

**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.

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):

Original Plan

Effective Date: July 1, 1998
Implementation Date: July 1, 1998

SPA #1

Medicaid Expansion to 150% FPL

Proposed effective date: July 1, 1999
Proposed 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: July 1, 2002
Implementation Date: July 1, 2002

SPA #6

Cost Sharing

Effective Date: July 1, 2003
Implementation Date: July 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 Payment**
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)
Effective Date: October 1, 2013
Implementation Date: October 1, 2013

SPA #14-0017 **Non-Financial Eligibility**
CS17 (Non-Financial Eligibility-Residency)

CS18 (Non-Financial-Citizenship)
CS19 (Non-Financial-Social Security)
CS20 (Substitution of Coverage)
Effective Date: January 1, 2014
Implementation Date: January 1, 2014

SPA #17-000 **Eligibility Process**
CS24 (Single, Streamlined application screen and enroll process renewals) supersedes previous
CS24)
Effective Date: July 1, 2017
Implementation Date: July 1, 2017

SPA #18-0001 **Parity**
Effective Date: October 2, 2017
Implementation Date: October 2, 2017

SPA #18-0002 **Eliminated Cost Sharing**
Effective Date: January 1, 2019
Implementation Date: January 1, 2019

SPA # KY-19-0001 **MCO Compliance**
Effective Date: January 1, 2018
Implementation Date: January 1, 2018

SPA # KY-20-0001 **Covid-19 Disaster**
Effective Date: March 1, 2020
Implementation Date: March 1, 2020

SPA # KY-CHIP 20-0002 **BH-SUPPORT**
Effective Date: October 24, 2019
Implementation Date: October 24, 2019

Superseding Pages of MAGI CHIP State Plan Material
State: Kentucky

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
KY-13-0013 Effective/ Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS10 CS15	Eligibility – Targeted Low Income Children Children with access to Public Employee Coverage MAGI-Based Income Methodologies	Supersedes the current sections – Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 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
KY-13-0014 Effective/ Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
KY-13-0015 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
KY-13-0016 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
KY-13-0017 Effective/ Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19	Non-Financial Eligibility – Residency Non-Financial – Citizenship Non-Financial – Social Security Number	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1-LR; Supersedes the current section 4.1.9.1

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
KY-13-0017 Effective/ Implementation Date: January 1, 2014	Non- Financial Eligibility	CS20	Substitution of Coverage	Supersedes the current section 4.4.4
KY-17-0000 Effective/Implementation Date: July 1, 2017		CS24	Single, Streamlined Application	Supersedes the previously approved CS24
KY-18-0001 Effective/Implementation Date: July 1, 2017			Parity/MHPEAH	Mental Health Parity Compliance
KY-18-0002 Effective/Implementation Date: January 1, 2019	Financial		Copayments eliminated	Section 8.2.3, 8.3, 8.4.5, 8.6 & 8.7 cost sharing and copayment language eliminated.
KY-CHIP 19-0001 Effective/Implementation Date: July 1, 2018			MCO Compliance	Ensure MCO Compliance
KY-CHIP 20-0001 Effective/Implementation Date: March 1, 2020	Eligibility		COVID-19	Section 1.4: allows temporary requirements and adjustments for eligibility policies; Section 4.3: Methodology
KY-CHIP 20-0002 Effective/Implementation Date: October 24, 2019			Behavioral Health	Section 6.2 BH-SUPPORT compliance

1.4-TC Tribal Consultation (Section 2107€(1)(C))

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. 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.

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.

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, 1996.⁴

<u>Category</u>	<u>Estimated # Uninsured</u>
Age of Uninsured Children:	
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. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered 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 Mental Health/Mental Retardation Services' 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

2.2.2. (2.2.2. replaced by 5.1.2)

2.3. (2.3 replaced by 5.1.3)

2.2.3. 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-

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

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 (Eligibility Standards and Methodology).

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

The service delivery system for the KCHIP Medicaid expansion and the separate insurance program will be the same as for all Medicaid recipients. Medicaid and KCHIP recipients will be mandatorily enrolled in a managed care capitated system with the exception of the region surrounding Louisville (which is served by Passport Healthcare Plan, the Health Care Partnership). Services are provided to Medicaid and KCHIP recipients through a Health Care Partnership in one region of Kentucky. The KenPAC program of PCCM will remain until the program is bid out to a managed care system.

As indicated, KCHIP recipients will be served through the Medicaid service delivery system described in Kentucky's approved Title XIX state plan and relevant approved Medicaid waivers. As the Medicaid service delivery system changes over time, KCHIP recipients will be included in the revised service delivery mechanisms.

Funding 10% for other forms of child health assistance Kentucky realizes it may use up to 10% of actual Federal and State benefit expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for direct services, other health service initiatives to improve children's health, outreach, and administrative costs. Kentucky estimates this amount to be approximately \$6.4 million dollars if all federal and state expenditure limits are reached.

Kentucky has received several proposals from a variety of providers, e.g., Title V agencies (primarily local health departments), to provide specific services designed to improve children's health. These include home visitation programs, school-based nurse programs, health education, and teen pregnancy prevention programs supported by school systems and Title V programs. Similar proposals are being developed by Federally Qualified Health Clinics and providers of specialized children's services or special children's populations.

State KCHIP administrative costs for implementation of the program will come from this same category and are still evolving. Additionally, the amount of these dollars is based on actual funds spent for benefits; it is therefore difficult to estimate the amount of funds available and how these funds will be used at this time. For example, a coalition of organizations is developing statewide to apply for Robert Wood Johnson funding to augment the KCHIP outreach effort described in this plan and to support local demonstration projects. Part of the 10% amount may be used for outreach, should this application not be chosen for RWJ funding.

Therefore, until more is known about state administrative costs and the amount of funds available, Kentucky will have as its first priority, providing benefits to children. Concurrent with this effort, Kentucky will solicit proposals from the many projects, initiatives, coalitions, and service providers currently serving targeted low-income children. These proposals will be evaluated for receipt of portions of the 10% amount based upon their ability to reach a unique part of the targeted low-income child population or to demonstrate cost-effective

strategies for ensuring creditable coverage reaches more of the targeted low-income group.

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

- No, the State does not use a managed care delivery system for any CHIP populations.
- Yes, the State uses a managed care delivery system for all CHIP populations.
- Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

- No
- Yes

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

- Managed care organization (MCO) (42 CFR 457.10)
- Capitation payment

Describe population served:

Children birth to 19 under 218% FPL.

Prepaid inpatient health plan (PIHP) (42 CFR 457.10)

Capitation payment

Other (please explain)

Describe population served:

Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)

Capitation Payment

Other (please explain)

Describe population served:

Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)

Case management fee

Other (please explain)

Primary care case management entity (PCCM Entity) (42 CFR 457.10)

Case management fee

Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))

Other (please explain)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as described in 42 CFR 457.10), in addition to PCCM services:

Provision of intensive telephonic case management

Provision of face-to-face case management

Operation of a nurse triage advice line

Development of enrollee care plans

Execution of contracts with fee-for-service (FFS) providers in the FFS program

Oversight responsibilities for the activities of FFS providers in the FFS program

Provision of payments to FFS providers on behalf of the State

Provision of enrollee outreach and education activities

Operation of a customer service call center

Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement

Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers

Coordination with behavioral health systems/providers

Other (please describe)

3.1.2.2 The State assures that if its contract with an MCO, PAHP, or PIHP allows the entity to use a physician incentive plan, the contract stipulates that the entity must comply with the requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

The State assures that Kentucky's MCO contracts allow the MCO to use a physician incentive plan and that the contract complies with requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

3.1.3 Nonemergency Medical Transportation PAHPs

The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(1) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

3.2.1 The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

3.2.2 The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

3.2.3 The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

3.2.4 The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

- Based on public or private payment rates for comparable services for comparable populations; and
- Consistent with actuarially sound principles as defined in 42CFR 457.10.(42CFR 457.123(a)).

3.3.2 The State assures that its rates are designed to reasonably achieve a medical loss ratio to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203 (C))

3.3.3 The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203 (a) through (c). (42 CFR.1203 (d)).

3.3.4 The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs and PAHPs. (42 CFR 457.1203(e), cross-referencing to 42 CFR 438.74(a)).

3.3.5 Does the State require an MCO, PIHP or PAHP to pay remittances through the contract meeting the minimum MLR required by the State? (42CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1)).

- No, the State does not require any MCO, PIHP or PAHP to pay remittances.
- Yes, the State requires all MCOs, PIHPs and PAHPs to pay remittances.
- Yes, the State requires some, but not all, MCOs, PIHPs and PAHPS to pay remittances.

If the State request some, but not all, MCOs PIHPs and PAHPS to pay remittance through the contract for not meeting the minimum MLR required by the State, please describe which types of managed care entities are and are not required to pay remittances. For example, if a state requires a medical MCO to pay a remittances but not a dental PAHP, please include this information.

If the answer to the assurance above is yes for any or all managed care entities, please answer the next assurance:

The State assures that it if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

- Reimburses CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in the Federal matching rate; and
- Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report provided to CMS that summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

3.3.6 The State assures that each MCO, PIHP, and PAHP calculates and reports the medical loss ratio in accordance with 42 CFR 438.8. (42 CFR 457.1203(f))

3.4 Enrollment

The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

- Accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(1));
- Will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(3)); and
- Will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. (42 CFR 457.1201(d), cross-referencing to 438.3(d)(4))

3.4.1 Enrollment Process

3.4.1.1 The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

3.4.1.2 The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))

Yes

No

If the State uses a default enrollment process, please make the following assurances:

The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))

The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably and does not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

3.4.2.1 The State assures that the State will notify enrollees of their right to dis-enroll consistent with the requirements of 42 CFR 438.56 at least annually. (42CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2)).

3.4.2.2 The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))

3.4.2.3 If a beneficiary dis-enrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

3.4.2.4 MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.

The State assures that contracts with MCOs, PIHP, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 FR 457.1212, cross0-referencing to 42 CFR 438.56(b))

3.4.2.5 Enrollee Requests for Disenrollment.

Does the State limit disenrollment from an MCO, PIHP, PAHP, PCCM and PCCM entity by an enrollee? (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

- Yes
 No

If the State limits disenrollment by the enrollee from an MCO, PIHP, PAHP, PCCM and PCCM entity, please make the following assurances (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)):

The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(0)(1))

The State assures that beneficiary requests to dis-enroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))

The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
 - At least once every 12 months thereafter;
 - If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity;
- and

- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

3.4.2.6 The State assures that the State ensures timely access to a State review for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(2))

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

3.5.2 The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))

3.5.3 The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

3.5.4 The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM and PCCM entity to use:

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
- Model enrollee handbooks and model enrollee notices. (42 CFR 457.1207, Cross referencing to 42 CFR 438.10(c)(4))
- The State assures that the Member Handbook will be in compliance effective July 1, 2019.

3.5.5 If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

- The format is readily accessible
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

3.5.6 The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:

- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
- Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees:
 - That oral interpretation is available for any language and written translation is available in prevalent languages;
 - That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
 - How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

3.5.7 ☒ The State assures that the State or its contracted representative provides the information specified in 42 CFR 457.1207, cross-referencing to 438.10(e)(2), and includes the information either in paper or electronic format, to all potential enrollees at the time the potential enrollee becomes eligible to enroll in a voluntary managed care program or is first required to enroll in a mandatory managed care program and within a timeframe that enables the potential enrollee to use the information to choose among the available MCOs, PIHPs, PAHPs, PCCMs and PCCM entities:

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;
- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity;
- Covered benefits including:
 - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
 - For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, where and how to obtain the service;
- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan;
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;

- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

3.5.8 ☒ The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually

3.5.9 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:

3.5.10 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of the MCO, PIH, PAHP or PCCM entity and enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.1(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
 - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
 - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
 - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
 - What constitutes an emergency medical condition and emergency services;
 - The fact that prior authorization is not required for emergency services; and
 - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning
- services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;

- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
 - The right to file grievances and appeals;
 - The requirements and timeframes for filing a grievance or appeal;
 - The availability of assistance in the filing process; and
 - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

3.5.11 The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))

3.5.12 The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

3.5.13 The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directories as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))

3.5.14 The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:

- 1) Which medications are covered (both generic and name brand); and
- 2) What tier each medication is on.

3.5.15 The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c))

3.5.16 The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.

3.5.17 The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))

3.5.18 The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260) .

3.6 Benefits and Services

3.6.1 The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)

3.6.2 The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.3 The State assures that it:

- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
- Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

3.6.4 Assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206).

3.6.5 The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:

- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
- Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
- Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b))

3.6.6 The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(1))

3.6.7 The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))

3.6.8 The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;

- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHI Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees.
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
- Establishing mechanisms to ensure compliance by network providers; Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider.
(42CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

3.6.9 ☒ The State assures that each MCO, PIHP and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State’s standards for access to care . (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)

3.6.10 ☒ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

3.6.11 ☒ Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:

- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and
- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

3.6.12 ☒ Except that 438.210(b)(2)(iii) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the authorization of services requirements under 42 CFR 438.210, including that:

- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures;
- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual with appropriate expertise in addressing the enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

3.6.13 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

3.6.14 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))

3.6.15 ☒ The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP implements the policy. (42 CFR 457.1216, cross-referencing to 42 CFR 438.62)

3.6.16 ☒ The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services;
- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;
- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b)) :

3.6.17 The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.

3.6.18 The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs (42 CFR 457.130 (C), cross-referencing to 42 CFR 438.208 (C)(2))

3.6.19 The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:

- Is in accordance with applicable State quality assurance and utilization review standards;
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))

3.6.20 The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

3.7.1 The State assures that it has established a uniform credentialing and re-credentialing policy that addresses acute, primary, behavioral, and substance use disorders providers and requires each MCO, PIHP and PAHP to follow those policies. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(b)(1))

3.7.2 The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:

Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));

MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));

MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross-referencing 42 CFR 438.12(a));

If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, or PAHP gives the affected

providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and

MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3 The State assures that each contracted MCO, PIHP, and PAHP complies with the sub-contractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:

- The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;
- All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable sub-regulatory guidance and contract provisions; and
- The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4 The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

3.7.5 The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))

3.7.6 The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and dis-enrollments for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.7 The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the

contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.8 The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the State has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004)

3.7.9 The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e))

3.8 Beneficiary Protections

3.8.1 The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))

3.8.2 The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))

3.8.3 The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:

- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))
- Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
- Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

3.9.1 The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?

Yes

No

3.9.5 The State assures that the external medical review is:

- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
- Independent of both the State and MCO, PIHP, or PAHP;
- Offered without any cost to the enrollee; and
- Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))

3.9.6 The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))

3.9.7 The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))

3.9.8 The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))

3.9.9 The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.

3.9.10 The State assures that the notice of an adverse benefit determination explains:

- The adverse benefit determination.
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
- The procedures for exercising the rights specified above under this assurance.
- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))

3.9.11 State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))

3.9.12 The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and

3.9.13 The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:

Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14 The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

3.9.15 The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

3.9.16 The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

3.9.17 The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))

3.9.18 ☒ The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

3.9.19 ☒ The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))

3.9.20 ☒ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 ☒ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:
 - The right to request a State review, and how to do so.
 - The right to request and receive benefits while the hearing is pending, and how to make the request.
 - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

3.9.22 ☒ For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))

3.9.23 ☒ **The State assures that if it offers an external medical review:**

- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
- The review is independent of both the State and MCO, PIHP, or PAHP; and
- The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(0))

3.9.24 ☒ The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))

3.9.25 ☒ The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
- The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

3.9.26 ☒ The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)

3.9.27 ☒ The State assures that if the MCO, PIHP, or PAHP, or the State review officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 CFR 457.1260, cross-referencing to 42 CFR 438.424(a))

3.10 Program Integrity

3.10.1 ☒ The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:

- 1) ☒ Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;
- 2) ☒ Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and
- 3) ☒ Including a mechanism for MCOs PIHPs and PAHPS to report to the State, to CMS or to the Office of Inspector General (OIG) as appropriate, Information on violations of law by subcontractors, providers or enrollees of an MCO, PIHP or PAHP and other individuals (42 CFR 457.1280)

3.10.2 ☒ The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)

3.10.3 ☒ The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on

behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))

3.10.4 The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP;
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least \$5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

3.10.5 The State assures that each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(2))

3.10.6 The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))

3.10.7 The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))

310.8 The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42CFR 457.1285, cross referencing 42 CFR 438.602 (C)) 310.9

3.10.9 The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

3.10.10 The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))

3.10.11 The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)

3.10.12 The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:

Encounter data in the form and manner described in 42 CFR 438.818.

Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.

Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.

Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.

Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.

The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13 The State assures that:

It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))

It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and

It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

3.10.14 The State assures that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors provides: written disclosure of any prohibited affiliation under 42 CFR 438.610, written disclosure of and information on ownership and control required under 42 CFR 455.104, and reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. (42 CFR 457.1285, cross referencing 42 CFR 438.608(c))

3.10.15 The State assures that services are provided in an effective and efficient manner. (Section 2101(a))

3.10.16 The State assures that it operates a Web site that provides:

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services;
- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g))

3.11 Sanctions

3.11.1 The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

3.11.2 The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.3 The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?

Yes

No

3.11.5 The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))

3.11.6 The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b) 3.11.7 x

3.11.7 The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review 3.12.1

Quality Strategy

3.12.1.1 The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
- A description of:
 - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
 - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);

- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to non-duplication of EQR-related activities) and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a "significant change" for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

3.12.1.2 The State assures that the goals and objectives for continuous quality improvement in the quality strategy are measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(2))

3.12.1.3 The State assures that for purposes of the quality strategy, the State provides the demographic information for each CHIP enrollee to the MCO, PIHP or PAHP at the time of enrollment. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(6))

3.12.1.4 The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))

3.12.1.5 The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii)).

3.12.1.6 The State assures that it will submit to CMS:

- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
- A copy of the revised strategy whenever significant changes are made to the document, or when ever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

3.12.1.7 Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:

- Make the strategy available for public comment; and
- If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))

3.12.1.8 The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

3.12.2.1.1 The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The elements of the assessment and program include at least:

- Standard performance measures specified by the State;
- Any measures and programs required by CMS (42 CFR 438.330(a)(2));
- Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);
- Mechanisms to detect both underutilization and overutilization of services; and
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1))

3.12.2.1.2 The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
- Planning and initiation of activities for increasing or sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

3.12.2.1.3 The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:

- Standard performance measures specified by the State;
- Mechanisms to detect both underutilization and overutilization of services; and
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

3.12.2.2.1 The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))

3.12.2.2.2 The State assures that it annually requires each MCO, PIHP, and PAHP to:

- Measure and report to the State on its performance using the standard measures required by the State;

- Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
- Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

3.12.2.2.3 The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:

- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and
- The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

3.12.3.1 The State assures that it requires each MCO, PIHP, and PAHP to inform the state whether it has been accredited by a private independent accrediting entity, and, if the MCO, PIHP, or PAHP has received accreditation by a private independent accrediting agency, that the MCO, PIHP, and PAHP authorizes the private independent accrediting entity to provide the State a copy of its recent accreditation review that includes the MCO, PIHP, and PAHP's accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(a) and (b)).

3.12.3.2 The State assures that it will make the accreditation status for each contracted MCO, PIHP, and PAHP available on the Web site required under 42 CFR 438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

The State assures that it will implement and operate a quality rating system that issues an annual quality rating for each MCO, PIHP, and PAHP, which the State will prominently display on the Web site required under 42 CFR 438.10(c)(3), in accordance with the requirements set forth in 42 CFR 438.334. (42 CFR 457.1240(d))

3.12.5 Quality Review

The State assures that each contract with a MCO, PIHP, PAHP, or PCCM entity requires that a qualified EQRO performs an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP or PCCM entity, except as provided in 42 CFR 438.362. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(a))

3.12.5.1 External Quality Review Organization

3.12.5.1.1 The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))

3.12.5.1.2 The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO

uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

3.12.5.2.1 The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1))

3.12.5.2.2 The State assures that if it elects to use non-duplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) — (iii), the State will document the use of non-duplication in the State's quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)

3.12.5.2.3 The State assures that if the State elects to use non-duplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) (iii), the State will ensure that all information from a Medicare or private accreditation review for an MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42 CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

3.12.5.2.4 The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
- A review, conducted within the previous 3-year period, to determine the PCCM entity's compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

3.12.5.3.1 The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))

3.12.5.3.2 The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).

3.12.5.3.3 The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:

- The EQRO has sufficient information to use in performing the review;
- The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;

- For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
- The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e) .

3.12.5.3.4 ☒ The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));
- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
 - Objectives;
 - Technical methods of data collection and analysis;
 - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and Conclusions drawn from the data;
 - An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
 - Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
 - Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
 - An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

3.12.5.3.5 ☒ The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))

3.12.5.3.6 ☒ The State assures that it finalizes the annual EQR technical report by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

3.12.5.3.7 ☒ The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by A

3.12.5.3.8 The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, **PIHP, PAHP**, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii)) April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.9 The State assures that it makes the information specified in 42 CFR 438.364(a) for the annual EQR technical report available in alternative formats for persons with disabilities, when requested. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(3))

3.12.5.3.10 **The** State assures that information released under 42 CFR 438.364 for the annual EQR technical report does not disclose the identity or other protected health information of any patient. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(d))



CHIP Eligibility

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

Eligibility for Medicaid Expansion Program	CS3
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	X
+	6	19	109	159	X

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collections of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09381148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer. Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

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. Yes

The date benefits are furnished is:

- 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 CHIPRA 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;
 - (viii) 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:
 - (i) Has been granted employment authorization; or
 - (ii) 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.1101(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)).



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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



CHIP Eligibility

.1.21k3 Control Number: 0938-
 1148 Expiration date: 10/31/2014

**Separate Child Health Insurance Program
 Eligibility - Targeted Low-Income Children**

CS7

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.310, 315 and 320

- Targeted Low-Income Children - Uninsured children under age 19 whose household income is within standards established by the state.
- ✓ The CHIP Agency operates this covered group in accordance with the following provisions:

Age
 Must be under age 19.
Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standards

Begin with lowest age range first.

Please note that the lower bound for CHIP eligibility should be the highest standard used for Medicaid poverty-level children for the same age group or groups entered here.

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	0	1	195	213	X
+	1	19	159	213	X

Age ranges may overlap. If there is an overlap, provide an explanation. Include the age ranges for each income standard that has overlapping ages and the reason for having different income standards.

Special Program for Children with Disabilities

Does the state have a special program for children with disabilities? No

PRA Disclosure Statement

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

% of the FPL (SHO #02-

**4.1.4 Resources of each separate eligibility group (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



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 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):

SPA # KY-13-0017

Approval Date: NOV 14 2013

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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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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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4.1.6 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, not to exceed 12 months:

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 other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:



CHIP Eligibility

OMB Control Number: 0938-1148

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

CS19

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

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4.1 LR - CS 18 NON-FINANCIAL SUPERSEDES 41 LR

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.

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

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

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

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

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

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

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

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



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program **CS24**
General Eligibility - Eligibility Processing

2102(b)(3) & 2107(e)(1)(O) 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, stream lined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

- 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.

An attachment is submitted.

- 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-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.

Yes

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 requirements of 457.348(b) and will provide this agreement to the Secretary upon request.



CHIP Eligibility

PRA Disclosure Statement

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V.20130709

4.3.0 Methodology (Section 2102)(b)(2)) (42CFR, 457.350)

In the event of a State or Federally declared disaster, the State will notify CMS of its intent to provide temporary adjustments to its policies as described below:

- **State delay in processing applications.**
At State discretion, requirements related to timely processing of applications may be temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area.
- **State delay in processing renewals and extension of renewals deadlines for families.**
At State discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area.
- **Extend the reasonable opportunity period.**
At State discretion, the agency may provide for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the State or Federally declared disaster or public health emergency.
- **Delay processing changes in circumstance**
The State will temporarily delay acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by a State or Federally declared disaster area such that processing the change in a timely manner is not feasible. The state will continue to act on the required changes in circumstance described in 42 CFR 457.342(a) cross-referencing 42 CFR 435.926(d).”



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program MAGI-Based Income Methodologies

CS15

2102(b)(1)(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.

If the 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(f)(2)(i) as a tax dependent.

- 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.

PRA Disclosure Statement



CHIP Eligibility

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CHIP Eligibility

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

Separate Child Health Insurance Program
General Eligibility - Eligibility Processing CS24

2102(b)(3) & 2107(e)(1)(O) 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, stream lined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

- 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.

An attachment is submitted.

- 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-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.

Yes

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 requirements of 457.348(b) and will provide this agreement to the Secretary upon request.



CHIP Eligibility

PRA Disclosure Statement

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V.20130709



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.

An 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



CHIP Eligibility

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

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

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 Part 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.

PRA Disclosure Statement



CHIP Eligibility

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130718

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 checkups); 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,
- 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-□ 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.

3) 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.

4) Outreach through Collaboration with Local County Agencies and Organizations

In order to involve concerned citizens 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.

6) 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.

7) 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 Benefind, 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 Benefind, 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 Benefind 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 Benefind 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 160% TO 213% 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))
- 6.2.2. Outpatient services (Section 2110(a)(2))
- 6.2.3. Physician services (Section 2110(a)(3))
- 6.2.4. Surgical services (Section 2110(a)(4))
- 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. Prescription drugs (Section 2110(a)(6))
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. Pre-natal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 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))
- 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))
- 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))
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15. Nursing care services (See instructions) (Section 2110(a)(15))
- 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))
- 6.2.17. Hearing Screenings and services (Section 2110(a)(24))
- 6.2.18. Case management services (Section 2110(a)(20))
- 6.2.19. Care coordination services (Section 2110(a)(21))
- 6.2.20. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.21. Hospice care (Section 2110(a)(23))
- 6.2.22. EPSDT consistent with requirements of sections 1905 (r) and 1902(1)(43) of the Act
- 6.2.23. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(28))
- 6.2.24. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.25. Medical Transportation

- 6.2.26 Enabling services (such as transportation, translation and outreach services) Section 2110(a)(27))
- 6.2.27 Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))
- 6.2.28 Dental services (Section 2110(a)(17))
- 6.2.29 Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.30 Outpatient substance abuse treatment services (Section 2110(a)(19))

6.2-BH Behavioral Health Coverage Section 2103(c)(6) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

- State-developed schedule
- American Academy of Pediatrics
- Other Nationally recognized periodicity schedule (please specify):
- Other (please describe:)

No difference between CHIP Population.

6.2.0- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS’s contract review process at 42 CFR 457.1201(l).

6.2.0.1-MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.0.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If “Other” is selected, please provide a description of that standard.

- International Classification of Disease (ICD)
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- State guidelines (Describe:)
- Other (Describe:)

6.2.0.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

- Yes
- No

6.2.0.2-MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a) (43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.0.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer “yes.”

Yes

No

6.2.0.2.2- MHPAEA EPSDT benefits are provided to the following:

All children covered under the State child health plan.

A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

6.2.0.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a) (43))

All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a) (43) (A))

All areas above apply to all State Plans except for KCHIP III recipients. They do not receive EPSDT special services, but receive all screenings. EPSDT Special Services may be preventive, diagnostic or treatment, or rehabilitative. The Special Service benefits are not MH/SUD related.

6.2.0.3-MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.0.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

The state defines the benefit classifications as follow:

- 1) Inpatient: All covered services or items provided to a member in a setting that requires an overnight stay including residential services.
- 2) Outpatient: All covered services or items provided to a member in a setting that does not require an overnight stay, which do not otherwise meet the definition of inpatient, prescription drug or emergency care services.
- 3) Emergency care: All covered emergency services or items to treat an emergency condition delivered in an emergency department (ED) setting.
- 4) Prescription drugs: Covered medications, drugs, and associated supplies and services that
 - a. require a prescription to be dispensed.

6.2.0.3.1.1 MHPAEA The State assures that:

The State has classified all benefits covered under the State plan into one of the four classifications.

The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.0.3.1.2-MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

Yes

No

All included as one. MCO's can separate out accordingly.

6.2.0.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

6.2.0.3.2 MHPAEA The State assures that:

Mental health/substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Annual and Aggregate Lifetime Dollar Limits

6.2.0.4-MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.0.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

Aggregate lifetime dollar limit is applied

Aggregate annual dollar limit is applied

No dollar limit is applied

6.2.0.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

Yes (Type(s) of limit:)

No

6.2.0.4.3 – MHPAEA States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR

457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

6.2.0.4.3.1 – MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

6.2.0.4.3.2 – MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

6.2.0.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

- The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

6.2.0.4.3.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Does Not Apply

Quantitative Treatment Limitations

6.2.0.5 - MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

Yes (Specify:)

No

6.2.0.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

6.2.0.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Does Not Apply

6.2.0.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to “substantially all” (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

6.2.0.5.3.1-MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The “predominant level” of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in

that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

- The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))
- The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Non-Quantitative Treatment Limitations

6.2.0.6 - MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.0.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

- The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

6.2.0.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.0.6.2.1 – MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

Yes

No

6.2.0.6.2.2 – MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorders benefits. Please assure the following:

- The State that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/substance use disorder benefits are comparable to and

applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out-of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.0.7-MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.0.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

- State
- Managed Care entities
- Both
- Other

MCO's are deemed compliant with this requirement if they disseminate practice guidelines in compliance with the Medicaid managed care rule (42 CFR 438.236 (c)). Also if they provide notice of adverse benefit determination for denials.

6.2.0.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

- State
- Managed Care entities
- Both
- Other

MCO's are deemed compliant with this requirement if they disseminate practice guidelines in compliance with the Medicaid managed care rule (42 CFR 438.236 (c)). Also if they provide notice of adverse benefit determination for denials.

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 non-emergency admission was:

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

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

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

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

Non-covered Services. Inpatient hospital services not covered shall include:

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

- a) A service which is not medically necessary including television, telephone, or guest meals;
- b) Private duty nursing;
- c) Supplies, drugs, appliances, or equipment which are furnished to the patient for use outside the hospital unless it would be considered unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which he is an inpatient;
- d) A laboratory test not specifically ordered by a physician and not done on a preadmission basis unless an emergency exists;
- e) Private accommodations unless medically necessary and so ordered by the attending physician;
- f) The following listed surgical procedures, except if a life-threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a hospital:
 - 1) Biopsy: breast, cervical node, cervix, lesions (skin, subcutaneous, submucous), lymph node (except high axillary excision), or muscle
 - 2) Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts or condylomas, anterior nose bleeds, or cervix;
 - 3) Circumcision;
 - 4) Dilation: dilation and curettage (diagnostic or therapeutic non-obstetrical); 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 proctosigmoidoscopy;
- 15) Removal; IUD, fingernail or toenails;
- 16) Tenotomy hand or foot;
- 17) Vasectomy; or
- 18) Z-plasty for relaxation of scar or contracture.

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

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

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

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

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

(a) A recipient;

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

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

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

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

Coverage Criteria.

(1) To be covered by the department:

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

1. Magnetic resonance imaging;
2. Magnetic resonance angiogram;
3. Magnetic resonance spectroscopy;
4. Positron emission tomography;
5. Cineradiography/video-radiography;
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. Medically necessary; and
2. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and
3. 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:

- a. A diagnostic service ordered by a physician;
- b. A therapeutic service, except for occupational therapy services as occupational therapy services shall not be covered under this administrative regulation, ordered by a physician;
- c. An emergency room service provided in an emergency situation as determined by a physician; or
- d. A drug, biological, or injection administered in the outpatient hospital setting.

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

- a. An advanced practice registered nurse [(APRN)] who has been designated by the Kentucky Board of Nursing as a nurse midwife;
or
- b. A registered nurse who holds a valid and effective permit to practice nurse midwifery issued by the Cabinet for Health and Family Services.

(6) The department shall cover:

- a. A screening of a lock-in recipient to determine if the lock-in recipient has an emergency medical condition; or
- b. An emergency service to a lock-in recipient if the department determines that the lock-in recipient had an emergency medical condition when the service was provided

(7) 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:
 - a) An individual has no obligation to pay; and
 - b) No other person has a legal obligation to pay;
 - c) 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;
 - d) A drug, biological, or injection purchased by or dispensed to a recipient;
 - e) A routine physical examination; [or]
 - f) A nonemergency service, other than a screening in accordance with Section 2(6)(a) of this administrative regulation, provided to a lock-in recipient:
 1. In an emergency department of a hospital; or
 2. If provided by a hospital that is not the lock-in recipient's designated hospital pursuant to 907 KAR 1:677; or
 - g) No Duplication of Service.
 - h) 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.
 - i) 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))

(1) Covered Services.

(A) To be covered by the department, a service shall be:

1. Medically necessary;
2. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
3. Except as provided in subsection (2) of this section, furnished to a recipient through direct physician contact; and
4. Eligible for reimbursement as a physician service.

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

- 1) A service provided by a:
 - a) 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;
 - b) Locum tenens physician who provides direct physician contact; or
 - c) Physician assistant in accordance with Section 7 of this administrative regulation;
 - d) A radiology service, imaging service, pathology service,
 - a. ultrasound study, echographic study, electrocardiogram, electromyogram,

- b. electroencephalogram, vascular study, or other service that is usually and
- c. customarily performed without direct physician contact;
- e) The telephone analysis of emergency medical systems or a cardiac pacemaker if provided under physician direction;
- f) A sleep disorder service; or
- g) A telehealth consultation provided in accordance with 907 KAR 3:170.

- (2) A service provided by another licensed medical professional shall be covered if the other licensed medical professional is:
 - a. Employed by the supervising physician; and
 - b. Licensed in the state of practice.

- (3) A sleep disorder service shall be covered if performed in:
 - A. A hospital; or
 - B. A sleep laboratory if the sleep laboratory has documentation demonstrating that it complies with criteria approved by the:
 - 1) American Sleep Disorders Association; or
 - 2) American Academy of Sleep Medicine; or
 - 3) 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:
 - 1) American Sleep Disorders Association; or
 - 2) American Academy of Sleep Medicine

(3) Service Limitations:

- (1) A covered service provided to a lock-in recipient shall be limited to a service provided by the lock-in recipient's designated primary care provider or designated controlled substance prescriber unless:
 - A. The service represents emergency care; or
 - B. The lock-in recipient has been referred to the provider by the lock-in recipient's designated primary care provider.

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

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

- (4) Except for the following, a drug administered in a physician's office shall not be covered as a separate reimbursable service through the physicians' program:
 - a) Rho immune globulin injection;
 - b) An injectable antineoplastic drug;
 - c) Medroxyprogesterone acetate for contraceptive use, 150 mg;
 - d) Penicillin G benzathine injection;
 - e) Ceftriaxone sodium injection;

- f) Intravenous immune globulin injection;
- g) Sodium hyaluronate or hylan G-F for intra-articular injection;
- h) An intrauterine contraceptive device;
- i) An implantable contraceptive device;
- j) Long acting injectable risperidone; or
- k) An injectable, infused, or inhaled drug or biological that:
 - 1. Is not typically self-administered;
 - 2. Is not excluded as a noncovered immunization or vaccine; and
 - 3. Requires special handling, storage, shipping, dosing, or administration.
- l) 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
- C. A fetal diagnostic ultrasound procedure shall be limited to two (2) per nine (9) month period per recipient unless the diagnosis code justifies the medical necessity of an additional procedure.
- D. An anesthesia service shall be covered if:
 - 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;
 - d) Medically necessary; and
 - e) Not provided as part of an all-inclusive CPT code.

(5) Shall not be covered:

- A. An acupuncture service;
- B. An autopsy;
- C. A cast or splint application in excess of the limits established in 907 KAR 3:010;
- D. Except for therapeutic bandage lenses, contact lenses;
- E. A hysterectomy performed for the purpose of sterilization;
- F. Lasik surgery;
- G. Paternity testing;
- H. A procedure performed for cosmetic purposes only;
- I. A procedure performed to promote or improve fertility;
- J. Radial keratotomy;
- K. A thermogram;

- L. An experimental service which is not in accordance with current standards of medical practice; [or]
- M. A service which does not meet the requirements established in Section 3(1) of this administrative regulation;
- N. Medical direction of an anesthesia service; or
- O. Medical assistance for another provider preventable condition in accordance with 907 KAR 14:005.

(6) Prior Authorization Requirements for Recipients Who are Not Enrolled with a Managed Care Organization.

A) The following procedures for a recipient who is not enrolled with a managed care organization shall require prior authorization by the department:

- 1) Magnetic resonance imaging;
- 2) Magnetic resonance angiogram;
- 3) Magnetic resonance spectroscopy;
- 4) Positron emission tomography;
- 5) Cineradiography or video-radiography;
- 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 covered procedure or service.

B) Prior authorization by the department shall not be a guarantee of recipient eligibility.

C) Eligibility verification shall be the responsibility of the provider

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

- a) An emergency service; or
- b) A radiology procedure if the recipient has a cancer or transplant diagnosis code.

(7) A referring physician, a physician who wishes to provide a given service, a podiatrist, a chiropractor, or an advanced practice registered nurse:

May request prior authorization from the department; and If requesting prior authorization shall request prior authorization by:

- 1) Mailing or faxing:

- a) A written request to the department with information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation; and
- b) If applicable, any required federal consent forms; or
- c) 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))

(A) Covered Benefits and Drug List.

(1) A covered outpatient drug, non- outpatient drug, or diabetic supply covered via this administrative regulation shall be:

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

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

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

- a) An electronic prescription;
- b) A faxed prescription; or
- c) A prescription telephoned by a prescriber.

- (4) To qualify as a tamper-resistant pad prescription, a prescription shall contain:
 - a) One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
 - b) One (1) or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and
 - c) One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms.
- (5)(a) Except as provided in paragraph (b) of this subsection, the department shall cover the diabetic supplies listed in this paragraph via the department's pharmacy program and not via the department's durable medical equipment program established in 907 KAR 1:479:
 - 1) A syringe with needle (sterile, 1cc or less);
 - 2) Urine test or reagent strips or tablets;
 - 3) Blood ketone test or reagent strip;
 - 4) Blood glucose test or reagent strips for a home blood glucose monitor;
 - 5) Normal, low, or high calibrator solution, chips;
 - 6) Spring-powered device for lancet;
 - 7) Lancets per box of 100; or
 - 8) Home blood glucose monitor.
- (b) The department shall cover the diabetic supplies listed in this paragraph via the department's durable medical equipment program established in 907 KAR 1:479 if:
 - 1) The supply has an HCPCS code of A4210, A4250, A4252, A4253, A4256, A4258, A4259, E0607 or E2100;
 - 2) The supply has an a HCPCS code of A4206 and a diagnosis of diabetes is present on the corresponding claim; or
 - 3) Medicare is the primary payor for the supply.
- (6) The department shall have a drug list which:**
 - a) Lists:
 - 1) Drugs, drug categories and related items not covered by the department and if applicable, excluded medical uses for covered drugs; and
 - 2) Maintenance drugs covered by the department.
 - b) Specifies those covered drugs for which the maximum quantity limit on dispensing may be exceeded;
 - c) Lists covered over-the-counter drugs;
 - d) Specifies those legend drugs which are permissible restrictions under 42
 - e) 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.
- (7) 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.**
 - (a) 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:
 - 1) Were used and were not an effective medical treatment or lost their effectiveness;
 - 2) Are reasonably expected to not be an effective medical treatment;

- 3) Resulted in, or are reasonably expected to result in, a clinically- significant adverse reaction or drug interaction; or
- 4) Are medically contraindicated.

(B) Exclusions and Limitations.

(1) The following drugs shall be excluded from coverage:

(a) A drug which the Food and Drug Administration considers to be:

- 1) A less-than-effective drug; or
- 2) Identical, related, or similar to a less-than-effective drug;

(b) A drug or its medical use in one (1) of the following categories unless the drug or its medical use is designated as covered in the drug list:

- 1) A drug if used for anorexia, weight loss, or weight gain;
- 2) A drug if used to promote fertility;
- 3) A drug if used for cosmetic purposes or hair growth;
- 4) A drug if used for the symptomatic relief of cough and colds;
- 5) Vitamin or mineral products other than prenatal vitamins and fluoride preparations;
- 6) An over-the-counter drug provided to a Medicaid nursing facility service recipient if included in the nursing facility's standard price;
- 7) A barbiturate;
- 8) A benzodiazepine;
- 9) A drug which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; or
- 10) A drug utilized for erectile dysfunction therapy unless the drug is used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the United States Food and Drug Administration;
- 11) 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;
- 12) 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;
- 13) A drug for which the department requires prior authorization if prior authorization has not been approved; and
- 14) 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:

- 1) 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

- 2) Non-controlled 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.

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

- a) The drug is designated in the department's drug list as a drug exempt from the thirty-two (32) day dispensing limit in which case the pharmacist may dispense the quantity prescribed not to exceed a three (3) month supply or 100 units, whichever is greater;
 - b) A prior authorization request has been submitted on the Drug Prior Authorization Request Form (MAP-82001) and approved by the department because the recipient needs additional medication while traveling or for a valid medical reason, in which case the pharmacist may dispense the quantity prescribed not to exceed a three (3) month supply or 100 units, whichever is greater;
 - c) The drug is prepackaged by the manufacturer and is intended to be dispensed as an intact unit and it is impractical for the pharmacist to dispense only a month's supply because one (1) or more units of the prepackaged drug will provide more than a thirty-two (32) day supply; or
 - d) The prescription fill is for an outpatient service recipient, excluding an individual who is receiving supports for community living services in accordance with 907 KAR 1:145.
 - e) 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:
 - f) The department determines that it is in the best interest of the recipient to dispense a smaller supply; or
 - g) 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.**

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

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

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

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

- a) Is one that the laboratory is certified to provide by Medicare and in accordance with 907 KAR 1:575;
- b) Is a covered service within the CPT code range of 80047-89356 except as excluded in Section 3 of this administrative regulation; Is prescribed in writing or by electronic request by a physician, podiatrist, dentist, oral surgeon, advanced registered nurse practitioner, or optometrist; and
- c) Is supervised by a laboratory director.

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

- (a) Is provided by a facility that:
 - 1) Is licensed to provide radiological services;
 - 2) Meets the requirements established in 42 C.F.R. 440.30;
 - 3) Is certified by Medicare to provide the given service;
 - 4) Is a Medicare-participating facility;
 - 5) Meets the requirements established in 42 C.F.R. Part 493 regarding laboratory certification, registration, or other accreditation as appropriate; and
 - 6) Is a Medicaid-enrolled provider;
- (b) Is prescribed in writing or by electronic request by a physician, oral surgeon, dentist, podiatrist, optometrist, advanced registered nurse practitioner, or a physician's assistant;
- (c) Is provided under the direction or supervision of a licensed physician; and 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
 - a. 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.

(1) Limitations of Services include:

- a) Admissions for diagnostic purposes are covered only if the diagnostic procedures cannot be performed on an outpatient basis.
- b) Patients may be permitted home visits; however, this must be clearly documented on billing statements as payment cannot be made for these days.
- c) Private accommodations will be reimbursed only if medically necessary and so ordered by the attending physician.
- d) 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.
- e) 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.
- f) 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.

(2) The following shall not be covered as PRTF services:

- a) Pharmacy services, which shall be covered as pharmacy services in accordance with 907 KAR 1:019
- b) 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
- c) covered if appropriate alternative services are available in the community.

(3) The following shall not qualify for a PRTF service:

- a) An admission that is not medically necessary
- b) An individual with a major medical problem or minor symptoms

- c) 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:

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

(b) An assessment provided by:

- 1) A licensed psychologist;
- 2) A licensed professional clinical counselor;
- 3) A licensed clinical social worker;
- 4) A licensed marriage and family therapist;
- 5) A physician;
- 6) A psychiatrist;
- 7) An advanced practice registered nurse;
- 8) A licensed psychological practitioner;
- 9) A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
- 10) A licensed professional counselor associate working under the supervision of a

- 11) licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
- 12) 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;
- 13) 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
- 14) A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(c) Psychological testing provided by:

- 1) A licensed psychologist;
- 2) A licensed psychological practitioner; or
- 3) A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

(d) Crisis intervention provided by:

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

(e) Service planning provided by:

- 1) A licensed psychologist;
- 2) A licensed professional clinical counselor;
- 3) A licensed clinical social worker;
- 4) A licensed marriage and family therapist;
- 5) A physician;
- 6) A psychiatrist;
- 7) An advanced practice registered nurse;
- 8) A licensed psychological practitioner;
- 9) A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
- 10) A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

- 11) A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
- 12) A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
- 13) A physician assistant working under the supervision of a physician
- 14) if the physician is the billing provider for the service;

(f) Individual outpatient therapy provided by:

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

(g) Family outpatient therapy provided by:

- 1) A licensed psychologist;
- 2) A licensed professional clinical counselor;
- 3) A licensed clinical social worker;
- 4) A licensed marriage and family therapist;
- 5) A physician;
- 6) A psychiatrist;
- 7) An advanced practice registered nurse;
- 8) A licensed psychological practitioner;
- 9) A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
- 10) A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
- 11) A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
- 12) A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

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

(h) Group outpatient therapy provided by:

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

(i) Collateral outpatient therapy provided by:

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

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

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

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

- 1) A physician; or
- 2) A psychiatrist; or
- 3) An advanced practice registered nurse;

(l) Day treatment provided by:

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

(m) Comprehensive community support services provided by:

- 1) A licensed psychologist;
- 2) A licensed professional clinical counselor;
- 3) A licensed clinical social worker;
- 4) A licensed marriage and family therapist;
- 5) A physician;
- 6) A psychiatrist;
- 7) An advanced practice registered nurse;
- 8) A licensed psychological practitioner;
- 9) A licensed psychological associate working under the supervision of a
- 10) licensed psychologist if the licensed psychologist is the billing provider for the service;
- 11) 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;
- 12) 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;
- 13) A marriage and family therapy associate working under the supervision
- 14) of a licensed marriage and family therapist if the licensed marriage and family therapist is
- 15) the billing provider for the service; or
- 16) A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(n) Peer support provided by:

- 1) A peer support specialist working under the supervision of a qualified mental health professional; or
- 2) A youth peer support specialist working under the supervision of a qualified mental health professional;

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

(p) Intensive outpatient program provided by:

- 1) A licensed psychologist;
- 2) A licensed professional clinical counselor;
- 3) A licensed clinical social worker;
- 4) A licensed marriage and family therapist;
- 5) A physician;
- 6) A psychiatrist;
- 7) An advanced practice registered nurse;
- 8) A licensed psychological practitioner;
- 9) A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

- 10) A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
- 11) A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
- 12) A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or
- 13) A physician assistant working under the supervision of a physician
- 14) If the physician is the billing provider for the service;

(q) Therapeutic rehabilitation program provided by:

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

(r) A screening shall:

- 1) Be the determination of the likelihood that an individual has a mental health disorder, substance use disorder, or co-occurring disorder;
- 2) Not establish the presence or specific type of disorder; and
- 3) Establish the need for an in-depth assessment.

(s) An assessment shall:

- 1) Include gathering information and engaging in a process with the individual that enables the provider to:
 - a) Establish the presence or absence of a mental health disorder or substance disorder;
 - b) Determine the individual's readiness for change;
 - c) Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and
 - d) Engage the individual in developing an appropriate treatment relationship;

- e) Establish or rule out the existence of a clinical disorder or service need;
- f) Include working with the individual to develop a treatment and service plan; and
- g) Not include psychological or psychiatric evaluations or assessments
- h) Establish the presence or absence of a mental health disorder or substance use disorder;
- i) Determine the individual's readiness for change;
- j) Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and
- k) Engage the individual in developing an appropriate treatment relationship;
- l) Establish or rule out the existence of a clinical disorder or service need;
- m) Include working with the individual to develop a treatment and service plan; and
- n) Not include psychological or psychiatric evaluations or assessments.

(t) Psychological testing shall include:

- 1) A psycho-diagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities; and
- 2) Interpretation and a written report of testing results.

(u) Crisis intervention:

- 1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to:
 - a) The recipient; or
 - b) Another individual;
- 2. Shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization interventions, or crisis prevention activities for individuals;
- 3. Shall be provided:
 - a) On-site at the provider's office;
 - b) As an immediate relief to the presenting problem or threat; and
 - c) In a face-to-face, one-on-one encounter between the provider and the recipient;
 - d) May include verbal de-escalation, risk assessment, or cognitive therapy; and
 - e) Shall be followed by a referral to non-crisis services if applicable.

(v) Service planning shall involve:

- 1) Assisting a recipient in creating an individualized plan for services needed for maximum reduction of an intellectual disability; and
- 2) Restoring a recipient's functional level to the recipient's best possible functional level.

(w) A service plan:

- 1) Shall be directed by the recipient; and May include:
 - a) A mental health advance directive being filed with a local hospital;
 - b) A crisis plan; or
 - c) A relapse prevention strategy or plan.

(x) Individual outpatient therapy shall:

1) Be provided to promote the:

- a) Health and wellbeing of the individual; or
- b) Recovery from a substance related disorder;

2. Consist of:

- a) A face-to-face, one-on-one encounter between the provider and recipient; and
- b) A behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

3. Be aimed at:

- a) Reducing adverse symptoms;
- b) Reducing or eliminating the presenting problem of the
- c) recipient; and Improving functioning; and
- d) Not exceed three (3) hours per day unless additional time is medically necessary.

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

- 1) Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and
- 2) To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment.

(z) 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.

(aa) Family outpatient therapy shall:

- 1) Be provided to promote the Health and wellbeing of the individual; or
- 2) Recovery from a substance related disorder; and
- 3) Not exceed three (3) hours per day per individual unless additional time is medically necessary.

(bb) Group outpatient therapy shall:

1) Be provided to promote the:

- a) Health and wellbeing of the individual; or recovery from a substance related disorder;
- b) Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;
- c) Be provided to a recipient in a group setting:
 - i. Of nonrelated individuals; and
 - ii. Not to exceed eight (8) individuals in size;
 - iii. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;
 - iv. Not include physical exercise, a recreational activity, an educational activity, or a social activity; and
 - v. Not exceed three (3) hours per day per recipient unless additional time is medically necessary.

- 2) **The group shall have a:**
 - a) Deliberate focus; and
 - b) Defined course of treatment.
- 3) **The subject of group outpatient therapy shall be related to each recipient participating in the group.**
4. **The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.**

(cc) Collateral outpatient therapy shall:

- 1) **Consist of a face-to-face behavioral health consultation:**
 - a) 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
 - b) That is provided in accordance with the recipient's treatment plan;
 - c) Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age; and
 - d) Not exceed three (3) hours per day per individual unless additional time is medically necessary.
 - e) 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.

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

- 1) Be an evidence-based early intervention approach for an individual with non-dependent substance use to provide an effective strategy for intervention prior to the need for more extensive or specialized treatment; and
- 2) **Consist of:**
 - a) Using a standardized screening tool to assess an individual for risky substance use behavior; Engaging a recipient, who demonstrates risky substance use behavior, in a short conversation and providing feedback and advice; and
 - b) Referring a recipient to:
 - 1) Therapy; or
 - 2) Other additional services to address substance use if the recipient is determined to need other additional services.
- 3) **Medication assisted treatment for a substance use disorder Shall include:**
 - a) Any opioid addiction treatment that includes a United States Food and Drug Administration-approved medication for the detoxification or maintenance treatment of opioid addiction along with counseling or other supports;
 - b) Comprehensive maintenance;
 - c) Medical maintenance;
 - d) Interim maintenance;
 - e) Detoxification; o
 - f) Medically supervised withdrawal;

4) May be provided in:

- a) An opioid treatment program;
- b) A medication unit affiliated with an opioid treatment program;
- c) A physician's office except for methadone; or
- d) Other community setting; and
- e) Shall increase the likelihood for cessation of illicit opioid use or prescription opioid abuse.

(ee) Day treatment

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

- a) An emotional disability or neurobiological or substance use disorder; and
- b) A high risk of out-of-home placement due to a behavioral health issue.

2) Day treatment services shall:

- a) Consist of an organized, behavioral health program of treatment and rehabilitative services (substance use disorder, mental health, or co-occurring mental health and substance use disorder);
- b) Have unified policies and procedures that:
 - 1) Address the program philosophy, admission and discharge criteria, admission and discharge process, staff training, and integrated case planning; and
 - 2) have been approved by the recipient's local education authority and the day treatment provider;
- c) Include:
 - 1) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;
 - 2) Behavior management and social skill training;
 - 3) Independent living skills that correlate to the age and development stage of the recipient; or
 - 4) 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:
 - 1) 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);
 - 2) On school days and during scheduled breaks;
 - 3) In coordination with the recipient's individual educational plan if the recipient has an individual educational plan;
 - 4) Under the supervision of a qualified mental health professional; and
 - 5) 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.

(ff) 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:
 - 1) Reminding a recipient to take medications and monitoring symptoms and side effects of medications;
 - 2) Teaching parenting skills;
 - 3) Teaching community resource access and utilization;
 - 4) Teaching emotional regulation skills;
 - 5) Teaching crisis coping skills;
 - 6) Teaching how to shop;
 - 7) Teaching about transportation;
 - 8) Teaching financial management;
 - 9) Developing and enhancing interpersonal skills; or
 - 10) Improving daily living skills; and
 - 11) To provide comprehensive community support services, a provider shall:
 - a) Have the capacity to employ staff authorized pursuant to 908 KAR 2:250 to provide comprehensive community support services in accordance with subsection (2)(m) of this section and to coordinate the provision of services among team members; and
 - b) Meet the requirements for comprehensive community support services established in 908 KAR 2:250

(gg) (1) Peer support services shall:

- a) Be social and emotional support that is provided by an individual who is employed by a provider group and who has experienced a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder to a recipient by sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change;
- b) Be an evidence-based practice;
- c) Be structured and scheduled nonclinical therapeutic activities with an
- d) individual recipient or a group of recipients;
- e) 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;
- f) Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and
- g) Be identified in each recipient's treatment plan.

(2) To provide peer support services a provider shall:

- a) Have demonstrated the capacity to provide the core elements of peer support services for the behavioral health population being served including the age range of the population being served;
- b) Employ peer support specialists who are qualified to provide peer support services in accordance with 908 KAR 2:220 or 908 KAR 2:240; and

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

(3) Parent or family peer support services shall:

- a) Be emotional support that is provided by a parent or family member, who is employed by a provider group, of a child who has experienced a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder to a parent or family member with a child sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change;
- b) Be an evidence-based practice;
- c) Be structured and scheduled non-clinical therapeutic activities with an individual recipient or a group of recipients;
- d) Be provided by a self-identified parent or family member of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health disorder services and substance use disorder services who has been trained and certified in accordance with 908 KAR 2:230;
- e) Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and
- f) Be identified in each recipient's treatment plan.

(4) To provide parent or family peer support services a provider shall:

- a) Have demonstrated the capacity to provide the core elements of parent or family peer support services for the behavioral health population being served including the age range of the population being served;
- b) Employ family peer support specialists who are qualified to provide family peer support services in accordance with 908 KAR 2:230; and
- c) Use a qualified mental health professional to supervise family peer support specialists.

(hh) (1) Intensive outpatient program services shall:

- a) Be an alternative to inpatient hospitalization or partial hospitalization for a mental health or substance use disorder;
- b) Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy;
- c) Be provided at least three (3) hours per day at least three (3) days per week;
- d) and include:
 - 1) Individual outpatient therapy;
 - 2) Group outpatient therapy;
 - 3) Family outpatient therapy unless contraindicated;
 - 4) Crisis intervention; or
 - 5) Psycho-education.
- e) During psycho-education the recipient or recipient's family member shall be:
 - 1) 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
 - 2) Taught how to cope with the recipient's diagnosis or condition in a successful manner.

(2) An intensive outpatient program services treatment plan shall:

- a) Be individualized; and
- b) Focus on stabilization and transition to a lesser level of care

(3) To provide intensive outpatient program services, a provider shall:

- a) Be employed by a provider group; and Have:
 - 1) Access to a board-certified or board-eligible psychiatrist for consultation;
 - 2) Access to a psychiatrist, other physician, or advanced practice registered nurse for medication management;
 - 3) Adequate staffing to ensure a minimum recipient-to-staff ratio of fifteen (15) recipients to one (1) staff person;
 - 4) The capacity to provide services utilizing a recognized intervention protocol based on recovery principles;
 - 5) 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;
 - 6) The capacity to provide the full range of intensive outpatient program services as stated in this paragraph;
 - 7) Demonstrated experience in serving individuals with behavioral health disorders;
 - 8) The administrative capacity to ensure quality of services;
 - 9) A financial management system that provides documentation of services and costs; and
 - 10) The capacity to document and maintain individual case records.

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

(5) A therapeutic rehabilitation program shall be:

- a) A rehabilitative service for an:
 - 1) Adult with a serious mental illness; or
 - 2) Individual under the age of twenty-one (21) years who has a serious emotional disability; and
 - 3) 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.

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

- a) A therapeutic rehabilitation program shall:
 - 1) Be delivered using a variety of psychiatric rehabilitation techniques;
 - 2) Focus on:
 - a) Improving daily living skills;
 - b) Self-monitoring of symptoms and side effects;
 - c) Emotional regulation skills;
 - d) Crisis coping skill; and
 - e) Interpersonal skills; and
 - f) Be delivered individually or in a group.

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

- 1) The licensing requirements established in 908 KAR 1:370;
- 2) The physical plant requirements established in 908 KAR 1:370;
- 3) The organization and administration requirements established in 908 KAR 1:370;
- 4) The personnel policy requirements established in 908 KAR 1:370;
- 5) The quality assurance requirements established in 908 KAR 1:370;
- 6) The clinical staff requirements established in 908 KAR 1:370; 7. The program operational requirements established in 908 KAR 1:370; and
- 7) The outpatient program requirements established in 908 KAR 1:370.
- 8) The detoxification program requirements established in 908 KAR 1:370 shall
- 9) apply to a provider of a detoxification service.
- 10) The extent and type of a screening shall depend upon the problem of the
- 11) individual seeking or being referred for services.
- 12) A diagnosis or clinic impression shall be made using terminology established in
- 13) the most current edition of the American Psychiatric Association Diagnostic and
- 14) Statistical Manual of Mental Disorders.
- 15) The department shall not reimburse for a service billed by or on behalf of an entity or individual who is not a billing provider.

(jj) Non-covered Services or Activities.

- (1) The following services or activities shall not be covered under this administrative regulation:
 - a) A service provided to:
 - i. A resident of;
 - ii. A nursing facility; or
 - iii. An intermediate care facility for individuals with an intellectual disability;
 - iv. An inmate of a federal, local, or state Jail, Detention center or Prison;
 - v. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - vi. 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;
 - vii. A consultation or educational service provided to a recipient or to others;
 - viii. Collateral therapy for an individual aged twenty-one (21) years or older;
 - ix. 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";
 - x. Travel time;
 - xi. A field trip;
 - xii. A recreational activity;
 - xiii. A social activity; or
 - xiv. 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.

(kk) Community Mental Health Center Services:

(1) Services covered by Community Mental Health Center Services shall include:

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

- 1) Individual outpatient therapy;
- 2) Group outpatient therapy;
- 3) Family outpatient therapy;
- 4) Collateral outpatient therapy;
- 5) Therapeutic rehabilitation services
- 6) Psychological testing;
- 7) Screening;
- 8) An assessment;
- 9) Crisis intervention;
- 10) Service planning;
- 11) A screening, brief intervention, and referral to treatment;
- 12) Medication assisted treatment for a substance use disorder;
- 13) Mobile crisis services;
- 14) Assertive community treatment;
- 15) Intensive outpatient program services;
- 16) Residential crisis stabilization services;
- 17) Partial hospitalization;
- 18) Residential services for substance use disorders;
- 19) Day treatment;
- 20) Comprehensive community support services;
- 21) Peer support services; or
- 22) Parent or family peer support services; or
- 23) Physical health services including:
- 24) Physical examinations; or
- 25) Medication prescribing and monitoring.

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

(a) Provided by a community mental health center that is:

- 1) Currently enrolled in the Medicaid Program in accordance with 907 KAR 1:672; and
- 2) Except as established in paragraph (b) of this subsection, currently participating in the Medicaid Program in accordance with 907 KAR 1:671; and Provided in accordance with:
 - a) This administrative regulation; and
 - b) The Community Mental Health Center Services Manual.
 - c) 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) 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:

- a) Be based on medical necessity and reasonableness;
- b) Be clinically appropriate pursuant to the criteria established in 907 KAR 3:130;

- c) Require prior authorization in accordance with Section 7 of this administrative regulation;
- d) Be provided in compliance with 42 C.F.R. 440.230(c); and
- e) Be restricted to an item used primarily in the home.
- f) Coverage of prosthetic devices shall not exceed \$1,500 per twelve month period per member of the family choices benefit plan.

(2) Unless otherwise established in this administrative regulation;

- a) Except as provided in paragraph (b) of this subsection, the criteria referenced in subsection (1)(a) of this section that was in effect on the date the durable medical equipment, prosthetic, orthotic, or medical supply is provided shall be used as the basis for the determination of coverage, subject to medical necessity override by the department to ensure compliance with 42 C.F.R. 40.230(c).
- b) If criteria referenced in subsection (1)(a) of this section does not exist or is unavailable for a given item or service, the Medicare criteria in effect on the date the durable medical equipment, prosthetic, orthotic, or medical supply is provided shall be used as the basis for the determination of coverage, subject to medical necessity override by the department to ensure compliance with 42 C.F.R. 440.230(c).

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

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

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

(6) A required CMN shall be:

- a) The appropriate Medicare CMN in use at the time the item or service is prescribed;
- b) A MAP-1000, Certificate of Medical Necessity; or
- c) A MAP-1000B, Certificate of Medical Necessity, Metabolic Formulas and Foods.

(7) A CMN shall contain:

- a) The recipient's name and address;
- b) A complete description of the item or service ordered;
- c) The recipient's diagnosis;
- d) The expected start date of the order;
- e) The length of the recipient's need for the item;
- f) The medical necessity for the item;
- g) The prescriber's name, address, telephone number, and
- h) National Provider Identifier (NPI), if applicable; and
- i) 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:**
 - 1) That the recipient wishes to receive the shipment of supplies;
 - 2) The quantity of supplies in the shipment; and
 - 3) Whether or not there has been a change in the use of the supply.
- (18) A verification referenced in subsection (17) of this section for each recipient shall be documented in a file regarding the recipient.**
- (19) If a supplier ships more than one (1) month supply of an item, the supplier shall assume the financial risk of nonpayment if the recipient's Medicaid eligibility lapses or a HCPCS code is discontinued.**
- (20) A supplier shall have an order from a prescriber before dispensing any DMEPOS item to a recipient.**
- (21) A supplier shall have a written order on file prior to submitting a claim for reimbursement.**

(22) Purchase or Rental of Durable Medical Equipment.

(1) The following items shall be covered for purchase only:

- a) A cane;
- b) Crutches;
- c) A standard walker;
- d) A prone or supine stander;
- e) A noninvasive electric osteogenesis stimulator; or
- f) 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:
 - g) Oxygen concentrator;
 - h) Stationary compressed gas oxygen;
 - i) Portable gaseous oxygen;
 - j) Portable liquid oxygen; or
 - k) Stationary liquid oxygen; or
- l) 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.

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

- a) The DME supplier shall ensure that the recipient or authorized representative reads and understands the MAP 1001;
- b) The recipient or authorized representative shall indicate on the MAP 1001 if the recipient chooses to receive a non-covered service;
- c) The DME supplier shall complete the supplier information on the MAP 1001;

- d) The DME supplier shall provide a copy of the completed MAP 1001 to the recipient; and
- e) 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.
- f) If an item or service was denied due to the supplier not meeting the timeframes to obtain a prior authorization or the item or service does not meet medical necessity for a prior authorization, the MAP 1001 shall not be used to obligate the recipient for payment.

Special Coverage.

- (1) An augmentative communication device or other electronic speech aid shall be covered for a recipient who is permanently unable to communicate through oral speech if:**
 - a) Medical necessity is established based on a review by the department of an
 - b) evaluation and recommendation submitted by a speech-language pathologist; and
 - c) The item is prior authorized by the department.

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

- (3) A physical therapy or occupational therapy evaluation shall be required for:**
 - a) A power wheelchair; or
 - b) A wheelchair for a recipient who, due to a medical condition, is unable to be reasonably accommodated by a standard wheelchair.

- (4) Orthopedic shoes and attachments shall be covered if medically necessary for:**
 - a) A congenital defect or deformity;
 - b) A deformity due to injury; or
 - c) Use as a brace attachment.

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

- (6) An enteral or oral nutritional supplement shall be covered if:**
 - a) The item is prescribed by a licensed prescriber;
 - b) Except for an amino acid modified preparation or a low-protein modified food product specified in subsection (7) of this section, it is the total source of a recipient's daily intake of nutrients;
 - c) The item is prior authorized; and
 - d) Nutritional intake is documented on the CMN.

- (7) An amino acid modified preparation or a low-protein modified food product shall be covered:**
 - c. If prescribed by a physician for the treatment of an inherited
 - d. metabolic condition specified in KRS 205.560;
 - e. If not covered through the Medicaid outpatient pharmacy program;
 - f. Regardless of whether it is the sole source of nutrition; and
 - g. If the item is prior authorized.

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

- (9) An electric breast pump shall be covered for the following:**
 - a) Medical separation of mother and infant;
 - b) Inability of an infant to nurse normally due to a significant feeding problem; or
 - c) An illness or injury that interferes with effective breast feeding.

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

Coverage of Repairs and Replacement of Equipment.

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

- (2) Reasonable repair to a purchased DME item, prosthetic, or orthotic shall be covered as follows:**
 - a) During a period of medical need;
 - b) If necessary to make the item serviceable;
 - c) If no warranty is in effect on the requested repair; and
 - d) In accordance with Section 6(2) of this administrative regulation.

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

- (4) The replacement of a medically necessary DME item, medical supply, prosthetic, or orthotic shall be covered for the following:**
 - a) Loss of the item;
 - b) Irreparable damage or wear; or
 - c) A change in a recipient's condition that requires a change in equipment.

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

Limitations on Coverage.

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

- (a) An item covered for Medicaid payment through another Medicaid program;
- (b) Equipment that is not primarily and customarily used for a medical purpose;
- (c) Physical fitness equipment;
- (d) Equipment used primarily for the convenience of the recipient or caregiver;
- (e) A home modification;
- (f) Routine maintenance of DME that includes:
 - 1) Testing;
 - 2) Cleaning;
 - 3) Regulating; and
 - 4) Assessing the recipient's equipment;
- (g) Except as specified in Section 7(1)(j) of this administrative regulation, backup equipment;
- (h) An item determined not medically necessary, clinically appropriate, or reasonable by the department; or
- (i) Diabetic supplies, except for:
 - 1) Those for which Medicare is the primary payor;
 - 2) Those with an HCPCS code of A4210, A4250, A4252, A4253, A4256, A4258, A4259, E0607 or E2100; or
 - 3) Those with a HCPCS code of A4206 if a diagnosis of diabetes is present on the corresponding claim.

(6) An estimated repair shall not be covered if the repair cost equals or exceeds:

- a) The purchase price of a replacement item; or
- b) The total reimbursement amount for renting a replacement
- c) item of equipment for the estimated remaining period of medical need.
- d) 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:

- (1) Private duty nursing agency that meets the requirements established in Section 3 of this administrative regulation; or
- (2) Home health agency that meets the requirements established in Section 3 of this administrative regulation; or

b. Licensed practical nurse employed by a:

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

- (2) 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

- a) Under the direction of the recipient's physician in accordance with 42 C.F.R. 440.80;
- b) Prescribed for the recipient by a physician; and
- c) 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;
- e) Prior authorized; and
- f) 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.

(4) 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:

- a) A personal care service;
- b) A skilled nursing service or visit; or
- c) A home health aide service.

(5) 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:

- a) An immediate family member of the recipient; or
- b) A legally responsible individual who maintains his or her primary residence with the recipient.

6.2.16. Abortion only if necessary, to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16) Abortions are only covered in the case of rape, incest, or life endangerment. All abortions must be prior authorized.

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

(1) A covered service shall be:

- a) Medically necessary;
- b) Except as provided in subsection (2) of this section, furnished to a recipient through direct practitioner contact; and
- c) Unless a recipient's provider demonstrates that dental services in excess of the following service limitations are medically necessary, limited to:
 - 1) Two (2) prophylaxis per twelve (12) month period for a recipient under age twenty-one (21);
 - 2) One (1) dental visit per month per provider for a recipient age twenty-one (21) years and over; and
 - 3) One (1) prophylaxis per twelve (12) month period for a recipient age twenty-one (21) years and over.

(2) A covered service provided by an individual who meets the definition of other licensed medical

professional shall be covered if the:

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

(3)(a) A medical resident may provide services if provided under the direction of a program

participating teaching physician in accordance with 42 C.F.R. 415.170, 415.172, and 415.174.

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

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

- a) Diagnostic;

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

(5) Diagnostic Service Coverage Limitations.

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

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

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

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

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

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

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

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

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

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

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

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

(6) Preventive Service Coverage Limitations.

(1)(a) Coverage of a prophylaxis shall be limited to:

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

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

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

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

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

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

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

- 1) Be limited to a recipient under age twenty-one (21); and Require the following:
 - a) Fabrication;
 - b) Insertion;
 - c) Follow-up visits; Adjustments; and
- c) Documentation in the recipient's medical record to:
 - 1) Substantiate the use for maintenance of existing inter-tooth space; and
 - 2) Support the diagnosis and a plan of treatment that includes follow-up visits.
 - 3) The date of service for a space maintainer shall be considered to be the date the appliance is placed on the recipient.
 - 4) 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.

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 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

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))

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

(7) 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.

(b) Coverage of a prefabricated crown shall be:

- 1) Limited to a recipient under age twenty-one (21); and
- 2) Inclusive of any procedure performed for restoration of the same tooth.

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

- 1) A permanent molar;
- 2) One (1) per tooth, per date of service, per recipient; and
- 3) Two (2) per permanent molar, per recipient.

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

- a) An amalgam, three (3) or more surfaces;
- b) A permanent prefabricated resin crown; or
- c) A prefabricated stainless steel crown.

(8) Endodontic Service Coverage Limitations.

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

- a) A pulp cap direct;
- b) Therapeutic pulpotomy; or
- c) Root canal therapy.

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

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

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

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

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

(9) Periodontic Service Coverage Limitations.

(1) Coverage of a gingivectomy or gingivoplasty procedure shall require prepayment review and shall be limited to: (a) A recipient with gingival overgrowth due to a:

- 1) Congenital condition;
- 2) Hereditary condition; or
- 3) Drug-induced condition; and
- 4) One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period.

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

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

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

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

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

- a) Not exceed one (1) per quadrant, per twelve (12) months, per recipient, per provider;
- b) Require prior authorization in accordance with Section 15(2) and (1) of this administrative regulation; and
- c) Require documentation to include:
 - d) A periapical film or bitewing x-ray; and
 - e) Periodontal charting of preoperative pocket depths.

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

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

(8)(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.

(9) Prosthodontic Service Coverage Limitations.

(10) A removable prosthodontic or denture repair shall be limited to a recipient under age twenty-one (21).

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

- a) Repair resin denture base; or
- b) Repair cast framework.

(12) 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:
 - c) Maxillary dentures; or
 - d) Mandibular dentures;
- e) An interim maxillary partial denture; or
- f) An interim mandibular partial denture.
- g) An interim maxillary or mandibular partial denture shall be limited to use:
 - h) During a transition period from a primary dentition to a permanent dentition;
 - i) For space maintenance or space management; or
 - j) As interceptive or preventive orthodontics.

(13) Maxillofacial Prosthetic Service Coverage Limitations.

(1) The following services shall be covered if provided by a board certified prosthodontist:

- a) A nasal prosthesis;
- b) An auricular prosthesis;
- c) A facial prosthesis;
- d) A mandibular resection prosthesis;
- e) A pediatric speech aid;
- f) An adult speech aid;
- g) A palatal augmentation prosthesis;
- h) A palatal lift prosthesis;
- i) An oral surgical splint; or
- i. An unspecified maxillofacial prosthetic.

(2) Oral and Maxillofacial Service Coverage Limitations.

- a) The simple use of a dental elevator shall not constitute a surgical extraction.
- b) Root removal shall not be covered on the same date of service as the extraction of the same tooth.
- c) Coverage of surgical access of an unerupted tooth shall:
 - 1) Be limited to exposure of the tooth for orthodontic treatment; and
 - 2) Require prepayment review.

(3) Coverage of alveoplasty shall:

- a) Be limited to one (1) per quadrant, per lifetime, per recipient; and
- b) Require a minimum of a three (3) tooth area within the same quadrant.

(4) An occlusal orthotic device shall:

- a) Be covered for temporomandibular joint therapy;
- b) Require prior authorization in accordance with Section 15(2) and (5) of
- c) this administrative regulation;
- d) Be limited to a recipient under age twenty-one (21); and
- e) Be limited to one (1) per lifetime, per recipient.

(5) Frenulectomy shall be limited to one (1) per date of service.

- a) Coverage shall be limited to one (1) per lifetime, per recipient, for removal of the following:
- b) Torus palatinus (maxillary arch);
- c) Torus mandibularis (lower left quadrant); or
- d) Torus mandibularis (lower right quadrant).

(6) 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.

- a) If performed by an oral surgeon, coverage of a service identified in CDT shall be limited to:
 - 1) Extractions;
 - 2) Impactions; and
 - 3) Surgical access of an unerupted tooth.

(7) Orthodontic Service Coverage Limitations.

- (a) Coverage of an orthodontic service shall:
 - 1) Be limited to a recipient under age twenty-one (21); and
 - 2) Require prior authorization.

- 3) The combination of space maintainers and appliance therapy shall be limited to two (2) per twelve (12) month period, per recipient.
- 4) Space maintainers and appliance therapy shall not be covered in conjunction with comprehensive orthodontics.
- 5) The department shall only cover new orthodontic brackets or appliances.
- 6) An appliance for minor tooth guidance shall not be covered for the control of harmful habits.

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

- a) Require a referral by a dentist; and
- b) Be limited to:
 - 1) The correction of a disabling malocclusion; or
 - 2) Transitional or full permanent dentition unless for treatment of a cleft palate or severe facial anomaly.

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

- a. Has a deep impinging overbite that shows palatal impingement of the majority of the lower incisors;
- b. Has a true anterior open bite that does not include:
 - 1) One (1) or two (2) teeth slightly out of occlusion; or
 - 2) Where the incisors have not fully erupted
- c. Demonstrates a significant antero-posterior discrepancy (Class II or III malocclusion that is comparable to at least one (1) full tooth Class II or III, dental or skeletal);
- d. Has an anterior crossbite that involves:
 - 1) More than two (2) teeth in crossbite;
 - 2) Obvious gingival stripping; or
 - 3) Recession related to the crossbite;
- e. Demonstrates handicapping posterior transverse discrepancies which:
 - 1) May include several teeth, one (1) of which shall be a molar; and
 - 2) Is handicapping in a function fashion as follows:
 - a) Functional shift;
 - b) Facial asymmetry;
 - c) Complete buccal or lingual crossbite; or
 - d) Speech concern;
- f. Has a significant posterior open bite that does not involve:
 - 1) Partially erupted teeth; or
 - 2) One (1) or two (2) teeth slightly out of occlusion;
- g. Except for third molars, has impacted teeth that will not erupt into the arches without orthodontic or surgical intervention;
- h. Has extreme overjet in excess of eight (8) to nine (9) millimeters and one (1) of the skeletal conditions specified in paragraphs (a) through (g) of this subsection;
- i. Has trauma or injury resulting in severe misalignment of the teeth or alveolar structures, and does not include simple loss of teeth with no other affects;
- j. Has a congenital or developmental disorder giving rise to a handicapping malocclusion;
- k. Has a significant facial discrepancy requiring a combined orthodontic and orthognathic surgery treatment approach; or

1. Has developmental anodontia in which several congenitally missing teeth result in a handicapping malocclusion or arch deformation.

(11) Coverage of comprehensive orthodontic treatment shall not be inclusive of orthognathic surgery.

(12) If comprehensive orthodontic treatment is discontinued prior to completion, the provider shall submit to the department:

- a) A referral form, if applicable; and
- b) A letter detailing:
 - 1) Treatment provided, including dates of service;
 - 2) Current treatment status of the patient; and
 - 3) Charges for the treatment provided.

(13) Remaining portions of comprehensive orthodontic treatment may be authorized for prorated coverage upon submission of the prior authorization requirements specified in Section 15(2) and (7) of this administrative regulation if treatment:

- a) Is transferred to another provider; or
- b) Began prior to Medicaid eligibility.

(14) Adjunctive General Service Coverage Limitations.

(1)(a) Coverage of palliative treatment for dental pain shall be limited to one (1) per date of service, per recipient, per provider.

(b) Palliative treatment for dental pain shall not be covered in conjunction with another service except radiographs.

(2)(a) Coverage of a hospital call shall be limited to one (1) per date of service, per recipient, per provider.

- (b) A hospital call shall not be covered in conjunction with:
- 1) Limited oral evaluation;
 - 2) Comprehensive oral evaluation; or
 - 3) Treatment of dental pain.

(3) (a) Coverage of intravenous sedation shall be limited to a recipient under age twenty- one 21).

(b) Intravenous sedation shall not be covered for local anesthesia or nitrous oxide.

6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

Inpatient psychiatric hospital services, including treatment for substance use disorders, must involve active treatment which is reasonably expected to improve the patient's condition or prevent further regression, so that eventually such services will no longer be necessary. Periodic medical and social evaluations should determine at what point a patient's progress has reached the stage where his/her needs can be met appropriately outside the institution. Federal regulations emphasize "active treatment" as one of the necessary elements of inpatient services. Active treatment is defined as the implementation of a professionally developed individual plan of care which sets forth treatment objectives and therapies enabling the individual's functioning to improve to the point that institutional care is no longer necessary.

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

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.
- 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:

- a) Be completed by a qualified substance abuse treatment professional; and
- b) Be provided for an individual prior to receiving a substance abuse treatment service or an indicated
 - a. prevention service.
- c) For an individual receiving an assessment, the assessment shall include an interview on the:
 - 1) Current level of substance intoxication or withdrawal;
 - 2) Current pattern of substance use including quantity, frequency, and personal use history;
 - 3) Identification of household members and significant others in the individual's life who use alcohol and other drugs;
 - 4) Family history of alcohol and drug abuse;
 - 5) History of emotional, sexual and physical abuse including current needs for safety;
 - 6) History of mental health problems and diagnoses; and
 - 7) Utilization of prenatal care and pediatric care for newborns.

(B) 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:

- a) Psychosocial history including:
 - 1) Presenting need;
 - 2) Current living arrangements;
 - 3) Marital and family history;
 - 4) History of involvement with child and adult protective services;
 - 5) Current custody status of an individual's children;
 - 6) Legal, employment, military, educational, and vocational history;
 - 7) Peer group relationships;

- 8) Religious background and practices;
- 9) Ethnic and cultural background;
- 10) Leisure and recreational activities; and
- 11) Individual strengths and limitations;
- 12) Current physical health status; and
- 13) Completion of a mental status screening.

(C) 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:

- a) Pregnancy or postpartum status; and
- b) A primary diagnosis of a substance-related disorder requiring treatment services; or
- c) The need for substance abuse prevention services; and
- d) The individual's need for:
 - 1) Prenatal care;
 - 2) A screening for health care problems for a postpartum woman;
 - 3) Pediatric care;
 - 4) Mental health, intellectual disability or developmental
 - 5) disability services; or
 - 6) Community services to meet immediate needs for
 - 7) safety, food, clothing, shelter or medical care.

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

- a) The presenting need or problem; and
- b) 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:
 2. An explanation of how this individual meets the admission criteria for this service;
 3. The name of the provider to whom the individual as established by the assessment fin individual is being referred for this service; and
 4. 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:
 - a) Emergency need. Emergency need shall indicate a substance-relate 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;
 - b) 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;
 - c) Routine need. A routine need shall pose no immediate risk of harm to self or another person but requires a clinical response;
 - d) Universal, selective, and indicated prevention services. A provider agency shall provide access to a substance abuse universal, selective or
 - e) 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.

(1) A prevention service shall:

- a) Be delivered as an individual or group service;
- b) 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
- c) 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.

(2) Universal prevention services shall consist of a protocol for reducing harm to the fetus that:

- a) Is designed to reduce the risk that an individual will use alcohol, tobacco or another drug during pregnancy or the postpartum period, thus protecting the child from
- b) subsequent risk for harm;
- c) Identifies specific risks associated with alcohol, tobacco or another drug use during
- d) pregnancy and lactation, including risks to a fetus, such as low birth weight and fetal alcohol spectrum disorder;
- e) Identifies signs of postpartum depression and addresses the risk for substance abuse following pregnancy; and
- f) 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;
- g) 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 Shall have reimbursement limited to no more than two (2) hours during a single pregnancy and postpartum period.

(3) Selective prevention services:

- (A)** 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.
2. The therapeutic risk reduction protocol shall:
- a) Increase the perception of personal risk for harm due to high-risk alcohol and drug use throughout life;
 - b) Identify the levels of alcohol and drug use that increase risk for problems during pregnancy and throughout life;
 - c) Address health and social consequences of high-risk drinking or drug choices;
 - d) 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
3. While not mandatory, it is desirable that the therapeutic risk reduction protocol also include information to help the individual:

- a. Change perceptions of normative alcohol and other drug behaviors;
- b. 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
- c. Address parental influences on alcohol and drug choices of children, family management issues, and the establishment of successful expectations and consequences;

(B) 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;

(1) Reimbursement shall be limited to:

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

(2) Indicated prevention service:

- (a) 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.

(3) A therapeutic risk reduction protocol shall:

- a) 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;
- b) Increase the perception of personal risk for harm due to high-risk alcohol and drug use;
- c) Identify the existence of biological, psychological, and social risk factors; and
- d) Identify levels of alcohol and other drug use that increase risk for problems; and

(4) A therapeutic risk reduction protocol for an indicated prevention service may include:

- a) Changing perceptions of normative alcohol and drug use behaviors;
- b) 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
- c) Addressing parental influences on the alcohol and drug choices of children, family management issues, and the establishment of successful expectations and consequences; and

(5) Reimbursement shall be limited to:

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

(C) Outpatient services.

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

- a) Is a face-to-face therapeutic interaction between an individual and a qualified substance abuse treatment professional; and
- b) Is for the purpose of reducing or eliminating a substance abuse problem and shall include the following services:

- 1) Treatment planning;
- 2) Referrals for other needed health and social services;
- 3) Information on substance abuse and its effects on health and fetal development;
- 4) Orientation to substance abuse related self-help groups; and
- 5) Participation in one (1) or more of the following modalities of outpatient treatment:
 - a) Individual therapy;
 - b) Group therapy;
 - c) Family therapy.
 - d) This modality shall be provided to an individual and one (1) or more persons with whom an individual has a family relationship;
 - e) Psychiatric evaluation provided by a psychiatrist or advanced registered nurse practitioner (ARNP);
 - f) 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;
 - g) Medication management provided by a physician or an advanced registered nurse practitioner; or
 - h) Collateral care.
 - i) 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.

c) 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.
- c) Collateral care shall be limited to individuals under age twenty-one (21).
- d) Psychiatric evaluations or psychological testing that do not result in an individual receiving substance abuse treatment shall not be reimbursable through this benefit.
- e) No more than eight (8) hours of outpatient services shall be reimbursed during a one (1) week period.

(D) Intensive outpatient services.

(1) An intensive outpatient service shall be an ambulatory care service for the purpose of reducing or eliminating an individual's substance abuse problem.

- a) The following components shall be provided in an intensive outpatient service as a face-to-face therapeutic interaction between an individual and
- b) a qualified substance abuse treatment professional:
 - 1) Treatment planning;
 - 2) A structured program of information on substance abuse and its effects on health, fetal development and family relationships which shall be provided either to an individual or an individual and
 - 3) one (1) or more persons with whom an individual has a close association; and
 - 4) Individual, group and family therapy.

- 5) 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:
 - a) Independent living skills training;
 - b) Parenting skill development;
 - c) Orientation to substance abuse and other self-help programs; or
 - d) Staff support to activities led by the individual.

(c) Service limitations

1. Group therapy.

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

2. Day rehabilitation services.

- a) A day rehabilitation service shall be provided in a residential facility for the purpose of reducing or eliminating an individual's substance abuse problem.
- b) The following components shall be provided in a day rehabilitation service as a face-to-face therapeutic interaction between an individual and a qualified substance abuse treatment professional:
 - 1) Treatment planning;
 - 2) A structured program of information on substance abuse and its effects on health, fetal development and family relationships which shall be provided to either an individual or an individual and one (1) or more persons with whom an individual has a close association; and
1. Individual, group and family therapy.
- c) The following components may be provided in a day rehabilitation service but shall be provided as a face-to-face activity between an individual and a qualified substance abuse treatment professional or a member of the therapeutic team, supervised by a qualified substance abuse treatment professional:
 - 1) Independent living skills training;
 - 2) Parenting skill development;
 - 3) Orientation to substance abuse and other self-help programs; or
 - 4) Staff support to activities led by the individual.

d) Service limitations.

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.

e) Group therapy.

- 1) There shall be no more than twelve (12) persons in a group therapy session.
- 2) 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.

f) Case-management services.

- 1) Case management shall be an ambulatory care service that:
 - a) 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:
 - 1) At least two (2) of the contacts shall be face to face with the individual; and
 - 2) The remaining contacts shall be by phone or face to face with or on behalf of the individual; and
 - 3) Is for the purpose of reducing or eliminating an individual's substance abuse problem by assisting an individual in gaining access to needed medical, social, educational and other support services.
 - b) Case-management services shall include:
 - 1) An assessment of an individual's case-management needs;
 - 2) Development of a service plan that identifies an individual's case management projected outcomes; and
 - 3) Activities that support the implementation of an individual's service plan.
 - c) Case-management services shall not be connected with a specific type of substance abuse treatment but shall follow an individual across the array of substance abuse treatment services identified in the individual's treatment plan.

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

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

h) Community-support services.

- (a) A community-support service shall be an ambulatory care service that shall be provided if the service is identified as a need in the individual's case-management service plan.
- (b) A community-support service shall be a face-to-face or telephone contact between an individual and a qualified community-support provider, who meets the requirements in Section 7(4) of this administrative regulation.
- (c) A community-support service shall include:
 - 1) Assisting the individual in remaining engaged with substance abuse treatment or community self-help groups;
 - 2) Assisting the individual in resolving a crisis in the individual's natural environment; and
 - 3) Coaching the individual in her natural environment to:
 - a) Access services arranged by a case manager; and
 - b) Apply substance abuse treatment gains, parent training and independent living skills to the individual's personal living situation.
- (d) A community-support provider shall coordinate the provision of community-support services with the individual's primary provider of case-management services.

d) Service limitation.

Transportation services solely for the purpose of transporting an individual shall not be reimbursed through this Medicaid benefit.

d) Service limitation for all substance abuse services.

- 1) 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))

1) 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:

- a) A written comprehensive assessment of the child's needs;
- b) Arranging for the delivery of the needed services as identified in the assessment;
- c) Assisting the child and his family in accessing needed services;
- d) 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;
- e) Performing advocacy activities on behalf of the child and his family;
- f) Preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
- g) Providing case consultation (i.e., consulting with the service providers/collateral's in determining child's status and progress); and
- h) performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services).

2) Excluded Activities.

The following activities shall not be considered case management activities:

- a) The actual provision of mental health or other Medicaid covered services or treatments;
- b) Outreach to potential recipients;
- c) Administrative activities related to Medicaid eligibility determinations; and
- d) 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))

(1) The department shall reimburse for a speech pathology service if:

(a) The service is provided:

- 1) By a speech-language pathologist who meets the requirements in Section of this administrative regulation; and
- 2) To a recipient;
- 3) Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for:
 - a) Maximum reduction of a physical or intellectual disability; or
 - b) Restoration of a recipient to the recipient's best possible functioning level;
 - c) Is prior authorized; and
 - d) Is medically necessary; and
 - e) A specific amount of visits is requested for the recipient by a speech-language pathologist, physician, physician assistant, or an advanced practice registered nurse.

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

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

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

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

(3) 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.

(4) 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

(5) The department shall reimburse for physical therapy if:

- (a) The therapy Is provided by a:
 - 1) Physical therapist who meets the requirements in Section 1(1) of this administrative regulation; or
 - 2) 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
 - 3) To a recipient;
- (b) Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for:
 - 1) Maximum reduction of a physical or intellectual disability; or
 - 2) Restoration of a recipient to the recipient's best possible functioning level;
 - 3) Is prior authorized; and
 - 4) Is medically necessary; and
 - 5) A specific amount of visits is requested for the recipient by a physical therapist, physician, physician assistant, or an advanced practice registered nurse.

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

- b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:
 - 1) Department, if the recipient is not enrolled with a managed care organization; or
 - 2) Managed care organization in which the enrollee is enrolled, if the recipient is an enrollee.
- c) Prior authorization by the department shall be required for each therapy visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

(7) No Duplication of Service

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.

(a) 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.

(8) The department shall reimburse for an occupational therapy service if:

The service:

(1) (a) Is provided by an:

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

b) To a recipient;

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

- a) Maximum reduction of a physical or intellectual disability; or
- b) Restoration of a recipient to the recipient's best possible functioning level;

(3) Is prior authorized; and

(4) Is medically necessary; and

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

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

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

- 1) Department, if the recipient is not enrolled with a managed care organization; or
- 2) Managed care organization in which the enrollee is enrolled, if the recipient is an enrollee.

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

(10) 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.

6.2.22.1 The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

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))

(1) Emergency Ambulance Services.

- a) An emergency ambulance service shall be covered to and from a hospital emergency room in the medical service area if the:
- 1) Service is medically necessary; and

- 2) Documentation is maintained for post-payment review to indicate immediate emergency medical attention was provided in the emergency room.
- b) 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:
 - 1) Medical necessity;
 - 2) Absence of a hospital emergency room in the medical service area; and
 - 3) Delivery of emergency care to the patient.

(2) Nonemergency Ambulance Services.

- a) A nonemergency ambulance service to a provider within the medical service area shall be covered if:
 - 1) The recipient's medical condition warrants transport by stretcher;
 - 2) The recipient is traveling to or from a Medicaid-covered service, exclusive of a pharmacy service; and
 - 3) The service is the least expensive available transportation for the recipient's needs.
- b) A nonemergency ambulance service provided outside the medical service area shall be covered if:
 - 1) The criteria specified in subsection (1) of this section are satisfied;
 - 2) The medical service required by the recipient is not available in the medical service area; and
 - 3) The recipient is referred by a physician.
 - 4) 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 (CDT¹) codes are included in the dental benefits:

- 1) Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)

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

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

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

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

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

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

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

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

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral benefit.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

- All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.
- The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders, and if there are differences in benefits based on the population or type of condition being treated, please specify those differences.

6.3.1- BH Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

6.3.1.1- BH The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

6.3.1.2- BH The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

- Psychological testing for individuals with mental health, substance use, or co-occurring mental health and substance use disorders may include:
Psycho-diagnostic assessment of personality, psychopathology, emotionality, and/or intellectual disabilities. The services also includes interpretation and written report of testing results.
- The state will facilitate Training and Screening Tool Updates for providers, by the use of provider letters, state webpage, Bimonthly meetings of the Children's Technical Advisory Committee (which includes advocates and community liaisons) and via monthly meetings with Managed Care Organizations.
- The state requires managed care organizations (MCO's) and their networks to use screening and assessment tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.2- BH Outpatient services (Sections 2110(a)(11) and 2110(a)(19)) **All benefit limits are based on medical necessity unless otherwise noted.**

6.3.2.1- BH Psychosocial treatment

Provided for: Mental Health Substance Use Disorder

Psychosocial treatment for Mental Health and SUD includes individual outpatient therapy, outpatient group therapy and outpatient family therapy as medically necessary.

6.3.2.2- BH Tobacco cessation

Provided for: Substance Use Disorder

Tobacco cessation treatment includes but is not limited to:

- All FDA approved medications for tobacco cessation are available.
- Prevention education in kindergarten through 12th grade with intensive instruction in middle school and reinforced in high school.
- Targeted community wide programs that address the role of families, community organizations, tobacco-related policies, anti-tobacco advertising, and other elements of an adolescents' social environment.
- Program-specific training for teachers
- Trained Peer Support to help counteract social pressures on youth to use tobacco
- Substance Use Disorder (SUD) Individuals with co-occurring mental health and SUDs may be treated for both disorders in inpatient and outpatient settings. Kentucky's Division of Behavioral Health handles all mental and SUD services and coordinates with Child (CPS) and Adult Protective Services using initiatives such as a pilot program called Sobriety Treatment and Recovery Team (START), which works with children that may be put into state custody due to SUD issues and tries to get parents into SUD treatment. The START program fills gaps in CHIP by focusing on prevention (i.e., keeping children from going into custody). Medicaid is billed for START program services provided to families covered by Medicaid.
- The START Program is not based on tobacco cessation alone.
- The target population for START is as follows:
 - Families with at least one child younger than 6 in the child welfare system with a parent whose substance use is determined to be a primary child safety risk factor.
- It is not likely that tobacco use alone would be determined to be a primary child safety risk factor by DCBS. The parents can have intensive SUD services, with or without medication included in the treatment based on recommendations by the clinician and/or physician.
- Counseling is available as part of the tobacco cessation benefit.

6.3.2.3- BH Medication Assisted Treatment

Provided for: Substance Use Disorder

6.3.2.3.1 Opioid Use Disorder

6.3.2.3.2 Alcohol Use Disorder

6.3.2.3.3 Other

Medication Assisted Treatment (MAT) is an evidence based practice with the use of all FDA approved medications, in combination with counseling, behavioral therapies, and other supports to provide a “whole patient” approach to the treatment of substance use disorder. The duration of treatment should be based on the individual needs of the person served. Prescribing is limited to Kentucky Medicaid enrolled DEA waived practitioners who have experience with addiction medicine. Kentucky’s estimated 1300 waived physicians are not able to prescribe medications for Opioid Use Disorder until receipt of their waiver license. Licensed Credentialed Addiction Treatment professionals and other support services including but not limited to Targeted Case Management, Drug and Alcohol Peer Support Specialists, and Substance Use specific Care Coordination must be co-located or virtually located at the same practice site as the DEA waived practitioner or have agreements in place for linkage to appropriate behavioral health treatment providers. Staff shall be knowledgeable in the assessment, interpretation, and treatment of the biopsychosocial dimensions of alcohol or other substance use disorders. MAT can be provided in primary care settings with the appropriate treatment linkage agreement, outpatient behavioral health settings, licensed organizations, or within SUD residential treatment programs that have care coordination in place.

6.3.2.4- BH Peer
Provided for: Mental Health Substance Use Disorder

Peer Support is an evidence-based practice providing social and emotional support by a Peer Support Specialist in a structured and scheduled non-clinical therapeutic activity with an individual or group of recipients. A peer is defined as a person in recovery from a mental health, substance use, or co-occurring mental health and substance use disorder, or family member of a person living with a behavioral health or substance use disorder. The Substance Abuse and Mental Health Service Administration (SAMHSA) defines a Peer Support Specialist as an individual offering and receiving help, based on shared understanding, respect and mutual empowerment between individuals in a similar situation. Peer Support Specialist are employed by a Medicaid enrolled provider group or licensed organization, and has successfully completed peer support specialist training and eligibility requirements approved by the Department of Behavioral Health, Developmental and Intellectual Disabilities (**DBHDID**).

6.3.2.5- BH Respite Care
Provided for: Mental Health Substance Use Disorder

Respite Care/Caregiver support is not covered under CHIP. Children in need of respite care and caregiver support services will be evaluated to determine whether the child is eligible for the state’s Medicaid 1915(c) waiver.

6.3.2.6- BH Intensive in-home services
Provided for: Mental Health Substance Use Disorder

Although intensive in-home services is not a defined covered service in Kentucky, the home is an approved place of service.

6.3.2.7- BH Intensive outpatient

Provided for: Mental Health Substance Use Disorder

Intensive Outpatient Program (IOP) is an alternative to or transition from inpatient hospitalization or partial hospitalization for mental health or substance use disorders. An IOP must offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient, group outpatient therapy, and family outpatient therapies. For the treatment of substance use disorders, intensive outpatient programs should meet the service criteria for this level of care using the current edition of *The American Society of Addiction Medicine's (ASAM) Criteria, Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*.

IOP services must be provided at least three (3) hours per day and at least three (3) days per week for adults and a minimum of 6 hours per week for adolescents. Programming must include individual outpatient therapy, group outpatient therapy, and family outpatient therapy unless contraindicated, crisis intervention as it would occur in the setting where IOP is being provided, and psycho-education. Psycho-education is one component of outpatient therapy for mental health conditions. During psycho-education, the recipient or their family is provided with knowledge about his diagnosis, the causes of that condition, and the reasons why a particular treatment might be effective for reducing his symptoms. Recipients and their families gain empowerment to understand and accept the diagnosis and learn to cope with it in a successful manner).

All treatment plans must be individualized, focusing on stabilization and transition to a lesser level of care.

6.3.2.8- BH Psychosocial rehabilitation

Provided for: Mental Health Substance Use Disorder

Services may require prior authorization determined by each MCO.

Psychosocial rehabilitation helps people develop the social, emotional and intellectual skills they need in order to live happily with the smallest amount of professional assistance they can manage. Psychosocial rehabilitation uses two strategies for intervention: Learning coping skills so that they are more successful in handling a stressful environment and developing resources that reduce future stressors.

PSR is a treatment approach designed to help improve the lives of people with disabilities. The goal of **psychosocial rehabilitation** is to teach emotional, cognitive, and social skills that help those diagnosed with **mental** illness live and work in their communities as independently as possible. Treatments and resources vary from case to case but can include medication management, psychological support, family counseling, vocational and independent living training, housing, job coaching, educational aide and social support

6.3.3- BH Day Treatment

Provided for: Mental Health Substance Use Disorder

Services are available for at least three hours and less than 24 hours each day the program is open. There is no limit on the scope, duration, or amount for this benefit.

Day Treatment services are covered in Fee for Service and all Managed Care Organization plans as part of the Behavioral Health benefit.

6.3.3.1- BH Partial Hospitalization

Provided for: Mental Health Substance Use Disorder

Partial Hospitalization is a short-term (average of four (4) to six (6) weeks), less than 24-hour, intensive treatment program for individuals experiencing significant impairment to daily functioning due to substance use disorders, mental health disorders, or co-occurring mental health and substance use disorders. Partial Hospitalization may be provided to adults or children. This service is designed for individuals who cannot effectively be served in community-based therapies or IOP.

The program consists of individual, group, family therapies and medication management. Educational, vocational, or job training services that may be provided as part of Partial Hospitalization are not reimbursed by Medicaid. The program has an agreement with the local educational authority to come into the program to provide all educational components and instruction which are not Medicaid billable or reimbursable. Services in a Medicaid-eligible child's Individual Education Plan (IEP) are coverable under Medicaid. Partial Hospitalization is typically provided for at least four (4) hours per day 5 days a week. Partial Hospitalization is typically focused on one primary presenting problem (i.e., Substance use, sexual reactivity, etc.).

6.3.4- BH Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for: Mental Health Substance Use Disorder

Inpatient services/PRTF's

Inpatient and residential SUD treatments are a covered behavioral benefit for beneficiaries through Chemical Dependency Treatment Centers, Residential Behavioral Health Services Organizations as well as Acute and Psychiatric Hospitals. PRTF's are treatment facilities for primary mental health diagnosis' but can treat SUD if identified while in treatment. Outpatient SUD treatment services are covered by PRTF's, BH multi-specialty groups, Behavioral Health Services Organizations, Chemical Dependency Treatment Centers, Community Mental Health Centers as well as Individual licensed enrolled providers with SUD treatment specialties.

PTRF I service providers must meet the coverage provisions and requirements of 907 KAR 9:005 and 907 KAR 9:015 to provide covered services. Any services performed must fall within the scope of practice for any provider. Listing of a service in the administrative regulation is not a guarantee of payment. Providers must follow Kentucky Medicaid regulations. All services must be medically necessary.

The following are not covered as PRTF services:

- Chemical dependency treatment services if the need for the services is the beneficiary's primary diagnosis. However, chemical dependency treatment services are covered as incidental treatment if minimal chemical dependency treatment is necessary for successful treatment of the primary diagnosis.
- Outpatient services
- Pharmacy services covered as pharmacy services in accordance with 907 KAR 23:010
- Durable medical equipment covered as a durable medical equipment benefit in accordance with 907 KAR 1:479

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

Services are not be covered if appropriate alternative services are available in the community. The following are not covered:

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

6.3.4.1- BH Residential Treatment

Provided for: Mental Health Substance Use Disorder

As the 2014 ACA expansion allowed the addition of behavioral health practitioners and services, Residential Treatment for mental health and substance use disorder, as well as other medically necessary behavioral health services may be provided in other approved settings including Community Mental Health Centers.

Mental Health:

Kentucky assures that the Community Mental Health Centers (CMHS) provide outpatient mental health services in the least restrictive community-based settings to promote appropriate and timely access to care for beneficiaries, which include Adult Residential Treatment services and Crisis Residential services.

SUDs:

Residential treatment is a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis (ASAM Level 3.1, 3.3, 3.5). Residential treatment services are provided in a continuum of care as per the five (5) levels of ASAM residential treatment levels.

- Adolescents – up to two 30-day periods, with a one-time 30-day extension in a 365-day period;
- Perinatal beneficiaries are provided residential treatment for the duration of their pregnancy and 60 days postpartum.

6.3.4.2- BH Detoxification

Provided for: Substance Use Disorder

All recipients who are appropriately placed in any level of withdrawal management must meet the most current edition of diagnostic criteria for substance withdrawal disorder found in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as well as the most current edition of the ASAM criteria dimensions of care for admission. Services may require prior authorization determined by each MCO.

Detoxification, also known as withdrawal management, is a covered service within the Substance Use Disorder (SUD) continuum of services. At the highest level of care, it is covered within an acute care hospital, chemical dependency treatment center, residential SUD treatment and outpatient services.

6.3.5- BH Emergency services

Provided for: Metal Health Substance Use Disorder

6.3.5.1- BH Crisis Intervention and Stabilization

Provided for: Mental Health Substance Use Disorder

As the 2014 ACA expansion allowed the addition of behavioral health practitioners and services for the treatment of mental health and substance use disorder, Emergency services for Crisis Intervention, Stabilization treatment as well as other medically necessary behavioral health services may be provided in other approved settings including Community Mental Health Centers.

Mental Health:

The county Community Mental Health Centers (CMHS) provide outpatient mental health services in the least restrictive community-based settings to promote appropriate and timely access to care for beneficiaries, which include Crisis Intervention/Stabilization services. Crisis Stabilization in an Emergency Room must be provided onsite at a licensed 24-hour health care facility, as part of a hospital-based outpatient program, certified by the state to perform crisis stabilization. Guidelines for urgent care follow the same as emergency room care.

SUDs:

Crisis Intervention outpatient services are made available through county SUD programs including MAT services when needed. Service duration limits depend on ASAM Level.

All recipients who are appropriately placed in any level of withdrawal management must meet the most current edition of diagnostic criteria for substance withdrawal disorder found in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as well as the most current edition of the ASAM criteria dimensions of care for admission. Services may require prior authorization determined by each MCO.

The state assures that amount, duration, and/or scope limitation associated with its benefits can be exceeded if medically necessary.

6.3.6- BH Continuing care services

Provided for: Mental Health Substance Use Disorder

Kentucky considers continuing care services to include outpatient community based services as described above in 6.3.2.1-BH; 6.3.2.2-BH; 6.3.2.3.3-BH; 6.3.2.7-BH; 6.3.4.1-BH; 6.3.5.1-BH; 6.3.9-BH.

6.3.7- BH Care Coordination

Provided for: Mental Health Substance Use Disorder

MCOs care management teams (including utilization management reviewers) will work collaboratively with providers, enrollees and community organizations to ensure the enrollee is treated in the least restrictive setting as is clinically appropriate with the goal to maintain enrollees safely in the community whenever possible. MCOs differ in the care programs they provide. They provide other care coordination programs, such as developing and monitoring care programs and shares among providers. The recipient's PCP plays a vital role in the recipient's care program.

6.3.7.1- BH Intensive wraparound

Provided for: Mental Health Substance Use Disorder

6.3.7.2- BH Care transition services

Provided for: Mental Health Substance Use Disorder

6.3.8- BH Case Management

Provided for: Mental Health Substance Use Disorder

Targeted Case Management for Children with Severe Emotional Disability or Severe Mental Illness

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
 - a. Taking client history;
 - b. Identifying the individual's needs and completing related documentation; and
 - c. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.
 - d. An assessment or reassessment must be completed at least annually, or more often if needed based on changes in the individual's condition.

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - e. Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

- e. Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - f. Identifies a course of action to respond to the assessed needs of the eligible individual.
3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
- a. Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
4. Monitoring and follow-up activities:
- a. Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - 1) Services are being furnished in accordance with the individual's care plan;
 - 2) Services in the care plan are adequate; and
 - 3) Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
 - 4) Monitoring shall occur no less than once every three (3) months and shall be face-to-face.

Limitations:

- 1. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- 2. Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- 3.
- 4. FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

5. The individuals in the target groups may not be receiving case management services under an approved waiver program.

6.3.9- BH Other

Provided for : Mental Health

Substance Use Disorder

Services may require prior authorization determined by each MCO.

1. **Collateral services** shall be limited to recipients under the age of twenty-one, who are recipients of the rendering provider. A collateral service shall be an encounter with a parent/caregiver, household member of a recipient, legal representative/guardian, school personnel or other person in a position of custodial control or supervision of the recipient, for the purpose of providing counseling or consultation on behalf of a recipient in accordance with an established plan of treatment. The parent or legal representative in a role of supervision of the recipient shall give written approval for this service. This written approval shall be kept in the recipient's medical record. This service is only reimbursable for a recipient under age 21.
2. **Psychological testing** for individuals with mental health, substance use, or co-occurring mental health and substance use disorders may include psycho-diagnostic assessment of personality, psychopathology, emotionality, and/or intellectual disabilities. The service also includes interpretation and written report of testing results
3. **Assertive community treatment (ACT)**, mental health only service, is an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for consumers with serious mental illnesses. ACT uses a multidisciplinary team of professionals including psychiatrists, nurses, case managers, therapists and peer support specialists.
4. **Component services** include assessment, person centered treatment planning, case management, individual outpatient therapy, family outpatient therapy, and group outpatient therapy, peer support, mobile crisis intervention, mental health consultation, , family support and basic living skills training. Mental health consultation involves brief, collateral interactions with other treating professionals who may have information for the purposes of treatment planning and service delivery. Family support involves the ACT team working with the recipient's natural support systems to improve family relations in order to reduce conflict and increase recipient autonomy and independent functioning. Basic living skills training shall be rehabilitative services focused on restoring activities of daily living to reduce disability and improve function (i.e., taking medications, housekeeping, meal preparation, hygiene, interacting with neighbors) necessary to maintain independent functioning and community living. Services are provided by a multidisciplinary team of providers whose backgrounds and training include social work, rehabilitation, counseling, nursing. Providers of ACT services consist of multidisciplinary staff organized as a team in which members function interchangeably to provide treatment, rehabilitation and support.
5. **Comprehensive Community Support Services** covers activities necessary to allow individuals with mental illnesses to live with maximum independence in the community.

Activities are intended to assure successful community living through utilization of skills training as identified in the individual treatment plan. Skills training is designed to reduce symptoms associated with a mental health disorder and restore the recipient to his best possible functional level. Comprehensive community support services consists of using a variety of psychiatric rehabilitation techniques to improve daily living skills, self-monitoring of symptoms and side effects, improve emotional regulation skills, crisis coping skills and developing and enhancing interpersonal skills.

1. Applied Behavior Analysis (ABA)

In accordance with KRS 319C.010, applied behavior analysis is described as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Applied behavior analysis interventions are based on scientific research and the direct observation and measurement of behavior and environment which utilize contextual factors, establishing operations, antecedent stimuli, positive reinforcement, and other consequences to help people develop new behaviors, increase or decrease existing behaviors, and elicit behaviors under specific environmental conditions.

Applied behavioral analysis services should apply principles, methods, and procedures of the experimental analysis of behavior and applied behavior analysis, including but not limited to applications of those principles, methods, and procedures to: Design, implement, evaluate, and modify treatment programs to change the behavior of individuals; Design, implement, evaluate, and modify treatment programs to change the behavior of individuals that interact with a recipient; Design, implement, evaluate, and modify treatment programs to change the behavior of a group or groups that interact with a recipient; and Consult with individuals and organizations.

1. All recipients who are appropriately placed in any level of withdrawal management must meet the most current edition of diagnostic criteria for substance withdrawal disorder found in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as well as the most current edition of the ASAM criteria dimensions of care for admission. Services may require prior authorization determined by each MCO.

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe the tool(s) used by the state or each managed care entity:

ASAM Criteria (American Society Addiction Medicine)

Mental Health Substance Use Disorders

- InterQual
- Mental Health Substance Use Disorders

- MCG Care Guidelines
- Mental Health Substance Use Disorders

- CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
- Mental Health Substance Use Disorders

- CASII (child and Adolescent Service Intensity Instrument)
- Mental Health Substance Use Disorders

- CANS (Child and Adolescent Needs and Strengths)
- Mental Health Substance Use Disorders

- State-Specific criteria (e.g. state law or policies)(please describe)
- Mental Health Substance Use Disorders

- Plan-Specific criteria (please describe)
- Mental Health Substance Use Disorders

- Other (please describe)
- Mental Health Substance Use Disorders

The contractor shall adopt Interqual for Medical Necessity and shall utilize the American Society of Addiction Medicine (ASAM) for substance use. If Interqual does not cover a behavioral health service, the Contractor shall adopt the following standardized tools for medical necessity determinations:

For adults: Level of Care Utilization System (LOCUS); For children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII).

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools. The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

6.4.2- BH Please describe the state’s strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

Under Kentucky’s Managed Care Organization contracts, plans and provider networks are required to use ASAM for SUD and InterQual for mental health conditions.

The MCOs have provider manuals for Behavioral Health services and the Department for Behavioral Health, Developmental and Intellectual Disabilities as our Mental Health State Authority offer trainings and resources to providers in our State on evidence based practices and tools. Providers receive updates annually and as often as changes are made.

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 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.

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 subcontractors providing coverage and services to the KCHIP children.

CAHPS is utilized for the KCHIP population under a Managed care system. The state is administering and analyzing the CAHPS questionnaire for families enrolled in KCHIP. Access and utilization data are also maintained for the managed care system. The state is analyzing claims data to evaluate access and utilization by children in 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 the managed care organizations; thus, the state can generate EPSDT data for KCHIP enrolled children in Managed Care.

Kentucky uses a statewide Immunization Registry (KYIR), known as an Immunization Information System (IIS), to track immunizations for KCHIP children. KYIR is a Web-based, statewide, centralized, population-based, across-the-lifespan, and easy-to-use system that includes standard tools such as patient history, dose forecasting according to ACIP recommendations, reminder-recall, prints official immunization records with no signature required, on-line inventory management, and automated reporting of doses administered. Automated report functions are available to assess immunization coverage as of a given date for each provider, the entire State, or subgroups within.

Quality improvement strategies for the will include methods and tools such as: CAHPS; access and utilization data on birth outcomes, EPSDT, immunizations, quality studies and other selected performance measures. 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 Managed Care 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. They review member education materials, provider credentials and practice issues, suspected cases of potential fraud and abuse, and monitor primary care provider assignments.

The 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(c))

Enrollees with chronic, complex, or serious medical conditions may either have a medical home through enrollment in Managed Care or may be served through fee-for-service Medicaid. The Department for Medicaid Services routinely monitors services provided by Managed Care Plans, 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 enrollees.

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.

8.8 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:

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))

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)

8.4.1.1- MHPAEA There is no separate accumulation of cumulative financial requirements, as defined in §457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits (§457.496(d)(3)(iii)).

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)

8.4.2.2- MHPAEA If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits (§457.496(d)(3)(ii)(A)).

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))

8.4.3.3- MHPAEA Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required §457.560 (§457.496(d)(i)(D)).

8.4.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

Yes (Specify:)

No

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

Yes

No

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class which are subject to the limitation. The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits (§457.496(d)(3)(i)(E)).

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (§457.496(d)(3)(i)(A))

Yes

No

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in §457.496(d)(3)(i)(B)(1)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (§457.496(d)(3)(i)(E))

The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification.

(§457.496(d)(2)(i)) 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))**

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)**

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))**

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))

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))

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))

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))

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 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

- 1) Improve the health status of Kentucky children with a focus on preventive and early primary care.
- 2) Increase the proportion of children in Kentucky who have creditable health insurance and therefore a usual source of care.
- 3) Reduce the financial barriers to affordable health care coverage for low-income families.
- 4) KCHIP will be available to all eligible children statewide within one year of plan approval.
- 5) Increase the number of children from birth to 19 who are enrolled in Medicaid.

**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 old’s 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 least one well child exam (Healthy Kentuckians goal = 80%)
 - c) 50% of children from 10 through 18 years of age will receive at least one well child exam annually ((Healthy Kentuckians goal = 50%)
 - d) 75% children will receive an eye exam by an eye care specialist between 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))

(1) 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.

- 1) Increase Medicaid Enrollment:**
Medicaid Eligibility System Report
- 2) Increase Health status of children:**
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.

(2) Increase numbers of kids with creditable coverage:

- 1) Medicaid and KCHIP enrollment data benchmarks.
- 2) Legislative Research Commission annual insurance studies.
 - a) 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.

(3) Reduce barriers to affordable health coverage:

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.

(4) Provide statewide coverage:

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:

- a) Advocates for Reform of Medicaid Services (ARMS)
- b) Brain Injury Provider Group
- c) Kentucky Association of Private Providers (KAPP)
- d) Kentucky Alliance of Regional Programs (KARP)
- e) Medicaid Consortium
- f) 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.

Provide a 1-year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 107(d)) (42CFR 457.140)

Planned use of funds, including:

- a) Projected amount to be spent on health services;
- b) Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- c) Assumptions on which the budget is based, including cost per child and expected enrollment.
- d) Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

CHIP Budget

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

NOTE: Include the costs associated with the current SPA.

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

The Source of State Share Funds: State general fund dollars

Section 10. Annual Reports and Evaluations (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 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)

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 put 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



Health Coverage & Help Paying Costs Application for One Person

THINGS TO KNOW

<p>Use this application to see what insurance choices you qualify for</p>	<ul style="list-style-type: none"> • 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
<p>Who is this application for?</p>	<p>Single individuals who:</p> <ul style="list-style-type: none"> • 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
<p>Apply faster online</p>	<p>Apply faster online at www.kynect.ky.gov.</p>
<p>What you may need to apply</p>	<ul style="list-style-type: none"> • 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)
<p>Why do we ask for this information?</p>	<p>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.</p> <p>If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.</p> <p>We'll keep all the information you give us private, as required by law.</p>
<p>What happens next?</p>	<ul style="list-style-type: none"> • Mail or fax your completed, signed application to: <ul style="list-style-type: none"> 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.
<p>To get help</p>	<ul style="list-style-type: none"> • Online: 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 Español: Llame a nuestro Servicio al Cliente gratis al 1-855- 4kynect (459-6328) • For TTY services call 1-855-326-4654



Health Coverage & Help Paying Costs Application for One Person

STEP 1 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.

- Religious Objection
- Not eligible to receive SSN due to alien status
- Applied for SSN
- Does not have an SSN and may only be issued an SSN for a valid non-work reason
- Refuse to provide SSN

4. Date of Birth (mm/dd/yyyy)

5. Gender

- Male
- Female

6. Do you live in Kentucky and plan to stay in Kentucky? Yes No

7. Home Address - **Check here if you do not have a Home Address. You will still have to enter a Mailing Address below.**

8. City

9. State

10. Zip Code

11. County

12. Mailing Address (Only required if different from home address)

13. City

14. State

15. Zip Code

16. County

17. Primary Phone Number Home Work Cell
()

18. Secondary Phone Number Home Work Cell
()

19. Check here to allow kynect to send text message alerts to your primary phone number.

20. 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)

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. **Form 1095-B** is sent by the Department for Medicaid Services if you had Medicaid coverage during the year. The forms 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



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

26. Do you want help paying for medical bills from the last 3 months? Yes No

If yes, which month(s)? _____

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

d. 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

31. 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? _____

36. If you are filling out this application on behalf of a person who recently passed away, enter the deceased person's date of death: _____



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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)? \$ _____		4. How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly	
5. IF SELF-EMPLOYED a. Type of work _____		b. Gross Income _____ c. Self-employment Expenses _____ d. NET income (Gross minus expenses) _____	e. 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? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly	
10. IF SELF-EMPLOYED a. Type of work _____		b. Gross Income _____ c. Self-employment Expenses _____ d. NET income (Gross minus expenses) _____	e. How often? _____

11. **Additional Income:** List 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.**

Type of Income	How Much?	How Often?		
<input type="checkbox"/> Social Security	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Pensions	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Interest or Dividend	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Disability Payments	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Unemployment	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Other _____	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> 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"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly
<input type="checkbox"/> Student Loan Interest	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly

13. **Yearly Income:** What is your estimated **yearly** income for the coverage year (including any monthly changes, bonuses, seasonal income, etc.)?

\$ _____



If you need help with your application or to apply faster online, go to www.kynect.ky.gov or call 1-855-4kynect (459-6328). Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

STEP 3 Other Healthcare Coverage

Do you have health coverage now, including **dental and major medical coverage** that is not Medicaid or KCHIP?

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 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.
- 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.

Yes, I want to apply to register to vote. An application will be mailed to me. **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.kynect.ky.gov or call **1-855-4kynect (459-6328)**. Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).

907 KAR 4:020. Kentucky Children's Health Insurance Program Medicaid Expansion Title XXI of the Social Security Act.

RELATES TO: KRS 205.510-205.647, 205.6481-205.6497, 211.461 - 211.466, 304.5-040, 304.17A-005(8), (14), 42 C.F.R. 432, 433, 435, 436, 440.230, 457, 42 U.S.C. 1396, 1397aa-jj

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3) 205.6485, 42 U.S.C. 1397aa-jj

NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.030(2) requires the Cabinet for Health and Family Services, Department for Medicaid Services, to administer Title XIX of the Federal Social Security Act, 42 U.S.C. 1396 to 1396v. KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth; to operate the programs and fulfill the responsibilities vested in the cabinet; and to implement programs mandated by federal law or to qualify for the receipt of federal funds. KRS 205.6485 authorizes the cabinet to establish the Kentucky Children's Health Insurance Program (KCHIP) to provide health care coverage and other coordinated health care services to children of the Commonwealth who are uninsured and otherwise not eligible for health insurance coverage. This administrative regulation establishes the KCHIP eligibility criteria, covered services, application requirements, grievance and appeal rights for recipients, and the requirements for providers who wish to participate with the Commonwealth to provide health care coverage to KCHIP members through an expansion of the Title XIX Medicaid Program.

Section 1. Definitions. (1) "Cabinet" means the Kentucky Cabinet for Health and Family Services or its designee.

(2) "Child" means an individual under the age of nineteen (19) years.

(1) "Creditable coverage" is defined by KRS 304.17A-005(8)(a)1-3 and 5-10.

(2) "Department" means the Department for Medicaid Services or its designee.

(3) "Excepted benefits" is defined by KRS 304.17A-005(14).

(4) "Health insurance" is defined by KRS 304.5-040.

(5) "KCHIP" means the Kentucky Children's Health Insurance Program administered in accordance with 42 U.S.C. 1397aa to jj.

Section 2. Eligibility Criteria. (1) A child shall be eligible for KCHIP if the child:

(a) Is a resident of Kentucky meeting the conditions for determining state residency under 42 C.F.R. 435.403;

(b) Is an alien who meets the requirement established in 907 KAR 20:005;

(c) Meets the technical requirements of 907 KAR 20:005;

(d) Provides to the department the information required in Section 4 of this administrative regulation;

(e) Meets the continuing eligibility requirements established in 907 KAR 20:010, Section 2;

(a) Meets the relative responsibility requirements established in 907 KAR 20:040;

(f) Is not eligible for Medicaid pursuant to 907 KAR 20:005 or 907 KAR 20:100; and

(g) Is an optional targeted low-income child as defined in 42 U.S.C. 1397jj(b) who:

1. Has family income that does not exceed 159 percent of the federal poverty guidelines updated annually in the Federal Register by the United States Department of Health and Human Services under authority of 42 U.S.C. 9902(2); and

2. Does not have creditable coverage and may be covered by excepted benefits. (2) Eligibility for KCHIP shall be determined by the department. Upon receipt of eligibility information defined in subsection (1) of this section, the department shall determine if a child is eligible for benefits pursuant to 42 U.S.C. 1396 or 1397aa to jj.

Section 3. Covered Services. (1) Health services shall be considered medically necessary in accordance with:

- (b) 907 KAR 3:130; and
- (c) 42 C.F.R. 440.230.

(2) Amount and duration of benefits covered by KCHIP shall be as established in Title 907 KAR.

(1) A medical service shall be covered through KCHIP Phase II if an individual is determined eligible for KCHIP benefits in accordance with Section 2 of this administrative regulation.

(2) Preventive and remedial public health services shall be provided to KCHIP Phase II members in accordance with 907 KAR 1:360.

(3) KCHIP Phase II shall be the payor of last resort.

Section 4. KCHIP Application Requirements. The following information shall be required from a child or responsible party for KCHIP enrollment:

(1) A child's demographics that shall include:

- (d) Name;
- (e) Address;
- (f) Sex;
- (g) Date of birth;
- (h) Race; and
- (i) Social Security number;

(2) Monthly gross earned income, if any, of a parent and a child for whom information is being submitted;

(3) An employer type and address, if any;

(4) Frequency of income;

(5) Name and address of a health insurance provider who currently provides creditable coverage;

(6) Creditable coverage policy number, policy holder's name, Social Security number, and individuals covered by the plan;

(7) Unearned income, if any, received weekly, biweekly, bimonthly, quarterly, or annually;

(8) Name and age of a child or disabled adult for whom care is purchased in order for a parent or responsible person to work; and

(9) Signature, date, and telephone number of a person submitting the information for a child.

Section 5. Provider Participation Requirements. A provider's enrollment, disclosure, and documentation for participation in KCHIP shall meet the requirements of:

(4) 907 KAR 1:671; and

(5) 907 KAR 1:672.

Section 6. Grievance, Hearing, and Appeal Rights. (1) If dissatisfied with an action taken by the department as to the application of Sections 1 through 5 of this administrative regulation, a child, the child's parent, or the child's guardian shall be entitled to a grievance, hearing, or appeal with the department, to be conducted in accordance with:

(a) 907 KAR 1:560, if pertaining to initial eligibility; or

(b) 907 KAR 1:563, if pertaining to a covered service.

(2) If a service is provided by a managed care organization, a dispute resolution between a provider and a child, the child's parent, or the child's guardian shall be in accordance with:

(j) KRS 211.461 through 211.466; and

(k) 907 KAR 17:010.

(3) A KCHIP Phase II eligible child or a responsible party shall be informed in writing of the right to and procedures for due process by the cabinet:

(l) At the time information to obtain KCHIP Phase II approval is submitted;

(m) If there is a change in eligibility status; or

(n) As required by federal and state laws.

Section 7. Quality Assurance and Utilization Review. The department shall evaluate the following on a continuing basis:

(6) Access to services;

(7) Continuity of care;

(8) Health outcomes; and

Services arranged or provided as established in 907 KAR Chapter 17. (26 Ky.R. 1055; 1425; eff. 1-12-2000; 29 Ky.R. 1143; 1658; eff. 12-18-2002; 43 Ky.R. 1077, 1774; eff. 5-5-2017; Crt eff. 12-6-2019.)

907 KAR 4:030. Kentucky Children's Health Insurance Program Phase III Title XXI of the Social Security Act.

RELATES TO: KRS 205.6481 – 205.6497, 211.461 – 211.466, 281.010(25), 304.5-040, 304.17A-005(8), (14), 42 C.F.R. 435.403, 440.230, 42 U.S.C. 1396, 1397aa

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6481/205.6497, 42 U.S.C. 1397aa

NECESSITY, FUNCTION, AND CONFORMITY: KRS 205.6485 authorizes the cabinet, by administrative regulations, to establish the Kentucky Children's Health Insurance Program (KCHIP) to provide health care coverage and other coordinated health care services to children of the Commonwealth who are uninsured and otherwise not eligible for health insurance coverage. This administrative regulation establishes the KCHIP Phase III eligibility criteria, quality assurance and utilization review, covered services, the approval process, grievance and appeal rights, and the requirements for delivery of health services for providers who wish to participate with the Commonwealth to provide health care coverage for KCHIP Phase III members through the provision of a separate health insurance program under Title XXI.

Section 1. Definitions. (1) "Cabinet" means the Kentucky Cabinet for Health and Family Services or its designee.

(2) "Child" means an individual under the age of nineteen (19) years.

(1) "Creditable coverage" is defined by KRS 304.17A-005(8)(a)1-3 and 5-10.

(2) "Department" means the Department for Medicaid Services or its designee.

(3) "Excepted benefits" is defined by KRS 304.17A-005(14).

(4) "Health insurance" is defined by KRS 304.5-040.

(5) "KCHIP" means the Kentucky Children's Health Insurance Program in accordance with 42 U.S.C. 1397aa through 42 U.S.C. 1397jj.

Section 2. Eligibility Criteria. (1) A child shall be eligible for KCHIP Phase III if the child:

(a) Is a resident of Kentucky meeting the conditions for determining state residency under 42 C.F.R. 435.403;

(b) Is an alien who meets the requirements established in 907 KAR 20:005;

(c) Is not an inmate of a public institution or a patient in an institution for mental diseases;

(d) Is not eligible for Medicaid pursuant to 907 KAR 20:005 or 907 KAR 20:100; and

(e) Is a targeted low-income child as defined in 42 U.S.C. 1397jj(b) who:

1. Has family income that does not exceed 213 percent of the federal poverty guidelines updated annually in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. 9902(2);

2. Does not have creditable coverage and may be covered by excepted benefits;

3. Provides to the department the information required in Section 4(4) of this administrative regulation;

4. Meets the continuing eligibility requirements established in 907 KAR 20:010, Section 2; and

5. Meets the relative responsibility requirements established in 907 KAR 20:040.

(2)(a) Eligibility for KCHIP Phase III shall be determined by the department.

(b) Upon receipt of the eligibility information established in subsection (1) of this section, the department shall determine if a child is eligible for benefits pursuant to 42 U.S.C. 1396 or 1397bb.

Section 3. Covered Services. (1) Health services shall be considered as medically neces-

sary in accordance with:

(a) 907 KAR 3:130; and

(b) 42 C.F.R. 440.230.

(2) Covered services shall exclude:

(c) EPSDT special services as established in 907 KAR 11:034, Section 7;

(d) Human service transportation delivery as defined by KRS 281.010(25) and as required by 603 KAR 7:080; and

(e) Locally authorized medical transportation as established in 907 KAR 1:060, Section 4.

(3) The amount and duration of benefits covered by KCHIP Phase III shall be as established in Title 907 KAR excluding the services identified in subsection (2) of this section.

(4) A medical service shall be covered through KCHIP Phase III if the individual is determined eligible for KCHIP benefits in accordance with Section 2 of this administrative regulation.

(5) Preventive and remedial public health services shall be provided to KCHIP Phase III members in accordance with 907 KAR 1:360.

(6) KCHIP Phase III shall be the payor of last resort.

Section 4. KCHIP Phase III Approval Process. The following information shall be required from a child or responsible party for KCHIP Phase III enrollment:

(1) A child's demographics that shall include:

(f) Name;

(g) Address;

(h) Sex;

(i) Date of birth;

(j) Race; and

(k) Social Security number;

(2) Monthly gross earned income, if any, of a parent and a child for whom information is being submitted, an employer type and address, if any, and frequency of income;

(3) The name and address of a health insurance provider who currently provides creditable coverage;

(4) The creditable coverage policy number, policy holder's name, Social Security number, and individuals covered by the plan;

(5) Unearned income, if any, received weekly, biweekly, bimonthly, quarterly, or annually;

(6) The name and age of a child or disabled adult for whom care is purchased in order for a parent or responsible person to work; and

(7) The signature, date, and telephone number of the person submitting the information for a child.

Section 5. Provider Participation Requirements. A provider's enrollment, disclosure, and documentation for participation in KCHIP Phase III shall meet the requirements established in:

(1) 907 KAR 1:671; and

(2) 907 KAR 1:672.

Section 6. Complaint, Grievance and Appeal Rights. (1) If dissatisfied with an action taken by the cabinet, the child, the child's parent, or the child's guardian shall be entitled to a complaint, grievance, or appeal with the cabinet to be conducted in accordance with:

(l) 907 KAR 1:560; or

(m) 907 KAR 1:563.

(2) If a service is provided by a managed care organization, a dispute resolution between a

provider and a child, the child's parent, or the child's guardian shall be in accordance with:

(n) KRS 211.461 through 211.466; and

(o) 907 KAR 17:010.

(3) A KCHIP Phase III eligible child or a responsible party shall be informed in writing of the right to and procedures for due process by the cabinet:

(p) At the time information to obtain KCHIP Phase III approval is submitted;

(q) If there is a change in eligibility status; or

(r) As required by federal and state laws.

Section 7. Quality Assurance and Utilization Review. The department shall evaluate the following on a continuing basis:

(3) Access to services;

(4) Continuity of care;

(5) Health outcomes; and

Services arranged or provided as established in 907 KAR Chapter 17. (26 Ky.R. 1879; eff. 6-12-2000; 43 Ky.R. 1080, 1775; eff. 5-5-2017.)

STATE EMPLOYEE DOCUMENTATION (HARDSHIP CALCULATION OF KY STATE EMPLOYEE)**Hardship Calculation Methodology to Determine Out-of-Pocket Expenses for State Employees Eligible for the Kentucky Children's Health Insurance Program (KCHIP)**Background

Kentucky has covered children of state employees in KCHIP since the creation of the program in 1998. The cost of providing benefits through KCHIP to children of state employees averages \$2 million per year. Funding for the services is 100% state general fund dollars. Kentucky is electing to cover children of state employees per authority outlined in Section 10203(6)(C) of the Patient Protection and Affordability Care Act. Specifically, this section grants an exception to coverage of children of state employees if the state determines that the annual aggregate amount of premiums and cost sharing imposed for coverage of the family of the child would exceed 5 percent of such family's income for the year involved. Kentucky determined that the annual amount of cost sharing imposed for all children of state employees who are not otherwise covered by health insurance would exceed 5% of the family's income.

Methodology

The Department analyzed all claims submitted for children of state employees in state fiscal year 2009. State fiscal year 2009 was used because it contained a full year of comprehensive data. Based on claims data for children of state employees enrolled in KCHIP, the state determined an average number of visits per provider type per child as demonstrated in chart 1.

The Department determined the average billed charge for each service utilized by children of state employees. The average billed charge was necessary in order to determine the amount of co-insurance for which state employees would be responsible. The Department then determined the amount of co-payment or co-insurance as outlined on the 2010 Kentucky Employees' Health Plan 2010 Benefits Grid and included as Attachment 2.

Assuming that not every child will access every service and in order to determine reasonable costs, the Department examined annual co-payments and co-insurance associated with a few basic services as outlined in chart 2. While it is reasonable to expect that a child may have one hospital visit per year, costs associated with hospital visits were removed from the analysis. Children of state employees averaged 1 hospital visit per year. Therefore, based on the average hospital billed charges, all families would meet their annual deductible, regardless of the benefit plan in which they were enrolled. In lieu of including costs associated with hospital visits, the annual family deductible was used in cost calculation.

It is the Department's contention that the costs in chart 2 that were utilized to determine a reasonable out-of-pocket expense for state employees are very modest and demonstrate that state employees not granted access to KCHIP face financial burdens not experienced by other families who do not work for state government and fall within the same income bracket as demonstrated in chart 4.

Chart 1: Summary of average utilization of services for children of state employees

No. Recipients Utilizing Services	Service Utilized/Provider Type	Average visits Per Year for Children of State Employees	Average Cost of Billed Charges per Claim per Child
14	Inpatient Hospital	1	\$12,179.90
5	Mental Hospital	2	\$6,504.36
411	Outpatient Hospital	3	\$1,013.04
10	Ambulatory Surgical Center	1	\$3,086.70
346	Preventive	6	\$49.16
31	Chiropractor	9	\$117.43
3	Other Lax/X Ray	1	\$374.94
66	DME	3	\$249.40
261	FQHC	9	\$91.57
91	CMHC	8	\$166.65
235	Rural Health	12	\$105.98
136	Laboratory	2	\$140.34
264	EPSDT Screen	2	\$116.39
13	Ambulance	1	\$1,646.18
747	Pharmacy	14	\$85
335	Optometry	2	\$163.11
479	Dental	3	\$259.49
755	Physician	13	\$190.80
131	Nurse Practitioner	4	\$118.94
1	Hearing	1	\$197.54
21	Podiatry	2	\$186.12
6	Physician Assistant	3	\$190.80

Chart 2 – Services Used to Calculate Out-of-Pocket **State Employees' Health Plan does not Include Dental

Service Utilized	Average visits Per Year for Children of State Employees	Average Cost of Billed Charges per Claim per Child Enrolled in Separate Program
Physician	13	\$190.80
Pharmacy	14	\$85.19
Dental**	3	\$259.49
Preventive	6	\$49.16
Optometry	2	\$163.11
EPSDT Screen	2	\$116.39

2012 Hardship Calculation for Children of Kentucky State Employees

No. Recipients Utilizing Services	Services Utilized	Average Rating Per Year for Children of State Employees	Average Cost of billed Charges per Claim per Separate Program	Assuming Deductible is Met Member Would be Responsible for This Amount in Community Health Grouping (PHO)	Assuming Deductible is Met Member Would be Responsible for This Amount in Maximum Choice Capitation/Health Care Grouping	Assuming Deductible is Met Member Would be Responsible for This Amount in Capitation/Health Care Grouping	Assuming Deductible is Met Member Would be Responsible for This Amount in Community Health Grouping (PHO)
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	EPSTD 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

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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 Capital Choice	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Standard PPO
	Physician	13	\$ 190.80	\$ 190.00	\$ 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
	EPSTD 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

SPA # KY-13-0013

Approval Date: **NOV 14 2013**

Effective Date: January 1, 2014

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 Optimum PPO	Average Out-of-Pocket for State Employees Enrolled in Maximum Choice	Average Out-of-Pocket for State Employees Enrolled in Capitol Choice	Average Out-of-Pocket for State Employees Enrolled in Commonwealth Standard	Difference in least	difference 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

SPA # KY-13-0013

Approval Date:

NOV 14 2013

Effective Date: January 1, 2014

2012 Hardship Calculation for Children of Kentucky State Employees

Service Utilized	Assuming Deductible is Met Member Would be Responsible for This Amount in Commonwealth Option 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 Caprol 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
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 Per 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

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