limited as follows:

1. A facility may assign a separate concentrator to any resident whom has needed oxygen during the prior or current month and for whom there is a doctor's standing order for oxygen. For the charge by an outside supplier to be considered as an allowable cost, the charge shall be based upon actual usage. A minimum charge by an outside supplier is allowable if this charge does not exceed twenty-five (25) percent of the Medicare Part B maximum. The minimum

charge is allowable if the concentrator is used less than an average of two (2) hours per day during the entire month (for example, less than 60 hours during a thirty (30) day month). The maximum allowable charge by the outside supplier shall not exceed one hundred (100) percent of the Medicare Part B maximum. For the maximum charge to a facility to be considered as the allowable cost, the concentrator shall have been used on average for a period of at least eight (8) hours per day for the entire month (for example, 240 hours during a thirty (30) day month). In those cases where the usage exceeds that necessary for the minimum charge and is less than the usage required for the maximum charge, the reimbursable shall be computed by dividing the hours of usage by 240 and then multiplying the result of this division by the Medicare Part B maximum charge (for example, if a concentrator is used less than 220 hours during a thirty (30) day month and the maximum Part B allowable charge is \$250.00; then the allowable charge is computed by dividing the 220 hours by 240 hours and then multiplying the product of this division by \$250.00 to obtain the allowable charge of \$229.17). Allowable oxygen costs outlined in this paragraph shall be considered to be ancillary costs.

3. A facility shall be limited to one (1) standby oxygen concentrator for each nurses' station. The Medicaid Services Program may grant waivers of this limit. This expense shall be considered as a routine nursing expense for any month in which there is no actual use of the equipment. The allowable cost for standby oxygen concentrators shall be limited to twenty-five (25) percent of the maximum allowable payment under Medicare Part B for in home use.

SECTION 280. INFLATION FACTOR

The inflation factor index shall be used in the determination of the prospective rate shall be established by the Department for Medicaid Services. The index shall be based on Data Resources, Inc. The index represents an average inflation rate for the year and shall have general applicability to all facilities.

The inflation factor shall be applied to nursing services costs and all other costs excluding capital costs.

SECTION 290. PROSPECTIVE RATE COMPUTATION

- A. Prospective rates are established annually for a universal rate year, July 1 through June 30. Rate setting shall be based on the most recent cost reports available by May 16. If a desk review or audit of the most recent cost report is complete after May 16 but prior to universal rate setting for the rate year, the desk reviewed or audited data shall be utilized for rate setting. If a facility's rate is based upon a report that has not been audited or desk reviewed, the facility's rate is subject to revision after the cost report has been audited or desk reviewed.
- B. Allowable routine Cost-Based Facility cost is divided into two components: Nursing Services Cost and All Other Cost.
- C. Allowable cost for the Nursing Services Cost component shall be trended to the beginning of the universal rate year and indexed for the period covering the rate year based on an inflation factor obtained from the Data Resources, Incorporated (DRI) forecast table for Skilled Nursing Facilities.
- D. Allowable cost for the All Other Cost center, with the exception of the Capital Cost sub-component shall be trended and indexed in the same manner as Nursing Services costs.
- E. The total Cost-Based Facility Cost for each category, after trending and indexing, shall be divided by total Certified Cost- Based Facility days in order to compute a per diem. A minimum occupancy limit of ninety (90) percent of certified bed days available, (except for state government-owned facilities shall be seventy (70) percent of certified bed days), or actual bed days used if greater, and a maximum occupancy limit of ninety-eight (98) percent computed in the same manner, shall be used in computing the per diem.

SECTION 300. ADJUSTMENT TO PROSPECTIVE RATE

- A. Upon request by participating facility, an increase in the prospective rate shall be considered if the cost increase is attributed to one (1) of the following reasons:
 - 1. Governmentally imposed minimum wage increases, unless the minimum wage increase was taken into account and reflected in the setting of the trending and index factor.
 - 2. Direct effect of newly published licensure requirements or new interpretations of existing requirements by the appropriate

governmental agency as issued in regulation or written policy material which affects all facilities within the class. The provider shall demonstrate through proper documentation that a cost increase is the result of a new policy interpretation; or

3. Other direct governmental actions that result in an unforeseen cost increase.

B. To receive a rate increase (except for Federal or State minimum wage increases), it shall be demonstrated by the facility that the amount of cost increase resulting directly from the governmental action exceeds on an annualized basis, the inflation factor allowance included in the prospective rate for the general cost area in which the increase occurs. For purposes of this determination, costs shall be classified into two (2) general categories, Nursing Service and all other.

Other Cost. Within each of these two (2) categories, costs are to be further broken down into "salaries and wages" and "other costs." Those costs directly related to salaries and fringe benefits shall be considered as "salaries and wages" when determining classifications.

C. Other unavoidable cost increases of a substantial nature, which can be attributed to a single unique causal factor, shall be evaluated with respect to allowing an interim rate change. Ordinarily budget items such as food, utilities, and interest where cost increases may occur in a generalized manner shall be excluded from this special consideration. Secondary or indirect effects of governmentally imposed cost increases shall not be considered as "other unavoidable cost increases."

D. The increase in the prospective rate shall be limited to the amount of the increase directly attributable to the governmental action to the extent that the increase on an annualized basis exceeds the inflation factor allowance included in the prospective rate for the cost center in question. In regard to minimum wage increases, the direct effect shall be defined as the time worked by total facility employees times the dollar amount of change in the minimum wage law. However, the amount allowed shall not exceed the actual salary and wage increase incurred by the facility in the month the minimum wage increase is effective. An exception to this shall be considered when there is an unusual occurrence that causes a decrease in the normal staff attendance in the months the minimum wage increase is effective.

- E. The effective date of a prospective rate adjustment shall be the first day of the calendar month in which the direct governmental action occurred. To be allowable, a request for an adjustment to the prospective rate shall be received by the Department for Medicaid Services within sixty (60) days of the direct governmental action, except where the costs are to be accumulated.
- F. If two (2) or more allowable reasons for a rate change occur in the same facility fiscal year, the costs may be accumulated and submitted at one (1) time. Each cost shall be documented. A rate adjustment, if allowed, shall be effective the first day of the calendar month in which the latest direct governmental action occurred if the request is made within the required sixty (60) days.

SECTION 310. RATE ADJUSTMENT FOR PROVIDER TAX

After January 1, 1994, provider tax forms shall be submitted to the Revenue Cabinet with the required supporting Revenue Cabinet schedules. Schedule J-Tax forms shall be submitted by providers by the end of the month in which corresponding filing with the Revenue Cabinet is made.

SECTION 320. OTHER OBRA NURSING HOME REFORM COSTS

Effective October 1, 1990 and thereafter, facilities shall be required to request preauthorization for costs that must be incurred to meet OBRA 87 Nursing Home Reform costs in order to be reimbursed for such costs. The preauthorization shall show the specific reform action that is involved and appropriate documentation of necessity and reasonableness of cost. Upon authorization by the Department for Medicaid Services, the cost may be incurred. A request for a payment rate adjustment may then be submitted to the Department for Medicaid Services with documentation of actual cost incurred. The allowable additional amount shall be added on to the facility's rate (effective with the date the additional cost was incurred) without regard to upper limits or the Cost Savings Incentive factor (i.e., the authorized Nursing Home Reform cost shall be passed through at 100 percent of reasonable and allowable costs) through June 30, 1991. For purposes of the July 1, 1991 rate setting, amounts associated with OBRA rate adjustments received prior to May 15, 1991 shall be folded into the applicable category of routine cost (subject to upper limits). Preauthorization shall not be required for

nursing home reform costs incurred during the period July 1, 1990, through September 30, 1990; however, the actual costs incurred shall be subject to tests of reasonableness and necessity and shall be fully documented at the time of the request for rate adjustment. Facilities may request multiple preauthorizations and rate adjustments (add-ons) as necessary for implementation of nursing home reform. Facility costs incurred prior to July 1, 1990, shall not (except for the costs previously recognized in a special manner. i.e., the universal precautions add-on and the nurse aid training add-on) be recognized as being nursing home reform costs. The special nursing home reform rate adjustments shall be requested using forms and methods specified by the Department for Medicaid Services a nursing home rate adjustment shall be included within the cost base for the facility in the rate year following the rate year for which the adjustment was allowed. Interim rate adjustments for nursing home reforms shall not be allowed for period after June 30, 1993. For purposes of the July 1, 1992 and July 1, 1993 rate setting, all amounts associated with OBRA rate adjustments for the preceding rate year shall be folded into the applicable category of routine cost. All nursing home reform rate adjustment requests shall be submitted by September 30, 1993.

SECTION 330. PAYMENT OF SPECIAL PROGRAM CLASSES

A. BRAIN INJURY UNIT

1. A nursing facility with a Medicaid certified brain injury unit providing pre-authorized specialized rehabilitation services for persons with brain injuries shall be paid at an all-inclusive (excluding drugs which shall be reimbursed through the pharmacy program) fixed rate which shall be set at \$475 per diem for services provided in the brain injury unit. The rates shall be increased or decreased based on the Global Insight Healthcare Cost Review, 1st Quarter Edition Index from the CMS Nursing Home without Capital Market Basket, Moving Average using the second quarter in the rate year.
2. A facility providing pre-authorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae shall be paid an all inclusive (excluding drugs) negotiated. The negotiated rate shall be a minimum of the approved rate for a Medicaid certified brain injury unit or a maximum of the lesser of the average rate paid by all payers for this service or the facilities usual and customary charges.
3. In order to participate in the Medicaid program as a Brain Injury Provider, the facility shall:
 - (a) Be Medicare and Medicaid certified;
 - (b) Designate at least ten (10) certified beds that are physically contiguous and identifiable; and,
 - (c) Be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)

- (d) Include administration and operations policies
- (e) Governing authority
- (f) Quality assurance and program evaluation.

B. VENTILATOR FACILITIES

A nursing facility recognized as providing distinct part ventilator dependent care shall be paid at an all-inclusive (excluding drugs which shall be reimbursed through the pharmacy program) fixed rate for services provided in the distinct part ventilator unit.

A distinct part ventilator unit shall:

1. Have a minimum of twenty (20) beds; and
2. Maintain a census of fifteen (15) patients.

The patient census shall be based upon the quarter preceding the beginning of the rate year, or the quarter preceding the quarter for which certification is requested if the facility did not qualify for participation as a distinct part ventilator care unit at the beginning of the rate year.

The fixed rate for hospital-based facilities shall be \$460 per day. The fixed rate for freestanding facilities shall be \$250 per day. The rates shall be increased or decreased based on the Data Resources, Inc. inflation factor for the rate year beginning July 1, 1997.

C. FEDERALLY DEFINED SWING BEDS

A federally defined swing bed shall meet the requirements pursuant to 42 CFR 482.66.

A federally defined swing bed shall be reimbursed pursuant to 42 CFR 447.280. -

SECTION 340. PAYMENT FOR ANCILLARY SERVICES

The reasonable, allowable, direct cost of ancillary services as defined provided as a part of total care shall be compensated through the Department for Medicaid Services on a reimbursable cost basis as an addition to the prospective rate. Ancillary services shall be subject to a year-end audit, retroactive adjustment and final settlement.

Each provider shall request a percentage factor tailored to its own individual cost and charge ratios for ancillary services. These ratios shall be limited to one hundred (100) percent and the Department shall analyze each request for

Medicaid Services staff to determine appropriateness of the requested percentage factor. Reimbursable ancillary costs shall be determined based on the ratio of Medicaid Program charges to total charges applied to direct departmental costs.

A retroactive settlement between actual direct allowable costs and actual payment made by the Department for Medicaid Services shall be made at the end of the accounting period based on the facility's annual Cost Report. Indirect ancillary costs shall be included in routine cost and reimbursed through the prospective rate.

The reasonable, allowable, direct cost of ancillary services as defined and provided as a part of total care shall be compensated through the Department for Medicaid Services on a reimbursable cost basis as an addition to the prospective rate. Ancillary services shall be subject to a year-end audit, retroactive adjustment and final settlement.

Each provider shall request a percentage factor tailored to its own individual cost and charge ratios for ancillary services. These ratios shall be limited to one hundred (100) percent and each request shall be analyzed by Department for Medicaid Services staff to determine appropriateness of the requested percentage factor. Reimbursable ancillary costs shall be determined based on the ratio of Medicaid Program charges to total charges applied to direct departmental costs. A retroactive settlement between actual direct allowable costs and actual payment made by the Department for Medicaid Services shall be made at the end of the accounting period based on the facility's annual Cost Report. Indirect ancillary costs shall be included in routine cost and reimbursed through the prospective rate.

SECTION 350. RETROACTIVE ADJUSTMENT FOR ROUTINE SERVICES

- A. A retroactive adjustment may be made for routine services in the following circumstances:
1. If incorrect payments have been made due to computational errors, i.e., mathematical errors, discovered in the cost basis or establishment of the prospective rate. Omission of cost data does not constitute a computational error.
 2. If a determination is made by the Department for Medicaid Services of misrepresentation on the part of the provider.

3. If a facility is sold and the funded depreciation account is not transferred to the purchaser.
4. If the prospective rate has been set based on an unaudited cost report and the prospective rate is adjusted based on a desk review
5. or field audit. The appropriate cost settlement shall be made to adjust the unaudited prospective payment amounts to the correct audited prospective payment amounts.
6. If adjustments are necessary, any amounts owed the provider shall be paid by the Department for Medicaid Services. Any amounts owed the Department for Medicaid Services shall be paid in cash or recouped through the MMIS payment system

B. **BANKRUPTCY OR INSOLVENCY OF PROVIDER.** If, on the basis of reliable evidence, the Department for Medicaid Services has a reasonable cause for believing that, with respect to a provider, proceedings have been or may shortly be instituted in a State or Federal court for purposes of determining whether the facility is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider shall be adjusted by the Department for Medicaid Services notwithstanding any other reimbursement principle or Department for Medicaid Services instruction regarding the timing or manner of adjustments, to a level necessary to insure that no overpayment to the provider is made. This section shall be applicable only to ancillary services.

SECTION 360. RETROACTIVE ADJUSTMENT FOR ANCILLARY SERVICES

- A. Actual cost reimbursable to a provider shall not be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment shall be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the ancillary services rendered to the Department for Medicaid Services recipients during that period.
- A. In order to reimburse the provider as quickly as possible, a partial retroactive adjustment may be made when the cost report is received. For this purpose, the costs shall be accepted as reported unless there are obvious errors or inconsistencies subject to later audit. When an audit is made and the final liability of the Department for Medicaid Services is determined, a final adjustment shall be made.

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- C. To determine the retroactive adjustment, the amount of the provider's total allowable ancillary cost apportioned to the Department for Medicaid Services for the reporting year is computed. This is the total amount of the reimbursement the provider is due to receive from the Department for Medicaid Services for covered ancillary services rendered during the reporting period. The total of the interim payments made by the Medicaid Program in the reporting year is computed. The difference between the reimbursement due and the payments made shall be the amount of retroactive adjustment.
- D. **ANCILLARY SERVICES.** Upon receipt of the facility's cost report, the Department for Medicaid Services shall as expeditiously as possible analyze the report and commence any necessary audit of the report. Following receipt and analysis of any audit findings pertaining to the report, the Department for Medicaid Services shall furnish the facility a written notice of amount of Medicaid reimbursement. The notice shall (1) explain the Department for Medicaid Service's determination of total Medicaid reimbursement due the facility for the reporting period covered by the cost report or amended cost report; (2) relate this determination to the facility's claimed total reimbursable costs for this period; and (3) explain the amount(s) and the reason(s) for the determination through appropriate reference to the Department for Medicaid Services policy and procedures and the principles of reimbursement. This determination may differ from the facility's claim.
- The Department for Medicaid Services' determination as contained in a notice of amount of Medicaid reimbursement shall constitute the basis for making the retroactive adjustment to any Medicaid payments for ancillary services made to the facility during the period to which the determination applies, including the suspending of further payments to the facility in order to recover, or to aid in the recovery of, any overpayment determined to have been made to the facility.
- E. **ROUTINE SERVICES.** When a retroactive adjustment is made to the routine rate, the Fiscal Agent shall adjust all routine payments made based on the rate that was adjusted.

SECTION 370. PAYMENTS FOR SERVICES TO MEDICARE/MEDICAID RESIDENTS

- A. Dually eligible residents and residents eligible for both Medicare and Medicaid (non-QMB) shall be required to Exhaust any applicable benefits under Title XVIII (Part A and Part B) prior to coverage under the Medicaid Program.
- B. APPLICATION. Services received by a resident that are reimbursable by Medicare shall be billed first to the Medicare Program. Any appropriate co-insurance or deductible payment due from the Medicaid Program shall be paid outside the Cost-based facility Cost-Related Payment System in a manner prescribed by the Department for Medicaid Services. Coinsurance and deductible payments shall be based on rates set by the Medicaid Program. A day of service covered in this manner shall be considered a Medicare resident day and shall not be included as a Medicaid resident day in the facility cost report.

SECTION 380. RETURN ON EQUITY OF PROPRIETARY PROVIDERS

An allowance for a return on equity capital invested and used in the provision of resident care shall not be allowed.

SECTION 390. DESK REVIEW AND FIELD AUDIT FUNCTION

After the facility has submitted the annual cost report, the Division of Long Term Care shall perform an initial desk review's of the report. During the desk review process, Medicaid staff shall subject the submitted Cost Report to various tests for clerical accuracy and reasonableness. If the Medicaid Program detects clerical error, the Department for Medicaid Services shall return the submitted Cost Report to the providers for correction. If Medicaid staff suspect possible errors rather than simple clerical errors, the Medicaid staff shall require the provider to submit supporting documentation to clarify any areas brought into question during the desk review. The desk review shall not be deemed to be completed until all clerical errors have been rectified and all questions asked of the provider during the desk review process have been answered fully.

Additionally, results of this desk review shall be used to determine whether a field audit, if any, is to be performed. The desk review and field audits shall be conducted for purposes of verifying prior year cost to be used in setting prospective rates which have been set based on unaudited data. Ancillary service cost shall be subject to the same.

desk review and field audit procedure to settle prior year costs. The field audit procedures shall include an audit of Resident Fund Accounts to insure the Medicaid Program that the providers are in compliance with appropriate federal and state regulations.

SECTION 400. REIMBURSEMENT REVIEW AND APPEAL

A NF may appeal department decisions as to the application of this regulation as it impacts the NF's cost-based reimbursement rate in accordance with 907 KAR 1:671, Section 10.

SECTION 410. INTRODUCTION TO PROVIDER COST THAT ARE REIMBURSABLE

- A. The material in this pall deals with provider costs that are reimbursable by the Department for Medicaid Services. In general, these costs are reimbursed on the basis of a provider's actual costs, providing these costs are reasonable and related to resident care. These costs are termed allowable costs. That portion of a provider's total allowable costs allocable to services provided to Medicaid Program recipients shall be reimbursable under the Medicaid Program.
- B. Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the facility's operating costs include amount not related to resident care, specifically not reimbursable under the Medicaid Program or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts shall not be allowable.
- C. It is not possible to include the treatment of all items in this manual. If a provider presents a question concerning the treatment of cost not specifically covered, or desires clarification of information in this manual, the provider may make a request for determination. The request shall include all pertinent data in order to receive a binding response. Upon receipt of the request, the Department for Medicaid Services shall issue a binding response within sixty (60) days.

SECTION 420. ADEQUATE COST DATA

- A. To receive reimbursement for services provided Medicaid Program recipients, providers shall maintain financial records and statistical data sufficient to allow proper determination of costs payable under the Medicaid Program. This cost data shall be of sufficient detail to allow verification by qualified auditors using General Accounting Office and American Institute of Certified Public Accountants guidelines. The cost data shall be based on Generally Accepted Accounting Principles.
- B. Use of the accrual basis of accounting is required. Governmental institutions that operate on a cash basis of accounting may submit cost data on the cash basis subject to appropriate treatment of capital expenditures.

Under the accrual basis of accounting, revenue is reported in the period in which it is earned regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid. To allow comparability, financial and statistical records shall be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to effect such change.

- C. Providers, when requested, shall furnish the Department for Medicaid Services copies of resident service charge schedules and changes as they are put into effect. The Department for Medicaid Services shall evaluate charge schedules to determine the extent to which they may be used for determining Medicaid payment.
- D. Where the provider has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for service costing or valued at \$10,000 or more over a twelve (12)-month period, the contract shall contain a clause giving the Cabinet for Health Services access to the subcontractor's books. Access shall also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor. The contract shall contain a provision allowing access until four (4) years have expired after the services have been furnished.

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- E. If the Department for Medicaid Services determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost, payments to the provider shall be suspended until the Department for Medicaid Services is assured that adequate records are maintained.
 - F. A newly participating provider of services shall, upon request, make available to the Department for Medicaid Services for examination its fiscal and other records for the purpose of determining the provider's ongoing record keeping capability.
 - G. Records shall be retained by the facility for three (3) years from the date the settled-without-audit or the audited cost report is received from the Department for Medicaid Services.

The financial records and statistical data that shall be kept shall include the following:

- 1. Records and documents relating to facility ownership, organization, and operation;
- 2. All invoices and purchase orders;
- 3. All billing forms or charge slips;
- 4. All agreements pertaining to asset acquisition, lease, sale or other action;
- 5. Documents pertaining to franchise or management arrangements including costs of parent or "home office" operations;
- 6. Resident service charge schedules;
- 7. Contracts pertaining to the purchase of goods or services;
- 8. All accounting books or original entry kept in sufficient detail to show source and reason for all expenditures and payments;
- 9. All other accounting books;
- 10. Federal and State income tax returns;
- 11. Federal withholding and State Unemployment returns; and,
- 12. All financial statements regardless whether prepared by the facility or by an outside firm;
- 13. Any documentation required by the Department shall be made available for examination; and,
- 14. All of these records shall be made available for examination at the facility, or at some other location within the Commonwealth, when requested by the Cabinet for Health Services.
Reasonable time

shall be given to out- of-state home offices to make the records available within the Commonwealth.

SECTION 430. APPORTIONMENT OF ALLOWABLE COST

- A. Consistent with prevailing practices where third party organizations pay for health care on a cost basis, reimbursement under the Medicaid Program involves a determination of(1) each provider's allowable costs of producing services, and (2) an apportionment of these costs between the Medicaid Program and other payors.

Cost apportionment is the process of recasting the data derived from the accounts ordinarily kept by a provider to identify costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and pro-ration of indirect costs.

- B. The objective of this apportionment is to ensure, to the extent reasonably possible, that the Medicaid Program's share of a provider's total allowable costs is equal to the Medicaid Program's share of the provider's total services, subject to Medicaid Program limitations on payments so as not to pay for inefficiencies and to provide a financial incentive for providers to achieve cost efficiencies.

SECTION 440. COST REPORTING

- A. The Medicaid Program requires each Cost-Based Facility o submit an annual report of its operations. The report shall be filed for the fiscal year used by the provider unless otherwise approved by the Medicaid Program.
- B. Amended cost reports (to revise cost report information that has been previously submitted by a provider) may be permitted or required as determined by the Medicaid Program.
- C. The cost report shall be due within sixty (60) days after the provider's fiscal year ends.
- D. Providers may request in writing a thirty (30) day extension. The request shall explain in detail why the extension is necessary. There shall be no automatic extension of time for the filing of the cost report. After the extension period has elapsed, the Medicaid Program shall suspend all payments to the provider until an acceptable cost report is received.

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- E. Newly participating providers not having a cost report on file containing twelve (12) months of actual data in the fiscal year shall submit a partial year cost report. Upon entry into the Medicaid Program, the provider shall inform the Department of Medicaid Services of the period ending date for the initial cost reporting period.
- F. A provider that voluntarily or involuntarily ceases to participate in the Medicaid Program or experiences a change of ownership shall file a cost report for that period under the Medicaid Program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement. The report shall be due within forty-five (45) days of the effective date of termination of the provider agreement. If a new owner's fiscal year end is less than six (6) months from the date of the change of ownership, Schedules A, D-5 and E as well as the ancillary portion of Schedule F shall be required to be filed at the end of the fiscal year. The rate paid to the new owner shall be the old owner's rate and shall remain in effect until a rate is again determined for a new universal rate year.

SECTION 450. BASIS OF ASSETS

- A. **PRINCIPLE.** Unless otherwise stated in this manual, the basis of an asset shall be the purchase price of that asset paid by the current owner.
- B. **REVALUATION UPON CHANGES IN OWNERSHIP.** If there is a change in ownership, the Medicaid Program shall treat the gain or loss on the sale of an asset in accordance with one (1) of the following methods (dependent on the date of the transaction) for purposes of determining a purchaser's allowable basis in relation to depreciation and interest costs.
1. For changes of ownership occurring prior to July 18, 1984, or if an enforceable agreement for a change of ownership was entered into prior to July 18, 1984, the following methodology applies:
 - a. The actual gain on the sale of the facility shall be determined. Gain shall be defined as any amount in excess of the seller's depreciated basis at the time of the sale as computed under the Medicaid Program policies. The value of Goodwill included in the purchase price shall not be

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- considered part of the gain for purposes of determining the purchaser's cost basis.
- b. Two-thirds (2/3) of one (j) percent of the gain for each month of ownership since the date of acquisition of the facility by the seller shall be added to the seller's appreciated basis to determine the purchaser's allowable basis. This method recognizes a graduated proportion of the gain on the sale of a facility that shall be added to the seller's depreciated basis for computation of the purchaser's allowable basis. This allows full consideration of the gain by the end of twelve and one-half (12 1/2) years.
2. For changes of ownership occurring on or after July 18, 1984, the allowable basis for depreciation for the purchaser shall be the lesser of: 1) the allowable basis of the seller, at the time of the purchase by the seller, less any depreciation allowed to the seller in prior periods; plus the cost of any improvement made by seller, less the depreciation allowed to the seller on those improvements, at the time of closing, or 2) the actual purchase price.
- C. If a provider wishes to change its fiscal year, approval shall be secured in advance from the Department for Medicaid Services prior to the start of the fourth quarter of the original reporting period. If a provider has changed its fiscal year and does not have twelve (12) months in its most recent fiscal year, the provider shall file a cost report for its new fiscal year and include twelve (12) months of data, i.e., the provider should use all months included in their new fiscal year plus additional months from the prior fiscal year to construct a twelve (12) month report.

SECTION 460. DEPRECIATION EXPENSE

- A. **PRINCIPLE.** An appropriate allowance for depreciation expense on buildings and equipment shall be an allowable expense. The depreciation shall be:
1. Identifiable and in the facility's accounting records
 2. Based on the allowable basis;
 3. Prorated over the useful life of the asset; and,
 4. Goodwill and other intangible assets shall not be depreciated

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- B. METHOD OF DEPRECIATION. Assets shall be depreciated using the straight-line method, unless Medicare has authorized another method for the facility; in which case, the facility may elect to utilize the method authorized for Medicare purposes.
 - C. USEFUL LIVES. In selecting a proper useful life, the 1988 Edition of the American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets" shall be used with respect to assets acquired in 1989 or later years. For assets acquired from 1983 through 1988, the 1983 Edition of the AHA's guidelines shall be used. For assets acquired before 1982, the 1973 Edition of the AHA's "Chart of Accounts for Hospitals" shall be used, or for assets acquired before 1981, guidelines published by the Internal Revenue Service, with the exception of those offered by the Asset Depreciation Range System, shall be used.

SECTION 470. INTEREST EXPENSE

- A. PRINCIPAL. Unless otherwise stated in this manual, interest expense shall be an allowable cost pursuant to 42 CFR 4 13.153 and it is both necessary and proper in accordance with the provisions of this manual.
- B. DEFINITIONS.
 - 1. "Interest" means interest is the cost incurred for the use of borrowed funds.
 - 2. "Necessary" means necessary requires that interest:
 - a. Be incurred on a loan made to satisfy a financial need of the provider that is related to resident care. Loans that result in excess funds or investments shall not be considered necessary.
 - b. Be incurred on a loan made for the following purposes:
 - c. Represent interest on a long-term debt existing at the time the provider enters the Medicaid Program plus interest on any new long-term debt, the proceeds of which are used to purchase fixed assets relating to the provision of the appropriate level of care not to exceed the allowable basis of the assets. If the debt is subject to variable interest rates found in "balloon"

type financing, renegotiated interest rates subject to tests of reasonableness should be allowable. The form of indebtedness may include mortgages, bonds, notes, and debentures when the principal is to be repaid over a period in excess of one year.

- (1) Other interest for working capital and operating needs that directly relate to providing resident care is an allowable cost. Working capital interest shall be limited to the interest expense that would have been incurred on two months of Medicaid Receivables. The amount of which this limitation is to be based is computed for cost reporting purposes by determining the monthly average Medicaid payments (both routine and ancillary) for the Cost Reporting period and multiplying the amount by two (2). Once the allowable amount of borrowing has been determined, it is multiplied by the provider's average working capital borrowing rate in order to determine the maximum allowable working capital interest. It should be emphasized that the two-month limit is a maximum. Working capital interest shall not be allowable simply because it does not exceed the two month limitation. Working capital interest that meets the two-month test shall meet all other tests of necessary and proper in order for it to be considered allowable.
- (2) Be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds, or have been separated, if necessary. When investment income is derived from combined or pooled funds, only that portion of investment income

resulting from the facility's assets after segregation shall be considered in the reduction of interest cost. Income from funded depreciation, a provider's qualified pension fund, or a formal deferred compensation plan shall not be used to reduce interest expense so long as these funds are used only for those purposes for which they were created.

3. Proper Interest Rate

- a. Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.
- b. Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans that meet one of the related party exemptions.

C. BORROWER-LENDER RELATIONSHIP.

1. To be allowable, interest expense shall be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans shall be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. Thus, interest paid by the facility to partners, stockholder, or related organizations of the facility shall not be allowable.
2. Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to those facilities classified as Intermediate Care Facilities prior to October 1, 1990, by partners, stockholders, or related organizations made prior to July 1, 1985 shall be allowable as cost, as determined under these principles, provided that the terms and conditions of payment of such loans

have been maintained in effect without subsequent modification subsequent to July 1, 1975. For facilities classified as Skilled

3. Facilities prior to October 1, 1990, the same policy applies for this type loan made prior to and maintained without modification subsequent to December 1, 1979. If the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment shall be accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a facility operated by members of a religious order borrows from the order, interest paid to the order shall be an allowable cost.
4. If funded depreciation is used for purposes other than improvements, replacement, or expansion of facilities or equipment related to resident care, allowable interest expense shall be reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment shall be accorded deposits in the provider's qualified pension fund where such deposits are used for other than the purposes for which the fund was established. If a facility is sold and the funded depreciation account is not transferred to the purchaser, the earnings of the funded depreciation account shall be treated as an investment income. Any investment income that had been earned by the funded depreciation account and had not been utilized to reduce interest expense, shall be considered an overpayment by the Medicaid Program and a retroactive cost settlement shall be computed at the time of the sale. If the funded depreciation account is transferred to the purchaser and the purchaser eliminates the account, any investment income earned in prior years by the account shall be offset against interest expense of the purchaser.

D. INTEREST NOT REASONABLY RELATED TO RESIDENT CARE

Interest expense is not reasonably related to resident care if:

1. It is paid on borrowings in excess of the allowable basis of the asset.
2. It is made to defer principle payments.
3. It is used to purchase goodwill or other intangible asset.
4. It is in the form of penalty payments.

- E. INTEREST EXPENSE ON PURCHASES OF FACILITIES ON OR AFTER JULY 18, 1984. For facilities purchased on or after July 18, 1984, but before October 1, 1985, the amount of interest expense allowed purchaser shall be limited to the amount that was allowable to the seller at the time of the sale. For facilities purchased on or after October 1, 1985, the amount of interest expense allowed to the purchaser shall be limited to the interest on the allowable basis of the asset reduced by the amount necessary (if applicable) to ensure that the increase in depreciation and interest paid to facilities purchased on or after October 1, 1985 does not exceed \$3,000,000 annually. Any reduction of allowable interest based on the \$3,000,000 limit shall be prorated proportionately among the affected facilities (i.e., the percentage reduction shall be applied equally.)

SECTION 480. FACILITY LEASE OR RENT ARRANGEMENTS

- A. For cost-based nursing facilities previously classified as Intermediate Care Facilities, the allowable cost of all lease or rent arrangements occurring after 4/20/76 shall be limited to the owner's allowable historical costs of ownership. The effective date of this limitation for nursing facilities previously classified as Skilled Nursing Facilities is 12/1/79. Historical costs of ownership can include the owner's interest expense, depreciation expense, and other costs such as taxes, insurance, maintenance, etc. In the event of the sale or leaseback arrangement, only the original owner's allowable basis shall be recognized. The owner's allowable historical cost shall be subject to the basis limitations as applied to property owned by providers. Additionally, allowable depreciation and interest shall not exceed that which would have been allowed had the provider owned the assets. In order to have the allowable cost determined and approved, all data pertaining to the lease or rent arrangement, including the name of previous owners, shall be submitted by the provider. In regard to lease or rent arrangements occurring prior to 4/20/76 for basic Intermediate Care and 12/1/79 for Skilled Nursing, the Medicaid Program shall determine the allowable Costs of such arrangements based on the general reasonableness of costs.
- B. Lease or Rent arrangements for land only shall be considered an allowable cost if the lease agreement does not contain an option to purchase at less than market value. if the lease amount is a set amount each year, the lease amount should be reclassified to the Depreciation Expense cost center. If

the lease amount varies from one (1) year to the next, the lease amount shall be reclassified to the Operation and Maintenance of Plant cost center.

SECTION 490. CAPITAL LEASES

Leases determined to be Capital Leases under Generally Accepted Accounting Principles (GAAP) shall be accounted for under the provisions of GAAP.

However, all basis limitations applicable to the depreciation and interest expense of purchased assets shall apply to Capital Leases.

SECTION 500. AMORTIZATION OF ORGANIZATION AND START-UP COSTS

Organization and start-up costs as defined in Health Insurance Manual 15 shall be amortized in accordance with the provisions of Health Insurance Manual 15.

SECTION 510. ACCELERATED DEPRECIATION TO ENCOURAGE REFINANCING

- A. To encourage facilities to refinance loans for long term debt in existence on December 1, 1992 at lower interest rates and for shorter duration than their current financing, the Kentucky Medicaid Program shall allow an increase in depreciation expense equal to the increased principal payments (principal payments on the allowable portion of the loan under the new financing minus the principal payments under the old financing on the allowable portion of the loan). However, this increase in allowable depreciation expense shall not exceed the reduction in allowable interest expense that results from the refinancing. Interest savings for any period shall be computed as follows: allowable interest expense which would have been incurred under the previous loan, plus allowable amortization of financing costs which would have been incurred under the previous financing arrangement, minus allowable interest expense under the new financing arrangement, minus allowable amortization of loan costs under the new loan (including any unamortized loan expense from the previous loan.) Total depreciation allowed (including the additional depreciation) shall reduce the allowable depreciable basis of the building. Total depreciation expense allowed over the lives of the assets that make up the facility shall not exceed the allowable undepreciated basis of the building. The additional depreciation allowed by the

provision shall first be applied against the allowable basis of the longest lived asset which has any remaining allowable undepreciated basis. The remaining allowable undepreciated basis of the facility at the end of the refinanced loan, shall be depreciated over the remaining useful lives of the assets utilizing straight line depreciation. If subsequent to the refinancing and claiming of accelerated depreciation, the facility is sold (either the operating entity holding the nursing facility licensure or the building on which the accelerated depreciation is claimed) or the facility voluntarily discontinues participation in the Medicaid Program, the following recapture provisions shall be applied:

1. The owner who claimed the accelerated depreciation shall pay the Medicaid Program an amount equal to the difference in depreciation claimed for the certified nursing facility with and without the accelerated depreciation times the average Medicaid percentage of total occupancy in the certified nursing facility.
2. If the facility remains in the Medicaid Program, the allowable depreciable basis for the new owner shall be the allowable depreciable basis had the prior owner never utilized accelerated depreciation for Medicaid reimbursement.

SECTION 520. BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES

- A. PRINCIPLE. Bad debts, charity, and courtesy allowances are deductions from revenue and shall not be included in allowable cost.
- B. DEFINITIONS.
 1. "Bad Debts" means a debt considered to be uncollectible from "accounts receivable" and "notes receivable" that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.
 2. "Charity allowances" means an allowance or reduction in charges made by the provider of services because of the indigence or medical indigence of the resident.
 3. "Courtesy Allowances" means an allowance that indicates a reduction in charges in the form of an allowance to physicians,

clergy, members of religious orders, and others as approved by the governing body of the facility, for services received from the facility. Employee fringe benefits, such as hospitalization and personnel health program, shall not be considered to be courtesy allowances.

- C. NORMAL ACCOUNTING TREATMENT - REDUCTION IN REVENUE. Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the services. These costs have already been incurred in the production of the services.
- D. CHARITY ALLOWANCES. Charity allowances have no relationship to recipients of the Medicaid Program and shall not be allowable costs.

SECTION 530. COST OF EDUCATIONAL ACTIVITIES

- A. PRINCIPLE. An appropriate part of the net cost of approved educational activities shall be an allowable cost.
- B. DEFINITIONS.
1. "Approved Educational Activity" means an educational activity formally organized or planned program of study usually engaged in by providers in order to enhance the quality of resident care in a facility. These activities shall be licensed where required by state law. If license is not required, the facility shall receive approval from the recognized national professional organization for the particular activity.
 2. "Net Cost" means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursements from grants, tuition, and specific donations.
 3. "Appropriate Part" means the net cost of the activity apportioned in accordance with the methods set forth in these principles.
- C. ORIENTATION AND ON-THE-JOB TRAINING. The costs of "orientation" and "on the job training" shall not be within the scope of this principle but shall be recognized as normal operating costs.

SECTION 540. RESEARCH COSTS

- A. PRINCIPLE. Costs incurred for research purposes, over and above usual resident care, shall not be included as allowable costs.
- B. APPLICATION. If research is conducted in conjunction with and as part of the care of residents, the costs of usual resident care shall be allowable to the extent that costs are not met by funds provided for the research. Under this principle, studies, analyses, surveys, and related activities to serve the facilities administrative and program needs shall not be excluded as allowable costs.

SECTION 550. GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

- A. PRINCIPLE. Unrestricted grants, gifts, and income from endowments shall not be deducted from operating costs in computing reimbursable cost. Grants, gifts, or endowment income designated by a donor for paying specific operating costs shall be deducted from the particular operating cost or group of costs.
- B. DEFINITIONS.
 - 1. "Unrestricted Grants, Gifts and Income from Endowments" means grants, gifts, and income from endowments, funds, cash or otherwise, given to a facility without restriction by the donor as to their use.
 - 2. "Designated or Restricted Grants, Gifts, and Income from Endowments" means grants, gifts, and income from endowments, funds, cash or otherwise, which shall be used only for the specific purpose designated by the donor. This does not refer to unrestricted grants, gifts, or income from endowments that have been restricted for a specific purpose by the facility.

SECTION 560. VALUE OF SERVICES OF NONPAID WORKERS

- A. PRINCIPLE. The value of services performed on a regularly scheduled basis by persons (in positions customarily held by full-time employees) as non-paid workers under arrangements without direct remuneration from the provider shall be allowed as an operating expense for the determination of allowable cost subject to limitations contained in paragraph (B) of this section. The amounts allowed shall not exceed those

paid others for similar work. Amounts shall be identifiable in the records of the facilities as a legal obligation for operating expense. Non-paid workers hired under arrangements with a Cabinet for Health Services authorized work experience program shall qualify for the purposes of the principles in this section.

- B. **LIMITATIONS - SERVICES OF NON-PAID WORKERS.** The service shall be performed on a regular, scheduled basis in positions customarily held by full-time employees and necessary to enable the provider to carry out the functions of normal resident care and operation of the facility. The value of services of a type for which facilities generally do not remunerate individuals performing those services shall not be allowed as a reimbursable cost under the Medicaid Program. For example, donated services of individuals in distributing books and magazines to residents, or in serving in a facility canteen or cafeteria or in a facility gift shop shall not be reimbursed.
- C. **APPLICATION.** The following illustrates how a facility shall determine an amount to be allowed under this principle: The prevailing salary for a lay nurse is \$5,000 for the year. The lay nurse receives no maintenance or special perquisites. A nun working as a nurse engaged in the same activities in the same facility receives maintenance and special perquisites which cost the facility \$2,000 and are included in the facility's allowable operating costs. The facility may then include in its records and additional \$3,000 to bring the value of the services rendered to \$5,000. The amount of \$3,000 shall be allowed if the facility assumes obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by the facility for the services.
- D. **APPLICATION**
- 1 Unrestricted funds, cash or otherwise, are generally the property of the provider to be used in any manner its management deems appropriate and shall not be deducted from operating costs. It would be inequitable to require providers to use the unrestricted funds to reduce the payments for care. The use of these funds is generally a means of recovering costs that are not otherwise recoverable. However, any interest earned on these funds shall be subject to the interest offset provisions of this manual.

2. Donor-restricted funds that are designated for paying certain operating expenses shall apply and serve to reduce these costs or groups of costs and benefit all residents who use the services covered by the donation. If costs are not reduced, the facility would secure reimbursement for the same expense twice; it would be reimbursed through the donor-restricted contributions as well as from residents and the Medicaid Program.

SECTION 570. PURCHASE DISCOUNTS AND ALLOWANCES AND REFUNDS OF EXPENSES

- A. PRINCIPLE. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.
- B. DEFINITIONS.
 1. "Discounts" means general reductions granted for the settlement of debts.
 2. "Allowances" means deductions granted for damage, delay shortage, imperfection, or other causes, excluding discounts and returns.
 3. "Refunds" means an amount paid back or credits allowed because of over collection.
- C. NORMAL ACCOUNTING TREATMENT - REDUCTION OF COSTS.

All discounts allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they shall be used to reduce the purchases or expenses of that period. However, if they are received in a Later accounting period, they shall be used to reduce the comparable purchases or expenses in the period in which they are received.

SECTION 580. COST TO RELATED ORGANIZATIONS

- A. PRINCIPLE. Cost applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are included in the allowable cost of the provider and is the cost of the related organization. However, the cost shall not exceed

the price of comparable services, facilities, or supplies that could be purchased elsewhere.

B. DEFINITIONS.

1. "Related to Provider" means that the provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by the organization furnishing the services, facilities, or supplies.
2. "Common ownership" means a relationship shall be considered to exist when an individual, including husband, wife, father, mother, brothers, sisters, sons, daughters, aunts, uncles, and in-laws, possesses five (5) percent or more of ownership or equity in the facility and the supplying business. A relationship shall also be considered to exist when it can be demonstrated that an individual or individual's control or influence management decisions or operations of the facility and the supplying business.
3. "Control" means if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

C. APPLICATION. If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is deemed to be a related organization, in effect the items are obtained from itself. Reimbursable cost shall include the cost for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider shall not exceed the market price. An example would be a corporation building a nursing home and then leasing it to another corporation controlled by the owner.

D. EXCEPTION. An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the Department for Medicaid Services that the supplying organization is a bona fide separate organization; that fifty-one (51) percent of the supplier's business activity of the type carried on with the facility is transacted with persons and organizations other than the facility and its related organizations and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by facilities such as the provider from other organizations and are not

a basic element of resident care ordinarily furnished directly to residents by facilities; and that the charge to the provider is in line with the charge for services, facilities, or supplies in the open market and not more than the charge made under comparable circumstances to others by the organization for services, facilities, or supplies. In these cases, the charge by the supplier to the facility for services, facilities, or supplies shall be allowable as cost.

SECTION 590. DETERMINATION OF ALLOWABLE COST OF SERVICES, SUPPLIES, AND EQUIPMENT

- A. PRINCIPLE. Reimbursement to providers for services, supplies and equipment shall be based on reasonable allowable cost as defined in this section.
- B. DETERMINING ALLOWABLE COST. The allowable cost of services, supplies and equipment shall exceed the lowest of:
1. The acquisition of cost the provider;
 2. The provider's usual and customary charge to the public;
 3. The prevailing charge in the locality as determined by Medicare or the Department for Medicaid Services as applicable; or
 4. If the item or service is identified in the Federal Register as one that does not vary significantly in quality from one supplier to another, the lowest charge level as defined in 42 CFR 450.30.

SECTION 600. COST RELATED TO RESIDENT CARE

- A. PRINCIPLE. All payments to facilities shall be based on the reasonable cost of covered services and related to the care of recipients. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost. However, payments to facilities shall be based on the lesser of the reasonable cost of covered services furnished to Medicaid Program recipients or the customary charges to the general public for such services.

Reasonable cost of any services shall be determined in accordance with the principles of reimbursement establishing the method or methods to be used, and the items to be included. These principles take into account both direct and indirect costs of facilities. The objective is that under the

methods of determining cost, the costs with respect to individuals covered by the Medicaid Program shall not be borne by individuals not so covered, and the costs with respect to individuals not so covered shall not be borne by the Medicaid Program.

SECTION 610. REIMBURSEMENT FOR SERVICES OF PHYSICIANS

- A. PRINCIPLE. If the physician bills the Medicaid Program for services provided to the resident directly, such amount is to be approved and paid in accordance with the established practices relating to the physician element of the Medicaid Program. If the physician does not bill the Medicaid Program for services provided to the resident, costs to the facility are recognized as indicated in paragraph (C) of this section.
- B. REASONABLE COST. For the purposes of determining reasonable costs of services performed by physicians employed full time or regular part-time, reasonable cost of the services shall not exceed what a prudent and cost-conscious buyer would pay for comparable services by comparable providers.
- C. APPLICATION. If the physician is compensated by the facility for medical consultations, etc., on a part-time basis, the amounts paid to the physician, if reasonable, shall be recognized by the Medicaid Program as an allowable cost. Physician services by a part-time facility employee for medically necessary direct resident services shall be paid the physician directly through the physician's element of the Medicaid Program. If the physician is a full-time employee of a nursing facility all reasonable costs including direct resident services, shall be recognized as routine facility costs and shall not be billed to the Medicaid Program directly by the physician.

SECTION 620. MOTOR VEHICLES

- A. Costs associated with motor vehicles that are not owned by the facility, including motor vehicles that are registered or owned by the facility but used primarily by the owner, or family members thereof, shall be excluded as allowable costs.

- B. In 1986 Kentucky state law established allowable motor vehicle costs to be \$15,000 per vehicle, up to three (3) vehicles, if the vehicle is used for facility business. The allowable amount is adjusted annually for inflation according to the increase in the consumer price index for the most recent twelve-month period. Medically equipped motor vehicles shall be exempt from the limit. The Department may approve costs exceeding the limit on a facility by facility basis upon demonstration by the facility that additional costs are necessary for the operation of the facility.

SECTION 630. COMPENSATION OF OWNERS

- A. PRINCIPLE. A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed and are a necessary function.
- B. DEFINITIONS
1. "Reasonableness" requires the compensation allowance:
 - a. Be an amount as would ordinarily be paid for comparable services by comparable facilities;
 - b. Depend upon the facts and circumstances of each case; and,
 - b. Be pertinent to the operation and sound conduct of the facility.
 2. "Necessary" requires had the owner not rendered the services, the facility would have had to employ another person to perform the services.
 3. "Owner" means as any person or related family member (as specified below) with a cumulative ownership interest of five (5) percent or more. Members of the immediate family' of an owner, include husband, wife, father, mother, brothers, sisters, sons, daughters, aunts, uncles, and in-laws and shall be treated as owners for the purpose of compensation.
 4. "Compensation" means the total benefit received by the owner, including but not limited to: salary amounts paid for managerial, administrative, professional and other services; amounts paid by

the facility for the personal benefit of the owner; the cost of assets and services received from the facility and deferred compensation.

- C. APPLICATION. The cost of full-time owner-employees may be included as an allowable cost if the compensation is reasonably comparable to compensation for similar positions in the industry but shall not exceed the applicable compensation limit for owner-administrator. The compensation of part-time owner-employees performing managerial type functions shall be allowable to the extent that the compensation does not exceed the percent of time worked times eighty (80) percent of the applicable compensation limits for an owner-administrator.

Full-time owner-administrators and full-time owner-employees who perform non-managerial functions in facilities other than the facility that they are primarily associated shall, for Medicaid purposes, be limited to reasonable compensation of not more than fourteen (14) hours per week in addition to the salary in the facility with which they are primarily associated. To be considered reasonable compensation, the owner shall prove performance of a necessary function and be able to document the time claimed for compensation. If managerial functions are performed in a non-primary facility by the full-time owner-administrator or full-time owner-employee of another facility, the cost of the services shall not be allowed for purposes of the Medicaid Program.

Compensation for services requiring a licensed or certified professional performed on an intermittent basis shall not be considered a part of compensation, nor shall it be limited to the application of the owner-administrator compensation schedule, if the professional services (e.g. legal services) would have necessitated the procurement of another person to perform the services.

- D. COMPENSATION LIMITATION. Compensation for an owner-administrator shall be limited based on the total licensed beds of the facility in accordance with the following schedule:

LICENSED BEDS COMPENSATION	MAXIMUM
0-50	\$33,500

51-99	\$38,500
100-149	\$43,000
150-199	\$51,300
200+	\$52,600

This schedule shall be in effect for the period from July 1, 1991 through June 30, 1992. The compensation maximum shall be increased on July of each year by the Inflation Factor Index for wages and salaries Data Resources, Inc.). The Department for Medicaid Services shall utilize the moving average for the coming July 1 - June 30 fiscal year based on the latest inflation data available. The adjusted amounts shall be published annually in a reimbursement letter to all cost-based facility providers. Perquisites routinely provided to all employees and board of director's fees shall not be considered in applying owner's compensation limits

E. OTHER REQUIREMENTS

1. SOLE PROPRIETORSHIPS AND PARTNERSHIPS

The allowance of compensation for services of sole proprietors and partners shall be the amount determined to be the reasonable value of the services rendered (not to exceed the amount claimed for these services on the annual cost reports submitted by the facility. The allowance shall be an allowable cost regardless of whether there is any actual distribution of profits or other payments to the owner. The operating profit (or loss) of the facility shall not affect the allowance of compensation for the owners services.

2. CORPORATIONS.

To be included in allowable costs, compensation for services rendered as an employee, officer, or director by a person owning stock in a corporate provider shall be paid (by cash, negotiable instrument, or in-kind) during the cost reporting period in which the compensation is earned or within seventy-five (75) days thereafter. If payment is not made during this time period, the unpaid compensation shall not be included in allowable costs, either in the period earned or in the period when actually paid. For this purpose, an instrument to be negotiable shall be in writing and signed, shall contain an unconditional promise or other to pay a certain sum of money on demand or at a fixed and determinable future time and shall be payable to order or to bearer.

3. ACCRUED EXPENSES PAYABLE.

To be included in allowable costs, an accrued expense payable to an officer, director, stockholder, organization or other party or parties having control shall be paid (by cash, negotiable instrument, or in-kind) during the cost reporting period in which it has been incurred or within seventy-five (75) days thereafter. If payment is not made during this time period, the unpaid expense shall not be included in allowable costs, either in the period incurred or in the period when actually paid.

4. DEFINITIONS

- a. "Control" shall exist if an individual or an organization has the ability, directly or indirectly, to influence, manage or direct the actions or policies of the provider regardless of ownership interest.
- b. "Negotiable Instrument" means the negotiable instrument shall be in writing and signed, shall contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and shall be payable to order or to bearer.

SECTION 640. OTHER COSTS

- A. The cost of maintaining a chapel within the facility shall be allowable providing the cost is reasonable.
- B. The cost associated with facility license fees shall be allowed if proper documentation proves that the payment is a fee and not a tax.
- C. The costs associated with political contributions and legal fees for unsuccessful lawsuits filed by the provider shall be excluded from allowable cost. Legal fees relating to lawsuits against the Cabinet for Health Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or when otherwise agreed to by the parties involved or ordered by the court.

- D. The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities that shall not be allowable costs. However, costs (excluding transportation costs) for training or educational purposes outside the Commonwealth of Kentucky (except for owners or administrators) shall be allowable costs. Meetings per se shall not be considered educational; however, if educational or training components are included, the cost, exclusive of transportation shall be allowable. However, travel and associated expenses outside the Commonwealth of Kentucky shall not be allowable for owners and administrators for any reason.
- E. The cost of corporate income tax preparation shall be an allowable cost.
- F. Stockholder maintenance or servicing costs, such as preparation of an annual report, fees for filings required by the SEC etc., shall be allowable costs.
- G. The cost of the Board of Directors' fees shall be allowable, but shall be limited to five (5) meetings annually for single facility organizations and twelve (12) meetings annually for multiple facility organizations and shall meet a test of reasonableness. Other cost associated with Board of Directors' meetings

in excess of the above limitations on the number of meetings shall also be considered to be unallowable costs.

- H. Profits or revenues of the parent organization which are from sources not related to the provision of Cost-Based Facility care shall not be considered as reductions in the cost to the Medicaid Program if the investment funds that generated these profits or revenues were not co-mingled with investment funds of the facility, or have been unco-mingled, if necessary, and the source of the funds can be identified according to generally accepted accounting procedures.
- I. Employee leave time, if vested, shall be generally an allowable cost. For leave pay to be vested there shall be no contingencies on the employee's right to demand cash payment for unused leave upon termination of employment. Facilities continue to have the option of accounting for leave on an accrual or cash basis. If a facility wishes to switch its accounting method to the accrual accounting basis, the accumulated carryover from the prior year(s) may be expensed as utilized, in accordance with the facility's personnel rules concerning the taking of leave. Concurrent with the expensing of the carryover, current vacation earned shall be accrued
- J. Costs resulting from anti-union activity shall be disallowed. Costs associated with union activity, unless prohibited by the National Labor Relations Act or unless the costs are unreasonable or unnecessary, shall be allowed.
- K. In accordance with KRS 216.560(4), payment of penalties shall not be made from monies used for direct resident care nor shall the payment of penalties be a reimbursable cost under Medicaid.
- L. The costs associated with private club memberships shall be excluded from allowable costs.

SECTION 650. ANCILLARY COST

- A. Reasonable cost of ancillary services provided as a part of total care are reimbursable, but may be subject to maximum allowable cost limits under Federal regulations.

Ancillary services include:

Physical therapy
Occupational Therapy
Speech Therapy
Laboratory procedures
X-Ray
Oxygen
Respiratory therapy (excluding the routine administration of oxygen)

Appropriate time and cost records of therapy services shall be maintained. All contracted services shall be documented by invoices which clearly delineate charges for the service(s) provided to include the resident who received the service, the date the service was provided, the length of time the service required, and the person providing the service. Supplies and equipment shall be itemized separately from treatment on these invoices.

- B. DIRECT ANCILLARY COSTS. The direct ancillary costs of Physical, Occupational, Speech and Respiratory Therapy shall include only costs of equipment used exclusively for the specific therapy services, and the salary costs, excluding fringe benefits, of qualified therapy personnel who perform the service, or persons who perform the service under the on-site supervision of qualified therapy personnel.

Personnel qualified for respiratory therapy direct ancillary cost purposes shall be those qualified individuals either licensed by the Kentucky Board of Respiratory Care or the Kentucky Board of Nursing. This definition applies without regard to whether they are facility or hospital-based, or are an independent contractor.

- C. The cost of providing general nursing care, including the routine administration of oxygen, routine suctioning¹ or for standby services shall not be direct ancillary costs. Acquisition, after December 1, 1979, of therapy equipment with a total value of \$1,000 for each asset shall have prior approval by the Department for Medicaid Services in order to be recognized as an allowable cost by the Medicaid Program.

SECTION 660. UNALLOWABLE COSTS

- A. COSTS EXCLUDED FROM ALLOWABLE COSTS

1. Ambulance service

2. Private duty nursing
3. Luxury items or services
4. Dental services
5. Noncompetitive agreement costs
6. Cost of meals for other than residents and provider personnel
7. Dry cleaning of the resident's personal clothing
8. Drug costs -
9. An allowance for a return on equity is not reimbursable.

SECTION 670. SCHEDULE OF IMPLEMENTATION

The reimbursement system outlined in this part of the Cost-Based Facility Reimbursement Manual took effect July 1, 1991 rate setting. The reimbursement system in effect as of July 1, 1990 shall remain in effect for Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled (ICFMRIDD) through June 30, 1991 with the following exceptions:

- A. Effective October 1, 1990, drugs shall no longer be treated as an ancillary for ICF- MR/DD facilities.
- B. Drugs shall be billed through the Pharmacy Program. The pharmacist shall bill Medicaid directly and the facility shall no longer act as a conduit for drug billings.
- C. Those medical supplies previously billed as drugs that cannot be billed through the Pharmacy Program shall be treated as routine-cost for services provided on or after October 1, 1990.

SECTION 680. INTRODUCTION TO THE COST-BASED PAYMENT SYSTEM

This payment system is designed for ICF-MR facilities that are providing services to Medicaid recipients and are to be reimbursed by the Department for Medicaid Services. Effective for costs used in rate setting as of July 1, 1991 except as specified in this manual supplement, policies and procedures as stated in the Department for Medicaid Services. Cost-Based Facilities Reimbursement shall be applicable to ICF-MR/JDD facilities.

The intent of this reimbursement system is to recognize the reasonable costs associated with the services and level of care provided by ICF—MR facilities.

SECTION 690. OCCUPANCY LIMITATION EXCEPTIONS

If a facility is mandated by a court to reduce the number of beds, the occupancy limitations shall not be applied while alternative placement of residents is being attempted in order to comply with the court ruling. During the transition period, defined by the court, the facility shall be allowed a rate adjustment, not more often than monthly, which utilizes the actual facility occupancy.

SECTION 700. DEFINITION OF ROUTINE AND ANCILLARY SERVICES

The definitions of routine and ancillary services as stated in the Cost-Based Facility Reimbursement Manual shall be applicable to the ICF- MR/DD facilities. Psychological and psychiatric services shall be billed as ancillary services by an ICF-MR/DD.

SECTION 705. MEDICARE UPPER PAYMENT LIMIT (UPL) — ROUTINE COSTS

The estimate of the amount that would be paid under Medicare payment principles ("the Medicare UPL") is based on the following methodology. A base year shall be established utilizing cost and utilization data from all state owned or operated ICF/MR/DD facilities most recent desk audited cost reports for state fiscal year (SFY) 2005. Excluding capital and ancillary costs from these cost reports, a weighted mean cost per day will be computed by dividing the total aggregate routine costs for state owned or operated ICF/MR/DDs by the total aggregate cost report days for state owned or operated ICF/MR/DDs. The weighted mean cost per day will be multiplied by 112% to determine an adjusted weighted mean cost per day. The adjusted weighted mean cost per day will be trended forward by applying a rate of change equal to the Global Insight Skilled Nursing Facility Market basket without capital for the rate year. This process will determine the estimated Medicare reimbursement cost per day for the rate year. To determine the Medicare UPL for SFY 2006, take the trended Medicare cost per day multiplied by the actual Medicaid patient days for the current fiscal year (SFY 2005). The current fiscal year patient days will be determined using actual Medicaid patient days from the previous SFY. Medicare UPL calculations for future SFYs will be determined by trending the prior year estimated Medicare reimbursement cost per day forward by the Global Insight Skilled Nursing Facility Market basket without capital for the rate year and multiplying this by actual Medicaid patient days from the previous SFY. This Medicare UPL process will remain in effect for each SFY until the designation of a new base year. A new base year shall be established no more frequently than once every three years based on the most recent desk audited cost report data available.

The Medicare UPL for non-state but government owned or operated and non-governmental ICF/MR/DDs shall be calculated using the same method as the state owned or operated ICF/MR/DDs; however, the aggregate cost and utilization data will come from their own most recent desk audited cost reports.

For each rate year, the estimated Medicare UPL calculated as described above shall only increase to take into account any cost that ICF/MR/DD facilities are required to incur to comply with the conditions described in Att. 4.19-D, page 3 or Section 300 of Att.4.19-D, Exhibit B, page 28 that were not in effect during the Medicare UPL base year. The increase will be equal to the average per diem cost of complying with such requirements times the total number of Medicaid patient days in the Medicare UPL current year as defined-above. The year-end cost settlement will incorporate the additional payments.

SECTION 706. MEDICARE UPPER PAYMENT LIMIT (UPL) — ANCILLARY AND CAPITAL COSTS

Ancillary and capital costs will be limited to actual allowable cost based on Medicare Principles of Reimbursement. Allowable cost will be determined based on the provider's annual cost reports that have been audited and cost settled by Kentucky's Department for Medicaid Services. The total allowable ancillary and capital costs will be added to the routine cost determined in Section 705. This total cost will be the final annual Medicare UPL.

SECTION 710. LEASE OR RENT ARRANGEMENTS

All lease or rent arrangements occurring after 2/23/77 shall be limited to the owner's historical cost of ownership. For lease or rent arrangements occurring prior to 2/23/77, the Medicaid Program shall determine the allowable costs of the arrangement based on the general reasonableness of costs.

SECTION 720. ALLOWABLE COST BASIS ON PURCHASE OF FACILITY AS AN ONGOING OPERATION

The allowable cost basis of a facility purchased as an ongoing operation after July 1, 1976, shall be determined in accordance with the policies outlined in the Cost-Based Facility Reimbursement Manual.

SECTION 730. INTEREST EXPENSE - EXCEPTION TO BORROWER-LENDER RELATIONSHIP

Exceptions to the general rule regarding interest on loans from controlled sources of funds shall be made in the following circumstances. Interest on loans to facilities by partners, stockholders, or related organizations made prior to July 1, 1975 shall be allowable as cost provided that the terms and conditions of payment of the loans have been maintained in effect without modification subsequent to July 1, 1975.

SECTION 740. REIMBURSEMENT FOR SERVICES OF PHYSICIANS, DENTISTS AND HOSPITALS

If physician (excluding psychiatry) or dental services are provided by an employee or if physician, dental or hospital services are provided under an ongoing contractual arrangement, all reasonable costs including direct resident services shall be recognized as routine service facility costs and shall not be billed to the Medicaid Program directly by the physician, dentist, or hospital. This provision shall apply only to staff personnel while performing services that are in the scope of their employment or contractual agreement with the facility.

SECTION 750. EDUCATIONAL COST

The cost associated with providing educational services to residents of ICF-MRs shall not be an allowable expense for reimbursement purposes. Education services provided in facilities or areas within an ICF - MR or on its property which are specifically identified for providing these services by or under contract with the state or local educational agency shall not be reimbursable. Examples of these costs are salaries, building depreciation costs, overhead, utilities, etc. Whether or not educational services are provided in a specifically identified facility or area, reimbursement shall not be available for education or related services provided to a client during the periods of time the Individual Education Plan (IEP) requires that educational and related services be provided. All the services described in the IEP shall be excluded for Medicaid reimbursement, whether provided by state employees, by staff of the ICF-MR or by others.

Related services may be reimbursed if the services are performed as a reinforcement and continuation of the same type of instruction before or after the formal training as part of the individual's program of active treatment.

Educational services not eligible for reimbursement shall be those which are:

- A. Provided in the building, rooms, or area designated or used as a school or educational facility;
- B. Provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students;

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- C. Included in the LEP for the specific student or required by Federal and State educational statutes or regulations; and,
 - D. Related services provided to a student under twenty-two (22) years of age.

SECTION 760. PURCHASE AND DISPOSAL OF SPECIALIZED MEDICAL EQUIPMENT

- A. Specialized medical equipment such as eyeglasses, dentures, adaptive wheelchairs, etc., shall be a part of routine cost when purchased by the provider. These items shall be either expensed in the year of acquisition when appropriate or capitalized and depreciated when meeting the criteria for the acquisitions. Examples of items to be expensed shall be most eyeglasses, dentures and other such items. Items to be capitalized and depreciated shall be adaptive wheelchairs, braces if applicable, etc. If an individual resident's family wishes to purchase any of these items for the resident, they may do so but any reimbursement to the facility shall be offset against the cost of the equipment to the extent the cost is reported on the facility's books.
- B. When a resident is discharged or voluntarily leaves a facility, the specialized equipment may be taken by the resident. If the facility charges the resident for the equipment and the equipment was originally expensed, this revenue shall be offset against the cost of medical supplies or administrative and general cost in the period when the resident leaves. If the equipment was capitalized and depreciated, then the transaction shall be handled as any disposable of appreciable asset would be. If, however, the facility does not charge the resident for the equipment when they leave, then any remaining depreciation shall be included in the period when the discharge occurred.

SECTION 770. INTRODUCTION TO INSTITUTIONS FOR MENTAL DISEASES

- A. This payment system is designed for the publicly operated cost-based nursing facilities defined as Institutions for Mental Disease (IMDs) which are providing services to Medicaid recipients and are to be reimbursed under the Department for Medicaid Services. This reimbursement system shall become effective with the rate setting on July 1, 1991.

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- B. The cost report submission requirements and the rate computation methodology effective July 1, 1991 shall be the same as those for other cost-based facilities.
 - C. The intent of this reimbursement system shall be to recognize the reasonable costs associated with the services and level of care provided by IMD facilities.

SECTION 780. DEFINITION

For purposes of this system, an IMD is a publicly operated cost-based facility primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Coverage shall be limited to individuals age sixty-five (65) and above.

SECTION 790. INTRODUCTION TO DUAL LICENSE PEDIATRIC FACILITIES

- A. This payment system shall be designed for dual licensed pediatrics facilities that are providing services to Medicaid recipients and shall be reimbursed by the Department for Medicaid Services. Except as specified in this manual supplement, policies and procedures as stated in the Department for Medicaid Services Cost-Based Facility Reimbursement Manual. This reimbursement system shall be effective with the rate setting on July 1, 1991.
- B. The cost report submission requirements and the rate computation methodology rates effective July 1, 1991 shall be the same as those for all other cost-based facilities. -
- C. The intent of this reimbursement system shall be to recognize the reasonable costs associated with the services and level of care provided by Dual License Pediatric Facilities.

SECTION 800. DEFINITION

A facility having Dual Licensed Pediatric Facility beds and providing pediatric care only shall be classified as a pediatric Dual Licensed facility and shall receive reimbursement in accordance with the payment mechanism developed for that class of facility.

SECTION 810. INTRODUCTION TO THE COST-BASED FACILITY COST REPORT

The Annual Cost-Based Facility Cost Report provides for the submission of cost and statistical data which shall be used in rate setting and in reporting to various governmental and private agencies. All required information is pertinent and shall be submitted as accurately as possible.

In general, costs shall be reported as they appear in the provider's accounting records. Schedules shall be provided for any adjustments or reclassifications that are necessary.

In the cost finding process, direct costing between Certified Cost-Based Facility and Non-certified Cost-Based Facility shall be used wherever possible. If direct costing is utilized, it shall be utilized, if possible, for all costs of a similar nature. Direct costing shall not be utilized on a selective basis in order to distort the cost finding process.

SECTION 1. SCHEDULE A - CERTIFICATION AND OTHER DATA;

This schedule shall be completed by all facilities.

- A. TYPE OF CONTROL. In Sections 1 through 3 indicate as appropriate the ownership or auspices under which the facility operates.
- B. Section B is provided to show whether the amount of costs to be reimbursed by the Medicaid Program includes costs resulting from services, facilities, and supplies furnished to the vendor by organizations related to the vendor by common ownership or control. Section B shall be completed by all vendors.
- C. Section C shall be completed when the answer in Part B is yes. The amount reported in Section C shall agree with the facility's books.
- D. Section D shall be completed when the answer in Part B is yes.
- E. Section E is provided to show the total compensation paid for the period to sole proprietors, partners, and corporation officers, as owner(s) of Certified Nursing Facilities. Compensation is defined in the Principles of Reimbursement as the total benefit received (or receivable) by the owner for the services he renders to the institution. It shall include salary

amounts paid for managerial, administrative, professional, and other services; amounts paid by the institution for the personal benefit of the owner; and the cost of assets and services which the owner receives from the institution and deferred compensation. List the name, title and function of owner(s), percent of workweek devoted to business, percent of stock owned, and total compensation.

- F. Section F is provided to show total compensation paid to each employed person(s) to perform duties as administrators or assistance administrators. List each administrator or assistance administrator who has been employed during the fiscal period. List the name, title, percent of customary workweek devoted to business, percent of the fiscal period employed, and total compensation for the period.
- G. Section G shall be completed by all providers.
- H. Section H shall be completed by all providers.

SECTION 2. SCHEDULE B - STATEMENT OF INCOME AND EXPENSES:

If a facility has an income statement that provides the same detail as this schedule, this statement may be submitted in lieu of Schedule B. This schedule shall be prepared for the reporting period. During preparation, consideration shall be given to the following items:

- A. Line 1. The amount entered on this line shall be the gross charges for services rendered to residents before reductions for charity, bad debts, contractual allowances, etc. -
- B. Line 2. Record total bad debts, charity allowances, contractual adjustments, etc. on this line. This line shall include the difference between amounts paid by the resident or 3rd party payor and the standard charge of the facility.
- C. Line 3. Subtract line 2 from line 1.
- D. Line 4. Enter total operating expenses from Schedule D-4, Line 26, Column 2.
- E. Line 5. Subtract line 4 from line 3.

- F. Lines 6a, 6b, 7a, and 7b. Complete these lines in accordance with the definitions of restricted and unrestricted as presented in the Principles of Reimbursement in this manual.
- G. Line 12. Include on this line rent received from the rental portions of a facility to other related or non-related parties, i.e., the rental of space to a physician, etc.
- H. Line 14. Purchase discounts shall be applied to the cost of the items to which they relate. However, if they are recorded in a separate account, the total of the discounts shall be entered on this line.
- I. Line 31. Total lines 6a through 30.
- J. Line 33-48. Enter amount of other expenses, including those incurred by the facility, which do not relate to resident care.
- K. Line 49. Total lines 33 through 48.
- L. Line 50. Subtract line 49 from line 32.

SECTION 3. SCHEDULE C -BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

Non-profit facilities shall complete only column 1. Proprietary facilities shall complete the entire schedule. -

- A. Column 1. Enter the balance recorded in the facility's books of accounts at the end of the reporting period (accrual basis of accounting is required as indicated in the Principles of Reimbursement). Attachments may be used if the lines on the schedule are not sufficient. The capital accounts shown on lines 41 through 45, are those applicable to the type of business organization under which the provider operates as follows:
 - Individual Proprietor - Proprietor's Capital Account
 - Partnership - Partner's Capital Accounts
 - Corporation - Capital Stock and Other Accounts
- B. Column 2. This column shall be used to show amounts of assets and liabilities included in a facility's balance sheet, which do not relate to the provider of resident care. Entries to this column shall be detailed on

Schedule C-i. NOTE: It shall not be necessary to attempt to remove the portion of assets applicable to other levels of care on this schedule. Some examples of adjustments, which may be required, include:

1. Line 2 - Notes and Accounts Receivable. The notes and accounts receivable total to be entered in column 2 shall represent total amounts expected to be realized by the provider from non-resident care services.
2. Lines 11, 13, 15, 17, 19- Fixed Assets. The amounts to be entered in column 2 shall be based on the historical cost of those assets, or in the case of donated assets, the fair market value at the time of donation, which are not related to resident care.
3. Line 12, 14, 16, 18, and 20- Accumulated Depreciation. The amounts in column 2 shall be the adjustment necessary to reflect accumulated depreciation on the straight-line method to the effective date of entry into this reimbursement program and amounts claimed thereafter, and shall also be adjusted for disposals and amounts of accumulated depreciation on assets not related to resident care. Assets not related to resident care shall be removed on lines 11, 13, 15, 17, and 19 respectively.
4. LINE 22 - INVESTMENTS. Investments includable in the equity capital balance sheet in column 3 shall be limited to those related to resident care. Primarily, these shall be temporary investments of excess operating funds. Operating funds invested for long periods of time shall be considered excess and not related to resident care needs and shall accordingly be removed in column 2.
5. LINE 25 - OTHER ASSETS. Examples of items which may be in this asset category and their treatment for equity capital purposes are as follows:
 - a. Goodwill purchased shall be includable in equity capital.
 - b. Organization Expense. Expenses incurred in organizing the business shall be] includable in equity capital. (Net of Amortization)
 - c. Discounts on Bonds Payable. This account represents a deferred charge to income and shall be includable in equity capital. Other asset amounts not related to resident care shall be removed in column 2.

6. LINES 37, 38 - LOANS FROM OWNERS. Do not make adjustments in column 2 with respect to funds borrowed by basic IC or IC/MR facilities prior to July 1, 1975 or by Skilled Nursing Facilities prior to December 1, 1979, provided the terms and conditions of the loan agreement have not been modified subsequent to July 1, 1975, or December 1, 1979, respectively. Such loans shall be considered a liability in computing equity capital as interest expense related to such loans is included in allowable costs.

If the terms and conditions of payment of loans made prior to July 1, 1975 for IC facilities and December 1, 1979 for Skilled Nursing facilities, have been modified subsequent to July 1, 1975 and December 1, 1979, respectively, such loans shall not be included as a liability in column 6, and therefore shall be adjusted in column 5. Loans made by owners after these dates shall also be treated in this manner.

- C. For Schedule C, line 1-45, adjust the amounts entered in column 1 (increase and decrease) by the amounts entered in column 2 and extend the net amounts to column 3. Column 3 is provided for the listing of the balance sheet amounts that represent equity capital for the Department for Medicaid Services purposes at the end of the reporting period.

SECTION 4. SCHEDULE C-I - ADJUSTMENT TO EQUITY CAPITAL

This schedule shall be used to explain all adjustments made by the facility on Schedule C, column 2, in order to arrive at the adjusted balance sheet for equity capital purposes.

SECTION 5. OVERVIEW OF THE ALLOCATION PROCESS - SCHEDULE D-1 THROUGH D-5

These schedules provide for separating the operating expenses from the facility's financial records into five (5) cost categories: 1) Nursing Services Costs, 2) Other Care Related Costs, 3) Other Operating Costs, 4) Capital Costs and 5) Ancillary Costs. These schedules also provide for any necessary adjustments and reclassifications to certain accounts. Schedules D-1 through D-5 shall be completed by all facilities. All accounts that can be identified as belonging to a

specific cost center shall be reported to the appropriate section of Schedules D-1 through D-5. Capital cost shall be reported on schedule D-4 and not allocated to specific cost centers.

All listed accounts will not apply to all providers and some providers may have accounts in addition to those listed. These shall be listed on the lines labeled "Other Expense."

The flow of the Schedules D-1 through D-4 is identical. Salaries shall be reported on the salary lines and all salaries for each cost center shall be sub-totaled on the appropriate line. The entries to the columns on these schedules shall be as follows:

- A. Column 2. The expenses in this column shall agree with the provider's accounting books and records.
- B. Column 3. This column shall be utilized for reclassification of expenses as appropriate. Such reclassifications shall be detailed on Schedule D-6.
- C. Column 4. This column shall be for adjustments to allowable costs as may be necessary in accordance with the general policies and principles. All adjustments shall be detailed on Schedule D-7.
- D. Column 5. Enter the sum of columns 2, 3, and 4,
- E. Column 6. This column shall be completed for each line for which an entry is made to column 5 in order to indicate the basis of the separation of the costs reported to Column 5 between Column 7 (Certified Cost-based facility Alloc. of Costs) and Column 8 (Non-Certified and Non-Cost-based facility Alloc. of Costs). A "D" shall be entered to this column on each line on which the adjusted costs (Column 5) are direct costed between Columns 7 and 8. An "A" shall be entered to this column on each line on which the adjusted costs in Column 5 are allocated between Columns 7 and 8 on the basis of the allocation ratios on Schedule F. All accounts which can be direct costed from the provider's records shall be direct costed to Columns 7 and 8. Accounts which are direct costed shall be direct costed in full. Any accounts which cannot be direct costed shall be allocated using statistics from Schedule F. Providers shall ensure that all costs which are reported to column 7 are reasonable, necessary and related to Certified Cost-based facility resident care.
- F. Columns 7 and 8. The adjusted balance figures from Column 5 are to be allocated between Certified Cost-based facility Costs (Column 5) and Non-Certified Non-Facility costs (Column 7). Any accounts that cannot

be direct costed shall be allocated using statistics from Schedule F. All costs entered to Column 7 shall be reviewed by the provider to ensure that they are necessary, reasonable and related to Certified Cost-based facility resident care.

- G. Column 9: This column shall be completed only by Hospital-Based providers. Instructions regarding this column can be found in the instructions for the Schedules, which include Column 9 (i.e. D-3 and D-4).

SECTION 6. SCHEDULE D-1 - NURSING SERVICES COST

- A. The costs associated with nursing services, which shall be included in the nursing service cost category, are as follows:
1. Nursing assessment of the health status of the resident and planning of appropriate interventions to overcome identified problems and maximize resident strengths;
 2. Bedside care and services;
 3. Administration of oral, sublingual, rectal and local medications topically applied, and appropriate recording of the resident's responses;
 4. Training, assistance, and encouragement for self-care as required for feeding, grooming, ambulation, toilet, and other activities of daily living including movement within the nursing home facility;
 5. Supportive assistance and training in resident transfer techniques including transfer from bed to wheelchair or wheelchair to commode;
 6. Care of residents with behavior problems and severe emotional problems requiring nursing care or supervision;
 7. Administration of oxygen;
 8. Use of nebulizers;
 9. Maintenance care of resident's colostomy, ileostomy, and urostomy;
 10. Administration of parenteral medications, including intravenous solutions;
 11. Administration of tube feedings;
 12. Nasopharyngeal aspiration required for maintenance of a clean airway;
 13. Care of suprapubic catheters and urethral catheters;
 14. Care of tracheostomy, gastrostomy, and other tubes in a body;

15. Costs of equipment and supplies that are used to complement the services in the nursing service cost category including incontinence pads, dressings, bandages, enemas, enema equipment, diapers, thermometers, hypodermic needles and syringes, and clinical reagents or similar diagnostic agents;
 16. Costs for education or training including the cost of lodging and meals of nursing service personnel;
 17. The salaries and wages of persons performing nursing services including salaries of the director, and assistant director of nursing, supervising nurses, medical records personnel, registered professional nurses, licensed practical nurses, nurse aides, orderlies, and attendants;
 18. The salaries or fees of medical directors, physicians, or other professionals performing consulting services on medical care which are not reimbursed separately on a fee for service basis; and
 19. The costs of travel necessary for training programs for nursing personnel required to maintain licensure, certification, or professional standards.
- B. If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Nursing Facility Costs). Any account that is direct costed shall be directed costed in full. Any account which cannot be direct costed shall be allocated using Schedule F, Statistic A. Multiply the Column 5 amount by the Certified Cost-based facility percentage from Schedule F, Statistic A, and enter the product in Column 7. Subtract Column 7 from Column 5 and enter the result in Column 8. Providers shall ensure that all costs reported to Column 7 are necessary, reasonable, and related to Certified Cost-based facility resident care.

SECTION 7. SCHEDULE D-2 - OTHER CARE RELATED COSTS

A. General

The costs that shall be reported in the other care-related services cost category include:

1. Food costs, not including preparation;

2. Direct costs of other care-related services, such as social services and resident activities;
3. The salaries and wages of activities directors and aides, social workers and aides, and other care-related personnel including salaries or fees of professionals performing consultation services in these areas which are not reimbursed separately under the Medicaid Program;
4. The costs of training including the cost of lodging and meals to meet the requirements of laws or rules for keeping an employee's salary, status, or position, or to maintain or update skills needed in performing the employee's present duties.

B. Specific Instructions

1. Lines 1-30: If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Cost-based facility Costs.) Any account which is direct costed shall be direct costed in full. If accounts cannot be direct costed use the nursing allocation percentage (Schedule F, Statistic A, Line 3) to calculate Certified Nursing Facility Other Care Related Costs. Multiply the Certified Cost-based facility percentage times the amount in Column 5 and enter the products in Column 7. Subtract Column 7 from Column 5 and enter the results in Column 8.
2. Line 31 : If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Cost-based facility Costs.) Any account, which is direct, costed between Certified Cost-based facility and Non-Certified Cost-based facility shall be direct costed in full. Any account that cannot be direct costed shall be allocated using the dietary allocation percentage (Schedule F, Statistic C, Line 1, Column 2). Multiple the Certified Cost-based facility percentage times the amount in Column 5 and enters the product in Column 7.

Subtract the amount in Column 7 from Column 5 and enter the result in Column 8.

SECTION 8. SCHEDULE D-3 - OTHER OPERATING COSTS

- A. Lines I through 19: If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Cost-based facility Costs.) Any account, which is direct costed, shall be direct costed in full. If an account cannot be direct costed, use the dietary allocation percentage (Schedule F, Statistic C, Line 1, and Column 2) to allocate Dietary Costs. Multiply the Certified Cost-based facility percentage times the amounts in Column 5 and enter the products in Column 7. Subtract the amounts in Column 7 from Column 5 and enter the results in Column 8.
- B. Lines 21 through 55: [-] If an account can be direct costed, between Certified Cost-Based Facility and Non-Certified Cost-Based Facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) either Column 7, Certified Cost-Based Facility Costs, or Column 8, Non-Certified and Non-Cost-Based Facility Costs.) Any account, which is direct costed, shall be direct costed in full. Any account that cannot be direct costed shall be allocated using the Certified Cost-based facility square foot percentage (Schedule F, Statistic B, Line 1, and Column 2). Multiply the percentage times amounts in Column 5 and enter the products in Column 7. Multiply the "Other" percentage (Schedule F, Statistic B, Line 2, and Column 2) times the amounts in Column 5 and enter the products in Column 8. For Hospital-Based Facilities only: add the ancillary square foot percentages (Schedule F, Statistic B, Lines 3 through 8, Column 2) together. Use the sum to allocate Housekeeping & Plant Operation costs of the ancillary cost centers to Column 9.
- C. Line 57 through 74 and 76 through 130: [] If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s), (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified

and Non-Cost-Based Facility Costs.) If an account cannot be direct costed, use the nursing allocation-percentage (Schedule F, Statistic A, Line 3) to calculate Certified Cost-Based Facility Laundry and Administrative & General costs. Multiply the Certified Cost-Based Facility percentage times amounts in Column 5 and enter the products in Column 7. Subtract the amounts in Column 7 from Column 5 and enter the results in Column 8.

SECTION 9. SCHEDULE D-4 - CAPITAL COSTS

- A. If an account can be direct costed, between Certified Cost-based facility and Non-Certified Cost-based facility² the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Cost-based facility Costs.) If an account cannot be direct costed, allocate capital costs using square footage (Schedule F, Statistic B, Column 2). Multiply the Certified Cost-based facility percentage on Line 1 times amounts in Column 5 and enter the products in Column 7. Multiply the "Other" percentage on Line 2 times amounts in Column 5 and enter the products in Column 8. For Hospital-Based Facilities only: add the ancillary square footage percentages from Schedule F, Statistic B (Lines 3 through 8, Column 2) together. Use the sum to allocate capital costs of the ancillary cost centers to Column 9.
- B. Lines 24 through 28 are provided for the computation of total costs per books, net reclassifications, net adjustments, and total adjusted costs for comparison and analysis.
1. Line 24: The entries to this line Columns 2 through 9 shall be the total of the entries to Columns 2 through 9 of Schedules D-1 through D-3 and D-4 through Line 22.
 2. Line 25, Column 7: The entry to this line shall be the sum of Schedule D-5, Column 8, Lines 12, 21, 30, 42, 51, 60, and 67.
 3. Line 26, Column 7: The entry to this line shall be the sum of Column 7, Lines 24 and 25.
 4. Line 27: The entries to this line columns 2 through 5 shall be the total of the entries to columns 2 through 5 of Schedule D-5. Add the entries from the appropriate column, Schedule D-5, Lines 12, 21, 30, 42, 51, 60 and 67 to compute the proper entry.

-
5. Line 28: The entries to this line shall be the totals of lines 24 and 27.
- a. Column 2: The amount entered to Line 26, Column 2 shall agree with the total costs of the facility as reported in its general ledger.
 - b. Column 3: The total reclassifications (the amount entered to Line 26, Column 3) shall net out to be zero (0).
 - c. Column 4: The amount entered to Line 26, Column 4 shall be the total of all adjustments entered to Scheduled D-1 through D-5. It shall agree with the total adjustments reported on Schedule D-7 (D-7, Line 53, Column 3).

SECTION 10. SCHEDULE D-5- ANCILLARY COSTS

- A. Column 2: Ancillary costs as shown in the provider's books shall be entered to the appropriate lines. All ancillary salaries shall be reported to the salaries lines and sub-totaled on the appropriate line.
- B. Column 3: This column shall be utilized for reclassification of Column 2 costs as may be necessary for compliance with the general policies and principles. Reclassifications shall be detailed on Schedule D-6.
- C. Column 4: This column shall be utilized for adjustments to allowable ancillary costs as may be necessary for compliance with the general policies and principles. Adjustments shall be detailed on-Schedule D-7.
- D. Column 5: Enter the sum of Columns 2, 3, and 4. The amount entered here shall be the total ancillary cost of the facility as defined by the general policies and procedures.
- D. Column 6: The cost entered to Column 5 shall be analyzed to identify the direct and indirect ancillary cost portions as defined in the general policies and principles. The direct ancillary Cost shall be entered to Column 6.
- E. Column 7: This column shall be utilized to report the indirect ancillary portion (as defined in the general policies and principles) of the amount entered to Column 5. Subtract Column 6 from Column 5 and enter the difference.

1. Lines 11, 20, 29, 41, 50, 59, and 66 shall be completed by Hospital- Based Providers only. The purpose of these lines shall be to compute each ancillary cost center's share of plant operations and maintenance, housekeeping and capital costs. The Column 7 amounts are derived by multiplying the appropriate Hospital Ancillary Square Foot Percentage (Schedule F, Statistic B, Column 4) by the amount on Schedule D-4, Line 24, Column 9.
- G. Column 8: This column shall be used for reporting the Certified Cost Based Nursing Facility's share of indirect cost. For each ancillary cost center, multiply the appropriate Certified Cost-based facility Ancillary Charge Percentage (Schedule F, Statistic D, Column 3) times the amounts reported in Column 7 to arrive at the correct amounts for Column 8.

SECTION 11. SCHEDULE D-6-RECLASSIFICATION OF EXPENSES

This work sheet provides for the reclassification of certain amounts necessary to effect proper cost allocation under cost finding. All providers that do not direct cost payroll fringe benefits to individual cost centers shall use this schedule to allocate fringe benefits to the various cost centers. Fringe benefits shall be reclassified to individual cost centers on the ratio of the salaries unless another, more accurate and documentable method can be determined. The reclassification to each cost center shall be entered to the appropriate Schedule D-1 through D-5 line titled "Employee Benefits Reclassification."

SECTION 12. SCHEDULE D.7-ADJUSTMENT TO EXPENSES

This schedule details the adjustments to the expenses listed on Schedule D-1 through D-5, column 4. Line descriptions indicate the nature of activities, which affect allowable costs as defined in this manual or result in costs incurred for reasons other than resident care, and thus require adjustment. Lines 22 through 52 are provided for other adjustments not specified earlier. A brief description shall be provided.

The adjusted amount entered in Schedule D-7, column 3, shall be noted "A" in Schedule D-7, column 2, when the adjustment is based on costs. When costs are not determinable, "B" shall be entered in column 2 to indicate that the revenue received for the service is the basis for the adjustment.

SECTION 13. SCHEDULE E - ANCILLARY SETTLEMENT

This schedule is designed to determine the Medicaid share of direct and indirect ancillary costs.

- A. Column 2: Enter direct ancillary cost for each ancillary cost center from Schedule D-5, Column 6.
- B. Column 3: Multiply the direct costs (Column 2) by the corresponding Medicaid charge percentages (Schedule F, Section D, Column 5, Lines I through 7).
- C. Column 4: Enter the total amount received from the Medicaid Program (including any amount receivable from the Medicaid Program at the report date) for ancillary services rendered to Medicaid Certified Cost-based facility recipients during the period covered by the cost report.
- D. Column 5: Subtract the Column 5 amount from the Column 4 amount and enter the difference in Column 6.

SECTION 14. SCHEDULE F - ALLOCATION STATISTICS

- A. Section A - Nursing Hours or Salaries

This allocation statistic shall be used as the basis for allocating the line item costs reported to Schedule D-1, Lines 1-33; Schedule D-2, Lines 1- 30; and D-3, Lines 57-1 30, which cannot be direct, costed to the levels of care. The allocation statistic may be based on the ratio of direct cost of nursing salaries, the ratio of direct nursing hours, a valid time study (as defined by the Department for Medicaid Services), another method which has been approved by the Department for Medicaid Services or, if no other reasonable basis can be determined, resident days. The computation of this statistic shall account for the direct salary costs associated with all material non-certified nursing activities of the facility (such as adult day care or home health services, for example). The computed statistic shall be reasonable and based on documented data. The method used in arriving at the allocation shall be identified at the appropriate place on Schedule F, Ratio A. For Hospital-Based Facilities Only: The salary costs of all departments and services of the hospital, including all ancillary departments as defined in the general policies and principles of the

Department for Medicaid Services, shall be included in the calculation of this statistic. Allocations of costs between Certified Cost-based facility and acute cost centers on the basis of resident days will be accepted only when the resulting allocation statistic can be documented and shown to be reasonable.

1. Line 1: Enter the Certified Cost-based facility figure (i.e., salaries or direct hours)
2. Line 2: Enter the "Other" nursing and direct service figure (i.e. salaries or direct hours)
3. Line 3: Divide Line 1 by the sum of Lines 1 and 2 and enter the percentage on Line 3. The percentage shall be carried out to four decimal places (i.e. xx.xxxx%).
4. NOTE: If salary cost figures are used in computing this allocation statistic, the amounts entered in Lines 1 and 2 shall usually agree to entities on the salary lines of Schedule D-1. If the Schedule F, Ratio A salary figures do not agree to Schedule D-1 salary lines, providers shall review both schedules to ensure that both schedules are correct. The provider shall be able to reconcile Schedule F, Ratio A to Schedule D-1 salary lines upon request.

B. Section B - Square Footage

1. Freestanding facilities shall only complete Columns 1 and 2 of this section. Hospital facilities shall complete all four columns.
 - a. Column 1, Lines 1-10: Enter the square feet in each applicable area of the facility. Direct resident room areas shall be allocated between Certified Cost-based facility and "Other" (PC, Non-certified, Acute, etc.). General resident areas, such as hallways, nursing stations, lounges, etc., which are utilized 100% by one level of care shall be directly allocated to the appropriate cost center. General resident areas used by more than one level of care and general service departments (administrator offices, dietary areas, etc.) shall be allocated between levels of care based on the ratio of Certified Cost-based facility room square footage to total room square footage. In freestanding facilities, ancillary departments shall be

considered general service departments and allocated to levels of care. In Hospital-Based facilities, direct ancillary square footage shall be entered on Lines 3 through 8.

b. Column 2, Lines 1-10: Percentages in Column 2 shall be derived by dividing Column 2, Lines 1 through 9, by Line 10 of Column 1. Line 10 shall be the sum of Lines 1 through 9 and should equal 100.0000%.

2. Columns 3 and 4 shall only be completed by Hospital-Based Facilities. These two columns compute allocation factors to allocate the indirect ancillary costs allocated to the pooled ancillaries in Column 9 of Schedules D-3 and D-4 to the individual ancillary cost centers on Schedule D-5.

- a. Column 3, Lines 3-9: The entries to these lines shall be identical to the entries on the same line number of Ratio B, Column 1.
- b. Column 3, Line 10: The entry to this line shall be the sum of the entries to Lines 3-9.
- c. Column 4, Lines 3-9: The entries to these lines shall be the percentages resulting from dividing the direct square footage allocated to each ancillary service in Column 3, Lines 3-9 by the total direct ancillary square footage computed at Column 3, Line 10. Percentages shall be carried to four digits (i.e., xx.xxxx%).
- d. Column 4, Line 10: The entry to this line shall be the sum of Column 4, Lines 3-9 and shall equal 100.0000%.

C. Section C - Dietary

Identify the method used in arriving at the number of meals served. An actual meal count for 3 X in resident days shall be used. If 3 X in resident days is used, the provider shall ensure that bed reserve days are not included in this calculation.

1. Column 1: Enter total meals in each category.
2. Column 2: To arrive at percentages, divide Lines 1 and 2 in Column 1 by Line 3 in Column 1.

D Section D - Ancillary Charges

1. Column 1: Enter the total charges for each type of ancillary service on Lines I through 7. Add Lines 1 through 7 and enter total on Line 8.
2. Column 2: Enter the total charge for each type of ancillary service provided to all Certified Cost-based facility residents (both Medicaid and non-Medicaid) on Lines I through 7. Add Lines I through 7 and enter the sum to Line 8.
3. Column 3: For each Line 1 through 8 divide total CNF resident charges as reported in Column 2 by the total resident charges (all facility residents) reported in Column 1. Enter the resulting percentage in column 3. Percentages shall be carried to four decimal places (i.e., xx.xxxx%).
4. Column 4: Enter the total charges for each type of ancillary service provided to Medicaid residents in certified beds on Lines 1 through 7. Add Lines I through 7 and total on Line 8.
5. Column 5: For each Line I through 8 divide Medicaid charges in Column 4 by total charges in Column 1. Enter the resulting percentage in Column 3. Percentages shall be carried out to four decimals (i.e. xx xxx%).

E. Section E - Occupancy Statistics

1. Lines 1 and 2. Enter the number of licensed bed days. Temporary changes due to alterations, painting, etc. do not affect bed capacity.
2. Line 3. Total licensed bed days available shall be determined by multiplying the number of licensed beds in the period by the number of days in the period. Take into account increases and decreases in the number of licensed beds and the number of days elapsed since the changes. If actual bed days are greater than licensed bed days available, actual bed days shall be used.
3. Line 4. Enter resident days for all residents in the facility. A resident day shall be the care of one resident during the period between one census taking period on two successive days, including bed reserve days. The day of admission shall be included and the day of discharge excluded. Do not include both. When a resident is admitted and discharged on the same day, this period shall be counted as one day.

4. Line 5. Percentage of occupancy shall be the percentage obtained by dividing total resident days by bed days available. The percentage calculation shall not be carried beyond one decimal place (xx.x%).
5. Line 6. A Medicaid resident day of care shall be an in-resident or bed reserve day covered under the Medicaid Program. A resident days covered by the Medicare Program for which a co-insurance or deductible is made by the Medicaid Pr

ANNUAL COST REPORT
 SCHEDULE A
 CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For the Period From: _____ Leap Year 365
 To: _____

- A. Type of Contract
- | | | |
|--|--|--|
| 1. Voluntary Non-Profit | 2. Proprietary | 3. Government |
| Church <input type="checkbox"/> | Individual <input type="checkbox"/> | <input type="checkbox"/> State _____ |
| Other (Specify) <input type="checkbox"/> | Partnership <input type="checkbox"/> | <input type="checkbox"/> County _____ |
| _____ | Corporation <input type="checkbox"/> | <input type="checkbox"/> City _____ |
| _____ | Other (Specify) <input type="checkbox"/> | <input type="checkbox"/> Other (Specify) _____ |
| | | _____ |

- B. Statement of cost of services from Related Organizations
1. In the amount of cost to be reimbursed by the Medicaid Program, are any cost included which are the result of transactions with a related organization?
- Yes No (IF "Yes" complete parts C & D). All Vendors are to complete E & F, if applicable.

C. Cost Incurred as the result of transactions with related organizations.

Schedule	Line #	Item	Amount
----------	--------	------	--------

D. Name & percent of direct or indirect ownership of the related organization.

Name of Owner	Name of Related Organization	Percent
---------------	------------------------------	---------

E. Statement of Compensation of Owners

Name	Title & Function	Percent of Customary Work Week Devoted to Business	Partners % of Operating Profit or Loss	Corp Ofc % of Vendor's Stock Owned	Total Compensation
------	------------------	--	--	------------------------------------	--------------------

ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For the Period From: _____
To: _____

F. Statement of Compensation Paid to Administrators and/or Assistant Administrators (Other than Owners).

Name	Title	Percent of Customary Work Week Devoted to Business	Percent Of Period Employed	Total Compensation For the Period
------	-------	--	----------------------------	-----------------------------------

G. Has the facility has a change of ownership in the past fiscal year? A change of ownership is defined as the transfer of assets of a facility. The sale of stock in a facility does not constitute a change of ownership.

Yes No

If yes, indicate the new owners and the percent owned. (If corporate owned, not individuals.)

Name	Percent Owned
------	---------------

H. Certification by Officer of Facility

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medicaid Cost Report for the period ended _____ and that, to the best of my knowledge and belief, they are true and correct statements prepared from the books and records of _____ in accordance with applicable program directives, except as noted.

(Signed)

Officer or Administrator of Facility

Title

ANNUAL COST REPORT
 SCHEDULE B
 STATEMENT OF INCOME AND EXPENSES

VENDOR NAME:	VENDOR NUMBER:	FYE
1. Total Patient Revenues		
2. Less Allowances and discounts on patients' accounts		
3. Net Patient Revenues		\$
4. Less: Total operating expenses		
5. Net income from services to patients		\$
OTHER INCOME		
6a. Unrestricted contributions, donations, bequests, etc.		
6b. Restricted contributions, donations, bequests, etc		
7a. Income from unrestricted investments		
7b. Income from restricted investments		
8. Vending machine commission		
9. Revenue from meals sold to employees and guests		
10. Revenue from sale of drugs, supplies, etc. sold to non-patients		
11. Revenue from telephone and telegraph services		
12. Revenue from rental of non-patient facilities		
13. Revenue from Beauty/Barber Shop		
14. Purchase discounts		
15. Other (specify)		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		
26.		
27.		
28.		
29.		
30.		
31. Total other income		
32. Total of line 5 and line 31		
33.		
34.		
35.		
36.		
37.		
38.		
39.		
40.		
41.		
42.		
43.		
44.		
45.		
46.		
47.		
48.		
49. Total Other Expenses		
50. NET INCOME FOR THE PERIOD (line 32 less line 49)		

TN # 00-04
 Supersedes
 TN # 96-10

Approved Aug 10, 2001

Eff. Date 1-1-00

ANNUAL COST REPORT
 SCHEDULE C
 BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME:

VENDOR NUMBER:

FYE

		(1)	(2)	(3)
		<u>ASSETS</u>		
		Per Books	Adjustments	Balance
Current Assets				\$
1.	Cash			\$
2.	Notes and Accounts Receivable			\$
3.	Other Receivables			\$
4.	Less Allowance for Uncollectable Accounts			\$
5.	Inventory			\$
6.	Prepaid Expenses			\$
7.	Investments			\$
8.	Other (Specify)			\$
				\$
				\$
9.	<i>Total Current Assets</i>	\$	\$	\$
Fixed Assets				\$
10.	Land			\$
11.	Building and Leasehold Improvements			\$
12.	Less Accumulated Depreciation			\$
13.	Fixed Equipment			\$
14.	Less Accumulated Depreciation			\$
15.	Major Movable Equipment			\$
16.	Less Accumulated Depreciation			\$
17.	Motor Vehicles			\$
18.	Less Accumulated Depreciation			\$
19.	Minor Equipment			\$
20.	Less Accumulated Depreciation			\$
				\$
21.	<i>Total Fixed Assets</i>	\$	\$	\$
Other Assets				\$
22.	Investments			\$
23.	Lease Deposits			\$
24.	Due from Owners or Officers (Specify)			\$
				\$
				\$
				\$
				\$
25.	Other (Specify)			\$
				\$
				\$
				\$
26.	<i>Total Other Assets</i>	\$	\$	\$
27.	Total Assets	\$	\$	\$

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 Supersedes
 TN # 96-10

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Eff. Date 1-1-00

ANNUAL COST REPORT
 SCHEDULE C (cont.)
 BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME: _____ VENDOR NUMBER: _____ FYE _____

	(1)	(2)	(3)
<u>LIABILITIES</u>			
Current Utilities	Per Books	Adjustments	Balance
28. Accounts Payable			\$
29. Notes Payable			
30. Current Portion of Long Term Debt			
31. Salaries and Fees Payable			
32. Payroll Taxes Payable			
33. Income Taxes Payable			
34. Deferred Income Payable			
35. Other (Specify)			
<hr/>			
36. <i>Total Current Liabilities</i>	\$	\$	\$
<u>Long Term Liabilities</u>			
37. Mortgage Payable			\$
38. Notes Payable			
39. <i>Total Long Term Liabilities</i>	\$		\$
40. <i>Total Liabilities</i>	<u>\$</u>	<u>\$</u>	<u>\$</u>

CAPITAL AND OWNERS' EQUITY

41. Common Stock			\$
42. Preferred Stock			
43. Treasury Stock			
44. Retained Earnings			
45. Other (Specify)			
<hr/>			
46. <i>Total Capital and Owners' Equity</i>	\$	\$	\$
47. <i>Total Liabilities and Capital</i>	<u>\$</u>	<u>\$</u>	<u>\$</u>

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ANNUAL COST REPORT
 SCHEDULE C-1
 BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL ADJUSTMENTS

VENDOR NAME:

VENDOR NUMBER:

FYE

	EXPLANATION	AMOUNT	CLASSIFICATION ADJUSTED ACCOUNT	LINE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53				
54				
55				
56	TOTAL			

TN # 00-04
 Supersedes
 TN # 96-10

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Eff. Date 1-1-00

ANNUAL COST REPORT – SCHEDULE D-1- NURSING SERVICES COSTS

Attachment 4.19-D Exhibit B Page 86-G	VENDOR NAME:	VENDOR NUMBER:					FYE	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Per Books	Reclass-ifications	Adjustments	Adjusted Balance	Direct Cost or Alloc.	Certified Nursing Facility Alloc. Of Costs	Non-Certified & Non-Nursing Fac. Alloc. Of Costs.
1	Director of Nursing Salary							
2	R.N. Salaries							
3	L.P.N. Salaries							
4	C.M.A. Salaries							
5	Aides Salaries							
6	Other Salaries							
7	Other Salaries							
8	Other Salaries							
9	<i>Subtotal - Salaries</i>							
10	Employee Benefits Reclassification							
11	Nursing Contracted Services							
12	Medical Records Salaries							
13	Medical Director Fees							
14	Pharmacy Consultant Fees							
15	Physician Services							
16	Nursing Education & Training							
17	Nursing Travel Expense							
18	Medical Supplies							
19	Adult Diapers & Underpads							
20	Nursing Equipment Rental							
21	Nursing Small Equip. Purchases							
22	Other Expenses							
23	Other Expenses							
24	Other Expenses							
25	Other Expenses							
26	Other Expenses							
27	Other Expenses							
28	Other Expenses							
29	Other Expenses							
30	Other Expenses							
31	Other Expenses							
32	Other Expenses							
33	Other Expenses							
34	<i>Total</i>							

Eff. Date 1-1-00

Approved AUG 10, 2001

TN # 00-04
Supersedes
TN # 96-10

ANNUAL COST REPORT – SCHEDULE D-2- OTHER CARE RELATED COSTS

Attachment 4.19-D Exhibit B Page 86-H	VENDOR NAME:	VENDOR NUMBER:					FYE	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Per Books	Reclassifications	Adjustments	Adjusted Balance	Direct Cost or Alloc.	Certified Nursing Facility Alloc. Of Costs	Non-Certified & Non-Nursing Fac. Alloc. Of Costs.
1	Activities Salaries							
2	Social Services Salaries							
3	Other Salaries							
4	Other Salaries							
5	Other Salaries							
6	<i>Subtotal - Salaries</i>							
7	Employee Benefits Reclassification							
8	Activities Supplies							
9	Social Services Supplies							
10	Training & Education Expense							
11	Travel Expense							
12	Other Expenses							
13	Other Expenses							
14	Other Expenses							
15	Other Expenses							
16	Other Expenses							
17	Other Expenses							
18	Other Expenses							
19	Other Expenses							
20	Other Expenses							
21	Other Expenses							
22	Other Expenses							
23	Other Expenses							
24	Other Expenses							
25	Other Expenses							
26	Other Expenses							
27	Other Expenses							
28	Other Expenses							
29	Other Expenses							
30	Other Expenses							
31	Raw Food							
32	<i>Total</i>							

Eff. Date 1-1-00

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TN # 00-04
Supersedes
TN # 96-10

ANNUAL COST REPORT – SCHEDULE D-3- OTHER OPERATING COSTS

Attachment 4.19-D
Exhibit B
Page 86-J

VENDOR NAME:		VENDOR NUMBER:							FYE
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	
	Per Books	Reclass-ifications	Adjustments	Adjusted Balance	Direct Cost or Alloc.	Certified Nursing Facility Alloc. Of Costs	Non-Certified & Non-Nursing Fac. Alloc. Of Costs.	Ancillary Hospital-Based Facility Only	
32	Repairs & Maintenance - Equipment								
33	Repairs & Maintenance- Grounds								
34	Small Equipment Purchases								
35	Gas								
36	Electricity								
37	<i>Water & Sewage</i>								
38	Garbage Pick-up								
39	Contracted Services								
40	Pest Control Services								
41	Property Taxes								
42	Insurance-Property, Plant & Equip.								
43	Other Hskg & Plant Op.								
44	Other Hskg & Plant Op.								
45	Other Hskg & Plant Op.								
46	Other Hskg & Plant Op.								
47	Other Hskg & Plant Op.								
48	Other Hskg & Plant Op.								
49	Other Hskg & Plant Op.								
50	Other Hskg & Plant Op.								
51	Other Hskg & Plant Op.								
52	Other Hskg & Plant Op.								
53	Other Hskg & Plant Op.								
54	Other Hskg & Plant Op.								
55	Other Hskg & Plant Op.								
56	<i>Total Housekeeping & Plant Oper.</i>								
	<u>Laundry</u>								
57	Laundry Salaries								
58	<i>Other Salaries</i>								
59	Other Salaries								
60	Other Salaries								
61	<i>Subtotal - Salaries</i>								
62	Employee Benefits Reclassification								
63	Laundry Supplies								
64	Linens & Bedding								

Eff. Date 1-1-00

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ANNUAL COST REPORT – SCHEDULE D-3- OTHER OPERATING COSTS

Attachment 4.19-D
Exhibit B
Page 86-K

VENDOR NAME:

VENDOR NUMBER:

FYE

Eff. Date 1-1-00

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Per	Reclass-		Adjusted	Direct	Certified	Non-Certified &	Ancillary
	Books	ifications	Adjustments	Balance	Cost or	Nursing Facility	Non-Nursing Fac.	Hospital-Based
					Alloc.	Alloc. Of Costs	Alloc. Of Costs.	Facility Only
65								
66								
67								
68								
69								
70								
71								
72								
73								
74								
75								
76								
77								
78								
79								
80								
87								
82								
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86								
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88								
89								
90								
91								
92								
93								
94								
95								
96								
97								

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ANNUAL COST REPORT – SCHEDULE D-3- OTHER OPERATING COSTS

Attachment 4.19-D
Exhibit B
Page 86-L

VENDOR NAME:

VENDOR NUMBER:

FYE

Eff. Date 1-1-00

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Per	Reclass-		Adjusted	Direct	Certified	Non-Certified &	Ancillary
	Books	ifications	Adjustments	Balance	Cost or	Nursing Facility	Non-Nursing Fac.	Hospital-Based
					Alloc.	Alloc. Of Costs	Alloc. Of Costs.	Facility Only
98		Contracted Services						
99		Utilization Review						
100		Travel & Seminars						
101		Advertising – Help Wanted						
102		Advertising – Other						
103		Small Equipment Purchases						
104		Licenses & Fees						
105		Interest Expense – Non-capital						
106		Other Expense						
107		Other Expense						
108		Other Expense						
109		Other Expense						
110		Other Expense						
111		Other Expense						
112		Other Expense						
113		Other Expense						
114		Other Expense						
115		Other Expense						
116		Other Expense						
117		Other Expense						
118		Other Expense						
119		Other Expense						
120		Other Expense						
121		Other Expense						
122		Other Expense						
123		Other Expense						
124		Other Expense						
125		Other Expense						
126		Other Expense						
127		Other Expense						
128		Other Expense						
129		Other Expense						
130		HEALTH CARE PROVIDER TAX						
131		<i>Total Admin & General Exp</i>						

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ANNUAL COST REPORT – SCHEDULE D-4- CAPITAL COSTS

Attachment 4.19-D
Exhibit B
Page 86-M

VENDOR NAME:

VENDOR NUMBER:

FYE

Eff. Date 1-1-00

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
		Per	Reclass-		Adjusted	Direct	Certified	Non-Certified &	Ancillary
		Books	ifications	Adjustments	Balance	Cost or	Nursing Facility	Non-Nursing Fac.	Hospital-Based
						Alloc.	Alloc. Of Costs	Alloc. Of Costs.	Facility Only
1	Depreciation – Building								
2	Depreciation – Equipment								
3	Interest Expense – Capital Related								
4	Rent								
5	Land Improvements								
6	Leasehold Improvements								
7	Amortization of Start up Costs								
8	Other Capital Costs								
9	Other Capital Costs								
10	Other Capital Costs								
11	Other Capital Costs								
12	Other Capital Costs								
13	Other Capital Costs								
14	Other Capital Costs								
15	Other Capital Costs								
16	Other Capital Costs								
17	Other Capital Costs								
18	Other Capital Costs								
19	Other Capital Costs								
20	Other Capital Costs								
21	Other Capital Costs								
22	Other Capital Costs								
23	<i>Total</i>								
24	<u>Grand Totals</u>	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
25	Totals of Schedules D-1 through D-4								
26	Total of Schedule of D-8, Column 8								
27	Total Routine CNF Cost								
28	Totals from Schedule D-5								
	Total Costs								

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ANNUAL COST REPORT – SCHEDULE D-5 – ANCILLARY COSTS

Attachment 4.19-D
Exhibit B
Page 86-N

VENDOR NAME:	VENDOR NUMBER:	FYE:					
(1)	(2) Per Books	(3) Reclassifications	(4) Adjustments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
<u>Physical Therapy</u>							
1 Physical Therapist Salaries							
2 Physical Therapist Asstnts, Salaries							
3 Physical Therapist Aides Salaries							
4 Other Salaries							
5 <i>Subtotal Salaries</i>							
6 Employee Benefits Reclassification							
7 Contracted Services							
8 Equipment Depreciation							
9 Other Expenses							
10 Other Expenses							
11 Hospital-Based Indirect Ancillary							
12 <i>Total</i>	<u>(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 3, Col 4)</u>						
<u>X-Ray</u>							
13 Professional Salaries							
14 Other Salaries							
15 <i>Subtotal Salaries</i>							
16 Employee Benefits Reclassification							
17 Supplies							
18 Equipment Depreciation							
19 Other Expenses							
20 Hospital-Based Indirect Ancillary							
21 <i>Total</i>	<u>(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 4, Col. 4)</u>						
<u>Laboratory</u>							
22 Professional Salaries							
23 Other Salaries							
24 <i>Subtotal Salaries</i>							
25 Employee Benefits Reclassification							
26 Supplies							
27 Equipment Depreciation							
28 Other Expenses							
29 Hospital-Based Indirect Ancillary							
30 <i>Total</i>	<u>(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 5, Col. 4)</u>						

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ANNUAL COST REPORT – SCHEDULE D-5 – ANCILLARY COSTS

Attachment 4.19-D
Exhibit B
Page 86-O

VENDOR NAME:	VENDOR NUMBER:	FYE:					
(1)	(2) Per Books	(3) Reclass- ifications	(4) Adjust- ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
<u>Oxygen/Respiratory Therapy</u>							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42							
<u>Speech</u>							
43							
44							
45							
46							
47							
48							
49							
50							
51							
<u>Other</u>							
52							
53							
54							
55							
56							
57							
58							
59							
60							

Eff. Date 1-1-00

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SCHEDULE D-6
RECLASSIFICATIONS OF EXPENSES

Attachment 4.19-D
Exhibit B
Page 86-Q

VENDOR NAME:

VENDOR NUMBER:

FYE:

	(1)	(2)	(3)	(4)
<u>Line</u>	<u>Explanation</u>	Increase Amount	Decrease Amount	Cost Center Affected (Schedule & Line # Affected) (cc D3-1)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
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54				
55				
56				
57				
58				
59				
60				
61	<i>Total</i>			

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Eff. Date: 1-1-00

SCHEDULE D-7
RECLASSIFICATIONS OF EXPENSES

Attachment 4.19-D
Exhibit B
Page 86-R

VENDOR NAME:

VENDOR NUMBER:

FYE:

Line	(1) Explanation	(2) Basis for Adjustment (A) or (B)	(3) Amount	(4) Sch & Line # Affected (cc D3-1)
1	Laundry & Linen			
2	Employee & Guest Meals			
3	Gift, Flower & Coffee Shop			
4	Grants, Gifts, & Income Designated By the donor for a specific purpose			
5	Beauty & Barber Shop			
6	Excess Owners Compensation			
7	Telephone Serv (Pay Serv. Excluded)			
8	Radio & Television Service			
9	Vending Machine Commission			
10	Sale of drugs to other than Patients			
11	Sale of Medical & Surgical Supplies To other than Patients			
12	Sale of Medical Record & Abstracts			
13	Sale of Scrap, Waste, Etc.			
14	Rental of Quarters to Emp & Others			
15	Rental of Facility Space			
16	Trade, Qty, Time & Other Discounts			
17	Rebates & Refunds of Expenses			
18	Interest Not Allowed			
19	Recovery of Insured Loss			
20	Depreciation			
21	Gain or Loss of Disposition of Assets			
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
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37				
38				
39				
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41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53	Total			

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ANNUAL COST REPORT – SCHEDULE E – ANCILLARY SETTLEMENT

Attachment 4.19-D
Exhibit B
Page 86-S

VENDOR NAME:

VENDOR NUMBER:

FYE:

	(1)	(2) Direct (From Sch. D-5, Col 6)	(3) Medicaid Direct	(4) Medicaid Payments	(5) Receivable From KMAP (Payable to KMAP)
1 Physical Therapy					
2 X-Ray					
3 Laboratory					
4 Oxygen/Respiratory Therapy					
5 Speech					
6 Other					
7 Drugs					
8 <i>Total</i>					

Medicaid Services use only	
TENTATIVE	ANCILLARY
ANCILLARY	SETTLEMENT
<input type="checkbox"/>	<input type="checkbox"/>

Eff. Date 1-1-00

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Supersedes

STATISTICS

VENDOR NAME: _____

FYE _____

FYE _____

VENDOR NUMBER: _____
 DAYS

MONTHS _____

A. NURSING SALARIES Leap Year 365

1	CERTIFIED NURSING FACILITY		
2	OTHER		
3	CERT. NURSING FAC. PERCENTAGE		
ALLOCATION METHOD:			
	PATIENT DAYS <input type="checkbox"/>	VALID TIME STUDY <input type="checkbox"/>	
	DIRECT COST <input type="checkbox"/>	DIRECT HOURS <input type="checkbox"/>	
	OTHER APPROVED METHOD <input type="checkbox"/>		

B. SQUARE FOOTAGE

	(1) SQ. FT.	(2) PERCENT	(3) HOSPITAL-BASED SQ. FT.	(4) PERCENT
1	CERT. NURSING FACILITY			
2	OTHER			
3	PHYSICAL THERAPY*			
4	X-RAY*			
5	LABORATORY*			
6	OXYGEN/RESP. THERAPY*			
7	SPEECH*			
8	OTHER*			
9	DRUGS*			
10	TOTAL			

*For Hospital-Based Certified Nursing Facility Only

C. DIETARY

	MEALS	PERCENT
1	CERT. NURSING FACILITY	
2	ALL OTHER	
3	TOTAL	
ALLOCATION METHOD:		
	MEAL COUNT: <input type="checkbox"/>	3*INPATIENT DAYS: <input type="checkbox"/>

D. ANCILLARY CHARGES

	(1) TOTAL	(2) CNF	(3) CNF %	(4) MEDICAID	(5) MEDICAID %
1	PHYSICAL THERAPY				
2	X-RAY				
3	LABORATORY				
4	OXYGEN/RESP. THERAPY				
5	SPEECH				
6	OTHER				
7	DRUGS				
8	TOTAL				

E. OCCUPANCY STATISTICS

	(1) CERTIFIED NURSING FACILITY	(2) OTHER LONG-TERM CARE	(3) ACUTE CARE
1	LICENSED BEDS AT BEGINNING OF PERIOD		
2	LICENSED BEDS AT END OF PERIOD		
3	BED DAYS AVAILABLE		
4	TOTAL PATIENT DAYS		
5	% OCCUPANCY		
6	KMAP PATIENT DAYS		
7	% KMAP OCCUPANCY		

F. ADDITIONAL STATISTICS

1	DIRECT ROUTINE NURSING HOURS – CERTIFIED NURSING FACILITY ONLY
2	TOTAL DIRECT DIETARY HOURS
3	TOTAL DIRECT HOUSEKEEPING HOURS

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Eff. Date 1-1-00

DISCLOSURE SECTION

VENDOR NAME:

FYE:

VENDOR NUMBER:

A. STATEMENT OF ORGANIZATIONS CONTRACTED WITH

NAME	TYPE OF BUSINESS	DATE OF CONTRACT
------	------------------	------------------

B. PROTESTED AMOUNTS (NON-ALLOWABLE COST REPORT ITEMS)

ITEM	AMOUNT	SCHEDULE AND LINE
------	--------	-------------------

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Kentucky

Attachment 4.19-E
Page 20.1

Timely Claims Payment

Definition of A Claim

- (1) "Claim" means:
 - (a) For physician, podiatry, dental, vision care, hearing aid dealers, home health, primary care clinics, mental health center clinics, pharmacy, hospital outpatient, and independent laboratory services, a line item of service;
 - (b) For tuberculosis and mental hospital services, all services for one recipient within a bill; and
 - (c) For all other services, a bill for services.

State Kentucky

Requirements for Third Party Liability
Identifying Liable Resources

The Title XIX single state agency is committed to compliance with all third party recovery requirements, including those shown in 42 CFR 433, Subpart D, Third Party Liability. For purposes of clarification, we state herein that the \$250 threshold applies only with regard to accident/trauma claims; there is a \$25 threshold amount for waiver claims such as pharmacy; there is no threshold amount for all other claims. The Kentucky Department for Medicaid Services may look back three (3) years for payment for any healthcare item or services submitted not later than three (3) years after the date such item or service was provided.

- (b) (1) An agreement has been developed with the Department for Social Insurance (DSI) for collecting and forwarding health insurance information for Kentucky's Title XIX recipients. The local DSI field worker collects TPL data during initial application and during the redetermination process. The information collected includes the name of the policy holder, relationship of policy holder to recipient, the social security number of the policy holder, the policy number, and type of coverage held and name and address of insurance company. The information is added daily to the TPL data base and claims are edited against the data each processing cycle. Social Security Numbers of absent parents are being obtained from Title IV-D agencies. Addresses of employers of absent parents are obtained from unemployment insurance.

Data exchanges have been arranged with Worker's Compensation and will be done quarterly. SWICA information is obtained during application and at least quarterly. SSA information is obtained during the application process from recipients for whom the information was not previously requested.

Data exchanges have been, and will continue to be, attempted as required by regulation with Motor Vehicle Registration.

State Kentucky

- (2) The state follows up within 30 days on all information obtained from SWIC, SSA wage and earnings files, and Title IV- A by entering any valid or appropriate data into the TPL avoidance file, or by utilizing the data for collection. The state will follow up the data exchanges with health insurers and worker's compensation files within sixty (60) days from the date of receipt of the tapes.
- (3) The state has attempted, and will continue its efforts, to develop a state motor vehicle accident report file.
- (4) Claims involving trauma diagnosis codes are processed in accordance with 42 CFR 433.138(3) and 433.139 with accumulated claims in excess of \$250 pursued for possible third party payment or recovery. A monthly listing is produced which identifies all recipients for whom \$250 or more has been paid within a prior ninety (90) day period with an indicator of trauma or accident. Each case is actively pursued for possible collection. The time frames within which incorporation of information from accident/trauma diagnosis code TPL procedures must be accomplished is thirty (30) days.
- (5) Providers are not required to bill the third party in situations where the third party liability is derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency. Kentucky uses the pay and chase method.
- (6) The state assures that the requirements of 42 CFR 433.145 through 433.148 are met for assignment for rights to benefits. Kentucky's statute KRS 205.624 (see Attachment 4.22-A, Exhibit A) requires assignment of third party payments. The application for Medical Assistance/AFDC and the Medical Assistance identification Card have a statement notifying the applicant/recipient of the third party assignment.

205.624. Assignment to cabinet by recipient of rights to third party payments - Right of recovery by cabinet. - (1) An applicant or recipient shall be deemed to have made to the cabinet an assignment of his rights to third party payments to the extent of medical assistance paid on behalf of the recipient under title XIX of the Social Security Act. The applicant or recipient shall be informed in writing by the cabinet of such assignment.

- (2) The cabinet shall have the right of recovery which a recipient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the cabinet for such care and treatment of the recipient under the provisions of title XIX of the Social Security Act.
- (a) If a payment for medical assistance is made, the cabinet, to enforce its right, may:
1. Intervene or join in an action or proceeding brought by the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors against a third party who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled recipient, in state or federal court; or
 2. Institute and prosecute legal proceedings against a third party who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled recipient, in state or federal court, either alone or in conjunction with the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors; or
 3. Institute the proceedings in its own name or in the name of the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors.
- (b) The injured, diseased, or disabled person may proceed in his own name, collecting costs without the necessity of joining the cabinet or the Commonwealth as a named party, provided the injured, diseased, or disabled person shall notify the cabinet of the action or proceeding entered into upon commencement of the action or proceeding. The injured, diseased, or disabled person must notify the cabinet of any settlement or judgment of his or her claim.
- (c) In the case of an applicant for or recipient of medical assistance whose eligibility is based on deprivation of parental care or support due to absence of a parent from the home, the cabinet may:
1. Initiate a civil action or other legal proceedings to secure repayment of medical assistance expenditures for which the absent parent is liable; and
 2. Provide for the payment of reasonable administrative costs incurred by such other state or county agency requested by the cabinet to assist in the enforcement of securing repayment from the absent parent. Enact. Acts 1980, ch. 252, § 4.

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I)

The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Requirements for Third Party Liability -
Payment of Claims

1. For accident/trauma claims, the state has established a two hundred and fifty dollar threshold amount in determining whether to seek reimbursement from liable third parties based on an accumulation of claims processed within a prior ninety day period, but with recoupment applied to all accumulated accident/trauma claims processed within a prior two year period.
2. The exception to the above policy is accident cases in litigation over \$250 (two hundred and fifty dollars). These cases will be pursued from the date the accident occurred, regardless of the ninety day period and two—year time period.
3. Effective July 1, 1988, for claims that are not cost avoided pursuant to Kentucky's approved waiver, there is a \$25 threshold with the \$25 accumulated throughout each calendar quarter.
4. The provider's compliance with the billing requirement in situations involving medical support enforcement by the state Title IV-D agency is determined by having the liable third parties notify the state at the time of the state's quarterly billing if the provider has not complied with the billing requirement. Duplicate payments will be recouped.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans
A	Cost Effectiveness
	(1) Enrollment in a group health insurance plan shall be considered cost effective when the cost of paying the premiums, coinsurance, deductibles and other cost-sharing obligations, and additional administrative costs is estimated to be less than the amount paid for an equivalent set of Medicaid services.
	(1) When determining cost effectiveness of a group health insurance plan, the department shall consider the following information:
	a. The cost of the insurance premium, coinsurance, and deductible;
	b. The scope of services covered under the insurance plan, including exclusions for pre-existing conditions, exclusions to enrollment, and lifetime maximum benefits imposed;
	c. The average anticipated Medicaid utilization:
	1. By age, sex, and coverage group for persons covered under the insurance plan; and
	2. Using a statewide average for the geographic component;
	d. The specific health-related circumstances of the persons covered under the insurance plan; and
	e. Annual administrative expenditures of an amount determined by the department per Medicaid participant covered under the group health insurance plan.
B.	Cost Effectiveness Review.
	(1) The department shall complete a cost effectiveness review:
	a. At least once every six (6) months for an employer-related group health insurance plan; or
	b. Annually for a non-employer-related group health insurance plan.
	(2) The department shall perform a cost effectiveness re-determination if:
	a. A predetermined premium rate, deductible, or coinsurance increases;
	b. Any of the individuals covered under the group health plan lose full Medicaid eligibility; or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

- c. There is a:
 - 1. Change in Medicaid eligibility;
 - 2. Loss of employment when the insurance is through an employer;
or
 - 3. A decrease in the services covered under the policy.
- (3) Changes in enrollment
 - a. A health insurance premium payment program participant, who is a Medicaid enrollee, or a person on that individual's behalf, shall report all changes concerning health insurance coverage to the participant's local Department for Community Based Services (DCBS), Division of Family Support within ten (10) days of the change.
 - b. Except as allowed in section (4) below, if a Medicaid enrollee who is a health insurance premium payment program participant fails to comply with paragraph (a) of this subsection, the department shall disenroll the HIPP program participating Medicaid enrollee, and any family member enrolled in the HIPP program directly through the individual if applicable, from the HIPP program.
- (4) The department shall not disenroll an individual from HIPP program participation if the individual demonstrates to the department, within thirty (30) days of notice of HIPP program disenrollment, good cause for failing to comply with subsection (3) of this section.
- (5) Good cause for failing to comply with subsection (3) of this section shall exist if:
 - a. There was a serious illness or death of the individual, parent, guardian, or caretaker or a member of the individual's, parent's guardian's, or caretaker's family;
 - b. There was a family emergency or household disaster – for example a fire, flood, tornado, or similar;
 - c. The individual, parent, guardian, or caretaker offers a good cause beyond the individual's, parent's, guardian's, or caretaker's control; or
 - d. There was a failure to receive the department's request for information or notification for a reason not attributable to the individual, parent, guardian, or caretaker or lack of a forwarding address shall be attributable to the individual, parent, guardian, or caretaker.
- C Coverage of Non-Medicaid Family Members.
 - (1) If determined to be cost effective, the department shall enroll a family member who is not a Medicaid enrollee into the HIPP program if the family member has group health insurance plan coverage through which the department can obtain health insurance coverage for a Medicaid-enrollee in the family.
 - (2) The needs of a family member who is not a Medicaid enrollee shall not be taken into consideration when determining cost effectiveness of a group health insurance plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

- (3) The department shall:
- a. Pay a HIPP program premium on behalf of a HIPP program participating family member who is not a Medicaid enrollee; and
 - b. Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a HIPP program-participating family member who is not a Medicaid enrollee.

State/Territory: Kentucky

Citation

Sanctions for Psychiatric Hospitals

1902(y)(1),
1902(y)(2)(A)
And Section
1902(y)(3)
of the Act
(P.L. 101-508,
Section 4755(a)(2))
1902(y)(1)(A)
of the Act

(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.

(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.

1902(y)(1)(B)
of the Act

(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:

1. terminate the hospital's participation under the State plan;
or
2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or
3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.

1902(y)(2)(A)
of the Act

(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State: Kentucky

Citation

Sanctions for MCOs and PCCMs

1932(e)
42 CFR 428.726

- (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:
- (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:
- (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by (MS under 42 CFR 438.730(e).
 - Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

Revision: HCFA-PM-98-4 (BERC)
March 1987

Attachment 4.33-A
Page 1
OMB No.: -0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

Medicaid cards are held in the local public assistance offices for pick-up by homeless individuals.

TN No. 87-15
Supersedes
TN No. None

Approval Date JAN 22, 1988

Effective Date 10-1-87

THE HEALTH CARE SURROGATE ACT OF KENTUCKY

Also enacted into law by the 1990 session of the Kentucky General Assembly and the Governor was Senate Bill No. 88, the Health Care Surrogate Act of Kentucky, which is codified at KRS 311.970-386 and allows an adult of sound mind to make a written declaration which would designate one or more adult persons who could consent or withdraw consent for any medical procedure or treatment relating to the grantor when the grantor no longer has the capacity to make such decisions. This law requires that the grantor, being the person making the designation, sign and date the designation of health care surrogate which, at his option, may be in the presence of two adult witnesses who also sign or he may acknowledge his designation before a notary public without witnesses. The health care surrogate cannot be an employee, owner, director or officer of a health care facility where the grantor is a resident or patient unless related to the grantor.

Except in limited situations, a health care facility would remain obligated to provide food and water, treatment for the relief of pain, and life sustaining treatment to pregnant women, notwithstanding the decision of the patient's health care surrogate.

DURABLE POWER OF ATTORNEY

A person may execute, pursuant to KRS 386.093, a document known as a durable power of attorney which would allow someone else to be designated to make decisions regarding health, personal, and financial affairs notwithstanding the later disability or incapacity of the person who executed the durable power of attorney.

Revision: HCFA-PM-95-4 (HSQS)
JUNE 1995

Attachment 4.35-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at S488.404(b)(1):

None

TN No. 95-13
Supersedes
TN No. 89-36

Approval Date: 1-16-96

Effective Date: 7/1/95

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

TN No. 95-13
Supersedes
TN No. 89-36

Approval Date: 1-16-96

Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at S1919(h)(2)(A)) for applying the remedy.

Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

Specified Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

Attachment 4.35-D

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

- | | | | |
|-------------------------------------|--|--------------------------|---|
| <input checked="" type="checkbox"/> | Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.) | <input type="checkbox"/> | Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.) |
|-------------------------------------|--|--------------------------|---|

TN No. 95-13
Supersedes
TN No. None

Approval Date: 1-16-96

Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy Alternative Remedy

(Will use the criteria and notice requirements specified in the regulation.)

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

- | | | | |
|-------------------------------------|--|--------------------------|---|
| <input checked="" type="checkbox"/> | Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.) | <input type="checkbox"/> | Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.) |
|-------------------------------------|--|--------------------------|---|

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents: Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A))

- | | | | |
|-------------------------------------|--|--------------------------|---|
| <input checked="" type="checkbox"/> | Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.) | <input type="checkbox"/> | Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.) |
|-------------------------------------|--|--------------------------|---|

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

Not applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

Not applicable

TN No. 92-2
Supersedes
TN No. None

Approval Date 2-26-92

Effective Date: 2-1-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

Not applicable

TN No. 92-2
Supersedes
TN No. None

Approval Date 2-26-92

Effective Date: 2-1-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

DEFINITION OF SPECIALIZED SERVICES

Mental Illness;

Specialized services (active treatment) is defined as the implementation of an individualized plan of care developed and supervised by a physician and provided by an interdisciplinary team of qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of serious mental illness, which necessitates continuous supervision by trained mental health personnel. Specialized services (active treatment) require the level of intensity provided in a psychiatric inpatient service.

Mental Retardation

Specialized services (active treatment) is defined as the continuous aggressive and consistent implementation of a program of specialized and generic training, treatment, health and related services, which are comparable to services an individual would receive in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), and in the Alternative Intermediate Services for Mental Retardation (AIS/MR) Waiver Program where 24-hour supervision is available that is directed toward: (1) the acquisition of the skills necessary for the person to function with as much self - determination and independence as possible; and (2) the prevention or deceleration of regression or loss of current optimal functional status. {NOTE: Continuous is defined as the interaction, at all times and in all settings, between staff and individuals served, in the implementation of specific Individual Program Plan (IPP) objectives.}

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CATEGORICAL DETERMINATIONS

**Advance Group Determination for Nursing Facility Level of Care
(Provisional Admission for up to 14 Days)**

An advance group determination, or provisional admission, is one in which the Level I reviewer, after nursing facility certification, takes into account certain diagnoses or the need for a particular service which clearly indicates that admission into or residence in a nursing facility is normally needed. Persons who enter the nursing facility under the provisional admissions category do not require an individualized evaluation to determine that specialized services are needed prior to admission. However, a request for a Level II PASARR should be made within nine (9) days of admission with each provisional admission if they are not going to be discharged within the fourteen (14) days. This allows the PASARR evaluator five (5) days to provide a verbal determination.

Provisional Admissions
(Nursing Facility Placement up to 14 Days)

- 1) A diagnosis of delirium as defined in the OSMITIR, allows for a fourteen (14) day admission pending further assessment, when an accurate diagnosis cannot be made until the delirium clears.
- 2) Respite is allowed to in-home care givers to whom the person with mental illness or mental retardation is expected to return following a fourteen (14) day or less stay.

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

REVISED
Attachment 4.40-A
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

State staff participate in regular and periodic provider training events. This participation includes serving as presenters and panel members as well as conducting sessions on regulations changes and implementation. Provider representatives include both administration and direct case staff. State staff also participate in resident council meetings and will be providing other training for facility residents and/or responsible parties as time and staff permit.

TN No. 93-6
Supersedes
TN No. None

Approval Date: 8-12-97

Effective Date 1-1-93

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

REVISED
Attachment 4.40-B
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect
and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

All allegations of abuse, neglect and misappropriation of resident property are immediately investigated by Division of Licensing and Regulation and Department for Social Services in a joint effort. During this investigation the accused individual is advised of the alleged incident. Prior to a final determination of substantiation the accused individual is afforded the opportunity to appeal. All substantiated investigations are subject to the appropriate appeal process. Substantiated cases of Nurse Aide abuse, neglect and/or misappropriation are entered on a centralized registry maintained by the State Survey Agency. The accused individual and all appropriate authorities are notified of the final determination and action taken.

TN No. 93-6
Supersedes
TN No. None

Approval Date: 8/12/97

Effective Date: 1-1-93
HCFA ID:

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

REVISED
Attachment 4.40-C
Page 1
OMB No.:

STATE PLAN UNDER TITLE: XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

In addition to federal procedures, the Division of Licensing and Regulation is prohibited by state law from giving any advance notice of long-term care facility surveys. Surveys to be conducted in a given month are sent to our regional offices. Schedulers in regional offices do not release schedules to staff until approximately one week prior to survey. Master schedules in regional offices are closely guarded.

Kentucky uses a flexible survey schedule where some facilities are surveyed in ranges of 9 to 15 months. Survey schedules are also based on performance in previous surveys and the number of complaints made against a facility.

TN No. 93-6
Supersedes
TN No. None

Approval Date 8-12-97

Effective Date 1-1-93
HCFA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following procedures to measure and reduce inconsistency in the application of survey results among surveyors.

Annual training sponsored by Licensing and Regulation plus quarterly in-service training in Regional Offices on specific problem areas that need addressing for statewide consistency in the application of the survey process. Basic training and other specialized courses are provided by HCFA. Also, all survey packets received in Central Office are reviewed by compliance analysts.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

- (i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;
- (ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or
- (iii) the State has reason to question the compliance of the facility with such requirements.

Refer to Attachment 4.40-C

All allegations of facility violations are investigated by the Division of Licensing and Regulation. All deficiencies resulting in Level A noncompliance are followed up for correction.

**Method for establishing Employee Education
Of False Claim Policies and Procedures**

1. The Department will query the Decision Support System (DSS) for FFY 2006 Fee-for-Service and Encounter Data as of January 1, 2007 to identify entities for the purposes of section 6032 of the Deficit Reduction Act of 2005 with distinct Federal Employer Identification Number (FEIN) receiving over \$5,000,000.
2. Each entity from the query in step 1, will be sent a provider letter reminding them that their provider agreement requires them to comply with all applicable State and Federal laws and advising them that the Deficit Reduction Act of 2005 section 6032 contains a new requirement that must be met. Any entity paid through the Medicaid FMAP signs the aforementioned provider agreements in order to receive a provider number and the ability to bill. This includes Passport, Transportation Brokers, and other state agencies. The letter will include a form that must be signed and returned certifying that they meet the following requirements from section 1902(a)(68) of the Social Security Act:
 - A. Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs(as defined in section 1128B(f));
 - B. include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
 - C. include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;
3. The entities will attach relevant documents in meeting the requirements from 1902(a)(68) of the Social Security Act. Relevant documents include but are not limited to policy memos, employee handbook, and any document that demonstrates how the entity satisfies the requirements. Responses will be due to the Department by September 1, 2007.
4. The Department will evaluate the entities responses, and certify the response as valid or state the reasons the conditions were not met in a response back to the entity by December 31, 2007.
5. For future years beginning with FFY 2009, a reassessment will occur at least every three years to ensure compliance with 1902(a)(68) of the Social Security Act. The following deadlines will apply in the given year:
 - A. Un-duplicated providers from the previous FFY's DSS query meeting the same criteria in step 1 as of January 1 following the end of the respective FFY will be sent the entity letters from step 2 by March 31 of the respective year;
 - B. Entity response to the letter will be due by June 30 of the respective year; and
 - C. The Department will send the response to the entity by September 30 of the respective year. The Department letter will validate the entities response' or state the reasons the conditions were not met.

MEDICAL ASSISTANCE PROGRAM

STATE OF KENTUCKY

KENTUCKY CITATION LISTING

1. Kentucky revised statutes, Chapter 18, on State Personnel, as amended through February 22, 1972, including the understanding contained in the March 16, 1972, letter from Carl V. Beeler, then Chief, Division of Intergovernmental Personnel Programs, USCSC, to Miss Cattle Lou Miller, Kentucky Commissioner of Personnel, that in the Grant-Aided Agencies the Federal standards must determine which assistant or deputy may be exempted from coverage. Also included is the understanding contained in paragraph 3 of the March 16, 1972, letter that the only effect of Section 3 (1) and Section 4 (1) and (2), of House Bill Number 120, is to remove the Commissioner of Personnel class from Merit System coverage and to revise the method of appointment to authorize direct appointment by the Governor.
2. Personnel rules of the Kentucky Department of Personnel, as amended through March 9, 1973, including the understanding contained in the October 31, 1961, letter from the Kentucky Commissioner of Personnel to the Regional Merit System Representative that provisional appointments will not be made or continued if there are as many as three (3) available eligibles for a position.
3. Policy memoranda in effect through November 25, 1970, which were issued by the Commissioner of Personnel to all Department and Agency Heads.

MEDICAL ASSISTANCE PROGRAM

STATE OF Kentucky METHODS OF ADMINISTRATION - CIVIL RIGHTS

The state agency's implementing methods of administration of the medical assistance program to ensure non-discrimination have been submitted and are on file.

I. Assignment of Responsibility

Responsibility for ensuring that Title VI compliance is maintained rests with the Coordinator, Civil Rights, Department for Human Resources. In accordance with administrative structure of the Department for Human Resources, Title VI reviews of hospitals, nursing homes and intermediate care facilities are conducted by the Division for Licensing and Regulation, Bureau for Administration and Operations, in conjunction with the Division's on-site validation surveys.

II. Dissemination of Information

A check insert was sent to all recipients of assistance in 1965 to advise that the adult and children's programs and medical assistance would be administered in accordance with the Civil Rights Act of 1964. The insert specified that no discrimination would be made due to race, color, or national origin, and that applicant or recipient who felt he was discriminated against for these reasons had the right to appeal. A pamphlet titled "Kentucky Public Assistance and Civil Rights" was prepared to explain the Civil Rights Act and was mailed to recipients of assistance payments to further advise them of the provisions of the Act. A copy of the pamphlet is given to each new applicant. Any applicant or recipient who appears not to understand his civil rights is given a complete verbal explanation to supplement the written material, and it is agency practice that in any initial interview with an applicant for assistance the worker summarizes the Title VI provisions and provides answers to any questions.

The Civil Rights pamphlet specifies the agency's compliance with Title VI, explains that applicants and recipients of federally aided programs will not be discriminated against by the agency or vendors of services, and that the applicant or recipient who feels he has been discriminated against may request a hearing with the agency or make the allegation of discrimination to the Kentucky Commission on Human Rights, Frankfort, Kentucky, or the Secretary of Health, Education, and Welfare, in Washington, DC.

MEDICAL ASSISTANCE PROGRAM

STATE OF: Kentucky METHODS OF ADMINISTRATION - CIVIL RIGHTS

The Manual of Operation of the Bureau for Social Insurance specifies that the Federal Government has been assured that public assistance programs will be administered in such a manner that no person is to be excluded from any benefits under the program or otherwise subjected to any discrimination on the grounds of race, color or national origin. Pamphlets, check inserts and similar civil rights material made available to applicants/recipients are also made available to staff, and circulars, memoranda, and similar communicative devices are used to further advise staff of actions required for compliance with the Civil Rights Act. Agency training and orientation for new workers provide explanation of Title VI of the Civil Rights Act and instructs workers in techniques of non-discrimination. Supervisory personnel are also from time to time, used to re-emphasize to agency workers the importance of non-discrimination and to correct any local practices which may be interpreted as discriminatory, whether real or potential.

Vendors are provided with Civil Rights information by pamphlets, Circulars or other appropriate means, and where required by Federal regulation their agreement to participate includes their agreement not to discriminate due to race, color or national origin. The billing system is designed so as to contain a statement to the effect that services provided under the Medical Assistance Program are provided without discrimination due to race, color or national origin.

The General Public is made aware of the agency's continuing compliance with Title VI by the use of public information releases to newspapers or other-news outlets at intervals as necessary.

III Maintaining and Assuring Compliance

Pursuant to federal regulations and utilizing federal guidelines on-site reviews are conducted at least annually of all participating hospitals, skilled nursing facilities and intermediate care facilities, unless a satisfactory and similar review for Title XVIII purposes has been accomplished for that period of time. The on-site review is conducted by trained personnel of the Division for Licensing and Regulation, Bureau for Administration and Operation, as an integral part of their annual on-site validation survey of these facilities, and includes a- survey of the physical facility, interviews with appropriate facility employees and patients, and an evaluation as to any actual or potential areas of discrimination.

MEDICAL ASSISTANCE PROGRAM

STATE OF Kentucky METHODS OF ADMINISTRATION CIVIL RIGHTS

The Bureau does not conduct regular on-site reviews for Civil Rights compliance monitoring of physicians, dentists, etc. However, the Bureau for Social Insurance has personnel assigned to specific area development districts who have as one of their functions vendor liaison to assist vendors in overcoming problems related to client identification, billing, program changes, etc. These liaison personnel do as a part of their assigned responsibility visit the offices, clinics and other facilities of individual vendors and would observe any overt or manifest indications of discriminatory practice or treatment. Whether discovered through the Title VI on-site review or other contact, any suspected discriminatory practice is investigated to determine the facts of the situation, and an evaluation as to actual or potential discrimination is made.

Should a discriminatory practice be found, the Bureau takes immediate action to secure compliance. In accordance with federal directives the individual, organization, or agency found to be in actual or potential non-compliance with the Civil Rights Act and agency practice in the provision of medical and related services is afforded the opportunity to voluntarily comply with the requirements. In the event efforts to solicit voluntary compliance fail, all available sanctions provided for in the law and regulations are invoked, including removal of a vendor from participatory status in all appropriate instances.

IV. Handling Complaints

At the time the client alleges discriminatory treatment, the local worker explores the situation and attempts to resolve it to the satisfaction of the client on an informal basis. If such resolution is not possible, the client may appeal through the usual hearing process, or file a complaint of discrimination based on race, color, or national origin.

When the client alleges that he is being denied eligibility for a money payment or medical assistance through discriminatory agency policy, or discriminatory application of agency policy, he would ordinarily use the hearing process which provides for determinations as to eligibility for benefits. The process includes a hearing before a Hearing Officer of the Bureau, recourse to the Appeal Board for a review of the Hearing Officer's decision, and final recourse to the judicial system. The complainant is afforded the right to counsel, or other representation of his choice, throughout the process. He may submit written or oral statements or other material to substantiate his allegation, and may appear personally to present evidence or have the case judged on the merits of the evidence previously introduced, during the review by the Appeal Board.

MEDICAL ASSISTANCE PROGRAM

STATE OF Kentucky METHODS OF ADMINISTRATION – CIVIL RIGHTS

A finding of discrimination established through the hearing process is considered binding on the agency, and decisions made to alleviate current discrimination or prevent future occurrences of a similar nature are implemented to the fullest possible extent by the agency.

When the client reports discrimination in the manner of provision of services, or refusal of access to medical benefits to which he is entitled, due to race, color or national origin, he would ordinarily use the complaint of discrimination process, which provides for correction of the situation through removal of a vendor in non-compliance status from participating status with the program. The complaint of discrimination is formally filed through completion of the Complaint of Discrimination form, which is immediately forwarded to the Area Manager for action.

Following action by the Area Manager, the client has further recourse to the Coordinator, Civil Rights, Department for Human Resources and to be Kentucky Commission on Human Rights. The client is afforded opportunity to substantiate his complaint of discrimination, and appropriate investigation is made at each responsible level. The Coordinator, Civil Rights, will maintain a file of all complaints made on the basis of discrimination, and the resolution of such complaints. (See attached Flow Chart, Attachment 7.2-A.1.)

The Ombudsman, Department for Human Resources, will receive complaints on discrimination that are addressed to that office by the client, and will forward such claims to the Coordinator, Civil Rights, for resolution.

The Director of the Division for Medical Assistance will remove from participatory status any vendor practicing discrimination if voluntary compliance cannot be secured, based on a finding of the Coordinator, Civil Rights, Department for Human Resources, or the Kentucky Human Rights Commission.

Recruitment and Training Programs

Agency recruitment is in accordance with Title VI of the Civil Rights Act, Chapter 18 of the Kentucky Revised Statutes, State Personnel Rules, and Public Assistance Regulation Number 14. Race, color, or national origin are not factors in recruiting, hiring, upgrading, conditions of employment, dismissals, referrals and training programs. In-service training is provided on a uniform basis to all employees, and training staff of the agency is the basis of merit, and minority group employees are made aware of such training programs and given the opportunity to participate.

MEDICAL ASSISTANC PROGRAM

STATE OF Kentucky

FLOW CHART - HANDLING CIVIL RIGHTS COMPLAINTS

Description and analysis, Flow Chart: Methods of Handling Complaints of Discrimination due to Race, Color, or National Origin.

1. The Bureau for Social Insurance worker receives the complaint and resolves it informally if possible. Based on a preliminary determination of facts, the client is advised as to the most appropriate appeal procedure. The Complaint Form, PA-664, is completed in all appropriate instances by the client (with the assistance of the worker) and is forwarded to the BSI Area Manager for corrective action.
2. The Area Manager conducts a preliminary or limited investigation to establish the basic facts of the situation. If discrimination is established, the Area Manager will attempt to informally persuade the person or facility practicing discrimination to amend the practice in question. The client will be notified of the disposition of the complaint, and the complaint and a copy of the resolution statement to the client will then be forwarded to the Coordinator, Civil Rights, Department for Human Resources. When the Area Manager is unable to resolve the complaint, the evidentiary data secured will be forwarded to the Coordinator for his further use. The Area Manager will maintain a Civil Rights Complaint File. The client may request further action by the Coordinator, Civil Rights, if not satisfied with the Area Manager's complaint resolution.
3. The Coordinator, Civil Rights, Department for Human Resources, will acknowledge receipt of any unresolved complaint and conduct/direct an immediate investigation to fully establish the facts and circumstances alleged in the complaint. If discriminatory practices are found, the Coordinator will seek to secure voluntary compliance through informal persuasion, and will notify the client of the resolution. Should a discriminatory practice not be voluntarily ended, a statement of findings would be forwarded to the Director, Division for Medical Assistance, for corrective action. A resolution by the Coordinator not satisfactory to the client would result in the complaint being forwarded to the Kentucky Commission on Human Rights for further action.
4. When a statement of findings is forwarded to the Director, Division for Medical Assistance, for corrective action the Director will afford the vendor the opportunity to voluntarily comply, prior to removal of the vendor from participatory status. When the complaint is referred to the Commission on Human Rights (HRC) for resolution, the HRS establishes legitimacy and validity of the complaint, conducts any necessary investigations and holds a hearing as appropriate, and attempts informal persuasion to secure voluntary compliance. A report of compliance or hearing report is issued.
5. When the report of HRC is reviewed by the Director, Division for Medical Assistance, the Director ensures that required corrective action is taken. When voluntary compliance by a vendor cannot be secured, removal of the vendor from participatory status will be accomplished.

Department for Human Resources, Bureau for Social Insurance Flow Chart depicting the handling of complaints of discrimination due to race, color or country of national origin.

