SUMMARY OF 895 KAR REGULATION FILING

On June 29, CHFS filed eleven new regulations creating a new chapter in subtitle of the Administrative Register 895 KAR Chapter 1. All are regular, not emergency, regulations and so will not be effective until after public comment and legislative review. If requested, a public hearing will be held on August 27, 2018, and written comments may be submitted until August 31. The regulations filed and the pages on which they are summarized in this document are as follows:

PAGE 9--895 KAR 1:055 Designation or determination of medically frail status or accommodation due to temporary vulnerability in the Kentucky HEALTH program.

Brief summaries of the new regulations are as follows:

895 KAR 1:010. Definitions for 895 KAR Chapter 1 defines some 52 terms used in KAR 895.

895 KAR 1:010 Eligibility for Kentucky HEALTH program. This regulation provides that a beneficiary meeting the eligibility standards of this section can only receive Medicaid services under the Kentucky HEALTH Program under Title 895 KAR. Subsection (2) provides a list of eligibility criteria. Individuals are eligible for Kentucky HEALTH if:

- They are Kentucky residents;
- Are not enrolled in (or for an ACA expansion adult) or eligible for Medicare enrollment;
- Not enrolled in a 1915(c) waiver, institutionalized, or receiving hospice services;
- Are eligible under one of several Medicaid assistance categories such as parent or caretaker relative, transitional medical assistance, former foster youth, pregnant women, or ACA expansion adult.

Section 2 deals with a presumptive eligibility period of 907 KAR 20:050 and provides that a beneficiary eligible under the ACA expansion shall receive Kentucky HEALTH ABP benefits (defined at 1:010 (4)) in accordance with 895 KAR 1:035. Section 3 provides for transition to Kentucky HEALTH, stating that an individual is enrolled if determined to be presumptively eligible under 907 KAR 20:050, applies for and is determined eligible for Kentucky HEALTH. Individuals transitioning from presumptive eligibility who are required to pay premium must be

enrolled in a copay plan and must pay within 60 days of receiving an invoice from a MCO. Section 4 sets out requirements and timelines relating to annual recertification for Kentucky HEALTH eligibility, including a non-eligibility period of six months, if recertification is not timely completed (page 4, line 7), as well as exemptions to non-eligibility for pregnant women, former foster youth, and the medically frail. Good cause exemptions and procedures are also set out in detail.

Section 5 sets out requirements for a beneficiary to report a change in circumstances affecting eligibility under any MAGI (see definitions) or other requirements and lays out procedures for disenrollment (page 6). Exemptions to disenrollment for pregnant women, former foster youth, and the medically frail. Good cause exemptions and procedures are also set out in detail.

Section 6 relates to initial eligibility appeals. Section 7 requires payment of premium pending appeal.

Section 8 relates to changing MCO's and generally provides that an individual must remain enrolled in the same MCO during the benefit year except for certain circumstances set out in Section 8 (page 8). Section 9 makes provisions for instances when a beneficiary changes MCO's.

Section 10 lays out cost share requirements and limitations on MCO's; collection of premiums, co-payments, or co-insurance (page 9).

Sections 11 to 13 are omitted in numbering, which may simply be a typographical error, and Section 14, beginning at the bottom of page 9, makes the coverage of services contingent upon federal financial participation and CMS approval of coverage. This provision relating to federal participation is also in all the rest of the regulations, as well.

895 KAR 1:015. Premium Payments Within the Kentucky HEALTH Program. The regulation sets out in Section 1 that premium payments or co-payplan requirements are mandatory for beneficiaries and must be remitted as provided in Section 3 Beneficiaries who make monthly payments do not incur any other cost sharing for healthcare coverage and have access to a MyRewards account.. Those with incomes above 100% of FPL must pay premium to retain Kentucky HEALTH covarage. Those under 100% of FPL are not required to pay premium for Kentucky HEALTH. All beneficiaries, except pregnant women, must pay premium for the MyRewards account. Section 2 provides for the calculation of a household's monthly premium amount by DMS, according to a formula and chart posted on the DMS website. Premium is capped at 4% of a beneficiary's aggregate household income, but all beneficiaries subject to premium payment must pay a $1 monthly premium to their MyRewards account. Detailed provisions for capping and adjusting premium, accounting for, and notifying beneficiaries of premium changes are set out on page 3.

Section 3 deals with entities allowed to make premium payment and includes the beneficiary or a third party on the beneficiary's behalf, including a provider or a provider-related entity, except a MCO, and sets conditions for such third party payments (page 4). These conditions include prohibitions on distinguishing between beneficiaries depending on whether they receive care from the provider, the inclusion of the cost of the payments in the cost of care, and reporting the cost as a shortfall or uncompensated care.

Section 4 relates to non-payment penalties, which vary depending on the beneficiary's household income, and sets terms and conditions of penalties depending on various detailed circumstances and situations (page 5-7). Section 5 lists categories that have the option to make

monthly premium payment in order to access MyRewards accounts, and penalties for failure to make payments.

895 KAR 1:020. PATH Requirements for the Kentucky HEALTH Program. Section 1 sets out criteria for beneficiaries who must complete PATH (see PATH definition at (40) **895 KAR 1:001 Definitions**) requirements such as age (between 19 and 65) and Medicaid category of ACA expansion adult, transitional Medical Assistance Section 2 lays out a timeframe and qualifying activity conditions for deemed compliance with the PATH requirements in great detail (pages 3 and 4), along with details of circumstances that would exempt the requirements (page 2-3) If these exemptions are not met, a beneficiary must use a Web site to report and track community engagement activities, document completion of a re-entry course, and request an exemption.. Section 3 deals with the consequences of failure to meet the PATH requirements or to make amends in the following month. These consequences include a suspension from the Kentucky HEALTH Program, A timeline and conditions for reinstatement are set out(pages 4-5). Section 4 lists beneficiary categories exempt from PATH requirements (See page 5, lines 11 to 23.

895 KAR 1:025. Beneficiary Premiums. This regulation in Section 1. sets a requirement for monthly premium payment as set in 895 KAR 1:015, subject to specific exceptions, and also sets deadlines for payments. A conditionally eligible beneficiary has 60 days from the first MCO invoice to begin making payments, and coverage is effective the first day of the month the premium is received by the MCO. Penalties accrue if payments are not timely. It also includes detailed provisions for a one-time fast track payment to expedite

eligibility (pages 1-2). Section 2 deals with the effective date for coverage, depending upon different categories of eligibility (Page 3).

895 KAR 1:030. Establishment and Use of the MyRewards Program. Section 1 states that the purpose of the MyRewards account is to give a beneficiary access to items and services not otherwise covered in the benefit package, including vision and dental services. Section 2 sets requirements for maintaining the MyRewards account as monthly premium payments for what appear to be all beneficiaries, except pregnant women. Section 3 sets out conditions for account accruals based on beneficiary behavior such as healthy behavior, community engagement, etc. Section 4 lists conditions for reductions from an account, including failure to make premium payment or non-emergent use of ER (Page 4). Section 5 allows beneficiaries who transfer to commercial insurance to receive a payout of the MyRewards account of up to $500, subject to conditions (page 4). Sections 6 and 7 deal with early re-entry or early re-activation of Kentucky HEALTH or MyRewards of the accounts where subject to a six-month penalty under certain circumstances.

895 KAR 1:035. Covered Services Within the Kentucky HEALTH Program. Section 1 sets out covered services, depending on eligibility category under federal or state law. For an ACA expansion adult not eligible as a pregnant woman, former foster youth, or medically frail or temporarily vulnerable will receive benefits services under the Kentucky HEALTH, Alternative Benefit Plan (ABP) (See **895 KAR 1:001 Definitions** (4)) Kentucky HEALTH ABP covered services are listed beginning at line 11, page 2. Services not covered by Kentucky Health ABP are listed beginning at line 3, page 3. Section 2 sets out five categories of

beneficiaries eligible for covered services under the Kentucky Medicaid State Plan (subject to limitations in KAR 907) and also lists services not covered for such beneficiaries at line 20, page 3. Section 3 (page 4) deals with preventive services, providing that such services are not tracked against the beneficiary's deductible account and sets out a list of preventative services.

895 KAR 1:040. Deductible Amounts Within the Kentucky Health Program. Section 1 establishes a benefit year deductible account with a dollar value equivalent to $1,000 for adult beneficiaries in order to track the first $1,000 of non-preventive covered services used in a benefit year. The deductible does not apply to pregnant women. Section 2 states that the deductible account is applicable to all Kentucky HEALTH non-preventive care services. Section 3 provides that an adult beneficiary receiving more than $1,000 worth of non-preventive services in a benefit year retains access to covered services, despite having exhausted the deductible amount. Beneficiaries will receive a monthly account statement of services used and the balance remaining (page 2). Adult beneficiaries with funds remaining in the account at the end of a benefit year may transfer 50% of the account balance to their MyRewards account.

895 KAR 1:045. Accommodations, Modifications, and Appeals for Beneficiaries Participating in the Kentucky HEALTH Program. Section 1 provides that reasonable accommodations will be provided to beneficiaries with protected disabilities (See **895 KAR 1:001 Definitions** (45)) to meet the Kentucky HEALTH requirements, if requested. These accommodations include exemption or modification of the PATH participation requirements, if the beneficiary is unable to particape for reasons of a protected disability, a modification of the number of housrs, provision of support services, assistance with demonstrating eligibility for

good-cause exemptions, or appealing a suspension and other accommodations. Section 2 (page 2) states that requirements and timeframes for Kentucky Medicaid and Title 907 KAR apply to a Kentucky HEALTH random control group (See **895 KAR 1:001 Definitions** (47)) . Sections 3 and 4 set out legal guidelines for appeals of eligibility and benefit determination, pursuant to KRS Chapter 13B and relevant sections of 907 KAR.

895 KAR 1:050. Enrollment and Reimbursement for Providers in the Kentucky HEALTH Program. Section 1 states that a provider is automatically eligible for Kentucky HEALTH participation if currently enrolled as a Medicaid provider or as a provider with an MCO. To enroll, a provider must comply with Medicaid enrollment procedures in title 907 KAR. Section 2 deals with provider reimbursement by stating that a provider will be reimbursed at the rate established by the MCO for MCO covered services. Reimbursement for services covered by 895 KAR 1:030 (vision and dental servies) is through the beneficiary's MyRewards account on a fee-for-service basis and not to be submitted to the beneficiary's MCO. There is no reimbursement under Title 895 KAR for services provided to individuals not eligible for or suspended from Kentucky HEALTH on the date of provision of service (page 2). Section 3 says that a provider that seeks reimbursement for a non-covered service that is reimbursable through a beneficiary's MyRewards account is at risk for the cost of the service under certain circumstances including the provider's failure to place a hold on funds in the account and non-availability of funds at the time services are billed, an inactive or suspended account at the time the service was rendered, or the hold on funds expired due to a provider's failure to submit a claim within 30 days of service. Vision or dental services may be billed to a beneficiary with an inactive or suspended MyRewards account for services not covered by the beneficiary's benefit

plan (page 3). Section 4 states that providers shall accept MCO reimbursement as payment in full, and shall not balance bill a beneficiary for services not reimbursed by the MCO. Providers are also required to collect co-pays Medicaid state plan for beneficiaries in the copay plan. Providers may seek beneficiary reimbursement for non-covered services received during a suspension or penalty period if certain conditions are met. These conditions include an established policy for billing all patients for services not covered by a third party and does not bill Medicaid or Kentucky HEALTH, having advised the patient that it is a non-covered service, and personal agreement by the patient, in writing, detailing the service and the amount to be paid by the patient. Section 5 states that third-party liability must comply with KRS 205.622. which says that third parties must be billed before KMAP, if a provider has knowledge the third party may be liable. Section 6 (page 4) says that the use of electronic signatures must comply with KRS 369.101 to 369.120, the **Uniform Electronic Transactions Act**. This section of the regulation also sets out several additional detailed requirements for the use of electronic signatures by providers (Page 4). Section 7 gives DMS or a MCO the authority to audit claims, health records, and documentation.

895 KAR 1:055. Designation or Determination of Medically Frail Status or Accommodation Due to Temporary Vulnerability in the Kentucky HEALTH Program. Section 1 deals with designation of medically frail individuals. Designation at the time of application occurs if the beneficiary has HIV or AIDS, is receiving RSDI, or is chronically homeless. Section 2 provides for a review of medically frail status at various times, including on beneficiary request, during the benefit year if documentation demonstrates what may be a medically frail condition, or claims history or provider documentation that demonstrates that the

beneficiary may no longer have a medically frail condition. The review is to occur at least annually by an MCO and procedures for MCO review are set out (page 2) directing consideration of medical records, claims, and other relevant information. Section 3 provides for accommodation due to temporary vulnerability and enumerates individuals who may be designated as such, including refugees and victims of domestic violence. Requirements for participation of those so deemed must pay premiums for a MyRewards account but are exempt from Kentucky HEALTH requirments like payment of premiums and copays for medical services and completion of PATH requirements. Section 4 sets out auditing authority for DMS or MCO's including the authority to audit claims, health records, or documentation related to use of a MyRewards account.