

**STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
KENTUCKY CHILDREN'S HEALTH INSURANCE PROGRAM  
(KCHIP)**

**Preamble**

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

**KENTUCKY CHILDREN'S HEALTH INSURANCE PROGRAM  
(KCHIP)**

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

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

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

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Lawrence Kissner, Commissioner  
Department for Medicaid Services

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

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

Lisa Lee, Deputy Commissioner  
Neville Wise, Deputy Commissioner  
Lee Guice, Division Director of Policy and Operations  
Department for Medicaid Services, 275 East Main Street: 6W-D Frankfort, KY 40632,  
Phone: 502-564-4321, Fax: 502-564-0509

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

**Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)**

**1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):**

- 1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR**
- 1.1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX); OR**
- 1.1.3.  A combination of both of the above.**

**Kentucky has been working since November 1996 to increase health care access by all age groups. At that time a workgroup was convened by the Cabinet for Health Services and included many interested parties. Three target groups were identified: 1) Uninsured children; 2) Uninsured adults; and 3) Elderly with difficulty affording needed medicines. As Title XXI funds became available, the children's program became a priority. Several subgroups were formed to tackle specific issues such as the benefits package, financing, and policy issues including outreach, coordination, and evaluation.**

**Kentucky's Title XXI State Plan will expand children's access to health coverage by implementing state enabling legislation and building on the experience and infrastructure of the Kentucky Medicaid program. The Kentucky Children's Health Insurance Program (KCHIP) will adopt two approaches to expanding health care coverage for children; a Medicaid expansion and a state designed health insurance program.**

**KCHIP Medicaid Expansion**

**The current Medicaid program will be expanded to cover poverty level children 14 to 19 to 100% FPL, July 1, 1998. An additional CHIP Medicaid expansion will take place on July 1, 1999, to cover targeted low-income children from one to 19 in families up to 150% FPL.**

**KCHIP Separate Insurance Program**

**This Medicaid look alike is designed to cover children from birth to 19 years of age who are not eligible for Medicaid or the KCHIP Medicaid Expansion and have family incomes at or below 200% FPL. This program will become effective on November 1, 1999. Health care services will include all current Medicaid services with the exception of non-emergency transportation and EPSDT Special Services. Health care services will be provided through the existing Medicaid service delivery system.**

**Outreach**

**Many new outreach efforts will be implemented under the Title XXI program. The goals for outreach in the state will be to inform families of the program, assist them with enrolling their**

children, and follow through to get the children enrolled. Eligibility determination will continue to be contracted by the Department for Medicaid Services to the Department for Community Based Services (DCBS). Local outreach will be coordinated by the Department for Public Health and will involve many community agencies and private non-profit organizations. Applicants may complete a mail-in application or go directly to the local offices to make an application. Local outreach is essential to explaining the process to potential applicants.

In 2013, the Department for Medicaid Services and KCHIP began collaborations with Kentucky's Health Benefits Exchange (HBE). This collaboration led to the development of a joint on-line application system. Beginning October 1, 2013 applicants can use the on-line application to apply for KCHIP benefits. In addition, KCHIP staff collaborates with the Kentucky's HBE to perform community based outreach activities that provides information regarding the on-line eligibility and enrollment system as well as KCHIP benefits and services. This collaboration allows Kentucky to perform targeted outreach to the entire families that do not have health insurance and may potentially be eligible for Medicaid, KCHIP, or insurance offered on Kentucky's HBE.

### **Implementation Timetable**

The Medicaid expansion will be effective on July 1, 1998 or upon approval of this plan if approval is after July 1, 1998. The state is asking for approval of the Medicaid expansion component prior to the full Title XXI Plan approval, if necessary, so that Kentucky can begin covering a portion of the target population as quickly as possible. The CHIP Medicaid coverage of children from one to 19 in families up to 150% FPL will be effective on July 1, 1999. The state designed KCHIP program will be a Medicaid look alike for children from birth to 19 who are not eligible for Medicaid or the KCHIP Medicaid expansion with family income at or below 200% FPL and will become effective on November 1, 1999.

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

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

**We assure that in Kentucky expenditures for child health assistance will not be claimed prior to the time that the state has legislative authority to operate the State plan or plan amendment as approved by CMS.**

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

We assure that Kentucky complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

	Effective date:	July 1, 1998
	Implementation date:	July 1, 1998
SPA #1 (Medicaid SCHIP Expansion to 150 FPL)		
	Effective date:	July 1, 1999
	Implementation date:	July 1, 1999
SPA #2 (Separate Insurance Program)		
	Effective date:	November 1, 1999
	Implementation date:	November 1, 1999
SPA #3 (Application and Recertification Process Change)		
	Effective date:	June 1, 2001
	Implementation date:	June 1, 2001
SPA #4 (Application Process Change and compliance)		
	Effective date:	July 1, 2002
	Implementation date:	July 1, 2002
SPA #5 (Cost Sharing)		
	Effective date:	August 1, 2002
	Implementation date:	August 1, 2002
SPA #6 (Cost Sharing)		
	Effective date:	June 1, 2003
	Implementation date:	June 1, 2003
SPA #7 (Cost Sharing)		
	Effective date:	November 1, 2003
	Implementation date:	November 1, 2003
SPA #8 (Benefit, Cost Sharing, Delivery System)		
	Effective date:	May 15, 2006
	Implementation date:	May 15, 2006

SPA #9 (Eligibility Determination)	
Effective date:	November 1, 2008
Implementation date:	Withdrawn
SPA #10 (Eligibility Determination)	
Effective date:	November 1, 2008
Implementation date:	November 1, 2008
SPA #11 (Premium Payments)	
Effective date:	July 1, 2010
Implementation date:	July 1, 2010
SPA #12 (Children of State Employees)	
Effective date:	October 1, 2010
Implementation date:	October 1, 2010
SPA #13 (Update portions impacted by the Affordable Care Act Provisions)	
Effective date:	January 1, 2014
Implementation date:	January 1, 2014
SPA #13-0013 (MAGI Eligibility & Methods)	
CS7 (Eligibility-Targeted Low Income Children)	
CS10 (Children with Access to Public Employee coverage)	
CS15 (MAGI-Based Income Methodologies)	
Effective date:	January 1, 2014
Implementation date:	January 1, 2014
SPA #13-0014 XXI Medicaid Expansion	
CS3 (Eligibility for Medicaid Expansion Program)	
Effective date:	January 1, 2014
Implementation date:	January 1, 2014
SPA #13-0015(Establish 2101(f) Group	
CS14 (Children ineligible for Medicaid as a Result of the Elimination of Income Disregards)	
Effective date:	January 1, 2014
Implementation date:	January 1, 2014
SPA #13-0016(Eligibility Process)	
CS24 (Single, Streamlined Application Screen and Enroll Process Screen)	
Effective date:	October 1, 2013
Implementation date:	October 1, 2013

**SPA #13-0017 (Non-Financial Eligibility)**  
**CS17 (Non-Financial Eligibility-Residency)**  
**CS18 (Non-Financial-Citizenship)**  
**CS19 (Non-Financial-Social Security)**  
**CS20 (Substitution of Coverage)**

## Superseding Pages of MAGI CHIP State Plan Material

State: Kentucky

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
<b>KY-13-0013</b>  Effective/ Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections – Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
		CS10	Children With Access to Public Employee Coverage	Supersedes only the information on dependents of public employees in Section 4.4.1; supporting documentation should be incorporated as an appendix to the current state plan
		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
<b>KY-13-0014</b>  Effective/ Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
<b>KY-13-0015</b>  Effective/ Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
<b>KY-13-0016</b>  Effective/ Implementation Date: October 1, 2013	Eligibility Process	CS24	Single, Streamlined Application Screen and Enroll Process Renewals	Supersedes the current section 4.3; 4.4
<b>KY-14-0017</b>  Effective/ Implementation Date: January 1, 2014	Non- Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5
		CS18	Non-Financial – Citizenship	Supersedes the current sections 4.1.0; 4.1-LR;
		CS19	Non-Financial – Social Security Number	Supersedes the current section 4.1.9.1

<b>Transmittal Number</b>	<b>SPA Group</b>	<b>PDF #</b>	<b>Description</b>	<b>Superseded Plan Section(s)</b>
<b>KY-14-0017</b> Effective/ Implementation Date: January 1, 2014	Non- Financial Eligibility	CS20	Substitution of Coverage	Supersedes the current section 4.4.4
KY-17-0000  Effective/Impleme ntation Date: July 1, 2017	Eligibility Process	CS24	Single, Streamlined Application Screen and Enroll Process Renewals	Supersedes the previously approved CS24

**1.4-TC Tribal Consultation** (Section 2107€(1)©) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Not applicable. There are no federally recognized American Indian Tribes in Kentucky

## **Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination** (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

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

Population estimates for 1996 show that there are 3,883,723 people living in Kentucky. Of those 1,011,166 are children under the age of 19. Approximately 93,346 (9.23%) of Kentucky's children are African American.<sup>1</sup> The child poverty rate in Kentucky has steadily risen since 1979. It is estimated that in 1996 nearly three in ten Kentucky children lived in poverty. Another two in ten lived just above the poverty level.<sup>2</sup>

The Kentucky Legislative Research Commission (LRC) has studied the insurance status of the state for the past three years. Data for the first two reports were collected in two separate, random surveys of Kentucky households: The Kentucky Health Insurance Survey in 1996 and 1997 and the Current Population Survey for various years. For the Kentucky Health Insurance Survey, telephone interviews were conducted with 1,259 households. Based on these sources for 1997, LRC estimated that there were 154,000 uninsured children in the state, 123,000 of whom are under 200% FPL. Of those children, 45,000 (approximately 30%) are believed to be eligible for Medicaid under the current eligibility requirements. An additional 23,000 children ages 14 to 19 are between 33% and 100% FPL and would be eligible for the proposed Title XXI Medicaid expansion. Approximately 35,000 uninsured children would be eligible for the CHIP Medicaid expansion to children from one to 19 in families up to 150% FPL, and the remaining 20,000 children have family incomes between 150% and 200% FPL. This report did not study children by race or ethnicity.<sup>3</sup>

The Legislative Research Commission has recently updated the "Status of the Health Insurance Market in Kentucky" to reflect 1998 Kentucky Health Insurance Survey data. The updated report indicated that approximately 139,000, or 13.7% of Kentucky children are without health insurance. There are approximately 63,000 (45%) children below 100% FPL, 33,000 (24%) children between 101% to 150% FPL, and 15,000 (11%) children between 151% to 200% FPL. The range of this estimate, with a confidence level of 95%, falls between 127,000 and 150,000. About 111,000 of these children have family incomes that would qualify them for traditional Medicaid or KCHIP. Although this figure reflects an apparent decrease from the previous estimate of 123,000 eligible children, this decrease is not statistically significant.

Any decrease that might be construed from these data cannot be attributed to KCHIP because the survey was conducted before KCHIP implementation. (Source: Michael Clark:

**Status of the Health Insurance Market in Kentucky, 1998, Frankfort, KY: Legislative Research Commission, February 2000.)**

**Medicaid is the only public health insurance program generally available in Kentucky. Medicaid currently covers children 0 to 1 at 185% FPL, from 1 through 5 up to 133% FPL, from 6 through 14 (effective SFY 2000) at 100% FPL, and 15 to 19 up to 33% FPL. Each year the State increases the age level of those covered at 100% FPL by one year.**

**In 1996, Medicaid served 348,045 children under 21 years of age, which is 29.3% of all Kentucky children under age 21 as of July 1, 1996.<sup>4</sup>**

<u>Category</u>	<u>Estimated # Uninsured</u>
<b>Age of Uninsured Children:</b>	
Age Under 1	5,560 (4%)
Age 1-5	26,410 (19%)
Age 6-15	77,840 (56%)
Age 16 -18	30,580 (22%)
Source: LRC Research Memorandum No. 290. See endnotes.	

**Based on this data, the state has estimated that there will be 50,624 children eligible for the Medicaid expansion. Approximately 15,624 children would be eligible for the KCHIP insurance program.**

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

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

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

### **Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))**

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

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

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

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

**This language replaces the existing description.**

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

approval. (Section 2103(f)(3))

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

- 3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

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

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

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

**The state assures that all managed care contracts comply with relevant provisions of Section 1932 of the Act.**



OMB Control Number: 0938-1148 Expiration date: 10/31/2014

<b>Eligibility for Medicaid Expansion Program</b>	<b>CS3</b>
42 CFR 457.320(a)(2) and (3)	

Income Eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards:

There should be no overlaps or gaps for the ages entered.

Age and Household Income Ranges

	From Age	To Age	Above (%FPL)	Up to and including (%FPL)	
+	1	6	142	159	<b>X</b>
+	6	19	109	159	<b>X</b>

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# CHIP Eligibility

OMB Control Number: 0938-1148  
Expiration Date: 10/13/2014

## Separate Child Health Insurance Program Non-Financial Eligibility-Citizenship

CS18

Sections 2105(c)(9) and 2107(e)(1)(J) of the SSA and 42 CFR 457.320(b)(6), (c) and (d)

### Citizenship

- ✓ The CHIP Agency provides CHIP eligibility to otherwise eligible citizens and nationals of the United States and certain non-citizens, including the time period during which they are provided with reasonable opportunity to submit verification of their citizenship, national status or satisfactory immigration status.
  - The CHIP Agency provides eligibility under the Plan to otherwise eligible individuals:

Who are citizens or nationals of the United States; or

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), and 1902(ee) of the Act, and 42 CFR 435.406, 407, 956 and 457.380.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

YES

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual. The date benefits are furnished is:

YES

- The date of application containing the declaration of citizenship or immigration status.
- The date the reasonable opportunity notice is sent.
- Other date, as described:

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3).

YES

Otherwise eligible children means children meeting the eligibility requirements of targeted low-income children with the exception of non-citizen status.

- The CHIP Agency provides assurance that lawfully residing children are also covered under the state's Medicaid program.



# CHIP Eligibility

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible pregnant women, lawfully residing in the United States, as provided in Section 214 of CHEPRA 2009, P.L. 111-3. The state may not select this option unless the state also elects to cover lawfully residing children. A state may not select this option unless the state also covers Targeted Low-Income Pregnant Women.

No

- An individual is considered to be lawfully residing in the United States if he or she is lawfully present and meets state residency requirements.
- An individual is considered to be lawfully present in the United States if he or she is:
  1. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);
  2. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));
  3. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;
  4. A non-citizen who belongs to one of the following classes:
    - (i) Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively;
    - (ii) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;
    - (iii) Granted employment authorization under 8 CFR 274a.12(c);
    - (iv) Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;
    - (v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;
    - (vi) Granted Deferred Action status;
    - (vii) Granted an administrative stay of removal under 8 CFR 241;
    - (i) Beneficiary of approved visa petition who has a pending application for adjustment of status;
  5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture, who:
    - (viii) Has been granted employment authorization; or
    - (ix) Is under the age of 14 and has had an application pending for at least 180 days;
  6. Has been granted withholding of removal under the Convention Against Torture;
  7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C.110I(a)(27)(J);
  8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
  9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).



**CMS CHIP Eligibility**

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

**PRA Disclosure Statement**

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4.1.4.Resources (including any standards relating to spend downs and disposition of resources):

**There will not be any resource testing for the insurance program for income eligible Medicaid applicants.**

# CMS

# CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

**Separate Child Health Insurance Program  
Non-Financial Eligibility-Residency**

**CS17**

42 CFR 457.320

## **Residency**

- ✓ The CHIP Agency provides CHIP to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

A child is considered to be a resident of the state under the following conditions:

A non-institutionalized child, if capable of indicating intent and who is emancipated or married, if the child is living in the state and:

1. Intends to reside in the state, including without a fixed address, or
2. Has entered the state with a job commitment or seeking employment, whether or not currently employed.

A non-institutionalized child not described above and a child who is not a ward of the state:

1. Residing in the state, with or without a fixed address, or
2. The state of residency of the parent or caretaker, in accordance with 42 CFR.435.403(h)(1), with whom the individual resides.

An institutionalized child, who is not a ward of the state, if the state is the state of residence of the child's custodial parent or m<sup>i</sup> caretaker at the time of placement, or

A child who is a ward of the state regardless of where the child lives, or

A child physically located in the state when there is a dispute with one or more states as to the child's actual state of residence.

If the state covers pregnant women, a pregnant woman is considered to be a resident under the following conditions:

A non-institutionalized pregnant woman who is living in the state and:

1. Intends to reside in the state, including without a fixed address, or if incapable of indicating intent, is living in the state, or
2. Entered with a job commitment or seeking employment, whether or not currently employed.

An institutionalized pregnant woman placed in an out-of-state-institution, as defined in 42 CFR 435.1010, including foster care homes, by an agency of the state, or

An institutionalized pregnant woman residing in an in-state-institution, as defined in 42 CFR 435.1010, whether or not the individual established residency in the state prior to entering the institution, or

A pregnant woman physically located in the state when there is a dispute with one or more states as to the pregnant woman's actual state of residence.

The state has in place related to the residency of children and pregnant women (if covered by the state):

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# CHIP Eligibility

One or more interstate agreement(s).  NO

A policy related to individuals in the state only for educational purposes.  NO

### PRA Disclosure Statement

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

4.1.7. Access to or coverage under other health coverage:

**(See Section 4.4.4)**

4.1.8. Duration of eligibility:

**Children are re-certified for eligibility every 12 months. Changes in income, residence, and insurance status must be reported by the family within 10 days and may result in termination of eligibility for KCHIP.**

4.1.9. Other standards (identify and describe):



# CHIP Eligibility

**Separate Child Health Insurance Program  
Non-Financial Eligibility - Social Security Number**

**CS19**

OMB Control Number: 0938-1148  
Expiration date: 10/31/2014

42 CFR 457.340(b)

## Social Security Number

As a condition of eligibility, the CHIP Agency must require individuals who have a social security number or are eligible for one as determined by the Social Security Administration, to furnish their social security number, or numbers if they have more than one number.

- ✓ The CHIP Agency requires individuals, as a condition of eligibility, to furnish their social security number(s), with the following exceptions:

Individuals refusing to obtain a social security number (SSN) because of well established religious objections, or

Individuals who are not eligible for an SSN, or

Individuals who are issued an SSN only for a valid non-work purpose.

- The CHIP Agency assists individuals, who are required to provide their SSN, to apply for or obtain an SSN from the Social Security Administration if the individual does not have or forgot their SSN.
- The CHIP Agency informs individuals required to provide their SSN:

By what statutory authority the number is solicited; and

How the state will use the SSN.

- ✓ The CHIP Agency provides assurance that it will verify each SSN furnished by an applicant or beneficiary with the Social Security Administration, not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by the Social Security Administration and that the state's utilization of the SSNs is consistent with sections 205 and 1137 of the Social Security Act and the Privacy Act of 1974.

The state may request non-applicant household members to voluntarily provide their SSN, if the state meets the requirements below.

The state requests non-applicant household members to voluntarily provide their SSN.

Yes

- ✓ When requesting an SSN for non-applicant household members, the state assures that:

- At the time such SSN is requested, the state informs the non-applicant that this information is voluntary and provides information regarding how the SSN will be used; and
- The state only uses the SSN for determination of eligibility for CHIP or other insurance affordability programs, or For a purpose directly connected with the administration of the state plan.

## PRA Disclosure Statement

The logo for CMS CHIP Eligibility features the letters 'CMS' in a bold, sans-serif font, with a stylized swoosh above the 'C' and 'M'. To the right of 'CMS', the words 'CHIP Eligibility' are written in a larger, bold, sans-serif font. Below the 'CMS' text, there is a small line of text: '11-11-1111 VOYM e-ll • WWL -14 -10'.

# CMS CHIP Eligibility

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SPA # KY-13-0017

Approval Date: Nov 14 2013

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Page 2 of 2

**4.1.9.2** Continuous eligibility

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

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



# CHIP Eligibility

OMB Control Number: 0938-1148  
Expiration date: 10/31/2014

## Child Health Insurance Program Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

**CS14**

Section 2101(f) of the ACA and 42 CFR 457.310(d)

Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.

The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.

The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

% FPL

The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.

Other.

Describe the benefits provided to this population:

This population will be provided the same benefits as are provided to children in the state's Medicaid program.

This population will be provided the same benefits as are provided to children in the state's separate CHIP.

Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

Cost sharing is the same as for children in the Medicaid program.



# CHIP Eligibility

- Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

## PRA Disclosure Statement

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4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

- 4.2.1. These standards do not discriminate on the basis of diagnosis.
- 4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3. These standards do not deny eligibility based on a child having a preexisting medical condition.

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

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

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

**4.2.3-DS** These standards do not deny eligibility based on a child having a preexisting medical condition.

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

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

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

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

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

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

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

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



# CHIP Eligibility

OMB Control Number: 0938-1148  
Expiration date: 10/31/2014

**Separate Child Health Insurance Program  
MAGI-Based Income Methodologies** **CS15**

2102(bX1)(B)(v) of the SSA and 42 CFR 457.315

The CHIP Agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups, as described below, and consistent with 42 CFR 457.315 and 435.603(b) through (i).

In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility, whichever is later.

lithe state covers pregnant women, in determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted just as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size.
- Projected annual household income for the remaining months of the current calendar year and family size.

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of the reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 457.315 and 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(t)(2)(i) as a tax dependent.

Yes

The CHIP Agency certifies that it has submitted and received approval for the conversion for all separate CHIP covered group income standards to MAGI-equivalent standards.

**An attachment is submitted.**



# CHIP Eligibility

## PRA Disclosure Statement

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# CHIP Eligibility



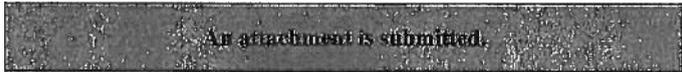
2102(b)(3) & 2107(e)(1)(0) of the SSA and 42 CFR 457, subpart C

- ✓ The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

## Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.
- An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.



An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the  agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.



- ✓ The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

- Other electronic means:

	Name of method	Description	
+	FAX	FAX	X

## Screen and Enroll Process

- ✓ The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-ILI income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:



# CHIP Eligibility

- Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and
- Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and
- Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA.

NO

## Redetermination Processing

- ✓ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:
  - Once every 12 months.
  - Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.
  - If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

## Screening by Other Insurance Affordability Programs

- ✓ The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.

The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

Check all types of agencies that apply:

The Exchange

Medicaid

Other agency administering insurance affordability programs

- ✓ The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the ILI requirements of 457.348(b) and will provide this agreement to the Secretary upon request.



# CHIP Eligibility

## PRA Disclosure Statement

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# CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

## Separate Child Health Insurance Program Eligibility - Children Who Have Access to Public Employee Coverage

CS10

Sec. 2110(b)(2)(B) and (b)(6) of the SSA

**Children Who Have Access to Public Employee Coverage** - Otherwise eligible targeted low-income children who have access to public employee coverage on the basis of a family member's employment.

The CHIP Agency operates this covered group in accordance with the following provisions:

**Select one of the following conditions as described in Section 2110(b)(6) of the Social Security Act:**

- Maintenance of agency contribution as provided in 2110(b)(6)(B) of the SSA.  
 Hardship criteria as provided in section 2110(b)(6)(C) of the Social Security Act.

Coverage under this option is extended to children whose household income is:

**Select one of the options for the income standard when compared to Targeted Low Income Children**

- The same as the standards for Targeted Low-Income Children  
 Lower than the income standards for Targeted Low-Income Children

**Indicate whether coverage under this option is extended to all children who have access to public employee coverage, or only certain children:**

- All children who have access to public employee coverage  
 Certain children who have access to public employee coverage:

Attach methodology the state has used to calculate financial hardship. **Attachment is submitted**

The state provides assurance that the state will, on an annual basis, recalculate the financial status to determine if the hardship condition continues to be met.

Children who are eligible for public employee health benefits coverage who are not described above are excluded from eligibility under the plan.

Children considered to have access to public employee coverage, and therefore not excluded from CHIP through this option, otherwise meet the definition of targeted low-income child provided at 42 CFR 457.310.

### PRA Disclosure Statement

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V.20131007

SPA\* KY-13-0013

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Page 1 of 1



# CHIP Eligibility

OMB Control Number: 0938-1148  
Expiration date: 10/31/2014

**Separate Child Health Insurance Program** **CS20**  
**Non-Financial Eligibility-Substitution of Coverage**

457.310(b)(2) and (b)(3), 457.320(a)(9) and 2110(b)(1)(C) of the SSA

**Substitution of Coverage**

✓ The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

- Substitution of coverage prevention strategy:

	Name of policy	Description	
+	Third Party Liability Verification	The joint Medicaid/HBE application, asks the applicant to report any health insurance coverage. If the family reports creditable coverage (most group health plans and health insurance coverage), the child will be found ineligible. There is no waiting period for children. To be eligible, a child must not be insured by a comparable group health plan. To determine the percent of enrollees who dropped group health insurance without good cause in order to gain eligibility for KCHIP, the Department will generate quarterly reports to compare the number of individuals under age 19 that were denied due to another insurance, reapplied and were approved for KCHIP who no longer report other insurance within a six (6) month time frame. If substitution exceeds ten (10) percent, the department will collaborate with CMS to identify a strategy to reduce substitution.	X
	A waiting period during which an individual is ineligible due to having dropped group health coverage.		NO

If the state covers pregnant women, the waiting period does not apply to pregnant women.

If the state elects to offer dental only supplemental coverage, the following assurances apply:

The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as

provided in section 2110(b)(5) of the SSA.

The waiting period does not apply to children eligible for dental only supplemental coverage.



# CHIP Eligibility

## PRA Disclosure Statement

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V.20130718

## **Section 5. Outreach and Coordination**

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

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

**There are a variety of agencies and organizations currently involved in identifying children with health needs, many of whom are either Medicaid eligible or without creditable coverage. These organizations will be the first line of effort to identify potential KCHIP children. Kentucky will start with these organizations to identify potentially eligible children for KCHIP.**

**The Kentucky Department for Public Health is the largest single provider of direct patient care as well as support care for the uninsured and Medicaid enrolled children and adolescents. Direct services for this population include: preventive child health services (well child check-ups); prenatal services; Women, Infants and Children supplemental nutrition [WIC] services; preventive health education; immunizations; and family planning program services. Support services include nursing and nutrition counseling for pregnant women, Resource Mothers program for pregnant and parenting teens, and the provision of information and referral via a toll-free telephone line. These services are funded through federal Title V Maternal and Child Health Block Grant funds, federal Title X Family Planning program funds, federal WIC funds, Medicaid reimbursements, federal immunization funds, state legislative appropriations, some local government appropriations, and a small amount of patient fee revenue. A variety of the above direct and support services are provided within each of the 53 District or County Health Departments, with health department service delivery sites in all 120 Kentucky counties. In State Fiscal Year 1996 over 175,500 children (birth through age 18 years) received services in local county health departments. This number excludes single service patients [STD-only, Immunization-only, WIC-only]. Additionally, there are 40 full-time, school-based clinics funded through Maternal and Child Health Block Grant funds. These clinic sites are nurse screening and referral models, and provide a variety of health screening services and facilitation of Medicaid enrollment. There are also 175 preventive health sites in schools established through the local health departments and Family Resource/Youth Services Centers (FRYSC) to provide EPSDT and well child services one day per week.**

**Local health departments participate in a variety of outreach activities. The allocation to**

local health departments for the Well Child Program (Title V funded) includes monies for conducting outreach to enroll children in preventive care. The outreach service is provided for children under 185% of poverty. Income assessments are performed in all local health department clinics. The income assessments are reviewed for possible Medicaid eligibility. New applications, as well as annual reviews of established patients, are assessed by the local health department intake staff for possible referral for medical assistance through Medicaid.

Local health departments have an agreement with Medicaid for reimbursement to provide the newly eligible Medicaid recipient with information and education on the need for preventive health services for children and the availability of screening services.

Kentucky has nine Federally Qualified Health Clinics (FQHC) and one FQHC look-alike serving the medically needy in the state. Eight of these centers provide outreach in their own capacity and two of the larger facilities have full-time outreach workers. The larger urban centers have departments that link with the community and social services. Eight centers also offer eligibility assistance to their patient population. They have on-site workers who help the patients determine whether they are eligible for Medicaid or any other type of assistance. The patients are then referred to the Department for Social Insurance for enrollment. Medicaid contracts with the Department for Social Insurance (DSI) for Medicaid eligibility determination and enrollment. Outreach within this capacity is done by giving them as much information as possible to ensure that the patient has some health care coverage. Outreach is also conducted informally through nurses, case managers, and social workers. In addition, Kentucky has 61 Rural Health Clinics (RHC) and 87 Primary Care Centers (PCC); most of which are dual licensed RHC/PCC. Many of these centers are owned and operated by hospitals and may also serve as satellite sites for the Community Health Centers in the state.

Currently the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities' role in assisting and obtaining creditable health coverage for children is fairly limited. When a child presents for services at a Community Mental Health Center (CMHC), registration data is collected, including information about family income and insurance coverage. If it is discovered that a child has no insurance and the child appears to be Medicaid eligible, the family is referred to the Department for Social Insurance (DSI) to apply for Medicaid benefits. In addition, CMHC case managers/service coordinators may assist families in completing the steps to apply for Medicaid benefits. Many CMHCs provide training for direct service providers on how to access DSI services. Training is often provided by DSI staff.

Kentucky's First Steps early intervention program serves children from birth to age three who have a developmental delay or a particular medical condition that is known to cause a developmental delay. First Steps has 15 intake offices located throughout the state, one in each Area Development District. In 1997 these offices received 3,677 referrals. It is estimated that 50% of children eligible for First Steps early intervention services are eligible

for Medicaid. Intake coordinators visit the families referred and discuss Medicaid eligibility. If the family is not presently in the Medicaid program but appears to be eligible, the coordinator makes an effort to have eligibility determined.

**Other possible sources of referral to Medicaid include:**

- \*Hospitals/Physicians/other providers
- \*School-based health centers
- \*FRYSC - Family Resource/Youth Services Centers
- \*County and state social services agencies
- \*Commission for Children with Special Health Care Needs
- \*Medicaid Managed Care Partnerships
- \*Insurance agents
- \*Churches

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

**Not Applicable; Kentucky does not have any public-private insurance programs.**

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

**Kentucky plans two avenues for children’s coverage:**

**1) The Medicaid program will be expanded to include poverty level children from 14 to 19, and targeted low income children one to 19 with family incomes at or below 150% FPL, and 2) a separate insurance product will be offered to children birth to 19 who are not eligible for the Medicaid program up to 200% FPL. The insurance program will be organizationally located within the Department for Medicaid Services, Cabinet for Health Services.**

**The application processes and eligibility determination for Medicaid for poverty level children and KCHIP are the same. Beginning October 1, 2013 the application**

process changed to include a web based application process that was created in collaborative effort with Kentucky's HBE. The web based application contains all of the components of the mail in application. In addition to the web based application, applicants will be able to access enrollment and eligibility assistance via telephone and at numerous sites across Kentucky including The Department for Community Based Service (offices, Health Departments, Family Resource and Youth Service Centers, as well as, other numerous local sites. Applicants can complete an application on-line, can mail-in an application form or go to the local DCBS office to apply for benefits. Once the application is processed, an approval notice and medical card or denial notice is generated by a management information system. If the application information is incomplete or required verification is missing, the applicant can upload the information via the web based application or can fax or mail the required documentation. In the event required information is not received, a Request for Information is system-generated, and it remains pending for 30 days or longer, if requested. A complaint system and tracking process are in place should a family have problems with accommodations.

Medicaid outreach is already being conducted at the locations mentioned in Section 5.3. With notification of the additional KCHIP coverage, outreach will be conducted at these locations targeting children potentially eligible for the Medicaid expansion or the separate insurance program. In addition, several new outreach efforts will be implemented as a result of KCHIP. These efforts will target all low-income children whether they are eligible for Medicaid or KCHIP separate insurance program. See Section 5 for specific outreach efforts.

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

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

**Kentucky's major outreach strategies will be to inform families about the availability of health coverage, assist families in a friendly environment with the eligibility application process, and follow through to enroll eligible children in either KCHIP separate insurance program, KCHIP Medicaid expansion, or Medicaid. All outreach strategies outlined in Section 5 apply to the Medicaid expansion as well as the separate insurance program.**

**Outreach to families of children who are likely to be eligible for the Title XXI Medicaid expansion or the new KCHIP separate insurance program will include the use of a statewide coalition of children's and advocacy organizations to assist the state in planning and implementing innovative avenues for outreach. Composition of this organization will include the Department for Public Health, Parent Teacher Organizations, state medical and pediatric societies, Head Start, Family Resource/Youth Service Centers (FRYSCs), childcare organizations, and others.**

**The level of involvement of various organizations will be contingent upon the expertise and competency of the staff and their proximity to children and their families. These organizations should have the potential of coming in contact with a large number of children.**

**Within the first year of plan approval, the KCHIP staff will investigate and finalize specific outreach strategies with the assistance of the statewide coalition described later in this section. The outreach process will be continuously refined for the purpose of reaching the greatest number of eligibles for both KCHIP and Medicaid.**

**Special and unique outreach and application assistance will target:**

- \* Families of migrant workers. KCHIP will work with Kentucky Migrant Education Program, Kentucky Migrant Network Coalition, and the Kentucky Migrant Health Program to develop specific outreach activities for migrants statewide,**
- \* Homeless children at homeless health centers and other service agencies for the homeless, and,**
- \* Children in rural areas. KCHIP will work with public health nurses, school enrollment campaigns, community/migrant health centers, and private physicians and hospitals that are located throughout the state.**

**Through the KCHIP Website, agencies and individuals will be able to access**

information about KCHIP, including a downloadable application that is available in English and Spanish. The Website information will be updated and changed, periodically.

### **Outreach and Coordination Strategies**

**KCHIP will be marketed statewide as a full benefit health plan, following seven primary strategies: 1) direct appeal to eligible families through press releases, broadcast and print media, videos, and brochures; 2) outreach through school districts; 3) outreach through employers; 4) outreach through collaboration with local county agencies and organizations; 5) outreach through regional health and social service agencies; 6) outreach through other state children's programs; and 7) outreach through foundation sponsored coalitions. KCHIP materials will be user friendly and designed for easy reading.**

**The process must appeal to both the chronically needy who have regular interaction with human service agencies and to the working poor who have traditionally avoided government programs. Outreach techniques will portray KCHIP as a low-cost health plan supported by state government rather than as a government-sponsored program.**

**Activities to accomplish the outreach strategies are:**

#### **1) Direct Appeal to Eligible Families through Press Releases, Public Service Announcements, Videos, and Brochures**

**Radio and television public service announcements and advertisements will be aired to support mailings of materials to community human service agencies. A toll-free number to call for more information will be featured in the public service announcements, printed materials, and press releases. Frequent news releases will be sent to the press about the increased coverage available. Radio stations, TV and cable stations, Kentucky daily and weekly newspapers and specialty publications and newsletters for professional associations in the areas of children's health care, parenting, day care and education will receive the press releases.**

**Outreach methods other than written materials will be employed whenever possible. A video, which explains the KCHIP health plan, will be produced and will be distributed for showing in waiting rooms of providers' offices and eligibility determination sites. All outreach materials will prominently feature the toll-free telephone number. Callers to the toll-free number may hear a recorded message about the plan, speak to a customer service representative, or leave their name and address to receive application information. Bilingual staff or translation services will be available.**

## **2) Outreach through School Districts**

**KCHIP will collaborate with the Kentucky Department of Education to conduct Back-to-School Enrollment Campaigns in school districts statewide and to develop School-Based Enrollment Projects in selected communities and other outreach programs as determined by the school districts. Schools will verify KCHIP eligibility when applicants are qualified for the meal program through a check off system for parents interested in learning more about KCHIP. The local health department will send information to all interested families. Back-to-school enrollment campaigns will also reach out to eligible families who have not applied for the school meal program. Information will be available to all eligible families through school employees who are most likely to speak with eligible families as determined by the school districts: the health aide, assistant principal, principal, school secretary, PTA contact, social worker, English as a Second Language coordinator, Child Find coordinator, physical education instructor, coach, and the teachers who have particularly close rapport with students and parents.**

**Information will also be distributed through other sources such as the Head Start Program and meals program. Enrollment kits with fliers and enrollment pamphlets will be mailed to schools identified by the district as interested in helping to conduct KCHIP outreach. Fliers will also be sent home to each family with the school's newsletter.**

## **1) Outreach through Employers**

**To encourage employers to provide information to employees with uninsured children, KCHIP will include the Kentucky Chamber of Commerce in regional planning meetings, make presentations to local chambers of commerce and business organizations, send press releases to trade publications, and contact employers through direct mail. Encouraging employers to participate in covering dependent children is the cornerstone of the transitional KCHIP approach.**

## **2) Outreach through Collaboration with Local County Agencies and Organizations**

**In order to involve concerned s at the community level, the KCHIP will invite county health departments to host annual regional planning meetings for health care providers, human service agencies, school districts, and community leaders to discuss the health care needs of under-served children in their community and to learn how KCHIP can help. Places of worship and civic groups will be given the opportunity to host informational meetings and provide their membership with KCHIP materials.**

**Outreach and training sessions on KCHIP eligibility will be conducted for the staff of county public health departments, county social services employees, WIC coordinators, Medicaid case workers, family resource center staff, school nurses, providers, the Commission for Children With Special Health Care Needs, etc.**

### **5) Outreach through Regional Health and Social Service Agencies**

KCHIP information will be available at community-based health care providers including Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSHs), community mental health centers, family planning clinics, rural health centers, school based health centers, and residency program family medicine centers.

### **3) Outreach through Other State Children's Programs**

KCHIP continues to coordinate with the following programs to promote KCHIP: school free and reduced school meal program; Special Nutrition Program for Women, Infants and Children (WIC); Commodity Supplemental Foods Program (CSFP); the Commission for Children With Special Health Care Needs; or other public health services. With the cooperation of the county level staff, all children in such a family who are under age 19 can enroll in KCHIP or Medicaid on one short application form.

First Steps is Kentucky's Early Intervention System (KEIS) that serves children birth to age three who have a developmental delay or a particular medical condition that is known to cause a developmental delay. First Steps services are provided statewide and coordinated by the lead agency, Cabinet for Health Services. First Steps has intake coordinators and primary service coordinators in all 15 Area Development Districts. The intake coordinators work closely with local Department for Community Based Services offices when they receive referrals to ensure coordination of outreach with families who may be eligible for Medicaid. Primary service coordinators work with families who are potentially Medicaid eligible to have eligibility determined.

Outreach for the KCHIP and Medicaid will continue to be conducted through Resource Persons and the newly established HANDS (Health Access; Nurturing Developmental Services) programs, home visitation programs for newborns, administered through local health departments. The Resource Persons and HANDS programs will be combined into one program. Home visitors give new parents KCHIP and Medicaid program brochures and answer questions of new parents. Visitors call parents at times coinciding with the child's immunization schedule to remind parents to have their children immunized and to inform them of the availability of free or reduced price immunizations and health care coverage.

### **4) Outreach through Foundation Sponsored Coalitions**

Health Kentucky, Inc., sponsored by the Kentucky Medical Association and the Good Samaritan Foundation, provides qualified applicants under 100% FPL with free single-visit access to health care providers. Persons who contact Health Kentucky are routinely screened for Medicaid eligibility and will be provided with KCHIP enrollment information as well.

**The University of Kentucky Center for Health Services Management and Research, the lead applicant, and other health care and children's organizations, in collaboration with the Cabinet for Health Services (the Title XXI agency) received the Robert Wood Johnson Foundation Grant: Covering Kids: A National Access Initiative for Low-Income, Uninsured Children. The grant facilitates and augments a close working relationship through state and local efforts in three areas: design and conduct of outreach programs that identify and enroll eligible children into Medicaid and KCHIP; simplification of enrollment processes; and coordination of existing coverage programs for low-income children. This coalition covers the entire state and includes: Family Resource/Youth Services Centers; Head Start; Commission for Children With Special Health Care Needs; public health departments; primary care centers; rural health centers; academic health centers; Kentucky Youth Advocates; Kentucky Chapter, American Academy of Pediatrics; Kentucky Hospital Association; Kentucky Medical Association; Kentucky Public Health Association; day care coalitions; school-based groups and other child advocacy groups.**

**There are a number of outreach efforts that are best accomplished through a coalition. The Kentucky Cabinet for Health Services, as the agency responsible for KCHIP, supports this coalition and will continue to participate and support it regardless of funding decisions made by RWJ.**

**8) Outreach through KYNect, Kentucky's Health Benefits Exchange**

**Beginning in early 2013, the Department began collaborations with the Office of Health Policy within the Cabinet for Health and Family Services to research, design, and implement a state based exchange as outlined in the Affordable Care Act. This collaboration led to the creation of KYNect, Kentucky's Health Benefits Exchange. A web based application was created that allows individuals to apply for health insurance benefits, including KCHIP and Medicaid. In addition, at this time Kentucky moved forward with Medicaid expansion.**

**A statewide marketing campaign began in the summer of 2013 that included joint participation by KYNect and KCHIP/Medicaid at local festivals, back-to-school events, and Kentucky's state fair. The outreach and marketing efforts are proving to be very successful with over 90,000 individuals enrolling in Medicaid and KCHIP by the end of February 2014.**

**Going forward, KCHIP/Medicaid plans to continue joint outreach efforts with KYNect and will participate in quarterly outreach and education meetings in order to maintain an adequate level of outreach to target populations.**

**Section 6. Coverage Requirements for Children’s Health Insurance (Section 2103)**

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan, and continue on to Section 7.**

6.1. The state elects to provide the following forms of coverage to children:  
(Check all that apply.) (42CFR 457.410(a))

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

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

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

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

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

6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania]  
Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

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

6.1.4.1. Coverage the same as Medicaid State plan

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

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

- 6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage
- 6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit-by-benefit comparison (Please provide a sample of how the comparison will be done)
- 6.1.4.7. Other (Describe)

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

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

**To be covered by the department:**

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

**(a) Medically necessary; and**

**(b) Clinically appropriate pursuant to the criteria established in 907**

**KAR 3:130; and.**

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

**(c) Medically necessary; and**

**(d) Clinically appropriate pursuant to the criteria established in 907**

**KAR 3:130.**

**Covered Admissions.** The department shall reimburse for an admission primarily indicated in the management of acute or chronic illness, injury or impairment, or for maternity care that could not be rendered on an outpatient basis.

**Noncovered Services.** Inpatient hospital services not covered shall include:

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

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

**(f) Private duty nursing;**

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

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

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

**(j) The following listed surgical procedures, except if a life-threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a**

**hospital:**

1. **Biopsy:** breast, cervical node, cervix, lesions (skin, subcutaneous, submucous), lymph node (except high axillary excision), or muscle;
2. **Cauterization or cryotherapy:** lesions (skin, subcutaneous, submucous), moles, polyps, warts or condylomas, anterior nose bleeds, or cervix;
3. **Circumcision;**
4. **Dilation:** dilation and curettage (diagnostic or therapeutic nonobstetrical); dilation or probing of lacrimal duct;
5. **Drainage by incision or aspiration:** cutaneous, subcutaneous, or joint;
6. **Pelvic exam under anesthesia;**
7. **Excision:** bartholin cyst, condylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, or subcutaneous fistulas;
8. **Extraction:** foreign body or teeth;
9. **Graft, skin (pinch, splint or full thickness up to defect size three-fourths (3/4) inch diameter);**
10. **Hymenotomy;**
11. **Manipulation and reduction with or without x-ray; cast change:** dislocations depending upon the joint and indication for procedure or fractures;
12. **Meatotomy or urethral dilation, removal calculus and drainage of bladder without incision;**
13. **Myringotomy with or without tubes, otoplasty;**
14. **Oscopy with or without biopsy (with or without salpingogram):** arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, gastroscopy, hysteroscopy, laryngoscopy, laparoscopy, peritoneoscopy, otoscopy, and sigmoidoscopy or procto sidmoidoscopy;
15. **Removal; IUD, fingernail or toenails;**
16. **Tenotomy hand or foot;**
17. **Vasectomy; or**
18. **Z-plasty for relaxation of scar or contracture.**

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

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

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

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

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

(m) A recipient;

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

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

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

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

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

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

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

**consent form; or**

- 14. An unlisted procedure or service; and**

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

**1.a. Medically necessary; and**

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

**2. For a lock-in recipient:**

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

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

**(2) The prior authorization requirements established in subsection (1) of this section shall not apply to:**

**(a) An emergency service;**

**(b) A radiology procedure if the recipient has a cancer or transplant diagnosis code; or**

**(c) A service provided to a recipient in an observation bed.**

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

**(4) The following covered hospital outpatient services shall be furnished by or under the supervision of a duly licensed physician, or if applicable, a duly-licensed dentist:**

- (d) A diagnostic service ordered by a physician;
  - (e) A therapeutic service, except for occupational therapy services as occupational therapy services shall not be covered under this administrative regulation, ordered by a physician;
  - (f) An emergency room service provided in an emergency situation as determined by a physician; or
  - (g) A drug, biological, or injection administered in the outpatient hospital setting.
- (5) A covered hospital outpatient service for maternity care may be provided by:
- (h) An advanced practice registered nurse [(APRN)] who has been designated by the Kentucky Board of Nursing as a nurse midwife; or
  - (i) A registered nurse who holds a valid and effective permit to practice nurse mid-wifery issued by the Cabinet for Health and Family Services.
- (6) The department shall cover:
- (j) A screening of a lock-in recipient to determine if the lock-in recipient has an emergency medical condition; or
  - (k) An emergency service to a lock-in recipient if the department determines that the lock-in recipient had an emergency medical condition when the service was provided.

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

- (1) An item or service that does not meet the requirements established in Section 2(1) of this administrative regulation;
- (2) A service for which:
  - (l) An individual has no obligation to pay; and
  - (m) No other person has a legal obligation to pay;
- (3) A medical supply or appliance, unless it is incidental to the performance of a procedure or service in the hospital outpatient department and included in the rate of payment established by the Medical Assistance Program for hospital outpatient services;
- (4) A drug, biological, or injection purchased by or dispensed to a recipient;
- (5) A routine physical examination; [or]
- (6) A nonemergency service, other than a screening in accordance with Section 2(6)(a) of this administrative regulation, provided to a lock-in recipient:
  - 15. In an emergency department of a hospital; or
  - 16. If provided by a hospital that is not the lock-in recipient's designated hospital pursuant to 907 KAR 1:677; or

**No Duplication of Service.** (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period. (2) For example, if a recipient is receiving speech therapy from a speech-language

pathologist enrolled with the Medicaid Program, the department shall not reimburse for speech therapy provided to the same recipient during the same time period via the out-patient hospital services program.

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

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

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

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

(d) Eligible for reimbursement as a physician service.

**(2) Direct physician contact between the billing physician and recipient shall not be required for:**

(a) A service provided by a:

17. Medical resident if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.174 and 415.184;

18. Locum tenens physician who provides direct physician contact; or

19. Physician assistant in accordance with Section 7 of this administrative regulation;

(b)[(c)] A radiology service, imaging service, pathology service, ultrasound study, echographic study, electrocardiogram, electromyogram, electroencephalogram, vascular study, or other service that is usually and customarily performed without direct physician contact;

(c)[(d)] The telephone analysis of emergency medical systems or a cardiac pacemaker if provided under physician direction;

(d) A sleep disorder service; or

(e) A telehealth consultation provided in accordance with 907 KAR 3:170].

**(3) A service provided by another licensed medical professional shall be covered if the other licensed medical professional is:**

(n) Employed by the supervising physician; and

(o) Licensed in the state of practice.

**(4) A sleep disorder service shall be covered if performed in:**

(a) A hospital; or

(b)1. A sleep laboratory if the sleep laboratory has documentation demonstrating that it complies with criteria approved by the:

c. American Sleep Disorders Association; or

d. American Academy of Sleep Medicine; or

2. An independent diagnostic testing facility that:

a. Is supervised by a physician trained in analyzing and

interpreting sleep disorder recordings; and

**b. Has documentation demonstrating that it complies with criteria approved by the:**

- (i) American Sleep Disorders Association; or**
- (ii) American Academy of Sleep Medicine**

**Service Limitations. (1) A covered service provided to a lock-in recipient shall be limited to a service provided by the lock-in recipient's designated primary care provider or designated controlled substance prescriber unless:**

**(p) The service represents emergency care; or**  
**(q) The lock-in recipient has been referred to the provider by the lock-in recipient's designated primary care provider.**

**(3) An EPSDT screening service shall be covered in accordance with 907 KAR 11:034.**

**(2) A laboratory procedure performed in a physician's office shall be limited to a procedure for which the physician has been certified in accordance with 42 C.F.R. Part 493.**

**(3) Except for the following, a drug administered in a physician's office shall not be covered as a separate reimbursable service through the physicians' program:**

- (r) Rho (D) immune globulin injection;**
- (s) An injectable antineoplastic drug;**
- (t) Medroxyprogesterone acetate for contraceptive use, 150 mg;**
- (u) Penicillin G benzathine injection;**
- (v) Ceftriaxone sodium injection;**
- (w) Intravenous immune globulin injection;**
- (x) Sodium hyaluronate or hylan G-F for intra-articular injection;**

- (y) An intrauterine contraceptive device;**
- (z) An implantable contraceptive device;**
- (aa) Long acting injectable risperidone; or**
- (bb) An injectable, infused, or inhaled drug or biological**

**that:**

**19. Is not typically self-administered;**

**20. Is not excluded as a noncovered immunization or vaccine;**

**and**

**21. Requires special handling, storage, shipping, dosing, or administration.**

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

**(4) Coverage for:**

**(a) A service designated as a psychiatry service CPT code and provided by a physician other than a board certified or board eligible**

psychiatrist or an advanced practice registered nurse with a specialty in psychiatry shall be limited to four (4) services, per physician, per recipient, per twelve (12) months;

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

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

(7) An anesthesia service shall be covered if:

(a) Administered by:

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

2. An individual who:

a. Is licensed in Kentucky to practice anesthesia;

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

and

c. Remains in attendance throughout the procedure;

(b) Medically necessary; and

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

(8) shall not be covered:

(dd) An acupuncture service;

(ee) An autopsy;

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

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

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

(gg) Lasik surgery;

(hh) Paternity testing;

(ii) A procedure performed for cosmetic purposes only;

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

(kk) Radial keratotomy;

(ll) A thermogram;

(mm) An experimental service which is not in accordance with current standards of medical practice; [or]

(nn) A service which does not meet the requirements established in Section 3(1) of this administrative regulation;

(oo) Medical direction of an anesthesia service; or

(pp) Medical assistance for another provider preventable condition in accordance with 907 KAR 14:005.

**Prior Authorization Requirements for Recipients Who are Not Enrolled with a Managed Care Organization. (1) The following procedures for a recipient who is not enrolled with a managed care organization shall require prior authorization by the department:**

(qq) Magnetic resonance imaging;  
 (rr) Magnetic resonance angiogram;  
 (ss) Magnetic resonance spectroscopy;  
 (tt) Positron emission tomography;  
 (uu) Cineradiography or videoradiography;  
 (vv) Xeroradiography;  
 (ww) Ultrasound subsequent to second obstetric  
 ultrasound;  
 (xx) Myocardial imaging;  
 (yy) Cardiac blood pool imaging;  
 (zz) Radiopharmaceutical procedures;  
 (aaa) Gastric restrictive surgery or gastric bypass  
 surgery;  
 (bbb) A procedure that is commonly performed for  
 cosmetic purposes;  
 (ccc) A surgical procedure that requires completion of a  
 federal consent form; or  
 (ddd) An unlisted covered procedure or service.  
 (2)(a) Prior authorization by the department shall not be a  
 guarantee of recipient eligibility.  
 (b) Eligibility verification shall be the responsibility of the  
 provider.  
 (3) The prior authorization requirements established  
 in subsection (1) of this section shall not apply to:  
 (eee) An emergency service; or  
 (fff) A radiology procedure if the recipient has a  
 cancer or transplant diagnosis code.  
 (4) A referring physician, a physician who wishes to provide  
 a given service, a podiatrist, a chiropractor, or an advanced practice registered  
 nurse:  
 (ggg) May request prior authorization from the  
 department; and  
 (hhh) If requesting prior authorization shall  
 request prior authorization by:  
 1. Mailing or faxing:  
 e. A written request to the department with information  
 sufficient to demonstrate that the service meets the requirements established  
 in Section 3(1) of this administrative regulation; and  
 f. If applicable, any required federal consent forms; or  
 2. Submitting a request via the department's web-based portal  
 with information sufficient to demonstrate that the service meets the  
 requirements established in Section 3(1) of this administrative regulation.

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

**All surgical services must meet medical necessity requirements and must be provided by licensed providers operating within their scope of practice.**

**Inpatient and outpatient surgical services will be covered when delivered by Medicaid enrolled providers. Surgical services will not be covered for cosmetic purposes.**

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

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

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

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

**(p) Medically necessary;**

**(q) Approved by the Food and Drug Administration; and**

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

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

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

**(s) An electronic prescription;**

**(t) A faxed prescription; or**

**(u) A prescription telephoned by a prescriber.**

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

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

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

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

**(5)(a) Except as provided in paragraph (b) of this subsection, the department shall cover the diabetic supplies listed in this paragraph via the**

department's pharmacy program and not via the department's durable medical equipment program established in 907 KAR 1:479:

3. A syringe with needle (sterile, 1cc or less);
4. Urine test or reagent strips or tablets;
5. Blood ketone test or reagent strip;
6. Blood glucose test or reagent strips for a home blood glucose monitor;
7. Normal, low, or high calibrator solution, chips;
8. Spring-powered device for lancet;
9. Lancets per box of 100; or
10. Home blood glucose monitor.

(b) The department shall cover the diabetic supplies listed in this paragraph via the department's durable medical equipment program established in 907 KAR 1:479 if:

11. The supply has an HCPCS code of A4210, A4250, A4252, A4253, A4256, A4258, A4259, E0607 or E2100;

12. The supply has an a HCPCS code of A4206 and a diagnosis of diabetes is present on the corresponding claim; or

13. Medicare is the primary payor for the supply.

(6) The department shall have a drug list which:

(a) Lists:

14. Drugs, drug categories, and related items not covered by the department and, if applicable, excluded medical uses for covered drugs; and

15. Maintenance drugs covered by the department;

(b) Specifies those covered drugs requiring prior authorization or having special prescribing or dispensing restrictions;

(c) Specifies those covered drugs for which the maximum quantity limit on dispensing may be exceeded;

(d) Lists covered over-the-counter drugs;

(e) Specifies those legend drugs which are permissible restrictions under 42 U.S.C. 1396r-8(d), but for which the department makes reimbursement;

(f) May include a preferred drug list of selected drugs which have a more favorable cost to the department and which prescribers are encouraged to prescribe, if medically appropriate;

(g) May be updated monthly or more frequently by the department; and

(h) Shall be posted on the department's Internet pharmacy Web site.

(6)(a) The department may implement drug treatment protocols requiring the use of medically-appropriate drugs which are available without prior authorization before the use of drugs which require prior authorization.

(b) The department may approve a request from the prescriber or a pharmacist for exemption of a specific recipient from the requirement established in paragraph (a) of this subsection, based on documentation that drugs available without prior authorization:

(a) Were used and were not an effective medical treatment or lost their effectiveness;

- (c) Are reasonably expected to not be an effective medical treatment;
- (iii) Resulted in, or are reasonably expected to result in, a clinically-significant adverse reaction or drug interaction; or
- (jjj) Are medically contraindicated.

**Section 3. Exclusions and Limitations. (1) The following drugs shall be excluded from coverage:**

- (a) A drug which the Food and Drug Administration considers to be:
  - 16. A less-than-effective drug; or
  - 17. Identical, related, or similar to a less-than-effective drug;
- (b) A drug or its medical use in one (1) of the following categories unless the drug or its medical use is designated as covered in the drug list:
  - 18. A drug if used for anorexia, weight loss, or weight gain;
  - 19. A drug if used to promote fertility;
  - 20. A drug if used for cosmetic purposes or hair growth;
  - 21. A drug if used for the symptomatic relief of cough and colds;
  - 22. Vitamin or mineral products other than prenatal vitamins and fluoride preparations;
  - 23. An over-the-counter drug provided to a Medicaid nursing facility service recipient if included in the nursing facility's standard price;
  - 24. A barbiturate;
  - 25. A benzodiazepine;
  - 26. A drug which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; or
  - 27. A drug utilized for erectile dysfunction therapy unless the drug is used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the United States Food and Drug Administration;
- (c) A drug for which the manufacturer has not entered into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a), unless there has been a review and determination by the department that it is in the best interest of a recipient for the department to make payment for the drug and federal financial participation is available for the drug;
- (d) A drug dispensed as part of, or incident to and in the same setting as, an inpatient hospital service, an outpatient hospital service, or an ambulatory surgical center service;
- (e) A drug for which the department requires prior authorization if prior authorization has not been approved; and
- (f) A drug that has reached the manufacturer's termination date, indicating that the drug may no longer be dispensed by a pharmacy. (2) If authorized by the prescriber, a prescription for a:
  - (a) Controlled substance in Schedule III-V may be refilled up to five (5) times within a six (6) month period from the date the prescription was written or ordered, at which time a new prescription shall be required; or

(b) Noncontrolled substance, except as prohibited in subsection (4) of this section, may be refilled up to eleven (11) times within a twelve (12) month period from the date the prescription was written or ordered, at which time a new prescription shall be required.

(3) For each initial filling or refill of a prescription, a pharmacist shall dispense the drug in the quantity prescribed not to exceed a thirty-two (32) day supply unless:

(kkk) The drug is designated in the department's drug list as a drug exempt from the thirty-two (32) day dispensing limit in which case the pharmacist may dispense the quantity prescribed not to exceed a three (3) month supply or 100 units, whichever is greater;

(lll) A prior authorization request has been submitted on the Drug Prior Authorization Request Form (MAP-82001) and approved by the department because the recipient needs additional medication while traveling or for a valid medical reason, in which case the pharmacist may dispense the quantity prescribed not to exceed a three (3) month supply or 100 units, whichever is greater;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**(bb)** Is supervised by a laboratory director.

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

(a) Is provided by a facility that:

**20.** Is licensed to provide radiological services;

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

**22.** Is certified by Medicare to provide the given service;

**23.** Is a Medicare-participating facility;

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

**25.** Is a Medicaid-enrolled provider;

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

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

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

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

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

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

(3) A service provided to a resident of a nursing facility or an intermediate

care facility for individuals with an intellectual disability; or

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

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

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

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

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

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

Federal regulations emphasize "active treatment" as one of the necessary elements of inpatient services. Active treatment is defined as the implementation of a professionally developed individual plan of care which sets forth treatment objectives and therapies enabling the individual's functioning to improve to the point that institutional care is

no longer necessary. Limitations of Services include:

- Admissions for diagnostic purposes are covered only if the diagnostic procedures cannot be performed on an outpatient basis.
- Patients may be permitted home visits; however, this must be clearly documented on billing statements as payment cannot be made for these days.

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

The physician's orders for and description of reasons for private accommodations must be maintained in the recipient's medical records. If a private room is the only room available, payment will be made until another room becomes available. If all rooms on a particular floor or unit are private rooms, payment will be made.

Psychiatric Residential Treatment Facilities (PRTFs) services are covered for residents ages 6 to 21 who require treatment on a continuous basis as a result of a severe mental or psychiatric illness. PRTFs are designed to serve children who need long-term, more intensive treatment, and a more highly structured environment than they can receive in family and other

**community-based alternatives to hospitalization.**

**Less restrictive and more homelike than hospitals, these facilities also serve children who are transitioning from hospitals, but who are still not ready for the demands of living at home or in a foster home.**

**The following shall not be covered as PRTF services:**

- Pharmacy services, which shall be covered as pharmacy services in accordance with 907 KAR 1:019**
- Durable medical equipment, which shall be covered as a durable medical equipment benefit in accordance with 907 KAR 1:479**

**A PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges. Services shall not be covered if appropriate alternative services are available in the community.**

**The following shall not qualify for a PRTF service:**

- An admission that is not medically necessary**
- An individual with a major medical problem or minor symptoms**
- An individual who might only require a psychiatric consultation rather than an admission to a psychiatric facility**
- An individual who might need only adequate living accommodations, economic aid or social support services.**

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

**Services provided by independent practitioners:**

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

- (a) Mental health disorder;**
- (b) Substance use disorder; or**
- (c) Co-occurring mental health and substance use disorder.**

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

**(a) A screening provided by:**

- 28. A licensed psychologist;**
- 29. A licensed professional clinical counselor;**
- 30. A licensed clinical social worker;**
- 31. A licensed marriage and family therapist;**
- 32. A physician;**
- 33. A psychiatrist;**
- 34. An advanced practice registered nurse;**
- 35. A licensed psychological practitioner;**
- 36. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;**

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

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

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

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

**(b) An assessment provided by:**

**29. A licensed psychologist;**

**30. A licensed professional clinical counselor;**

**31. A licensed clinical social worker;**

**32. A licensed marriage and family therapist;**

**33. A physician;**

**34. A psychiatrist;**

**35. An advanced practice registered nurse;**

**36. A licensed psychological practitioner;**

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

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

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

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

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

**(c) Psychological testing provided by:**

**42. A licensed psychologist;**

**43. A licensed psychological practitioner; or**

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

**(d) Crisis intervention provided by:**

**45. A licensed psychologist;**

**46. A licensed professional clinical counselor;**

**47. A licensed clinical social worker;**

4. A licensed marriage and family therapist;
  48. A physician;
  49. A psychiatrist;
  50. An advanced practice registered nurse;
  51. A licensed psychological practitioner;
  52. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
  53. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
  54. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
  55. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
  56. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;
- (e) Service planning provided by:
57. A licensed psychologist;
  58. A licensed professional clinical counselor;
  59. A licensed clinical social worker;
  60. A licensed marriage and family therapist;
  61. A physician;
  62. A psychiatrist;
  63. An advanced practice registered nurse;
  64. A licensed psychological practitioner;
  65. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
  66. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
  67. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
  68. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
  69. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;
- (f) Individual outpatient therapy provided by:
1. A licensed psychologist;

2. A licensed professional clinical counselor;
  70. A licensed clinical social worker;
  71. A licensed marriage and family therapist;
  72. A physician;
  73. A psychiatrist;
  74. An advanced practice registered nurse;
  75. A licensed psychological practitioner;
  76. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
  77. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
  78. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
  79. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
  80. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;
- (g) Family outpatient therapy provided by:
81. A licensed psychologist;
  82. A licensed professional clinical counselor;
  83. A licensed clinical social worker;
  84. A licensed marriage and family therapist;
  85. A physician;
  86. A psychiatrist;
  87. An advanced practice registered nurse;
  88. A licensed psychological practitioner;
  89. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
  90. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
  91. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
  92. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
  93. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

**(h) Group outpatient therapy provided by:**

**94. A licensed psychologist;**

**95. A licensed professional clinical counselor;**

**96. A licensed clinical social worker;**

**97. A licensed marriage and family therapist;**

**98. A physician;**

**99. A psychiatrist;**

**100. An advanced practice registered nurse;**

**101. A licensed psychological practitioner;**

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

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

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

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

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

**(i) Collateral outpatient therapy provided by:**

**107. A licensed psychologist;**

**108. A licensed professional clinical counselor;**

**109. A licensed clinical social worker;**

**110. A licensed marriage and family therapist;**

**111. A physician;**

**112. A psychiatrist;**

**113. An advanced practice registered nurse;**

**114. A licensed psychological practitioner;**

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

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

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

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

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

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

**119. A licensed psychologist;**

**120. A licensed professional clinical counselor;**

**121. A licensed clinical social worker;**

**122. A licensed marriage and family therapist;**

**123. A physician;**

**124. A psychiatrist;**

**125. An advanced practice registered nurse;**

**126. A licensed psychological practitioner;**

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

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

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

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

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

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

**132. A physician;[or]**

**133. A psychiatrist; or**

**134. An advanced practice registered nurse;**

**(l) Day treatment provided by:**

**135. A licensed psychologist;**

**136. A licensed professional clinical counselor;**

**137. A licensed clinical social worker;**

**138. A licensed marriage and family therapist;**

**139. A physician;**

**140. A psychiatrist;**

**141. An advanced practice registered nurse;**

**142. A licensed psychological practitioner;**

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

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

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

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

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

**(m) Comprehensive community support services provided by:**

**147. A licensed psychologist;**

**148. A licensed professional clinical counselor;**

**149. A licensed clinical social worker;**

**150. A licensed marriage and family therapist;**

**151. A physician;**

**152. A psychiatrist;**

**153. An advanced practice registered nurse;**

**154. A licensed psychological practitioner;**

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

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

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

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

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

**(n) Peer support provided by:**

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

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

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

**(p) Intensive outpatient program provided by:**

**162. A licensed psychologist;**

**163. A licensed professional clinical counselor;**

**3. A licensed clinical social worker;**

**164. A licensed marriage and family therapist;**

**165. A physician;**

**166. A psychiatrist;**

- 167. An advanced practice registered nurse;
  - 168. A licensed psychological practitioner;
  - 169. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
  - 170. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
  - 171. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
  - 172. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
  - 173. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;
- (q) Therapeutic rehabilitation program provided by:
- 174. A licensed psychologist;
  - 175. A licensed professional clinical counselor;
  - 176. A licensed clinical social worker;
  - 177. A licensed marriage and family therapist;
  - 178. A physician;
  - 179. A psychiatrist;
  - 180. An advanced practice registered nurse;
  - 181. A licensed psychological practitioner;
  - 182. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
  - 183. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
  - 184. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
  - 185. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
  - 186. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service.
- (3)(a) A screening shall:
- 187. Be the determination of the likelihood that an individual has a mental health disorder, substance use disorder, or co-occurring disorder;
  - 188. Not establish the presence or specific type of disorder; and
  - 189. Establish the need for an in-depth assessment.
- (b) An assessment shall:
- 1. Include gathering information and engaging in a process with the individual that enables the provider to:

**g. Establish the presence or absence of a mental health disorder or substance use disorder;**

**h. Determine the individual's readiness for change;**

**i. Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and**

**j. Engage the individual in developing an appropriate treatment relationship;**

**2. Establish or rule out the existence of a clinical disorder or service need;**

**3. Include working with the individual to develop a treatment and service plan;**

**and**

**4. Not include psychological or psychiatric evaluations or assessments.**

**(c) Psychological testing shall include:**

**190. A psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities; and**

**191. Interpretation and a written report of testing results.**

**(d) Crisis intervention:**

**1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to:**

**k. The recipient; or**

**l. Another individual;**

**2. Shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization interventions, or crisis prevention activities for individuals;**

**3. Shall be provided:**

**m. On-site at the provider's office;**

**n. As an immediate relief to the presenting problem or threat; and**

**o. In a face-to-face, one-on-one encounter between the provider and the recipient;**

**4. May include verbal de-escalation, risk assessment, or cognitive therapy; and**

**5. Shall be followed by a referral to noncrisis services if applicable. (e)1. Service planning shall involve:**

**p. Assisting a recipient in creating an individualized plan for services needed for maximum reduction of an intellectual disability; and**

**q. Restoring a recipient's functional level to the recipient's best possible functional level.**

**r. 2. A service plan:**

**s. Shall be directed by the recipient; and**

**t. May include:**

**(i) A mental health advance directive being filed with a local hospital;**

**(ii) A crisis plan; or**

**(i) A relapse prevention strategy or plan.**

**(f) Individual outpatient therapy shall:**

**1. Be provided to promote the:**

**u. Health and wellbeing of the individual; or**

**v. Recovery from a substance related disorder;**

**2. Consist of:**

w. A face-to-face, one-on-one encounter between the provider and recipient;  
and

x. A behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

3. Be aimed at:

y. Reducing adverse symptoms;

z. Reducing or eliminating the presenting problem of the recipient; and

aa. Improving functioning; and

4. Not exceed three (3) hours per day unless additional time is medically necessary.

(g)1. Family outpatient therapy shall consist of a face-to-face behavioral health therapeutic intervention provided:

bb. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and

cc. To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment.

3. A family outpatient therapy session shall be billed as one (1) service regardless of the number of individuals (including multiple members from one (1) family) who participate in the session.

192. Family outpatient therapy shall:

a. Be provided to promote the:

(iii) Health and wellbeing of the individual; or

(iv) Recovery from a substance related disorder; and

b. Not exceed three (3) hours per day per individual unless additional time is medically necessary.

(h)1. Group outpatient therapy shall:

a. Be provided to promote the:

(v) Health and wellbeing of the individual; or

(vi) Recovery from a substance related disorder;

b. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

c. Be provided to a recipient in a group setting:

(vii) Of nonrelated individuals; and

(viii) Not to exceed eight (8) individuals in size;

d. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;

e. Not include physical exercise, a recreational activity, an educational activity, or a social activity; and

f. Not exceed three (3) hours per day per recipient unless additional time is medically necessary.

2. The group shall have a:

dd. Deliberate focus; and

ee. Defined course of treatment.

3. The subject of group outpatient therapy shall be related to each recipient participating in the group.

**4. The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.**

**(i) 1. Collateral outpatient therapy shall:**

**a. Consist of a face-to-face behavioral health consultation:**

**(ix) With a parent or caregiver of a recipient, household member of a recipient, legal representative of a recipient, school personnel, treating professional, or other person with custodial control or supervision of the recipient; and**

**(x) That is provided in accordance with the recipient's treatment plan;**

**b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age; and**

**c. Not exceed three (3) hours per day per individual unless additional time is medically necessary.**

**2. Consent to discuss a recipient's treatment with any person other than a parent or legal guardian shall be signed and filed in the recipient's health record.**

**(j) Screening, brief intervention, and referral to treatment for a substance use disorder shall:**

**193. Be an evidence-based early intervention approach for an individual with non-dependent substance use to provide an effective strategy for intervention prior to the need for more extensive or specialized treatment; and**

**194. Consist of:**

**ff. Using a standardized screening tool to assess an individual for risky substance use behavior;**

**gg. Engaging a recipient, who demonstrates risky substance use behavior, in a short conversation and providing feedback and advice; and**

**hh. Referring a recipient to:**

**(i) Therapy; or**

**(ii) Other additional services to address substance use if the recipient is determined to need other additional services.**

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

**1. Shall include:**

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

**jj. Comprehensive maintenance;**

**kk. Medical maintenance;**

**ll. Interim maintenance;**

**mm. Detoxification; or**

**nn. Medically supervised withdrawal;**

**2. May be provided in:**

**oo. An opioid treatment program;**

**pp. A medication unit affiliated with an opioid treatment program;**

**qq. A physician's office except for methadone; or**

**rr. Other community setting; and**

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

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

**ss. An emotional disability or neurobiological or substance use disorder; and**

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

**2. Day treatment services shall:**

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

**b. Have unified policies and procedures that:**

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

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

**c. Include:**

**(xiii) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;**

**(xiv) Behavior management and social skill training;**

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

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

**d. Be provided:**

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

**(iv) On school days and during scheduled breaks;**

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

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

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

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

**(m)1. Comprehensive community support services shall:**

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

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

**c. Include:**

- (viii) Reminding a recipient to take medications and monitoring symptoms and side effects of medications;
- (ix) Teaching parenting skills;
- (x) Teaching community resource access and utilization;
- (xi) Teaching emotional regulation skills;
- (xii) Teaching crisis coping skills;
- (xiii) Teaching how to shop;
- (xiv) Teaching about transportation;
- (iv) Teaching financial management;
- (xv) Developing and enhancing interpersonal skills; or
- (xvi) Improving daily living skills[and

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

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

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

(n)1. Peer support services shall:

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

xx. Be an evidence-based practice;

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

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

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

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

2. To provide peer support services a provider shall:

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

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

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

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

fff. Be emotional support that is provided by a parent or family member, who is employed by a provider group, of a child who has experienced a mental health

disorder, substance use disorder, or co-occurring mental health and substance use disorder to a parent or family member with a child sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change;

ggg. Be an evidence-based practice;

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

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

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

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

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

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

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

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

(p)1. Intensive outpatient program services shall:

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

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

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

rrr. Include:

(xv) Individual outpatient therapy;

(xvi) Group outpatient therapy;

(xvii) Family outpatient therapy unless contraindicated;

(xviii) Crisis intervention; or

(xix) Psycho-education.

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

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

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

3. An intensive outpatient program services treatment plan shall:

uuu. Be individualized; and

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

- 4. To provide intensive outpatient program services, a provider shall:**
- www. Be employed by a provider group; and**
  - xxx. Have:**
    - (xx) Access to a board-certified or board-eligible psychiatrist for consultation;**
    - (xxi) Access to a psychiatrist, other physician, or advanced practice registered nurse for medication management;**
    - (xvii) Adequate staffing to ensure a minimum recipient-to-staff ratio of fifteen (15) recipients to one (1) staff person;**
    - (xviii) The capacity to provide services utilizing a recognized intervention protocol based on recovery principles;**
    - (v) The capacity to employ staff authorized to provide intensive outpatient program services in accordance with this section and to coordinate the provision of services among team members;**
    - (xix) The capacity to provide the full range of intensive outpatient program services as stated in this paragraph;**
      - (i) Demonstrated experience in serving individuals with behavioral health disorders;**
        - (i) The administrative capacity to ensure quality of services;**
        - (xx) A financial management system that provides documentation of services and costs; and**
        - (xxi) The capacity to document and maintain individual case records.**
- 5. Intensive outpatient program services shall be provided in a setting with a minimum recipient-to-staff ratio of fifteen (15) to one (1).**
  - (q)1. A therapeutic rehabilitation program shall be:**
    - a. A rehabilitative service for an:**
      - (xxii) Adult with a serious mental illness; or**
      - (xxiii) Individual under the age of twenty-one (21) years who has a serious emotional disability; and**
    - b. Designed to maximize the reduction of an intellectual disability and the restoration of the individual's functional level to the individual's best possible functional level.**
  - 2. A recipient in a therapeutic rehabilitation program shall establish the recipient's own rehabilitation goals within the person-centered service plan.**
- 22. A therapeutic rehabilitation program shall:**
  - a. Be delivered using a variety of psychiatric rehabilitation techniques;**
  - b. Focus on:**
    - (xxiv) Improving daily living skills;**
    - (xxv) Self-monitoring of symptoms and side effects;**
    - (xxvi) Emotional regulation skills;**
    - (xxvii) Crisis coping skill; and**
    - (xxviii) Interpersonal skills; and**
  - c. Be delivered individually or in a group.**

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

- 23. The licensing requirements established in 908 KAR 1:370;**
- 24. The physical plant requirements established in 908 KAR 1:370;**
- 25. The organization and administration requirements established in 908 KAR 1:370;**
- 26. The personnel policy requirements established in 908 KAR 1:370;**
- 27. The quality assurance requirements established in 908 KAR 1:370;**
- 28. The clinical staff requirements established in 908 KAR 1:370;**
- 7. The program operational requirements established in 908 KAR 1:370; and**
- 195. The outpatient program requirements established in 908 KAR 1:370.**

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

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

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

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

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

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

**1. A resident of:**

**yyy. A nursing facility; or**

**zzz. An intermediate care facility for individuals with an intellectual disability;**

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

**aaaa. Jail;**

**bbbb. Detention center; or**

**cccc. Prison;**

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

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

**(c) A consultation or educational service provided to a recipient or to others;**

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

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

**(f) Travel time;**

**(g) A field trip;**

- (h) A recreational activity;**
- (i) A social activity; or**
- (j) A physical exercise activity group.**

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

#### **Community Mental Health Center Services:**

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

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

- 29. Individual outpatient therapy;**
- 37. Group outpatient therapy;**
- 38. Family outpatient therapy;**
- 39. Collateral outpatient therapy;**

**5 Therapeutic rehabilitation services**

- 6. Psychological testing;**
- 40. Screening;**
- 41. An assessment;**
- 30. Crisis intervention;**
- 31. Service planning;**
- 32. A screening, brief intervention, and referral to treatment;**
- 33. Medication assisted treatment for a substance use disorder;**
- 34. Mobile crisis services;**
- 35. Assertive community treatment;**
- 36. Intensive outpatient program services;**
- 37. Residential crisis stabilization services;**
- 38. Partial hospitalization;**
- 39. Residential services for substance use disorders;**
- 40. Day treatment;**
- 41. Comprehensive community support services;**
- 42. Peer support services; or**
- 43. Parent or family peer support services; or**

**(b) Physical health services including:**

- 42. Physical examinations; or**
- 43. Medication prescribing and monitoring.**

**(2)(a) To be covered , a service listed in this section shall be:**

**1. Provided by a community mental health center that is:**

**d. Currently enrolled in the Medicaid Program in accordance with 907 KAR 1:672;**

**and**

**e. Except as established in paragraph (b) of this subsection, currently participating in the Medicaid Program in accordance with 907 KAR 1:671; and**

**2. Provided in accordance with:**

**a. This administrative regulation; and**

**b. The Community Mental Health Center Services Manual.**

**(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.**

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

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

**44. Be based on medical necessity and reasonableness;**

**45. Be clinically appropriate pursuant to the criteria established in 907 KAR 3:130;**

**46. Require prior authorization in accordance with Section 7 of this administrative regulation;**

**47. Be provided in compliance with 42 C.F.R. 440.230(c); and**

**48. Be restricted to an item used primarily in the home.**

**(b) Coverage of prosthetic devices shall not exceed \$1,500 per twelve (12) month period per member of the family choices benefit plan.**

**(2) Unless otherwise established in this administrative regulation;**

**(qqq) Except as provided in paragraph (b) of this subsection, the criteria referenced in subsection (1)(a) of this section that was in effect on the date the durable medical equipment, prosthetic, orthotic, or medical supply is provided shall be used as the basis for the determination of coverage, subject to medical necessity override by the department to ensure compliance with 42 C.F.R. 440.230(c).**

**(rrr) If criteria referenced in subsection (1)(a) of this section does not exist or is unavailable for a given item or service, the Medicare criteria in effect on the date the durable medical equipment, prosthetic, orthotic, or medical supply is provided shall be used as the basis for the determination of coverage, subject to medical necessity override by the department to ensure compliance with 42 C.F.R. 440.230(c).**

**(3) Unless specifically exempted by the department, a DME item, medical supply, prosthetic, or orthotic shall require a CMN that shall be kept on file by the supplier for the period of time mandated by 45 C.F.R. 164.316.**

**(4) An item for which a CMN is not required shall require a prescriber's written order.**

**(5) If Medicare is the primary payor for a recipient who is dually eligible for both Medicare and Medicaid, the supplier shall comply with Medicare's CMN requirement and a separate Medicaid CMN shall not be**

**required.**

**(6) A required CMN shall be:**

**(sss) The appropriate Medicare CMN in use at the time the item or service is prescribed;**

**(ttt) A MAP-1000, Certificate of Medical Necessity; or**

**(uuu) A MAP-1000B, Certificate of Medical Necessity,**

**Metabolic Formulas and Foods.**

**(7) A CMN shall contain:**

**(vvv) The recipient's name and address;**

**(www) A complete description of the item or service ordered;**

**(xxx) The recipient's diagnosis;**

**(yyy) The expected start date of the order;**

**(zzz) The length of the recipient's need for the item;**

**(aaaa) The medical necessity for the item;**

**(bbbb) The prescriber's name, address, telephone number, and National Provider Identifier (NPI), if applicable; and**

**(cccc) The prescriber's signature and date of signature.**

**(8) Except as specified in subsections (9) and (10) of this section, a prescriber shall examine a recipient within sixty (60) days prior to the initial order of a DME item, medical supply, prosthetic, or orthotic.**

**(9) Except as specified in subsection (11) of this section, a prescriber shall not be required to examine a recipient prior to subsequent orders for the same DME item, medical supply, prosthetic, or orthotic unless there is a change in the order.**

**(10) A prescriber shall not be required to examine a recipient prior to the repair of a DME item, prosthetic, or orthotic.**

**(11) A change in supplier shall require a new CMN signed and dated by a prescriber who shall have seen the recipient within sixty (60) days prior to the order.**

**(12) A CMN shall be updated with each request for prior authorization.**

**(13) The department shall only purchase a new DME item.**

**(14) A new DME item that is placed with a recipient initially as a rental item shall be considered a new item by the department at the time of purchase.**

**(15) A used DME item that is placed with a recipient initially as a rental item shall be replaced by the supplier with a new item prior to purchase by the department.**

**(16) A supplier shall not bill Medicaid for a DME item, medical supply, prosthetic, or orthotic before the item is provided to the recipient.**

**(17) A supplier shall not ship supplies to a recipient unless the supplier has:**

**(a) First had direct contact with the recipient or the recipient's caregiver; and**

**(b) Verified:**

**49. That the recipient wishes to receive the shipment of supplies;**

**50. The quantity of supplies in the shipment; and**

**51. Whether or not there has been a change in the use of the supply.**

**(18) A verification referenced in subsection (17) of this section for each recipient shall be documented in a file regarding the recipient.**

**(1) If a supplier ships more than one (1) month supply of an item, the supplier shall assume the financial risk of nonpayment if the recipient's Medicaid eligibility lapses or a HCPCS code is discontinued.**

**(2) A supplier shall have an order from a prescriber before dispensing any DMEPOS item to a recipient.**

**(3) A supplier shall have a written order on file prior to submitting a claim for reimbursement.**

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

**(d) A cane;**

**(e) Crutches;**

**(f) A standard walker;**

**(g) A prone or supine stander;**

**(h) A noninvasive electric osteogenesis stimulator; or**

**(i) Other items designated as purchase only in the Medicaid DME Program Fee**

**Schedule.**

**(2) The following items shall be covered for rental only:**

**(a) An apnea monitor;**

**(b) A respiratory assist device having bivalve pressure capability with backup rate feature;**

**(c) A ventilator;**

**(d) A negative pressure wound therapy electric pump;**

**(e) An electric breast pump;**

**(f) The following oxygen systems:**

**52. Oxygen concentrator;**

**53. Stationary compressed gas oxygen;**

**54. Portable gaseous oxygen;**

**55. Portable liquid oxygen; or**

**56. Stationary liquid oxygen; or**

**(g) Other items designated as rental only in the Medicaid DME Program**

**Fee Schedule.**

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

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

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

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

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

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

**59. The DME supplier shall complete the supplier information on the MAP 1001;**

**60. The DME supplier shall provide a copy of the completed MAP 1001 to the recipient; and**

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

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

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

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

**(eeee) The item is prior authorized by the department.**

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

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

**(ffff) A power wheelchair; or**

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

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

**(hhhh) A congenital defect or deformity;**

**(iiii) A deformity due to injury; or**

**(jjjj) Use as a brace attachment.**

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

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

**(kkkk) The item is prescribed by a licensed prescriber;**

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

**(c) The item is prior authorized; and**

**(mmmm) Nutritional intake is documented on the CMN.**

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

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

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

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

**(qqqq) If the item is prior authorized.**

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

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

**(rrrr) Medical separation of mother and infant;**

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

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

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

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

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

**(uuuu) During a period of medical need;**

**(vvvv) If necessary to make the item serviceable;**

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

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

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

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

**(yyyy) Loss of the item;**

**(zzzz) Irreparable damage or wear; or**

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

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

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

- (a) An item covered for Medicaid payment through another Medicaid program;**
- (b) Equipment that is not primarily and customarily used for a medical purpose;**
- (c) Physical fitness equipment;**
- (d) Equipment used primarily for the convenience of the recipient or caregiver;**
- (e) A home modification;**
- (f) Routine maintenance of DME that includes:
  - 62. Testing;**
  - 63. Cleaning;**
  - 64. Regulating; and**
  - 65. Assessing the recipient's equipment;****
- (g) Except as specified in Section 7(1)(j) of this administrative regulation, backup equipment;**
- (h) An item determined not medically necessary, clinically appropriate, or reasonable by the department; or**
  - (i) Diabetic supplies, except for:
    - 66. Those for which Medicare is the primary payor;**
    - 67. Those with an HCPCS code of A4210, A4250, A4252, A4253, A4256, A4258, A4259, E0607 or E2100; or**
    - 68. Those with a HCPCS code of A4206 if a diagnosis of diabetes is present on the corresponding claim.****
- (2) An estimated repair shall not be covered if the repair cost equals or exceeds:
  - (bbbb) The purchase price of a replacement item; or**
  - (cccc) The total reimbursement amount for renting a replacement item of equipment for the estimated remaining period of medical need.****
- (3) Durable medical equipment, prosthetics, orthotics and medical supplies shall be included in the facility reimbursement for a recipient residing in a hospital, nursing facility, intermediate care facility for individuals with an intellectual disability, or an institution for individuals with a mental disease and shall not be covered through the durable medical equipment program.**

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

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

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

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

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

**(a) Provided:**

**1. By a:**

**a. Registered nurse employed by a:**

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

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

**b. Licensed practical nurse employed by a:**

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

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

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

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

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

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

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

**(ddddd) Prior authorized; and**

**(eeee) Medically necessary.**

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

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

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

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

- (5) A personal care service;
- (6) A skilled nursing service or visit; or
- (7) A home health aide service.

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

- (8) An immediate family member of the recipient; or
- (9) A legally responsible individual who maintains his or her primary residence with the recipient.

**6.2.16.** Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16) Abortions are only covered in the case of rape, incest, or life endangerment. All abortions must be prior authorized.

**6.2.17.** Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) General Coverage Requirements. (1) A covered service shall be:

- (ffff) Medically necessary;
- (ggggg) Except as provided in subsection (2) of this section, furnished to a recipient through direct practitioner contact; and
- (hhhhh) Unless a recipient's provider demonstrates that dental services in excess of the following service limitations are medically necessary, limited to:
  - 44. Two (2) prophylaxis per twelve (12) month period for a recipient under age twenty-one (21);
  - 45. One (1) dental visit per month per provider for a recipient age twenty-one (21) years and over; and
  - 46. One (1) prophylaxis per twelve (12) month period for a recipient age twenty-one (21) years and over.

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

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

(3)(a) A medical resident may provide services if provided under the

direction of a program participating teaching physician in accordance with 42 C.F.R. 415.170, 415.172, and 415.174.

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

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

- (lllll) Diagnostic;
- (mmmmm) Preventive;
- (nnnnn) Restorative;
- (ooooo) Endodontics;
- (ppppp) Periodontics;
- (qqqqq) Removable prosthodontics;
- (rrrrr) Maxillofacial prosthetics;
- (sssss) Oral and maxillofacial surgery;
- (ttttt) Orthodontics; or
- (uuuuu) Adjunctive general services.

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

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

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

- 47. A limited oral evaluation for trauma related injuries;
- 48. Space maintainers;
- 49. Root canal therapy;
- 50. Denture relining;
- 51. Transitional appliances;
- 52. A prosthodontic service;
- 53. Temporomandibular joint therapy;
- 54. An orthodontic service;
- 55. Palliative treatment; or
- 56. A hospital call.

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

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

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

- 196. A periapical x-ray;
- 197. Bitewing x-rays;
- 198. A panoramic x-ray;
- 199. Resin, anterior;
- 200. A simple or surgical extraction;
- 201. Surgical removal of a residual tooth root;
- 202. Removal of a foreign body;
- 203. Suture of a recent small wound;
- 204. Intravenous sedation; or
- 205. Incision and drainage of infection.

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

1. Bitewing x-rays shall be limited to four (4) per twelve (12) month period, per recipient, per provider;

2. Periapical x-rays shall be limited to fourteen (14) per twelve (12) month period, per recipient, per provider;

3. An intraoral complete x-ray series shall be limited to one (1) per twelve (12) month period, per recipient, per provider;

4. Periapical and bitewing x-rays shall not be covered in the same twelve (12) month period as an intraoral complete x-ray series per recipient, per provider;

5. A panoramic film shall:

dddd. Be limited to one (1) per twenty-four (24) month period, per recipient, per provider; and

eeee. Require prior authorization in accordance with Section 15(2) and (3) of this administrative regulation for a recipient under age six (6);

6. A cephalometric film shall be limited to one (1) per twenty-four (24) month period, per recipient, per provider; or

7. Cephalometric and panoramic x-rays shall not be covered in conjunction with a comprehensive orthodontic consultation.

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

206. An x-ray necessary for a root canal or oral surgical procedure; or

207. An x-ray that exceeds the established service limitations and is determined by the department to be medically necessary.

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

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

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

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

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

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

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

**212. An occlusal surface that is noncarious.**

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

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

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

**214. Require the following:**

**ffff. Fabrication;**

**gggg. Insertion;**

**hhhh. Follow-up visits;**

**iiii. Adjustments; and**

**jjjj. Documentation in the recipient's medical record to:**

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

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

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

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

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

**(2) Coverage of a prefabricated crown shall be:**

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

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

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

**(ff) A permanent molar;**

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

**(hh) Two (2) per permanent molar, per recipient.**

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

**(ii) An amalgam, three (3) or more surfaces;**

**(jj) A permanent prefabricated resin crown; or**

**(kk) A prefabricated stainless steel crown.**

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

- (ll) A pulp cap direct;**
- (mm) Therapeutic pulpotomy; or**
- (nn) Root canal therapy.**

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

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

- 215. Treatment of the entire tooth;**
- 216. Completion of the therapy; and**
- 217. An x-ray taken before and after completion of the**

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

- 218. The Sargenti method of root canal treatment; or**
- 219. A root canal on one (1) root of a molar.**

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

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

- 220. Congenital condition;**
- 221. Hereditary condition; or**
- 222. Drug-induced condition; and**

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

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

**224. Coverage of a per-tooth procedure shall be limited to no more than two (2) teeth within the same quadrant.**

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

- (oo) Pocket-depth measurements;**
- (pp) A history of nonsurgical services; and**
- (qq) Prognosis.**

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

**(rr) Not exceed one (1) per quadrant, per twelve (12) months, per recipient, per provider;**

**(ss) Require prior authorization in accordance with Section 15(2) and (4) of this administrative regulation; and**

**(c) Require documentation to include:**

- 225. A periapical film or bitewing x-ray; and**
- 226. Periodontal charting of preoperative pocket depths.**

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

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

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

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

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

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

**(wwwww) Repair resin denture base; or**

**(xxxxx) Repair cast framework.**

**(3) Coverage for the following services shall not exceed one (1) per twelve (12) month period, per recipient:**

**(a) Replacement of a broken tooth on a denture;**

**(b) Laboratory relining of:**

**60. Maxillary dentures; or**

**61. Mandibular dentures;**

**(c) An interim maxillary partial denture; or**

**(d) An interim mandibular partial denture.**

**(4) An interim maxillary or mandibular partial denture shall be limited to use:**

**(yyyyy) During a transition period from a primary dentition to a permanent dentition;**

**(zzzzz) For space maintenance or space management; or**

**(aaaaaa) As interceptive or preventive orthodontics.**

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

**(10) A nasal prosthesis;**

**(11) An auricular prosthesis;**

**(12) A facial prosthesis;**

**(13) A mandibular resection prosthesis;**

**(14) A pediatric speech aid;**

**(15) An adult speech aid;**

**(16) A palatal augmentation prosthesis;**

**(17) A palatal lift prosthesis;**

**(18) An oral surgical splint; or**

**(1) An unspecified maxillofacial prosthetic.**

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

**(2) Root removal shall not be covered on the same date of service as the**

extraction of the same tooth.

(3) Coverage of surgical access of an unerupted tooth shall:

(bbbbbb) Be limited to exposure of the tooth for orthodontic treatment; and

(ccccc) Require prepayment review.

(4) Coverage of alveoplasty shall:

(dddddd) Be limited to one (1) per quadrant, per lifetime, per recipient; and

(eeeeee) Require a minimum of a three (3) tooth area within the same

quadrant.

(5) An occlusal orthotic device shall:

(ffffff) Be covered for temporomandibular joint therapy;

(gggggg) Require prior authorization in accordance with Section 15(2) and (5) of this administrative regulation;

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

(iiiiii) Be limited to one (1) per lifetime, per recipient.

(6) Frenulectomy shall be limited to one (1) per date of service.

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

(jjjjj) Torus palatinus (maxillary arch);

(kkkkkk) Torus mandibularis (lower left quadrant); or

(lllll) Torus mandibularis (lower right quadrant).

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

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

(mmmmmm) Extractions;

(nnnnnn) Impactions; and

(oooooo) Surgical access of an unerupted tooth.

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

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

(qqqqqq) Require prior authorization.

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

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

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

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

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

(a) Require a referral by a dentist; and

(b) Be limited to:

69. The correction of a disabling malocclusion; or

**70. Transitional or full permanent dentition unless for treatment of a cleft palate or severe facial anomaly.**

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

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

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

**71. One (1) or two (2) teeth slightly out of occlusion; or**

**72. Where the incisors have not fully erupted;**

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

**(d) Has an anterior crossbite that involves:**

**73. More than two (2) teeth in crossbite;**

**74. Obvious gingival stripping; or**

**75. Recession related to the crossbite;**

**(e) Demonstrates handicapping posterior transverse discrepancies which:**

**76. May include several teeth, one (1) of which shall be a molar; and**

**77. Is handicapping in a function fashion as follows:**

**f. Functional shift;**

**g. Facial asymmetry;**

**h. Complete buccal or lingual crossbite; or**

**i. Speech concern;**

**(f) Has a significant posterior open bite that does not involve:**

**78. Partially erupted teeth; or**

**79. One (1) or two (2) teeth slightly out of occlusion;**

**(g) Except for third molars, has impacted teeth that will not erupt into the arches without orthodontic or surgical intervention;**

**(h) Has extreme overjet in excess of eight (8) to nine (9) millimeters and one (1) of the skeletal conditions specified in paragraphs (a) through (g) of this subsection;**

**(i) Has trauma or injury resulting in severe misalignment of the teeth or alveolar structures, and does not include simple loss of teeth with no other affects;**

**(j) Has a congenital or developmental disorder giving rise to a handicapping malocclusion;**

**(k) Has a significant facial discrepancy requiring a combined orthodontic and orthognathic surgery treatment approach; or**

**(l) Has developmental anodontia in which several congenitally missing teeth result in a handicapping malocclusion or arch deformation.**

**(8) Coverage of comprehensive orthodontic treatment shall not be inclusive of orthognathic surgery.**

**(9) If comprehensive orthodontic treatment is discontinued prior to completion, the provider shall submit to the department:**

**(j) A referral form, if applicable; and**

**(k) A letter detailing:**

**80. Treatment provided, including dates of service;**

**81. Current treatment status of the patient; and**

**82. Charges for the treatment provided.**

**(10) Remaining portions of comprehensive orthodontic treatment may be authorized for prorated coverage upon submission of the prior authorization requirements specified in Section 15(2) and (7) of this administrative regulation if treatment:**

- (rrrrrr) Is transferred to another provider; or**
- (ssssss) Began prior to Medicaid eligibility.**

**Adjunctive General Service Coverage Limitations. (1)(a) Coverage of palliative treatment for dental pain shall be limited to one (1) per date of service, per recipient, per provider.**

**(b) Palliative treatment for dental pain shall not be covered in conjunction with another service except radiographs.**

**(2)(a) Coverage of a hospital call shall be limited to one (1) per date of service, per recipient, per provider.**

**(b) A hospital call shall not be covered in conjunction with:**

- 83. Limited oral evaluation;**
- 84. Comprehensive oral evaluation; or**
- 85. Treatment of dental pain.**

**(3)(a) Coverage of intravenous sedation shall be limited to a recipient under age twenty-one (21).**

**(b) Intravenous sedation shall not be covered for local anesthesia or nitrous oxide.**

**6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))**

**Inpatient psychiatric hospital services, including treatment for substance use disorders, must involve active treatment which is reasonably expected to improve the patient's condition or prevent further regression, so that eventually such services will no longer be necessary. Periodic medical and social evaluations should determine at what point a patient's progress has reached the stage where his/her needs can be met appropriately outside the institution.**

**Federal regulations emphasize "active treatment" as one of the necessary elements of inpatient services. Active treatment is defined as the implementation of a professionally developed individual plan of care which sets forth treatment objectives and therapies enabling the individual's functioning to improve to the point that institutional care is**

no longer necessary.

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

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

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

**Limitations of Services include:**

- Admissions for diagnostic purposes are covered only if the diagnostic procedures cannot be performed on an outpatient basis. Patients may be permitted home visits; however, this must be clearly documented on billing statements as payment cannot be made for these days.**
- Private accommodations will be reimbursed only if medically necessary and so ordered by the attending physician.**
- physician.**

**The physician's orders for and description of reasons for private accommodations must be maintained in the recipient's medical records. If a private room is the only room available, payment will be made until another room becomes available. If all rooms on a particular floor or unit are private rooms, payment will be made.**

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

- **Screening**
- **Assessment**
- **Service Planning**
- **Individual Therapy**
- **Group Therapy**
- **Family Therapy**
- **Peer Support**

**There are two levels of residential treatment:**

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

#### **Short Term**

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

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

#### **Long Term**

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

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

**6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19)) Substance Abuse Services. The following services shall be covered in accordance with this administrative regulation.**

**(1) Assessment.**

**(a) An assessment shall:**

**227. Be completed by a qualified substance abuse treatment professional; and**

**228. Be provided for an individual prior to receiving a substance abuse treatment service or an indicated prevention service.**

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

**1. Current level of substance intoxication or withdrawal;**

**4. Current pattern of substance use including quantity, frequency, and personal use history;**

**229. Identification of household members and significant others in the individual's life who use alcohol and other drugs;**

**230. Family history of alcohol and drug abuse;**

**231. History of emotional, sexual and physical abuse including current needs for safety;**

**232. History of mental health problems and diagnoses; and**

**233. Utilization of prenatal care and pediatric care for newborns.**

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

**1. Psychosocial history including:**

**kkkk. Presenting need;**

**llll. Current living arrangements;**

**mmmm. Marital and family history;**

**nnnn. History of involvement with child and adult protective services;**

**oooo. Current custody status of an individual's children;**

**pppp. Legal, employment, military, educational, and vocational history;**

**qqqq. Peer group relationships;**

**rrrr. Religious background and practices;**

**ssss. Ethnic and cultural background;**

**tttt. Leisure and recreational activities; and**

**uuuu. Individual strengths and limitations;**

**2. Current physical health status; and**

**3. Completion of a mental status screening.**

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

**1. Pregnancy or postpartum status; and**

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

**www. The need for substance abuse prevention services; and**

**2. The individual's need for:**

**xxxx. Prenatal care;**

**yyyy. A screening for health care problems for a postpartum woman;**

**zzzz. Pediatric care;**

**aaaa. Mental health, intellectual disability or developmental disability services; or**

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

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

1. The presenting need or problem; and
2. Substance abuse services needed by the individual as established by the assessment findings and the service placement criteria in Section 6 of this administrative regulation to include:

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

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

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

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

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

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

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

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

(2) Prevention services.

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

234. Be delivered as an individual or group service;

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

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

(b) Universal prevention services:

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

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

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

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

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

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

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

**(c) Selective prevention services:**

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

**a. The therapeutic risk reduction protocol shall:**

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

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

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

**(viii)** Address biological, psychological, and social factors that may increase risk for alcohol and other drug use during pregnancy and lactation and alcohol and other drug abuse throughout life; and

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

**(xxviii)** Change perceptions of normative alcohol and other drug behaviors;

**(xxix)** Develop skills for making and maintaining behavioral changes in alcohol and drug use and in developing social and psychological supports for these changes throughout life; or

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

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

3. Reimbursement shall be limited to:

iiii. During a single pregnancy and postpartum period; and

jjjj. A maximum of seventeen (17) hours for a therapeutic risk reduction protocol targeted at preventing alcohol and drug problems throughout the life of the individual.

(d) Indicated prevention service:

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

a. A therapeutic risk reduction protocol shall:

(i) Address the health and social consequences of high-risk drinking or drug choices, including consequences to a fetus in the case of any alcohol or drug use during pregnancy;

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

(xxxiii) Identify the existence of biological, psychological, and social risk factors; and

(xxxiv) Identify levels of alcohol and other drug use that increase risk for problems; and

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

(iii) Changing perceptions of normative alcohol and drug use behaviors;

(iv) Developing skills for making and maintaining behavioral changes, including changes in alcohol and drug use, and developing social and psychological supports to maintain the changes throughout life; and

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

2. Reimbursement shall be limited to:

j. During a single pregnancy and postpartum period; and

k. A maximum of twenty-five (25) hours for a protocol targeted at prevention of alcohol and drug problems throughout the life of the individual.

(3) Outpatient services.

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

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

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

**l. Treatment planning;**

**m. Referrals for other needed health and social services;**

**n. Information on substance abuse and its effects on health and fetal development;**

**o. Orientation to substance abuse related self-help groups; and**

**p. Participation in one (1) or more of the following modalities of outpatient treatment:**

**(xxxvi) Individual therapy;**

**(xxxvii) Group therapy;**

**(xxxviii) Family therapy. This modality shall be provided to an individual and one (1) or more persons with whom an individual has a family relationship;**

**(xxxix) Psychiatric evaluation provided by a psychiatrist or advanced registered nurse practitioner (ARNP);**

**(xl) Psychological testing provided by a licensed psychologist who holds the designation of health service provider, certified psychologist with autonomous functioning, certified psychologist, licensed psychological practitioner, or licensed psychological associate;**

**(xli) Medication management provided by a physician or an advanced registered nurse practitioner; or**

**(ii) Collateral care. This modality shall provide face-to-face consultation or counseling to a person who is in a position of custodial control or supervision of an individual under age twenty-one (21), in accordance with an individual's treatment plan.**

**(b) Service limitations.**

**1. Group therapy.**

**a. There shall be no more than twelve (12) persons in a group therapy session.**

**b. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse and other self-help groups.**

**2. Collateral care shall be limited to individuals under age twenty-one (21).**

**3. Psychiatric evaluations or psychological testing that do not result in an individual receiving substance abuse treatment shall not be reimbursable through this benefit.**

**4. No more than eight (8) hours of outpatient services shall be reimbursed during a one (1) week period.**

**(4) Intensive outpatient services.**

**(a) An intensive outpatient service shall be an ambulatory care service for the purpose of reducing or eliminating an individual's substance abuse problem.**

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

**62. Treatment planning;**

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

**64. Individual, group and family therapy.**

**(c) The following components may be provided in an intensive**

outpatient service as a face-to-face activity between an individual and a qualified substance abuse treatment professional or a member of the therapeutic team, supervised by a qualified substance abuse treatment professional:

- 88. Independent living skills training;
- 89. Parenting skill development;
- 90. Orientation to substance abuse and other self-help

programs; or

- 91. Staff support to activities led by the individual.

(d) Service limitations.

1. Group therapy.

q. There shall be no more than twelve (12) persons in a group therapy session.

r. Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse or other self-help groups.

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

(5) Day rehabilitation services.

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

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

92. Treatment planning;

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

94. Individual, group and family therapy.

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

95. Independent living skills training;

96. Parenting skill development;

97. Orientation to substance abuse and other self-help

programs; or

98. Staff support to activities led by the individual.

(d) Service limitations.

1. In accordance with 42 U.S.C. 1396d(a) and 1396d(i), payment shall not be made for care or services for any individual who is a patient in an

**institution of more than sixteen (16) beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.**

**2. Group therapy.**

**kkkkk.** There shall be no more than twelve (12) persons in a group therapy session.

**llll.** Group therapy shall not include physical exercise, recreational activities or attendance at substance abuse or other self-help groups.

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

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

**(6) Case-management services.**

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

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

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

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

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

**(b) Case-management services shall include:**

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

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

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

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

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

**241. An outreach or case-finding activity to secure a potential individual for services;**

**242. Administrative activities associated with Medicaid or eligibility determinations;**

**243. Transportation services solely for the purpose of transporting the individual; and**

**244. The actual provision of a service other than a case-management service.**

**(7) Community-support services.**

**(a) A community-support service shall be an ambulatory care service that shall be provided if the service is identified as a need in the**

**individual's case-management service plan.**

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

**(c) A community-support service shall include:**

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

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

**101. Coaching the individual in her natural environment to:**  
**s. Access services arranged by a case manager; and**  
**t. Apply substance abuse treatment gains, parent training and independent living skills to the individual's personal living situation.**

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

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

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

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

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

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

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

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

**(26) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-**

up on services rendered, and performing periodic reassessments of the child's changing needs;

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

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

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

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

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

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

(31) Outreach to potential recipients;

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

(33) Institutional discharge planning.

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

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

The department shall reimburse for a speech pathology service if:

(a) The service:

1. Is provided:

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

ppppp. To a recipient;

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

qqqqq. Maximum reduction of a physical or intellectual disability;

or

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

**3. Is prior authorized; and**

**4. Is medically necessary; and**

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

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

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

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

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

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

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

**(2) For example, if a recipient is receiving a speech pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for the speech pathology service provided to the same recipient during the same time period via the home health program**

**The department shall reimburse for physical therapy if:**

**(a) The therapy:**

**1. Is provided:**

**a. By a:**

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

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

**b. To a recipient;**

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

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

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

**3. Is prior authorized; and**

**4. Is medically necessary; and**

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

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

**(b) of this subsection.**

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

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

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

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

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

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

**The department shall reimburse for an occupational therapy service if:**

**(a) The service:**

**1. Is provided:**

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

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

**(2) For example, if a recipient is receiving an occupational therapy service from an occupational therapist enrolled with the Medicaid Program, the department shall not reimburse for the same**

**occupational therapy service provided to the same recipient during the same time period via the home health program.**

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

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

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

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

**In order to receive Hospice services, the recipient must elect Hospice coverage using the MAP-374 - Election of Medicaid Hospice Benefit Form. Recipients that elect Hospice will receive treatment for conditions related to their terminal illness by their Hospice provider.**

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

**Hospice benefits shall consist of two (2) ninety (90) day periods. Additional 60 day extension of Hospice benefits periods are covered until revocation or termination for other reasons such as ineligibility or death.**

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

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

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

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

**(tttttt) Service is medically necessary; and**

**(uuuuuu) Documentation is maintained for postpayment review to indicate immediate emergency medical attention was provided in the emergency room.**

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

**(vvvvvv) Medical necessity;**

**(wwwwww) Absence of a hospital emergency room in the medical service area; and**

**(xxxxxx) Delivery of emergency care to the patient.**

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

**(yyyyyy) The recipient's medical condition warrants transport by stretcher;**

**(zzzzzz) The recipient is traveling to or from a Medicaid-covered service, exclusive of a pharmacy service; and**

**(aaaaaaa) The service is the least expensive available transportation for the recipient's needs.**

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

**(bbbbbbb) The criteria specified in subsection (1) of this section are satisfied;**

**(ccccccc) The medical service required by the recipient is not available in the medical service area; and**

**(ddddddd) The recipient is referred by a physician. Non-emergency medical transportation is not covered.**

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

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

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

**6.2.1-DC State Specific Dental Benefit Package.** The State assures dental services represented by the following categories of common dental terminology (CDT<sup>1</sup>) codes are included in the dental benefits:

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

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

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

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

**6.2.2.1-DC** FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT<sup>2</sup> codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

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

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

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

**6.3.1.** The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

**6.3.2.** The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage

under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

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

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

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

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

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

2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

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

**6.4.2.1.** Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

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

The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c)) **6.4.3-PA: Additional State Options for Providing Premium Assistance** (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income

children? Yes  
 No

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

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

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

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

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

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

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

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

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

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

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

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

of premium assistance subsidies under the State child health plan? (Section 2102(c))

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

Yes  
No

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

**6.6.3.5.2-PA** Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

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

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

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

6.4.2.3.

## Section 7. Quality and Appropriateness of Care

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.**

7.1. Describe the methods (including external and internal monitoring) used to assure the

quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

**Will the state utilize any of the following tools to assure quality?**

**(Check all that apply and describe the activities for any categories utilized.)**

- 7.1.1. Quality standards**
- 7.1.2. Performance measurement**
  - 7.1.2 (a) CHIPRA Quality Core Set**
  - 7.1.2 (b) Other**
- 7.1.3. Information strategies**
- 7.1.4. Quality improvement strategies**

**KCHIP will use quality standards, performance measures, information, and quality improvement strategies to assure high-quality care for KCHIP enrollees. KCHIP will be incorporated into Kentucky's Health Care Partnerships. They will use quality assurance methods and tools such as NCQA accreditation standards, Health Plan Employer Data and Information Set (HEDIS), Consumer Assessment of Health Plan Survey (CAHPS) data and/or other quality improvement data. The standards used will be adapted from the 1115 Waiver required of the Medicaid managed care Partnership's entities. This will allow comparisons across provider and patient cohorts. Quality measures will be required of all managed care entity contractors and sub-contractors providing coverage and services to the KCHIP children.**

**CAHPS is utilized for the KCHIP population under the PCCM and managed care system. The state is administering and analyzing the CAHPS questionnaire for families enrolled in KCHIP. The KenPAC program of PCCM will remain until the program is bid out to a full managed care system. CAHPS and HEDIS will also be utilized when the population is bid out to a managed care program.**

**Access and utilization data are also maintained for PCCM and the managed care system. The state is analyzing claims data to evaluate access and utilization by children in PCCM and Managed Care, by regions of the state and by age.**

**EPSDT administrative data are collected through new codes developed for providers to record recipient encounters. These codes are used by PCCM providers and managed care organizations; thus, the state can generate EPSDT data for both KCHIP enrolled children in PCCM and Managed Care.**

**Immunizations are more difficult to track for KCHIP children under PCCM. The Department for Medicaid Services has been discussing alternative solutions to improving data collection and retention of records for immunizations with the Department for Public Health. No long-term solutions have been identified, and there is no statewide registry.**

**Administrative data are used for tracking, but using this data source is problematic. Currently, Kentucky ranks third in the nation on the percentage of children ages 19 to 35 months (88.6%) who have been immunized. This is based on the National Immunization Survey implemented by CDC in 1994, which began tracking immunizations in Kentucky in 1995.**

**Quality improvement strategies for the primary care case management program, KenPAC, will include methods and tools such as: CAHPS; access and utilization data on birth outcomes, EPSDT, immunizations and other selected performance measures; and selected quality studies. Quality study designs will be based on methods developed by NCQA.**

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

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

**Under the KenPAC (PCCM) program, the recipients' primary care providers manage access to well-baby care, well-child care, and well-adolescent care. In addition, the Department for Medicaid Services assesses access to care, evaluates the member and provider complaints, grievances, appeals and denials of care for KenPAC. They review member education materials, provider credentials and practice issues, suspected cases of potential fraud and abuse, and monitor primary care provider assignments. The KenPAC program of PCCM will remain until the program is bid out to a managed care system.**

**Both KenPAC and managed care entities will solicit input through the committees comprised of providers, advocates and parents of children eligible for the program.**

**Managed care entities are required to demonstrate adequate provider networks and access to care prior to contract award and through periodic reporting, with monitoring by the Department for Medicaid Services.**

**The Department for Medicaid Services conducts an annual patient satisfaction survey, CAHPS, to KCHIP recipients.**

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

**Emergency services are monitored in the same manner as 7.2.1.**

**7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic,  
complex, or serious medical conditions, including access to an adequate**

number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(e))

**Enrollees with chronic, complex, or serious medical conditions may either have a medical home through enrollment in Passport Health Plan or the KenPAC program, or may be served through fee-for-service Medicaid. The Department for Medicaid Services routinely monitors services provided by Passport Health Plan, including management of enrollees with chronic, complex, or serious medical conditions, through review and follow-up of regular written reports, review and follow-up of complaint data, and on site reviews. Families, care coordinators, service providers and advocates monitor access to care for children with serious medical conditions. The Department relies primarily on complaints and grievances to track the population for KenPAC and fee-for-service enrollees. The KenPAC program of PCCM will remain until the program is bid out to a managed care system.**

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or**, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

**Decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patients, within 14 days after the receipt of a request for services.**

**Section 8. Cost Sharing and Payment** (Section 2103(e))

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.**

8.1. Is cost sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1.  YES

8.1.2.  NO, skip to question 8.8.

8.2. Describe the amount of cost sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.

(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

**Not Applicable**

8.2.2. Deductibles:

**Not Applicable**

8.2.3. Coinsurance or copayments:

**Acute inpatient hospital admission \$50 copayment**

**Outpatient hospital or ambulatory surgical center visit \$4 copayment**

**Generic prescription drug \$1 copayment**

**Preferred brand name drug \$4 copayment**

**Non preferred brand name drug \$8 copayment**

**Non emergency use of emergency room \$8 copayment**

**DME \$4 copayment**

**Podiatry office visit \$3 copayment**

**Chiropractic office visit \$3 copayment**

**Dental office visit \$3 copayment**

**Optometry office visit \$3 copayment**

**General Ophthalmological Office visit \$3 copayment**

**Physician office visit \$3 copayment\**

**Office visit for care by a physician assistant, advanced practice registered nurse, certified pediatric and family nurse practitioner or a nurse midwife \$3**

**Office visit for care by a behavioral health professional \$3**

**Rural Health Clinic visit \$3**

**Federally Qualified Health Care visit \$3**

**Primary Care Center visit \$3**

**Physical, Speech, or Occupational Therapy visit \$3  
Laboratory, diagnostic or radiological service \$3 copayment**

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

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(B)) (42CFR 457.505(b))

**Public notice regarding cost sharing amounts were published in all major newspapers within the state prior to implementation. The announcement included information related to the cumulative maximum. In addition, information regarding cost sharing amounts is posted on the Medicaid website and inserted into member handbooks.**

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

8.4.1. Cost sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. No cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ✕ No additional cost sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

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

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

**assessed a copayment.**

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

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

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

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

- 8.7.1.1.** State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

**No premiums, coinsurance or deductibles are assessed. Providers cannot refuse to provide services to enrollees who cannot or do not pay the applicable cost sharing amount. No enrollee is disenrolled for failure to pay copayments.**

- 8.7.1.2.** The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

**Enrollees are not disenrolled for failure to pay copayments.**

- 8.7.1.3.** In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

**Not applicable. Enrollees are not disenrolled for failure to pay**

**copayments.**

**8.7.1.4** The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

**Not applicable. Enrollees are not disenrolled for failure to pay**

**copayments.**

- 8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))
- 8.8.1. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
  - 8.8.2. No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5)) (42CFR 457.224) (Previously 8.4.5)
  - 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
  - 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
  - 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)
  - 8.8.6.  No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

## **Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)**

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

### **Strategic Objectives and Performance Goals for the Plan Administration**

These goals have been developed in conjunction with “Healthy Kentuckians 2000 and updated for 2010”, Kentucky’s response to “National Health Promotion and Disease Prevention Objectives.” As indicated, the following objectives and goals are to be completed within one, two or five years of plan approval and implementation.

#### **Objectives for increasing extent of coverage**

- 5) Increase the number of children from birth to 19 who are enrolled in Medicaid.**
- 6) Improve the health status of Kentucky children with a focus on preventive and early primary care.**
- 7) Increase the proportion of children in Kentucky who have creditable health insurance and therefore a usual source of care.**
- 8) Reduce the financial barriers to affordable health care coverage for low-income families.**
- 9) KCHIP will be available to all eligible children statewide within one year of plan approval.**

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

#### **Performance Goal for Each Objective**

**Within two years of plan approval and implementation, increase Medicaid enrollment**

- 1) 10,000 new 14 to 19 year olds in families up to 100% FPL will be covered by Medicaid by June 30, 2000, and 17,500 new children from one to 19 years of age in families up to 150% FPL will be covered by Medicaid by June 30, 2000.**
- 2) An additional 10,000 currently Medicaid eligible children will be enrolled in Medicaid within two years of plan approval and implementation.**
- 3) Within five years of plan approval and implementation, increase health status of children**
  - a) 75% of children under 2 years of age will receive the recommended number of well child visits,**
  - b) 67% of children from 3 through 5 years of age will receive at**

- c) least one well child exam (Healthy Kentuckians goal = 80%), 50% of children from 10 through 18 years of age will receive at least one well child exam annually (Healthy Kentuckians goal = 50%),
- a) 75% children will receive an eye exam by an eye care specialist between age 3-6.

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

**Performance Measurement:**

The following measurements will be used to measure progress towards performance objectives:

The managed care entities will be encouraged to submit HEDIS 3.0. Administrative data on well child visits and immunizations and patient satisfaction information will be collected and analyzed on children covered by KCHIP.

The managed care entities are required to provide HEDIS data reports on well child visits and immunizations that are submitted on a quarterly and annual basis, but the managed care entities are not required to be NCQA accredited.

Additionally, the following means will be used to evaluate performance objective progress.

**Increase Medicaid enrollment:**

- 1) Medicaid Eligibility System Report.

**Increase health status of children:**

- 2) HEDIS 3.0 or identified performance measures will be tracked through administrative data.

Percentage of well child care and adolescent well care visits will be determined through administrative data. The established claims data system will enable KCHIP to track for the percentage of visits. It is possible to track for periodicity, but the data is not readily available.

**Increase numbers of kids with creditable coverage:**

- 3) Medicaid and KCHIP enrollment data benchmarks.
- 4) Legislative Research Commission annual insurance studies.

The study uses calculated averages from a three year average, March supplement to the CPS produced by Bureau of Census and augmented by LRC household

survey.

**Reduce barriers to affordable health coverage:**

- 6) KCHIP will report on enrollees by family income level. Clients who disenroll before their eligibility expires will be asked for a reason. Responses to that question will be tracked and analyzed to evaluate the extent that KCHIP has reduced financial barriers to affordable health care coverage.**

**Provide statewide coverage:**

**10) Cabinet KCHIP Annual Report.**

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

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

- 9.4.  The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)
- 
- 9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)
- 
- 9.6. The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)
- 
- 9.7. The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

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

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

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

**The development of the Kentucky Children's Health Insurance Program has been an open and inclusive process from its origin in November, 1996. At that time the Universal Access Workgroup was convened by staff from the Health Policy Development Branch in the Department for Public Health at the request of the Secretary of the Cabinet Its membership is included in Appendix K. The purpose of the group was to develop recommendations for improving access to health care for several groups consisting of children, adults (working poor), and the elderly without drug benefits.**

**Work began in several areas, including types of programs possible, the financing of such programs, and the scope of the problem to be solved. As the Balanced Budget Act of 1997 made children's health insurance funding a reality, the workgroup expanded to begin the process of program design. Committees on benefits and finance were established in the fall of 1997 (See Appendix K, KCHIP Planning Participants). These groups were responsible**

for developing recommendations regarding funding sources for the state match and benefit package to be used. (See Appendix L, KCHIP Meeting Minutes).

As the benefit plan became finalized, other groups were established to provide recommendations on selective parts of the Title XXI state plan development. An employer group was also established to discuss the opportunities and challenges in developing an employer subsidy program. Membership of these groups is also found in Appendix K.

The state's enabling legislation for the implementation of KCHIP provides for a seven member advisory council appointed by the Governor and ensures ongoing public involvement. This council is comprised of health care providers, families with children eligible for KCHIP and child advocates. Meetings are held on a regularly scheduled basis and upon call of the Chair. All meetings are in accordance with the requirements of the Kentucky Open Meetings Law. These ongoing meetings give members and the public an opportunity to learn about and comment on proposed changes in KCHIP, to identify problems, and to advise and make recommendations.

Ongoing public involvement is also ensured through the regulatory process. When regulations are changed a legislative committee provides review and oversight, and public hearings are held.

In terms of the development of the Family Choices plan, public involvement was paramount in creating buy-in from advocates, consumers and legislators. Kentucky has made a conscientious effort to ensure public input during both the development of the program and the CMS negotiation process. As such, we have continued to participate in numerous public meetings regarding the waiver. During the last three months members of DMS leadership team have met with the following groups:

- c. Advocates for Reform of Medicaid Services (ARMS)
- d. Brain Injury Provider Group
- e. Kentucky Association of Private Providers (KAPP)
- f. Kentucky Alliance of Regional Programs (KARP)
- g. Medicaid Consortium
- h. Mental Health Consumer Council

Following our meeting with CMS in November, we conducted a briefing with the team assisting Kentucky with our Medicaid transformation, KyHealth Choices, which is comprised of consumers and representatives from various advocacy organizations. Members of that team were specifically selected to ensure the dissemination of information to consumers and family members across the state. An additional meeting is scheduled this week to go over the financial sections of the waiver as it pertains to recent CMS discussions.

Additionally, numerous presentations were made to various legislative health and welfare committees as well as with individual Kentucky legislators from both the house and senate.

**In anticipation of final CMS approval and recognizing our ambitious timeline, the Commonwealth has undertaken steps to ensure judicious implementation of KyHealth Choices by creating teams for various strategic components.**

**During the past few months, several organizations have submitted various documents often referred to as “white papers” as to their suggestions for improving current regulations and policies as we move toward implementation of KyHealth Choices. We have accumulated these documents and utilize the transformation team of advocates, providers and consumers to work through each area, reach a consensus on a response and make recommendations to the Cabinet.**

**Finally, we have had numerous individual meetings with person and/or organizations wishing to express their views or ask questions.**

**Kentucky genuinely values public input and finds it to be very helpful to see KyHealth Choices through other eyes. By utilizing the multiple team approach, we are creating a process that will ensure public input not only during the development and negotiation phase of KyHealth Choices but through the entirety of transformation project.**

**9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))**

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

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

**Provisions regarding cost sharing were announced in major newspapers within the state in September and December of 2013. In addition, applicants receive information about cost sharing when they apply from the eligibility determination caseworker. There are educational materials available in the local Department for Community Based Services offices where applicants go to apply for services that explain co-pays.**

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

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

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

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

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  
- Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

**CHIP Budget**

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

**NOTE: Include the costs associated with the current SPA.**

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

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

**Section 10. Annual Reports and Evaluations (Section 2108)**

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

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

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

10.3.

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

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

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

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.**

- 11.1 The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))
- 11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*
- 11.2.1. 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
  - 11.2.2. Section 1124 (relating to disclosure of ownership and related information)
  - 11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)
  - 11.2.4. Section 1128A (relating to civil monetary penalties)
  - 11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)
  - 11.2.6. Section 1128E (relating to the National health care fraud and abuse data collection program)

## **Section 12. Applicant and enrollee protections (Sections 2101(a))**

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

### Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

**The review process for eligibility and enrollment matters for the Kentucky Children's Health Insurance Program, Medicaid expansion program and separate insurance program is described in 907 KAR 1:560 – Medicaid hearings and appeals regarding eligibility and in 907 KAR 1:705 – demonstration project: services provided through regional managed care partnerships. These regulations are incorporated in the regulations governing the SCHIP Medicaid expansion program (907 KAR 4:020) and the SCHIP separate insurance program (907 KAR 4:030). A copy of 907 KAR 1:560 is attached in Appendix M.**

### Health Services Matters

12.2 Please describe the review process for **health services matters** that comply with 42 CFR 457.1120.

**The review process for health service matters for the Kentucky Children's Health Insurance Program, Medicaid expansion program and separate insurance program is described in 907 KAR 1:563 – Medicaid covered services hearings and appeals and in 907 KAR 1:705 – demonstration project: services provided through regional managed care partnerships. These regulations are incorporated in the regulations governing the SCHIP Medicaid expansion program (907 KAR 4:020) and the SCHIP separate insurance program (907 KAR 4:030). A copy of 907 KAR 1:563 is attached in Appendix M.**

### Premium Assistance Programs

12.

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

**Not applicable**

ATTACHMENTS

ATTACHMENT B- CS 10- STATE EMPLOYEE DOCUMENTATION



Kentucky's Healthcare Connection

# Health Coverage & Help Paying Costs Application for One Person

THINGS TO KNOW

Use this application to see what insurance choices you qualify for

- Free or low-cost insurance from Medicaid or the Kentucky Children's Health Insurance Program (KCHIP)
- Payment Assistance that can help you pay for your health coverage
- Affordable health insurance plans that offer comprehensive coverage to help you stay well

Who is this application for?

Single individuals who:

- Live in Kentucky and plan to stay in Kentucky
- Do not have any dependents and cannot be claimed as a dependent on someone else's tax return

Apply faster online

Apply faster online at [www.kynect.ky.gov](http://www.kynect.ky.gov).

What you may need to apply

- Your social security number (or document number if you are a legal immigrant)
- Employer and income information (for example, paystubs, W-2 forms, or wage and tax statements)

Why do we ask for this information?

We ask about your **Social Security Number (SSN)**, your **income** and other information to see if you qualify for and if you can get any help paying for your health coverage costs.

If you need help getting an SSN, call 1-800-772-1213 or visit [socialsecurity.gov](http://socialsecurity.gov). TTY users should call 1-800-325-0778.

We'll keep all the information you give us private, as required by law.

What happens next?

- Mail or fax your completed, signed application to:

**Kentucky Office of the Health Benefit and Information Exchange  
P.O. Box 2104  
Frankfort, KY 40602**

**Fax: 1-502-573-2005**

- If you don't have all the information we ask for, submit your application anyway. We will contact you for the missing information if we cannot complete the determination based on the information you give us.
- If we can make a determination, we will send you detailed information about the steps you will need to follow to select a plan. You will need to go online, call us, or get assistance from an insurance agent or kynector to enroll in a plan.

To get help

- Online: [www.kynect.ky.gov](http://www.kynect.ky.gov)
- By phone: Call Customer Service at **1-855- 4kynect (459-6328)**
- In person: Find a list of places near where you live by visiting our website or calling us.
- En Espanol: Llame a nuestro Servicio al Cliente gratis al **1-855- 4kynect (459-6328)**
- For TTY services call **1-855-326-4654**

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Kentucky's Fleethcare Connection

# Health Coverage & Help Paying Costs Application for One Person

## STEP I Tell Us about Yourself

If someone else is helping you fill out this application, use **Appendix B** to give us that person's information.)

1. First Name, Middle initial, Last name, Suffix (as it appears on your Social Security card)

2. Social Security Number (SSN)

We need your SSN if you want coverage and have a SSN. We use SSNs to check income and other information to see if you are eligible for help with health coverage costs.

3. If you want coverage and SSN is not provided, select reason for not providing it.

- SSN due to alien status**
- Religious Objection**
- Not eligible to receive**
- Applied for SSN**

4. Date of Birth (mm/dd/yyyy)

1.

Gender  
 Male

- Does not have an SSN and may only be issued an SSN for a valid non-work reason**
- Refuse to provide SSN**

6. Do you live in Kentucky and plan to stay in Kentucky?  Yes  No

4. Home Address -  Check here if you do not have a Home Address. You will still have to enter a Mailing Address below.

13. City		14. State	15. Zip Code	16. County
17. Primary Phone Number ( ) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		18. Secondary Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		
19. <input type="checkbox"/> Check here to allow kynect to send text message alerts to your primary phone number.		20. <input type="checkbox"/> Check here to allow kynect to send text message alerts to your secondary phone number.		
21. Preferred Spoken Language (if not English)		22. Preferred Written Language (if not English)		

5. City	9. State	10. Zip Code	11. County
---------	----------	--------------	------------

12. Mailing Address (Only required if different from home address)

23. Form 1095-A is sent by kynect to you and the IRS to report enrollment information and the amount of payment assistance a household has received during the coverage year, if any. This form will be sent to you via postal mail, or if you create an account on kynect, we can notify you via email instead that the form is ready for viewing. If you would like to be notified via email, enter your email address:

24. Have you had a pregnancy end (giving birth or losing a pregnancy) in the past three months or are you currently pregnant?  Yes. If yes, answer questions a—c.  No

a. What is the due date or the last date of pregnancy? (mm/dd/yyyy) \_\_\_\_\_

b. How many children are/were expected with this pregnancy? \_\_\_\_\_

c. Would you like to be referred to the program that offers food to Women, Infants and Children (WIC)?  Yes  No

25. Are you offered health coverage from a job (including someone else's job, like a parent's job)?  Yes. If yes, you will need to complete and include Appendix A with this application.  No

26. Do you want help paying for medical bills from the last 3 months?  Yes  No  
If yes, which month(s)?

If you need help with your application or to apply faster online, go to [www.kvnect.kv.gov](http://www.kvnect.kv.gov) or call 1-855-4kynect (4596328). Para ayuda en Espanol, llame gratis al 1-855-4kynect (459-6328).



27. Do you plan to file a federal income tax return NEXT YEAR?  
(You can apply for health insurance even if you don't file a federal income tax return.)

YES. If yes, answer questions a & b.  NO. If no, go to question b.

a. Will you file as a single person with no dependents?  Yes  No  
If No, stop using this form. Use the *Health Coverage & Help Paying Costs Application for More Than One Person* to include your tax dependents (even if you do not want to apply for health coverage for them.)

b. Are you claimed as a dependent on someone else's tax return?  Yes  No  
If Yes, stop using this form. You will need to apply for coverage with the person claiming you on their tax return (even if that person does not want coverage.)

28. Are you a U.S. citizen or national?

Yes  No

29. If you are not a U.S. citizen or national, do you have immigration status?

Yes. Answer questions a—d below.

a. Immigration Document Type: \_\_\_\_\_

b. Document ID Number: \_\_\_\_\_

c. Have you lived in the U.S. since 1996?  Yes  No

a. Are you a veteran or active-duty member of the U.S. military?  Yes  No

30. Are you of Hispanic, Latino or Spanish origin? (OPTIONAL)  Yes  No

1. Race (OPTIONAL)

- |  |  |                                   |  |   |
|--|--|-----------------------------------|--|---|
| <input type="checkbox"/> White                     | <input type="checkbox"/> American Indian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Vietnamese      | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Alaska Native   | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Asian     | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Chinese                   | <input type="checkbox"/> Asian Indian    | <input type="checkbox"/> Korean   | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Other Pacific Islander |

32. Are you American Indian or Alaska Native?

Yes. If yes, complete Appendix C and mail it with this application.  No

33. Are you currently in prison or jail or have you been released in the past three months?

Yes. If yes, answer questions a—c.  No

a. When did you enter prison? (mm/dd/yyyy)

b. When did you leave prison? (mm/dd/yyyy)

c. Are you currently waiting for a decision on charges?  Yes  No

33. Do you need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home?

Yes  No

34. Are you blind or permanently disabled?  Yes  No

35. Were you receiving Medicaid when you became too old to be eligible for foster care placement?  Yes  No

If yes, in what state were you living?

How old were you?

2. If you are filling out this application on behalf of a person who recently passed away, enter the deceased person's date of death: \_\_\_\_\_



If you need help with your application or to apply faster online, go to [www.kvnect.ky.gov](http://www.kvnect.ky.gov) or call 1-855-4kynect (4596328). Para ayuda en Espanol, llame gratis al 1-855-4kynect (459-6328).

# STEP 2 Current Job and Income Information

Use additional sheets of paper if you need to add more than two jobs.

## Income from Job 1

1. Who earns this income? \_\_\_\_\_

2. Who is this person's employer? \_\_\_\_\_

3. What is the gross amount this person makes (before taxes)? I4. How often?  Weekly  Twice a month  
 Every two weeks  Monthly \_\_\_\_\_

### 5. IF SELF-EMPLOYED

a. Type of work \_\_\_\_\_

c. Gross Income \_\_\_\_\_

b. Self-employment Expenses \_\_\_\_\_

b. NET income (Gross minus expenses) \_\_\_\_\_

c. How often? \_\_\_\_\_

## Income from Job 2

6. Who earns this income? \_\_\_\_\_

7. Who is this person's employer? \_\_\_\_\_

8. What is the gross amount this person makes (before taxes)? \$ \_\_\_\_\_  
 9. How often?  Weekly  Twice a month  
 Every two weeks  Monthly e. How often? \_\_\_\_\_

### 10. IF SELF-EMPLOYED

a. Type of work \_\_\_\_\_

b. Gross Income \_\_\_\_\_

a. Self-employment Expenses \_\_\_\_\_

a. NET income (Gross minus expenses) \_\_\_\_\_

e. How often? \_\_\_\_\_

### 11. Additional

here any additional income you may receive, give the amount and how often you get it. Do not include income from child support, Supplemental Security Income (SSI), veteran's income, or Worker's Compensation. **If none leave blank.**

Income: List income you may

Type of Income	How Much?	How Often?
<input type="checkbox"/> Social Security	\$ _____	<input type="checkbox"/> W <input type="checkbox"/> Twice a <input type="checkbox"/> Mont
<input type="checkbox"/> Pensions	_____	<input type="checkbox"/> W <input type="checkbox"/> Twice a <input type="checkbox"/> Mont
<input type="checkbox"/> Interest or Dividend	\$ _____	<input type="checkbox"/> W <input type="checkbox"/> Twice a <input type="checkbox"/> Mont
<input type="checkbox"/> Disability Payments	\$ _____	<input type="checkbox"/> W E Twice a month CI Monthly
<input type="checkbox"/> Unemployment	\$ _____	<input type="checkbox"/> W <input type="checkbox"/> Twice a CI Monthly
<input type="checkbox"/> Other	_____	<input type="checkbox"/> W <input type="checkbox"/> Twice a CI Monthly

12. **Household Deductions:** Give us information about things that you pay and that can be deducted on an income tax return. Giving us this information could make the cost of health insurance lower.

Type of Deduction	How Much?	How Often?
<input type="checkbox"/> Alimony Paid	_____	<input type="checkbox"/> W <input type="checkbox"/> Twice a CI Monthly
<input type="checkbox"/> Student Loan Interest	_____	<input type="checkbox"/> W eekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Mont hly

13. **Yearly Income:** What is your estimated yearly income for the coverage year (including any monthly changes, bonuses, seasonal income, etc.)? \_\_\_\_\_



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## STEP 3 Other Healthcare Coverage

Do you have health coverage now, including **dental and major medical coverage** that is not Medicaid or KCHI P?

YES. If yes, complete the information below.

NO.

Type of coverage

Policy Number

Name of policy holder

Coverage start date

Name of insurance company

Coverage end date

Insurance Company's Address

## STEP 4 Sign and Date this Application

- I am signing this application under penalty of perjury which means I have given true answers to all the questions on this form to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell kynect if anything changes from what I wrote on this application within 30 days of the change. I can visit [kynect.ky.gov](http://kynect.ky.gov) or call **1-855-4kynect (459-6328)** to report any changes.
- If I think kynect has made a mistake, I can appeal its decision. To appeal means to tell someone at kynect that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).
- I understand that kynect will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or any other trusted source. If the information does not match, I may be asked to send proof.

**Renewal of coverage in future years:** To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow kynect to use income data, including information from tax returns and other trusted data sources. kynect will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next: (select one)

5 years (maximum allowed)  4 years  3 years  2 years  1 year

Do not use information from tax returns or other data sources to renew my coverage.

**Voter Registration:** If I am not registered to vote or not registered where I currently live, I can choose to register to vote by checking yes below. If I check yes, I will receive a voter registration application in the mail. Checking yes or no below does not affect the outcome of this application.

application will be mailed to me.

Yes, I want to apply to register to vote. An  
 No, I don't want to register to vote.

If I am eligible for Medicaid:

- I understand that if Medicaid pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid to reimburse it for the expense.
- I understand that my application may be reviewed to make sure that eligibility was determined correctly. If my application is reviewed, I must cooperate with the review.

Signature

Date (mm/dd/yyyy)



If you need help with your application or to apply faster online, go to [www.hmect.kv.gov](http://www.hmect.kv.gov) or call **1-855-4kynect (4596328)**. Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

2012 Hardship Calculation for Children of Kentucky State Employees

No. Recipients Utilizing Services	Service Utilized	Average visits Per Year for Children of State Employees	Average Cost of Billed Charges per Claim per Child Enrolled in Separate Program	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Optimum PPO	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Maximum Choice	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Capitated Choice	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Standard PPO
14	Inpatient Hospital	1	\$ 12,179.90	\$ 1,826.99	\$ 1,217.99	\$ 100.00	\$ 3,044.98
5	Mental Hospital	2	\$ 6,504.36	\$ 1,951.31	\$ 1,300.87	\$ 200.00	\$ 3,252.18
411	Outpatient Hospital	3	\$ 1,013.04	\$ 455.87	\$ 101.30	\$ 202.61	\$ 253.26
10	Ambulatory Surgical Center	1	\$ 3,086.70	\$ 463.01	\$ 308.67	\$ 50.00	\$ 771.68
346	Preventive	6	\$ 49.16	\$ 60.00	\$ 4.92	\$ 90.00	\$ 12.29
31	Chiropractor	9	\$ 117.43	\$ 90.00	\$ 11.74	\$ 128.23	\$ 29.36
3	Other Lax/X Ray	1	\$ 374.94	\$ 10.00	\$ 37.49	\$ 74.99	\$ 93.74
66	DME	3	\$ 249.40	\$ 249.40	\$ 24.94	\$ 49.88	\$ 62.35
261	FQHC	9	\$ 91.57	\$ 90.00	\$ 9.16	\$ 135.00	\$ 22.89
91	CMHC	8	\$ 166.65	\$ 80.00	\$ 16.67	\$ 120.00	\$ 41.66
235	Rural Health	12	\$ 105.98	\$ 120.00	\$ 10.60	\$ 180.00	\$ 26.50
136	Laboratory	2	\$ 140.34	\$ 20.00	\$ 14.03	\$ 28.07	\$ 35.09
264	EPSDT Screen	2	\$ 116.39	\$ 20.00	\$ 11.64	\$ 30.00	\$ 29.10
13	Ambulance	1	\$ 1,646.18	\$ 246.93	\$ 164.62	\$ 329.24	\$ 411.55
747	Pharmacy	14	\$ 85	\$ 190.00	\$ 8.52	\$ 190.00	\$ 21.30
335	Optometry	2	\$ 163.11	\$ 163.11	\$ 163.11	\$ 163.11	\$ 163.11
479	Dental	3	\$ 259.49	\$ 259.49	\$ 259.49	\$ 259.49	\$ 259.49
755	Physician	13	\$ 190.80	\$ 130.00	\$ 19.08	\$ 195.00	\$ 47.70
131	Nurse Practitioner	4	\$ 118.94	\$ 40.00	\$ 11.89	\$ 60.00	\$ 29.74
1	Hearing	1	\$ 197.54	\$ 15.00	\$ 19.75	\$ 15.00	\$ 49.39
21	Podiatry	2	\$ 186.12	\$ 30.00	\$ 18.61	\$ 30.00	\$ 46.53
6	Physician Assistant	3	\$ 190.80	\$ 60.00	\$ 19.08	\$ 45.00	\$ 47.70
Total Co-Pay and Co-insurance Once Deductible is Met				\$ 6,571.09	\$ 3,754.18	\$ 2,675.61	\$ 8,751.55
Deductible Per Family				\$ 600.00	\$ 3,000.00	\$ 1,500.00	\$ 1,500.00
Annual Premium per Family				\$ 2,118.24	\$ 1,306.32	\$ 1,728.24	\$ 99.36
Allowance for HRA					\$ 1,500.00	\$ 500.00	
Potential Out-of-Pocket for 1 Child				\$ 9,289.33	\$ 6,560.50	\$ 5,403.85	\$ 10,350.91

2012 Hardship Calculation for Children of Kentucky State Employees

	Service Utilized	Average visits Per Year for Children of State Employees	Average Cost of Billed Charges per Claim per Child Enrolled in Separate Program	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Optimum PPO	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Maximum Choice	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Capitol Choice	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Standard PPO
	Physician	13	\$ 190.80	\$ 130.00	\$ 19.08	\$ 195.00	\$ 47.70
	Pharmacy	14	\$ 85.19	\$ 190.00	\$ 8.52	\$ 190.00	\$ 21.30
	Dental	3	\$ 259.49	\$ 259.49	\$ 259.49	\$ 259.49	\$ 259.49
	Preventive	6	\$ 49.16	\$ 60.00	\$ 4.92	\$ 90.00	\$ 12.29
	Optometry	2	\$ 163.11	\$ 163.11	\$ 163.11	\$ 163.11	\$ 163.11
	EPSDT Screen	2	\$ 116.39	\$ 20.00	\$ 11.64	\$ 30.00	\$ 29.10
Total Co-Pay and Co-insurance Per Child After Deductible is Met				\$ 822.60	\$ 466.75	\$ 927.60	\$ 532.99
Deductible Per Family				\$ 600.00	\$ 3,000.00	\$ 1,500.00	\$ 1,500.00
Annual Premium per Family				\$ 2,118.24	\$ 1,306.32	\$ 1,728.24	\$ 99.36
Allowance for HRA or Up-Front Benefit Allowance					\$ (1,500.00)	\$ (500.00)	
Total Annual Out-of-Pocket for Family with 1 Child				\$ 3,540.84	\$ 3,273.07	\$ 3,655.84	\$ 2,132.35
Out-of-Pocket for Each Additional Child				\$ 822.60	\$ 466.75	\$427.60 (\$927.60-\$500)	\$ 532.99

Family Size	200% of FPL	5% of annual income (Max out-of-pocket allowed per CHIP)	Average Out-of-Pocket for State Employees Enrolled in	Average Out-of-Pocket for State Employees Enrolled in Maximum	Average Out-of-Pocket for State Employees Enrolled in Commonwealth Capitol Choice	Average Out-of-Pocket for State Employees Enrolled in Commonwealth Standard	Difference in least	diference in most
2	\$29,140.00	\$1,457.00	\$ 3,540.84	\$ 3,273.07	\$ 3,655.84	\$ 2,132.35	\$ 675.35	\$ 2,083.84
3	\$36,620.00	\$1,831.00	\$ 4,363.44	\$ 3,739.82	\$ 4,083.44	\$ 2,665.34	\$ 834.34	\$ 2,532.44
4	\$44,100.00	\$2,205.00	\$ 5,186.04	\$ 4,206.57	\$ 4,511.04	\$ 3,198.33	\$ 993.33	\$ 2,981.04
5	\$51,580.00	\$2,579.00	\$ 6,008.64	\$ 4,673.32	\$ 4,938.64	\$ 3,731.32	\$ 1,152.32	\$ 3,429.64
6	\$59,060.00	\$2,953.00	\$ 6,831.24	\$ 5,140.07	\$ 5,366.24	\$ 4,264.31	\$ 1,311.31	\$ 3,878.24
7	\$66,540.00	\$3,327.00	\$ 7,653.84	\$ 5,606.82	\$ 5,793.84	\$ 4,797.30	\$ 1,470.30	\$ 4,326.84
8	\$74,020.00	\$3,701.00	\$ 8,476.44	\$ 6,073.57	\$ 6,221.44	\$ 5,330.29	\$ 1,629.29	\$ 4,775.44

2012 Hardship Calculation for Children of Kentucky State Employees

Service Utilized	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Optimum PPO	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Maximum Choice	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Capitol Choice	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Standard PPO
Physician	\$ 130.00	\$ 19.08	\$ 195.00	\$ 47.70
Pharmacy	\$ 190.00	\$ 8.52	\$ 190.00	\$ 21.30
Dental	\$ 259.49	\$ 259.49	\$ 259.49	\$ 259.49
Preventive	\$ 60.00	\$ 4.92	\$ 90.00	\$ 12.29
Optometry	\$ 163.11	\$ 163.11	\$ 163.11	\$ 163.11
EPSDT Screen	\$ 20.00	\$ 11.64	\$ 30.00	\$ 29.10
<b>Total Co-Pay and Co-Insurance Per Child After Deductible is Met</b>	\$ 822.60	\$ 466.75	\$ 927.60	\$ 532.99
<b>Deductible Per Family</b>	\$ 600.00	\$ 3,000.00	\$ 1,500.00	\$ 1,500.00
<b>Annual Premium per Family</b>	\$ 2,118.24	\$ 1,306.32	\$ 1,728.24	\$ 99.36
<b>Allowance for HRA or Up-Front Benefit Allowance</b>		\$ (1,500.00)	\$ (500.00)	
<b>Total Annual Out-of-Pocket Per Family with 1 child</b>	\$ 3,540.84	\$ 3,273.07	\$ 3,655.84	\$ 2,132.35
<b>Out-of-Pocket for Each Additional Child</b>	\$ 822.60	\$ 466.75	\$427.60 (\$927.60-\$500)	\$ 532.99

\_\_\_\_\_