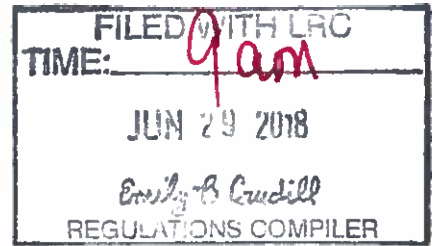

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (New Administrative Regulation)

5 895 KAR 1:010. Eligibility for Kentucky HEALTH program.

6 RELATES TO: KRS 205.520, 42 U.S.C. 1315, 1396a, 42 C.F.R. 435.916, 438.56, 457.343

7 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

8 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services,

9 Department for Medicaid Services has responsibility to administer the Medicaid Program in

10 accordance with Title XIX of the Social Security Act. KRS 205.520(3) authorizes the cabinet, by

11 administrative regulation, to comply with any requirement that may be imposed or opportunity

12 presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

13 Pursuant to state and federal law, including 42 U.S.C. 1315, the Kentucky HEALTH

14 demonstration waiver has been approved and it shall, on a continuing basis, determine and

15 establish how the commonwealth provides Medicaid services and supports for certain Medicaid

16 members. This administrative regulation establishes the eligibility requirements for Kentucky

17 HEALTH.

18 Section 1. Eligibility Groups. (1) Except for a beneficiary assigned to the random control

19 group pursuant to 895 KAR 1:045, Section 2, a beneficiary that meets the eligibility standards

1 established in this section and who is therefore eligible for participation in the Kentucky

2 HEALTH program shall only receive services from the Medicaid program as established in Title

3 895 KAR.

4 (2) An individual shall be eligible for participation in Kentucky HEALTH if the individual:

5 (a) Is a resident of Kentucky;

6 (b) Is not enrolled in, or, for an ACA expansion adult, eligible for, enrollment in the federal

7 Medicare program;

8 (c) Is not enrolled in a 1915(c) waiver, institutionalized, or receiving hospice services; and

9 (d) Is eligible under any of the following Medicaid assistance categories:

10 1. Parent and caretaker relative;

11 2. Transitional medical assistance;

12 3. Former foster youth;

13 4. Pregnant women; or

14 5. ACA expansion adult.

15 Section 2. Presumptive Eligibility Period. (1) During the presumptive eligibility period as

16 established in 907 KAR 20:050, a beneficiary who is eligible under the ACA expansion adult

17 group shall receive benefits:

18 (a) As established in the Kentucky HEALTH alternative benefit plan approved by the

19 Centers for Medicare and Medicaid Services; and

20 (b) In accordance with KAR 1:035.

21 (2) A Kentucky HEALTH beneficiary in a suspension period or a non-eligibility period shall

22 not be eligible for presumptive eligibility as established in 907 KAR 20:050.

23 Section 3. Transition to Kentucky HEALTH. (1) An individual shall be enrolled in Kentucky

1 HEALTH on the first day of the month of the Kentucky HEALTH eligibility determination if the

2 individual:

3 (a) Is determined to be presumptively eligible pursuant to 907 KAR 20:050; and

4 (b) Subsequently applies for Kentucky HEALTH and is determined eligible for Kentucky

5 HEALTH.

6 (2) A Kentucky HEALTH beneficiary transitioning to Kentucky HEALTH from a

7 presumptive eligibility period who is required to pay premiums in accordance with 895 KAR

8 1:015 shall:

9 (a) Be enrolled in the copay plan and

10 (b) Have sixty (60) days from the date of the invoice from the MCO to make a payment and

11 avoid a non-payment penalty.

12 Section 4. Requirements Relating to Annual Recertification. (1) (a)The annual eligibility

13 recertification process operated by the department shall be:

14 1. Consistent with 42 C.F.R. 435.916 for the renewal of Medicaid eligibility; and

15 2. If applicable, consistent with 42 C.F.R. 457.343 for the renewal of CHIP eligibility.

16 (b) For a beneficiary receiving premium assistance and who is covered by a parent or

17 caretaker's employer-sponsored insurance, including children enrolled in either Medicaid or

18 CHIP, the annual recertification shall be aligned with the parent or caretaker's employer

19 sponsored insurance open enrollment period.

20 (2) A beneficiary shall comply with all requirements of the recertification process, including

21 the requirement of providing the State with all necessary information or documentation to

22 complete the process.

23 (3) Following a recertification process in which all requirements were not met, a beneficiary

1 shall be:

2 (a) Disenrolled from Kentucky HEALTH; and

3 (b) Granted an additional ninety (90) day reconsideration period in which to submit

4 recertification paperwork to be reenrolled in Kentucky HEALTH. Reenrollment shall be

5 effective the first day of the month in which the recertification requirements were completed,

6 unless the individual was subject to a suspension during the recertification process.

7 (4)(a) Except as provided by paragraph (b) of this subsection, an individual who has failed to

8 submit all required recertification information and documentation upon the expiration of the

9 ninety (90) day reconsideration period established in subsection (3) of this section shall be

10 subject to a non-eligibility period of six (6) months.

11 (b) A beneficiary shall be exempt from paragraph (a) of this subsection if the beneficiary is:

12 1. A pregnant woman;

13 2. Former foster youth; or

14 3. Determined to be medically frail, or temporarily vulnerable.

15 (5) An individual subject to the non-eligibility period shall have the opportunity to re-enter

16 Kentucky HEALTH prior to the expiration of the six (6) month penalty period by completing the

17 early re-entry requirements established in 895 KAR 1:020.

18 (6)(a) A beneficiary who is subject to the non-eligibility penalty period under this section

19 may request a good cause exemption by providing verification of any of the following:

20 1. The individual was hospitalized, otherwise incapacitated, or has a protected disability, and,

21 as a result, was unable to provide information necessary to complete the recertification during

22 the recertification reporting period;

23 2. The individual has a protected disability, and the individual requested but was not

1 provided reasonable modifications needed to complete the recertification process;

2 3. The individual has a protected disability and there were no reasonable modifications that

3 would have enabled the individual to complete the recertification process;

4 4. A member of the individual's immediate family who was living in the home with the

5 individual who failed to report the change in circumstances during the reporting period as

6 required by Section 4 of this administrative regulation:

7 a. Was institutionalized; or

8 b. Died;

9 5. A member of the individual's immediate family who was living in the home with the

10 individual who failed to complete the recertification process has a protected disability, and

11 caretaking or other disability-related responsibilities resulted in the individual's inability to

12 complete recertification;

13 6. The individual either obtained or lost private insurance coverage during the recertification

14 reporting period;

15 7. The individual was evicted from a home or experienced homelessness during the

16 recertification reporting period;

17 8. The individual was a victim of domestic violence during the recertification reporting

18 period; or

19 9. The individual was the victim of a declared disaster that occurred during the recertification

20 reporting period.

21 (b) If a good cause exemption is granted, the beneficiary:

22 1. May re-enroll prior to the expiration of the non-eligibility penalty period; and

23 2. Shall not be required to complete the early re-entry requirements established by 895 KAR

1 1:020.

2 Section 5. Requirements for a Beneficiary to Report a Change in Circumstance. (1) A

3 beneficiary shall report any change in circumstance that would affect eligibility under any MAGI

4 or non-MAGI requirements within thirty (30) days of the change in circumstance.

5 (2) A beneficiary with a change in circumstance affecting eligibility shall be disenrolled:

6 (a) If the department determines the individual ineligible for all other bases of Medicaid

7 eligibility; and

8 (b) After the department reviews the individual for eligibility for other insurance affordability

9 programs in accordance with 42 C.F.R. 435.916(f).

10 (3)(a) Except as provided by paragraph (b) of this subsection, a beneficiary who failed to

11 report a change within the time frames required by subsection (1) of this section and that failure

12 resulted in the beneficiary receiving a benefit for which the beneficiary was not eligible shall be

13 disenrolled and subject to a non-eligibility period of six (6) months,

14 (b) A beneficiary shall be exempt from paragraph (a) of this subsection if the beneficiary is:

15 1. A pregnant woman;

16 2. A former foster youth; or

17 3. Determined to be medically frail or temporarily vulnerable.

18 (4) A beneficiary who is subject to a non-eligibility period under this section shall have the

19 opportunity to re-enter Kentucky HEALTH prior to the expiration of the six (6) month penalty

20 period by completing the early re-entry requirements set forth at 895 KAR 1:020.

21 (5) (a) A beneficiary who is subject to disenrollment and a non-eligibility penalty period

22 under this section may request a good cause exemption by providing verification of any good

23 cause exemption established in Section 4(6) of this administrative regulation.

1 Section 6. Kentucky HEALTH Initial Eligibility Appeals – premium payment required. (1) If
2 an applicant was determined ineligible for Kentucky HEALTH but subsequently receives a
3 favorable decision on appeal under this chapter, and is a beneficiary of any group set forth in 895
4 KAR 1:015 for which premium payments are required as a condition of eligibility, upon
5 resolution of the appeal, the beneficiary shall be:
6 (a) Enrolled in Kentucky HEALTH; and
7 (b) Required to make a premium payment within sixty (60) days of the date of initial invoice
8 from the MCO.
9 (2) In accordance with subsection (1)(b) of this section, an individual who does not make the
10 required premium payment within sixty (60) days of the date of invoice shall be subject to the
11 non-payment penalty provisions established in 895 KAR 1:015.
12 Section 7. Continued payment to retain benefits pending appeal. (1) If a beneficiary is
13 required to make premium payments, the beneficiary shall continue to make any monthly
14 premium payments that become due during an appeal within sixty (60) days of the MCO's date
15 of invoice in order to continue Kentucky HEALTH benefits.
16 (1) A beneficiary's premium payments submitted during the appeal process shall be subject to
17 the following requirements:
18 (a) If the issue being appealed is recalculation of the beneficiary's required premium amount,
19 the recalculated premium amount shall remain in effect as established in 895 KAR 1:015 while
20 the appeal is pending; and
21 (b) If the recalculated premium determination is overturned on appeal, excess premium
22 amounts paid, if any, shall be credited to the beneficiary's premium payment in the next
23 administratively feasible month.

(3) A beneficiary shall receive continued benefits pending the outcome of an administrative hearing if the beneficiary requests in writing that plan benefits be maintained pending the administrative appeal and the action is not a result of the beneficiary's nonpayment of required premiums.

Section 8. Changing MCOs. (1) Except as provided in subsections (2) or (3) of this section, a beneficiary shall remain enrolled with the same MCO during the beneficiary's benefit year.

(2) A beneficiary may change MCO upon request and without cause, only in the following circumstances:

(a) If the change is requested prior to the earlier of:

1. The date the beneficiary makes an initial fast-track payment or premium payment; or

2. The date the beneficiary has enrolled in Kentucky HEALTH after the sixty (60) day initial payment period has expired;

(b) The beneficiary is a pregnant woman or a former foster youth, in which case the beneficiary shall be allowed to change MCOs without cause for ninety (90) days after enrollment in Kentucky HEALTH; or

(c) During the beneficiary's annual open enrollment opportunity for the following benefit year.

(3) A beneficiary shall remain enrolled with the same MCO during the beneficiary's benefit year and may change MCOs upon request, for cause, as established in 907 KAR 17:010 and as provided for at 42 C.F.R. 438.56(c)(1).

Section 9. MCO Requirements when a Beneficiary Changes MCO. (1) Each MCO shall ensure that a beneficiary transferring from another MCO does not experience an interruption in care.

(2) For a beneficiary transitioning to a new MCO, the MCO from which the beneficiary is transferring shall refund any balance of the beneficiary's premium within thirty (30) days of the last date of the beneficiary's participation with the MCO.

(3) The MCO from which the beneficiary is transferring shall provide the beneficiary's deductible account balance to the new MCO.

Section 10. Cost Share Requirements and Limitations. (1) An MCO shall not charge, collect, or impose cost sharing, including premiums, copayments, or coinsurance, for any covered service to a beneficiary who is pregnant.

(2) An MCO shall not charge, collect, or impose, and shall require that any network providers do not charge, collect, or impose cost sharing, including premiums, copayments, or coinsurance, to a beneficiary for covered services, except for the following:

(a) Copayments as set forth in the Kentucky Medicaid state plan for a beneficiary enrolled in the copay plan; and

(b) Premiums as established in 895 KAR 1:015.

(3) An MCO may attempt to collect any debt but shall not:

(a) Report the premium amount owed to a credit reporting agency;

(b) Place a lien on the beneficiary's or disenrolled individual's home;

(c) Refer the case to a debt collector;

(d) File a lawsuit; or

(e) Seek a court order to seize a portion of the beneficiary or disenrolled individual's earnings.

Section 14. Federal approval and federal financial participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

1 (1) Receipt of federal financial participation for the coverage; and

2 (2) Centers for Medicare and Medicaid Services' approval for the coverage.

REVIEWED:

6/22/2018
Date

[signature]
Jill R. Hunter, Acting Commissioner
Department for Medicaid Services

APPROVED:

6.27.18
Date

[signature]
Adam M. Meier, Secretary
Cabinet for Health and Family Services

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on August 27, 2018, at 9:00 a.m. in Suites A & B, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by August 20, 2018, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until August 31, 2018. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Laura Begin, Legislative and Regulatory Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, KY 40621, Phone: 502-564-6746, Fax: 502-564-7091; Laura.Begin@ky.gov.

REGULATORY IMPACT ANALYSIS

AND TIERING STATEMENT

Administrative Regulation #: 895 KAR 1:010

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Laura Begin, (502) 564-6746, laura.begin@ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes which individuals are eligible for the Kentucky HEALTH program, establishes a presumptive eligibility period for Kentucky HEALTH beneficiaries, annual recertification requirements, requirements for reporting a change in circumstances, an appeals process and additional appeals requirements for a beneficiary, and change of MCO and cost-sharing requirements

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish eligibility requirements and processes for the Kentucky HEALTH program.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing eligibility requirements that allow for full receipt of federal funds and full participation in the Medicaid Program for Kentucky HEALTH beneficiaries.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the statutes by establishing a clear eligibility process for Kentucky HEALTH beneficiaries, providers, MCOs, and the department.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The Department for Medicaid Services, any contracted Medicaid managed care organization that delivers services to individuals eligible for Medicaid through the Kentucky HEALTH program, any enrolled provider that delivers

services to individuals eligible for Medicaid through the Kentucky HEALTH program, and any beneficiary whose eligibility for Medicaid will be governed by the Kentucky HEALTH program. Currently, more than 1.2 million individuals in Kentucky receive Medicaid.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Beneficiaries will need to verify if they are eligible for participation in Kentucky HEALTH, recertify annually, report changes in circumstances that impact eligibility, and continue payments of premiums.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The costs experienced by beneficiaries will vary depending on income level, compliance with premium payment requirements, certification and documentation requirements, and PATH requirement, and the beneficiary's eligibility status.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Beneficiaries who meet eligibility requirements will be able to receive healthcare benefits via participation in the Kentucky HEALTH program as established in Title 895 KAR.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The department anticipates no additional costs in the implementation of this administrative regulation.

(b) On a continuing basis: The department anticipates no additional costs in the continuing operation of this administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under the Social Security Act, Title XIX and state matching funds from general fund and restricted fund appropriations are utilized to fund this administrative regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees or funding is necessary to implement this regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This new administrative regulation neither establishes or increases any fees.

(9) Tiering: Is tiering applied? Tiering is applied in that pregnant women, former foster youth, and individuals who are determined to be medically frail or temporarily vulnerable are exempted from a non-eligibility period and pregnant women are not subject to cost sharing requirements for covered services.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 895 KAR 1:010
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; or Laura Begin, (502) 564-6746, laura.begin@ky.gov.

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1315; 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438

2. State compliance standards. KRS 194A.010(1), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), and 205.560

KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1315 establishes the 1115 waiver authority. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

This administrative regulation establishes a premium and potential co-pay requirement for certain beneficiaries that fail to comply with the premium requirement.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

A federal demonstration waiver has been approved pursuant to 42 U.S.C. 1315 and on an ongoing basis it shall determine and establish how Medicaid services are provided to Medicaid members who are eligible pursuant to this regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 895 KAR 1:010
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; or Laura Begin, (502) 564-6746, laura.begin@ky.gov.

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Cabinet for Health and Family Services, Department for Medicaid Services

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 205.560.

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year?

None

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years?

None

(c) How much will it cost to administer this program for the first year? Pursuant to the budget neutrality analysis in the application for the approved federal 1115 waiver, Kentucky HEALTH is projected to save taxpayers over $2.2 billion dollars in state and federal funding over the five year waiver period.

(d) How much will it cost to administer this program for subsequent years? Pursuant to the budget neutrality analysis in the application for the approved federal 1115 waiver, Kentucky HEALTH is projected to save taxpayers over $2.2 billion dollars in state and federal funding over the five year waiver period.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation: