



Commonwealth of Kentucky
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August 24, 2016

The Honorable Sylvia Burwell
Secretary of the Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madame Secretary:

On behalf of the people of the Commonwealth of Kentucky, I am pleased to submit our request for a Section 1115 demonstration waiver for Kentucky HEALTH.

Last year, we began the process of transforming Kentucky's Medicaid program in an effort to produce better health outcomes while ensuring the long-term fiscal sustainability of the program. The need for change is urgent. Almost twenty percent of our residents live in poverty, we are 47th in the nation for median household income, nearly one-third of Kentuckians are on Medicaid, and our workforce participation is among the worst in the nation at less than 60 percent. Kentucky also ranks third in the nation for drug related fatalities. I know, from our conversations, that these facts concern you deeply.

As you are aware, next year we will be required to start paying a portion of the costs of Medicaid expansion for the first time. This is expected to cost Kentucky taxpayers approximately \$1.2 billion in new spending for fiscal years 2017 through 2021. This is an expense Kentucky cannot afford without jeopardizing funding for education, pension obligations, public safety and the traditional Medicaid program for our most vulnerable citizens.

Kentucky HEALTH is a transformative program designed not only to stabilize the program financially, but to improve health outcomes and overall quality of life for its members. Our demonstration waiver seeks to continue health coverage for our existing Medicaid population while evaluating new policies designed to prepare individuals for self-sufficiency and private market coverage. In addition, our proposal seeks to strengthen our behavioral health delivery system, which is critical to addressing Kentucky's substance abuse epidemic.

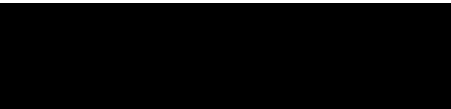
As part of the waiver's development, we had a robust public comment process, which included three public hearings, and an extended comment period to ensure every Kentuckian that wanted to be heard could be included. In total, we received nearly 1,350 comments and made adjustments to our waiver application to address our citizens' most pressing concerns. The resulting waiver request includes the preservation of allergy testing benefits, as well as additional protections for the medically frail population.

The Kentucky HEALTH Section 1115 demonstration application represents our good faith effort to continue Medicaid expansion in a responsible manner. It is within your authority to approve our request as written. This is what I am humbly asking you to do. In fact, most of the features of Kentucky HEALTH have already been approved by your agency in other states. We believe the Commonwealth of Kentucky should be given the same opportunity as others to reform our Medicaid program to meet the unique needs of our Commonwealth. We need a lifeline.

In the interest of the Commonwealth of Kentucky, I hope you will view our application favorably. My team and I stand ready and committed to continue our conversations. By working together in an expeditious manner, Kentucky will have a transformative Medicaid program that will better serve the over 400,000 Kentuckians who are currently receiving healthcare benefits under expanded Medicaid.

Thank you in advance for your thoughtful consideration of our request.

Sincerely,

A black rectangular redaction box covers the signature of Matthew G. Bevin. A thin black line extends from the bottom-left corner of the box towards the text below.

Matthew G. Bevin
Governor



Helping to Engage and Achieve Long Term Health

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Section 1: Kentucky HEALTH Program Overview

Kentucky HEALTH is the Commonwealth of Kentucky's 1115 demonstration project focused on "Helping to Engage and Achieve Long Term Health (HEALTH)". The proposed demonstration project is part of an overall initiative to transform the Kentucky Medicaid program to empower individuals to improve their health and gain employer sponsored coverage or other commercial health insurance coverage, while simultaneously ensuring the program's long-term fiscal sustainability. Only by helping members engage in their healthcare and their communities, will the Commonwealth achieve long term improvements in the health of its citizens and improved fiscal health for the Commonwealth and its Medicaid program. To this end, the Commonwealth seeks a five-year Section 1115 waiver from the Centers for Medicare & Medicaid Services (CMS) to implement and evaluate Kentucky HEALTH, a demonstration project designed to provide dignity to individuals as they move towards self-reliance, accountability, and ultimately independence from public assistance.

The program seeks to break the cycle of poverty through efforts on several fronts. First, the program encourages members to improve their health by incentivizing preventive care, participation in disease management programs, and healthy lifestyles. Second, the program embraces private market policies and principles to familiarize members with commercial health insurance coverage to prepare them for the commercial market. Third, the program focuses on addressing Kentucky's growing drug abuse epidemic, which based on a recent Centers for Disease Control and Prevention (CDC) study determined that nearly half of all counties in the Commonwealth are at risk for an HIV or hepatitis C outbreak.¹ This risk analysis was based in part on unemployment rates. Addressing employment goes hand in hand with health, and therefore the program will also focus on engaging members in the community, either through employment or preparing for employment, as well as volunteer activities. Further, in addition to creating new requirements for members, the program also raises accountability for the healthcare system by furthering the "Triple Aim" of improving the patient experience, improving population health, and lowering costs.

While Kentucky HEALTH is uniquely designed for the specific challenges facing Kentucky, most of the individual federal authorities necessary to implement this demonstration project have been previously approved in other states. Through this waiver application, the Commonwealth is seeking the opportunity to evaluate these new program components in Kentucky, with the goal of dramatically improving member outcomes. The Kentucky HEALTH program, as outlined below, represents the terms under which the Commonwealth will continue Medicaid expansion.

1.1 Historical Narrative and Rationale

In 2014, as part of the Affordable Care Act (ACA), the Commonwealth of Kentucky expanded its Medicaid program to all newly eligible adults with income below 138% of the federal poverty level (FPL). The expansion placed able-bodied adults into a program designed for disabled individuals, pregnant women and children, and other vulnerable populations likely to be dependent on the State over the long-term. As a result, Kentucky's total Medicaid enrollment has increased dramatically—by April 2016, more than 428,000 low-income non-disabled adults were enrolled in the Medicaid expansion program,

¹ A. Campo-Flores & B. McKay, CDC Identifies Counties at Risk of HIV Outbreaks: Agency Lists Areas Prone to HIV and Hepatitis C Spreading Among Injection-drug Users, WALL STREET JOURNAL (June 3, 2016), <http://www.wsj.com/articles/cdc-identifies-counties-at-risk-of-hiv-outbreaks-1464912264>.

nearly one-third of the State's total Medicaid program enrollment.² Further, due to expansion, the State experienced significant increases in enrollment across all Medicaid eligibility categories. In fact, total Kentucky Medicaid and Children's Health Insurance Program (CHIP) enrollment increased 68% between December 2013 (prior Medicaid expansion) and April 2016.³ Following this dramatic enrollment increase, over 1.35 million Kentuckians (almost a third of the State's entire population) are being served by Medicaid.⁴ However, the expansion has yet to impact the health status of Kentuckians. For example, during the first year following implementation, fewer than 10% of beneficiaries received an annual wellness or physical exam.⁵

In addition, the Commonwealth faces many challenges. Kentucky's rate of unemployment, nearly 6%, and the poverty rate, approximately 19%, are both well above the national average, and workforce participation rates and wages are below the national average and among the worst in the nation.⁶ These factors are known to impact rates of drug use as well as HIV rates. Over the past decade, the number of Kentuckians who die from drug overdoses has steadily climbed to more than 1,200 each year.⁷ Kentucky now ranks third highest in the nation for the number of drug related fatalities.⁸ A June 2016 preliminary report from the Centers for Disease Control & Prevention (CDC) identified 220 counties in the nation at risk for an HIV or hepatitis C outbreak, and 54 of the total at-risk counties were located in Kentucky.⁹ Further, the State also has the seventh highest incarceration rate in the nation, far outpacing the national average.¹⁰

² *Total Monthly Medicaid and CHIP Enrollment: Timeframe Mar 2016*, THE HENRY J. KAISER FAMILY FOUNDATION, <http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/> (last visited June 6, 2016); Stephen P. Miller, Commissioner, Kentucky Department for Medicaid Services, Presentation to the Kentucky Senate Health & Welfare Committee (April 11, 2016).

³ Kentucky Department for Medicaid Services, Comparison of December 2013 member enrollment and April 2016 member enrollment (June 14, 2016) (on file with the State).

⁴ Stephen P. Miller, Commissioner, Kentucky Department for Medicaid Services, Presentation to the Kentucky Senate Health & Welfare Committee (April 11, 2016).

⁵ In 2014, 33,233 individuals received an annual wellness or physical exam. Deloitte, Commonwealth of Kentucky: Medicaid Expansion Report (2014), available at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf

⁶ *Economy at a Glance: Kentucky*, UNITED STATES DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, <http://www.bls.gov/eag/eag.ky.htm> (data extracted June 03, 2016); *Quick Facts: Kentucky*, UNITED STATES CENSUS BUREAU, <http://www.census.gov/quickfacts/table/PST045215/21> (last visited June 6, 2016). Kentucky ranks 45th in the nation for total percent of population age 16+ in civilian labor force, at 59.4%, and 47th in the nation for median household income, at \$43,342. *Id.*

⁷ COMMONWEALTH OF KENTUCKY JUSTICE AND PUBLIC SAFETY CABINET, 2015 OVERDOSE FATALITY REPORT: KENTUCKY OFFICE OF DRUG CONTROL POLICY (2015), available at <http://odcp.ky.gov/Documents/2014-%20ODCP%20Overdose%20Death%20Report%20final1.pdf>.

⁸ Number of deaths due to drug injury of any intent (unintentional, suicide, homicide, or undetermined) per 100,000 population. The 3-year average from 2011-2015 for Kentucky was 24 deaths, while the national average was 13.5. *Drug Deaths: United States*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/all/drugdeaths> (last visited June 6, 2016).

⁹ A. Campo-Flores & B. McKay, CDC Identifies Counties at Risk of HIV Outbreaks: Agency Lists Areas Prone to HIV and Hepatitis C Spreading Among Injection-drug Users, WALL STREET JOURNAL (June 3, 2016), <http://www.wsj.com/articles/cdc-identifies-counties-at-risk-of-hiv-outbreaks-1464912264>.

¹⁰ PRISON POLICY INITIATIVE, <http://www.prisonpolicy.org> (last visited June 6, 2016).

The Commonwealth also consistently ranks near the bottom of the nation in several key population health metrics. For example, over 26% of Kentuckians smoke cigarettes (second highest rate in the nation), 31.6% of adults in the Commonwealth are obese (twelfth highest rate in the nation), and the number of infant deaths per 1,000 live births is 6.8 (seventeenth highest in the nation).¹¹ In addition, Kentucky has both the highest number of cancer deaths, as well as the highest number of preventable hospitalizations, in the nation.¹² Further, Kentucky also faces significant health challenges related to high rates of diabetes and heart disease, ranking 45th and 47th in the nation respectively.¹³ Despite these poor health outcomes, Kentucky's managed care organizations (MCOs) are only spending approximately 80% of their total \$530 per member per month capitation on direct healthcare spending, while the remainder contributed to administrative costs and profit (which on average were the highest profit margins in the nation for Medicaid managed care plans).¹⁴

In addition to poor health outcomes, the Medicaid program is financially unsustainable. To date, the Commonwealth has only covered half the administrative cost of the expansion program and none of the costs associated with the benefits provided to the expansion population. The remaining costs were funded entirely by the federal government. However, over the next five years the federal share of the cost of benefits provided to the expansion population will decline and the required State share will increase. As such, the cost of these benefits to Kentucky taxpayers is estimated to increase from \$74 million in 2017 to approximately \$363 million by 2021, for a total of approximately \$1.2 billion over the next five years.¹⁵ These costs have the potential to challenge the overall state budget and could create funding issues for other programs, such as education, pensions, and infrastructure, as well as also jeopardize funding for the traditional Medicaid program that covers the aged, blind, disabled, pregnant women and children.

When expansion was implemented there was no plan to finance the program long-term, and instead the Kentucky expansion plan counted on increased State revenues. In 2013, prior to the implementation of the Medicaid expansion program, the previous administration commissioned a study of the potential impact of Medicaid expansion under the ACA on the State's anticipated Medicaid population, its budget,

¹¹ *Smoking: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/KY/Smoking/59> (last visited June 6, 2016); *Adult Obesity in the United States*, TRUST FOR AMERICA'S HEALTH AND THE ROBERT WOOD JOHNSON FOUNDATION, <http://stateofobesity.org/adult-obesity/> (last visited June 6, 2016); *Infant Mortality: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/KY/IMR> (last visited June 6, 2016).

¹² AMERICA'S HEALTH RANKINGS, ANNUAL REPORT: KENTUCKY (2015), available at <http://cdnfiles.americashealthrankings.org/SiteFiles/StateProfiles/Kentucky-Health-Profile-2015.pdf>.

¹³ *Diabetes: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/ALL/Diabetes> (last visited June 16, 2016); *Heart Disease: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/IL/CHD> (last visited June 16, 2016).

¹⁴ The average medical loss ratio for Kentucky's five Medicaid MCOs was reported at 80.5%, below the national average of 85.4%. JEREMY D. PALMER & CHRISTOPHER T. PETTIT, MILLIMAN, MEDICAID RISK-BASED MANAGED CARE: ANALYSIS OF FINANCIAL RESULTS FOR 2015 (2016), available at <http://www.milliman.com/uploadedFiles/insight/2016/medicaid-risk-based-managed-care-analysis-2015.pdf>.

¹⁵ Stephen P. Miller, Commissioner, Kentucky Department for Medicaid Services, Presentation to the Kentucky Senate Health & Welfare Committee (April 11, 2016).

and its economy.¹⁶ The actual results of the implementation of Medicaid expansion differ dramatically from the projections set forth in the original study. The reality is, the number of Kentuckians who have enrolled in Medicaid expansion is more than double the number projected, while the number of new jobs created and the economic impact from Medicaid expansion has been significantly lower than forecasted.

Specifically, the 2013 study projected that 147,634 newly eligible members would enroll in the Medicaid expansion program during the period from July 1, 2013 through June 30, 2014, and that number would increase to 187,898 over the next six years.¹⁷ In contrast to these projections, Kentucky's Medicaid expansion population currently exceeds 428,000.¹⁸ In addition, the 2013 study claimed that Medicaid expansion would add 40,000 jobs through June 30, 2021, and would have a positive economic impact of \$802.4 million through that same date.¹⁹ Although difficult to quantify with any appreciable degree of certainty, preliminary economic impact analysis would support a conclusion that the figures cited in the 2013 study were overly optimistic and not likely to be achieved by the cited date of June 30, 2021. The reality is that Medicaid expansion does not pay for itself as envisioned by the prior administration, and the Commonwealth of Kentucky cannot afford the cost of the Medicaid expansion program without this demonstration waiver.

Kentucky HEALTH's design saves taxpayer dollars, critical to ensuring the program's long-term financial viability. In total, Kentucky HEALTH is expected to save taxpayers over \$2.2 billion dollars over the five-year waiver period. While changes to the existing Medicaid program are necessary for the fiscal sustainability of Medicaid expansion, Kentucky HEALTH's primary goal is to improve the health status of Kentuckians and provide members with the tools to develop or enhance their job skills and achieve economic security.

1.2 Program Summary

Kentucky HEALTH is an innovative, transformative healthcare program designed to not only stabilize the program financially, but to also improve the health outcomes and overall quality of life for all members. This demonstration waiver seeks to evaluate new policies and program elements designed to engage members in their healthcare and provide the necessary education and tools required to achieve long term health and an improved quality of life. Ultimately, Kentucky HEALTH seeks to: (1) improve the health of members; (2) engage members in the community and prepare them for employment; and (3) provide members the tools to successfully utilize commercial market health insurance and eventually transition off Medicaid.

¹⁶ Deloitte, Commonwealth of Kentucky: Medicaid Expansion Report (2014), available at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf

¹⁷ Deloitte, Commonwealth of Kentucky: Medicaid Expansion Report (2014), available at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf

¹⁸ Stephen P. Miller, Commissioner, Kentucky Department for Medicaid Services, Presentation to the Kentucky Senate Health & Welfare Committee (April 11, 2016).

¹⁹ Deloitte, Commonwealth of Kentucky: Medicaid Expansion Report (2014), available at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf

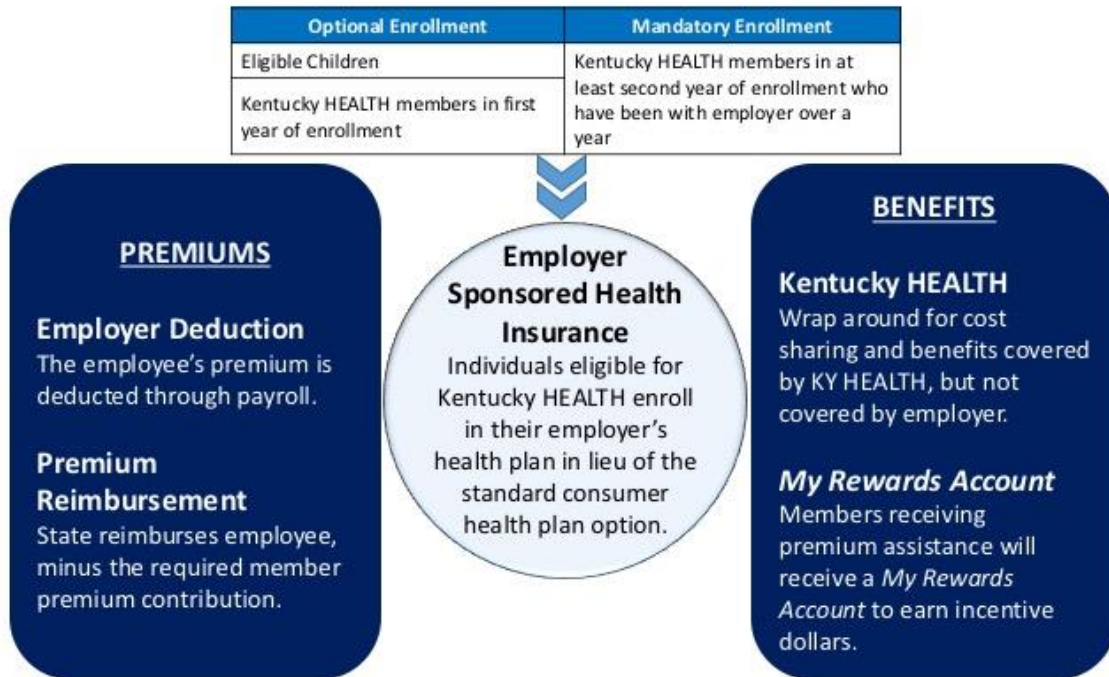
Kentucky HEALTH offers eligible individuals two pathways to coverage: (1) the employer premium assistance program, which offers premium assistance to assist individuals in purchasing employer-sponsored health insurance coverage; and (2) the consumer driven health plan, which offers members a high deductible health plan with commercial market benefits equivalent to the Kentucky State Employees' Health Plan while maintaining current mental health and substance use disorder benefits. In addition, the program includes two member managed accounts, one to fund the deductible, and another to fund enhanced healthcare benefits such as vision, dental, over the counter medications, and gym memberships.

1.2.1 Employer Premium Assistance Program Overview

As part of the overall waiver effort to support and promote employment, eligible members who currently have access to health insurance through their employer will have the option, and ultimately the obligation, to enroll their family into their employer-sponsored health insurance plan. Participation in the member's employer-sponsored health insurance plan in lieu of Kentucky HEALTH is optional during their first year of enrollment, and mandatory for members in their second year of enrollment, provided the member has been with their employer at least one year. In addition, to promote family coverage and keep parents in the same plan as their children, the State will subsidize family-based employer coverage, so that children eligible for the Kentucky Children's Health Insurance Plan (KCHIP) may participate in the same health plan as their parents.

The employer premium assistance program will subsidize the member's employer plan by paying the member an advance premium reimbursement payment to cover the costs of the employee's share of the premium. However, individuals eligible for the employer premium assistance program will be required to also contribute a share of their monthly premium amount equal to the monthly contribution amounts required of Kentucky HEALTH members, as detailed in *Section 4.2*.

Once enrolled, the member will have full access to their employer-sponsored health plan benefits and network providers. To ensure benefit parity, the employer premium assistance program will also wrap-around benefits to ensure that members have access to all Kentucky HEALTH benefits not otherwise reimbursed by their employer plan. Beneficiary out-of-pocket expenses will also be covered. Eligible employer plans must be cost-effective for the State, as further described in *Section 3.2*. The employer premium assistance program provides members with greater choice of coverage and helps prevent crowd-out of private plans, while also encouraging employment.



1.2.2 Kentucky HEALTH Overview

Kentucky HEALTH will continue to be delivered through a managed care delivery system, but will offer a new benefit package modeled after the Kentucky State Employees' Health Plan. However, current Medicaid benefits will be maintained for children, pregnant women, medically frail individuals, and any individuals eligible for Medicaid prior to the passage of the Affordable Care Act. Similar to the employer premium assistance program, Kentucky HEALTH promotes family health coverage by also enrolling the Medicaid eligible children of Kentucky HEALTH participating adults. Single family coverage not only streamlines eligibility processes for the family and the State, it also reduces network and provider fragmentation between adults and children, thus improving access to care. Although children will be included in this Section 1115 demonstration, all children participating in Kentucky HEALTH will maintain their current benefit packages and will be exempt from all Kentucky HEALTH cost-sharing and plan structure changes.

Eligible Populations. Kentucky HEALTH targets the Medicaid expansion populations, specifically adults with income up to 138% FPL. However, the State will also include children and all non-disabled adults currently covered under traditional Medicaid, including low-income parents and caretakers eligible under Section 1931, individuals eligible for transitional medical assistance, and pregnant women. Kentucky HEALTH will not include any of the following: former foster youth up to age 26, individuals eligible for 1915(c) waivers, individuals on Medicaid due to a disability, including those with an SSI determination, individuals over 65 years of age, and individuals residing in an institution, such as a nursing facility.

Beneficiary Responsibility. Kentucky HEALTH will be structured as a consumer-driven, high deductible health plan paired with two member controlled healthcare spending accounts, one to cover deductible expenses and the other to accrue savings that can be used to purchase enhanced benefits not covered in the base benefits. The plan will require that members pay a

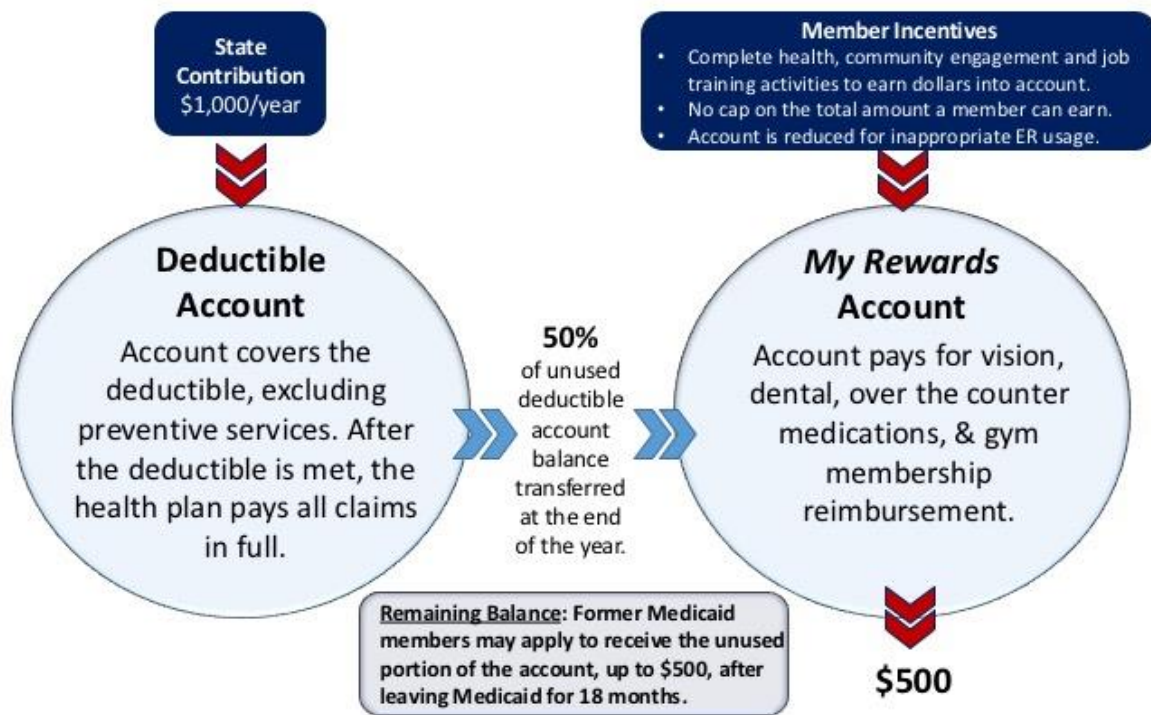
monthly premium amount in lieu of copayments, increasing on a sliding scale based on family income, ranging from \$1.00 per month up to a maximum of \$15.00 per month. The monthly premium will be applied on a family basis, and will not be separately charged to each Kentucky HEALTH member in the household. Please refer to *Section 4.2* for additional information regarding member cost-sharing.

Deductible Account. Each member enrolled in Kentucky HEALTH, with the exception of pregnant women and children, will be provided a deductible account, which will be used to fund the health plan's \$1,000 deductible. The State will fully fund the deductible account to ensure funds are available for the member to cover initial medical expenses for the deductible. The deductible account exposes members to the cost of healthcare and encourages members to be active consumers of healthcare by evaluating cost and quality as they seek care. Please refer to *Section 4.1.1* for additional detail regarding the deductible account.

Rewards Account. In addition to the deductible account, all Kentucky HEALTH members, with the exception of children, will be provided a *My Rewards Account*. Members may use the account to choose from an array of enhanced benefits not otherwise covered in the member's base benefit plan, such as dental benefits, vision services, over the counter medications, and limited reimbursement for the purchase of a gym membership. While these benefits are not required to be offered to beneficiaries under federal Medicaid law, these benefit enhancements will be available through the *My Rewards Account*.

Members will be able to accrue funds in the *My Rewards Account* upon completion of specified health-related or community engagement activities, such as participating in community service or job training activities. Members will be able to utilize these funds to personalize their benefits by selecting from certain enhanced benefit options, up to the accrued balance in their account. To encourage appropriate healthcare utilization, account funds may also be withdrawn from the *My Rewards Account* each time a member utilizes a hospital emergency department for a non-emergency medical condition or excessively misses healthcare appointments without appropriate cancellation. In addition, the account will be utilized to further encourage employment, as members who become employed and successfully transition to commercial health insurance coverage for at least eighteen months will be eligible to receive the balance of their *My Rewards Account* in cash, up to \$500. Please refer to *Section 4.1.2* for additional detail regarding the *My Rewards Account*.

Together, the deductible account and the *My Rewards Account* empower individuals to be active consumers of healthcare and make cost-conscious decisions, while simultaneously providing incentives for members to improve their health and be active members of the community.



Commercial Market Policies. One of the primary goals of Kentucky HEALTH is to educate and familiarize members with commercial market coverage, while creating safeguards to ease the transition to commercial health insurance coverage. This is particularly important given the high rate of movement between coverage options. One study estimated that approximately half of adults with income below 200% FPL will move between Medicaid eligibility and Marketplace coverage at least once a year, while 25% will move between the two programs more than once.²⁰ Policy alignment with commercial market policies is important to avoid beneficiary confusion as members move between programs. Without similar policies, members are unprepared to move to Marketplace or employer-sponsored coverage, and the drastically differing policies have the potential to create a perverse incentive for individuals to remain on Medicaid. Kentucky HEALTH is designed to help educate members about commercial market policies so that members are prepared to eventually transition to commercial health insurance coverage.

Kentucky HEALTH seeks to prepare individuals for commercial health insurance coverage by aligning Medicaid and Marketplace policies in several areas. For example, similar to the standard commercial market policies, Kentucky HEALTH will require monthly member premiums, and benefits will start prospectively from the initial premium payment. Kentucky HEALTH also creates disincentives for program non-compliance, similar to the private market. For example, Kentucky HEALTH will establish a client-specific open enrollment period. Specifically, if an individual is disenrolled from the program in accordance with current practice for failing to comply with annual eligibility redetermination requirements, the individual will be required to

²⁰ B. D. Sommers & S. Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFFAIRS 228 (2011).

wait six months for a new open enrollment period. This policy will educate members of the importance of meeting commercial market open enrollment deadlines, while also allowing members to rejoin the program at any time prior to the six-month date by completing a financial or health literacy course. Each Kentucky HEALTH program disincentive is paired with a critical “on-ramp” to help support individuals to get back on the right path and successfully utilize the Kentucky HEALTH program and access all of its benefits, resources, and tools.

Community Engagement and Employment. The cornerstone of the Kentucky HEALTH program is the introduction of a community engagement and employment initiative aimed at increasing workforce participation rates in Kentucky, which is critical to improving the health status of Kentuckians. The recent study by the Centers for Disease Control identified counties at risk of an HIV epidemic, in part based on county unemployment rates and other factors. Recognizing this important connection between employment and healthy lifestyles, CMS has long supported Medicaid employment initiatives. In fact, Section 1901 of the Social Security Act requires “for the purpose of enabling each State, as far as practicable under the conditions in such State to furnish (1) medical assistance on behalf of . . . individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . . .”²¹ In addition, CMS states on its website that “employment is a fundamental part of life for people with and without disabilities.”²² Meaningful work and participating as a contributing member of society is recognized as part of a healthy lifestyle and “essential to individual’s economic self-sufficiency, self-esteem and well-being.”²³ CMS’s statements support scores of extensive research that has long supported a strong link between community engagement and health.²⁴ In addition to its health benefits, research also indicates that community engagement and volunteerism improves an individual’s employability. One study found that volunteering increased the chances of employment by 51% among individuals without a high school diploma, and by 55% among individuals living in rural areas.²⁵

Therefore, to assist with employment, Kentucky HEALTH will require that all able-bodied working age adult members without dependents participate in the community engagement and employment initiative to maintain enrollment.²⁶ Engagement activities include volunteer work,

²¹ Social Security Act §1901, 42 U.S.C. §1396-1 (2015).

²² Medicaid Employment Initiatives, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 7, 2016).

²³ Medicaid Employment Initiatives, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 7, 2016).

²⁴ Hergenrather K, Zeglin R, McGuire-Kuletz M, and Rhodes S. Employment as a Social Determinant of Health: A Systematic Review of Longitudinal Studies Exploring the Relationship Between Employment Status and Physical Health. *Rehabilitation Research, Policy, and Education*. 2015;29(25):2-26.

²⁵ C. SPERA ET AL., CORPORATION FOR NATIONAL AND COMMUNITY SERVICE, OFFICE OF RESEARCH AND EVALUATION, VOLUNTEERING AS A PATHWAY TO EMPLOYMENT: DOES VOLUNTEERING INCREASE ODDS OF FINDING A JOB FOR THE OUT OF WORK? (2013), *available at* http://www.nationalservice.gov/sites/default/files/upload/employment_research_report.pdf.

²⁶ For purposes of clarification, adults with dependents will only be exempt from the community engagement and employment initiative if the individual has primary caretaking responsibilities for a dependent, including a minor child or a disabled adult dependent.

employment, caretaking, job training, or job search activities. Through a design that gradually increases the requirement for community engagement, individuals increase their connections to potential employment resources and opportunities available in their communities, as well as increase their own self-confidence. While completion of community engagement and/or employment activities is a program expectation for non-disabled working age adult members without dependents, Kentucky HEALTH also offers corresponding incentives to further encourage members to seek employment and successfully transition to commercial health insurance coverage. Children, pregnant women, individuals determined medically frail, and adults who are the primary caregiver of a dependent, including a minor child or a disabled adult dependent, are exempt from the community engagement and employment initiative.

Ultimately, these efforts to improve Kentucky employment rates are critical to addressing the drug abuse epidemic, reducing overall poverty, and sustaining the Medicaid program, as without more robust workforce participation, the State will be unable to continue to financially sustain a Medicaid program that is quickly including nearly one third of the entire State population. Please refer to *Section 2.2* for additional detail regarding Kentucky HEALTH's community engagement and employment initiative.

Substance Use Disorder. This waiver application also seeks delivery system improvements aimed at addressing the drug abuse epidemic facing the State. Kentucky HEALTH will maintain all current mental health and substance use disorder (SUD) benefits. However, this demonstration project will greatly expand access to these robust services available to members by requesting a waiver of the federal exclusion of institutions of mental disease (IMD) providers. Please refer to *Section 5.1.1* for additional detail regarding Kentucky HEALTH's SUD initiative.

Chronic Disease Management. Kentucky faces a series of public health challenges. Not only does the State have exceedingly high infant mortality, obesity, diabetes, heart disease, and smoking rates, as a likely result, it ranks highest in the nation with respect to cancer deaths and preventable hospital conditions.²⁷ While these health indicators are demonstrative of residents' overall health status, they also lead to higher utilization of healthcare services and increased healthcare expenditures, particularly among the State's most vulnerable populations. As such, this demonstration project will align various program components in support of the State's existing public health infrastructure and current efforts to improve chronic disease prevention and management. In addition, the State will work with Kentucky's Medicaid managed care organizations to implement best practices from nationally recognized disease management programs, such as the National Diabetes Prevention Program. Please refer to *Section 5.1.2* for additional information regarding the chronic disease management initiative.

Managed Care Reform. The creation of Kentucky HEALTH is just one piece of a larger transformation aimed at strengthening the existing Medicaid program in the State. The State

²⁷ *Smoking: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/KY/Smoking/59> (last visited June 6, 2016); *Adult Obesity in the United States*, TRUST FOR AMERICA'S HEALTH AND THE ROBERT WOOD JOHNSON FOUNDATION, <http://stateofobesity.org/adult-obesity/> (last visited June 6, 2016); *Infant Mortality: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/KY/IMR> (last visited June 6, 2016); AMERICA'S HEALTH RANKINGS, ANNUAL REPORT: KENTUCKY (2015), available at <http://cdnfiles.americashealthrankings.org/SiteFiles/StateProfiles/Kentucky-Health-Profile-2015.pdf>.

has already taken a critical look at its managed care contract rates, as Kentucky MCOs have the highest profit margin of any state Medicaid program in the nation.²⁸ Prior to implementing Kentucky HEALTH, the State will continue to align incentives across the delivery system by introducing mechanisms to control spending, as well as payment incentives for providers and MCOs to improve quality and align with member incentives. In addition, the Department for Medicaid Services will continue to seek improvements and administrative efficiencies in the existing Medicaid managed care program, such as uniform credentialing and formulary alignment. Please refer to *Section 5.1.3* for additional detail regarding managed care reforms.

1.3 Purpose and Goals

Kentucky HEALTH seeks to comprehensively transform Medicaid and accomplish the following goals:

1. Improve members' health and help them be responsible for their health;
2. Encourage individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance;
3. Empower people to seek employment and transition to commercial health insurance coverage;
4. Implement delivery system reforms to improve quality and outcomes; and
5. Ensure long-term fiscal sustainability.

1.4 Hypothesis

The State will extensively test and evaluate achievement of the above listed program goals throughout the demonstration approval period. Please see **Attachment I** for the State's proposed hypothesis and preliminary evaluation plan.

1.5 Demonstration Area and Timeframe

The State seeks a five-year waiver approval period. Kentucky HEALTH will operate statewide, however, some program components will be phased in. For example, changes to coverage of vision and dental services will be delayed for three months past the initial program implementation date to allow members a chance to accrue funds in their *My Rewards Account*. In addition, the community engagement and employment initiative may be phased in by county. Please refer to *Section 6* for additional detail regarding program implementation.

1.6 Impact to Medicaid and CHIP

The demonstration is part of the State's overall effort to comprehensively transform Kentucky's Medicaid program. While most of the reforms introduced in this waiver target the expansion population, several new program elements (as detailed in this waiver application) will be introduced to the non-disabled traditional Medicaid population as well. Collectively, the Kentucky HEALTH reforms aim to transform Medicaid from a program that passively provides healthcare coverage to one that educates and empowers members to actively engage in their health.

In addition to eligibility, benefits, cost-sharing and delivery system reforms, each of which is described more fully below, the demonstration will modify Medicaid and CHIP programs to allow families the

²⁸ The average underwriting ratio (profit margin) for Kentucky's five Medicaid MCOs was reported at 11.3%, significantly above the national average of 2.6% (3.3% for expansion states). JEREMY D. PALMER & CHRISTOPHER T. PETTIT, MILLIMAN, MEDICAID RISK-BASED MANAGED CARE: ANALYSIS OF FINANCIAL RESULTS FOR 2015 (2016), available at <http://www.milliman.com/uploadedFiles/insight/2016/medicaid-risk-based-managed-care-analysis-2015.pdf>.

opportunity to enroll in a family plan. This promotes integrated family healthcare by enrolling adults and their KCHIP eligible children in Kentucky HEALTH or, if applicable, the parent’s employer-sponsored health insurance plan through the employer premium assistance program. By providing family coverage, Medicaid eligible families will be able to seek care within the same provider network and with the same health plan, thus reducing administrative burdens and promoting better care integration for all family members.

Section 2: Eligibility

Kentucky HEALTH is designed specifically for able-bodied, working age adults and their families. Currently, the State has expanded Medicaid to cover this new adult group up to 138% FPL. This expansion will be maintained only under this demonstration waiver. In addition, the State will seek to transition all other non-disabled adult Medicaid recipients to the Kentucky HEALTH program, including low-income parents and caretakers eligible under Section 1931, individuals eligible for transitional medical assistance, and pregnant women. Finally, Kentucky HEALTH will seek to provide seamless coverage for entire families through the inclusion of children covered under the KCHIP program.

Only individuals eligible for Medicaid on the basis of an eligibility group listed in *Table 2.1(A)* are subject to the provisions of this waiver. Individuals eligible for 1915(c) waivers, such as Acquired Brain Injury (ABI), Home and Community Based (HCB), Michelle P. (MPW), or the Supports for Community Living (SCL), are excluded from this waiver. In addition, the waiver will also exclude (1) individuals eligible for Medicaid on the basis of blindness or disability, including individuals eligible for Social Security Income (SSI); (2) individuals over 65 years of age; and (3) individuals residing in an institution, such as a nursing facility. Also, Kentucky HEALTH will not impact coverage for former foster children up to age 26, who are also excluded from this waiver.

2.1 Populations Eligible for Kentucky HEALTH

Table 2.1(A): Kentucky HEALTH Eligibility Chart

Eligibility Group Name	Social Security Act and CFR Citations	Income Level	
Adult group	1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	0-138% FPL with a 5% income disregard	
Parents and other caretaker relatives	1902(a)(10)(A)(i)(I) 1931(b) and (d) 42 CFR 435.110	Household Size	Standard
		1	\$235
		2	\$291
		3	\$338
		4	\$419
		5	\$492
		6	\$556
7	\$621		
Transitional medical assistance	408(a)(11)(A) 1931(c)(2) 1925 1902(a)(52)	First 6 months: N/A Additional 6 months: 0-185% FPL	
Pregnant women	42 CFR 435.116	0-195% FPL	
Newborn Children	1902(e)(4) 42 CFR 435.117	N/A – deemed status for newborns whose mother is	

		enrolled in Medicaid on date of birth
Infants and Children Under Age 19	1902(a)(10)(A)(i)(III), (IV), (VI), (VII) 1931(b) and (d) 42 CFR 435.118	Ages 0-1: 0-195% FPL Ages 1-18: 0-159% FPL
Title XXI Separate CHIP Program	Title XXI 42 CFR 457.310	Ages 0-1: >195% - ≤213% FPL Ages 1-18: >159% - ≤213% FPL

Table 2.1(B): Medicaid Populations Not Included In Kentucky HEALTH

1. Individuals qualifying for Medicaid on the basis of blindness.
2. Individuals qualifying for Medicaid on the basis of disability, including, but not limited to: <ul style="list-style-type: none"> a. 1915 (c) waiver recipients; b. Individuals determined eligible for Supplemental Security Income (SSI) on the basis of a disability; c. Medicaid buy-in program for working disabled adults.
3. Individuals qualifying for Medicaid on the basis of age.
4. Institutionalized individuals assessed a patient contribution towards the cost of care.
5. Individuals receiving Medicare.
6. Former foster care children up to age 26.

2.2 Community Engagement and Employment Initiative

Promotion of work through coverage of certain employment supports and vocational rehabilitation for people with disabilities has been a longstanding policy within CMS.²⁹ Kentucky seeks to replicate those priorities for able bodied individuals in the program through the community engagement and employment initiative. As noted earlier, on its website, CMS recognizes that “employment is a fundamental part of life for people with and without disabilities. Employment provides a sense of purpose, how we contribute to our community and are associated with positive physical and mental health benefits.”³⁰ To this end, CMS policy allows states to provide *supported employment benefits* through Home and Community Based Services.³¹ Ultimately, connecting Medicaid recipients to services to help such “families and individuals attain or retain capability for independence or self-care” is one of the fundamental purposes of the Medicaid program, as set forth in the Social Security Act.³²

In addition to health benefits, increasing engagement and employment may reduce poverty. The United States Census Bureau determined that among adults aged 18-64 living in poverty, more than half

²⁹ *Medicaid Employment Initiatives*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 13, 2016).

³⁰ *Medicaid Employment Initiatives*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 13, 2016).

³¹ 42 C.F.R. 440.180(c)(2)(iii) (2015); *Medicaid Employment Initiatives*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 13, 2016).

³² Social Security Act §1901, 42 U.S.C. §1396-1 (2015).

(approximately 61.7%) did not work at least one week in 2014.³³ Government assistance programs can only lessen the burdens of poverty—beneficiaries may only truly escape the bonds of generational poverty and improve their quality of life through obtaining stable employment, as recently demonstrated in Maine following its reinstated work requirement for able-bodied SNAP beneficiaries. The initial evaluation tracked compliant members, non-compliant members that were removed from the program, and members leaving the program due to increased income. The report concluded that implementation of the work requirement rule led to a significant increase in total wages the following year among all three groups, including the non-compliant group.³⁴

In addition to reducing poverty, an initiative to increase employment is imperative to address the drug abuse epidemic facing the State. This complex health crisis requires a multi-faceted solution that not only treats the health related consequences, but also addresses some of the underlying social root causes of the epidemic, including low employment. Kentucky HEALTH seeks to connect beneficiaries with critical vocational skills, job training, education and support to encourage self-sufficiency.

To this end, Kentucky HEALTH will offer several incentives and resources to support members in becoming actively engaged in their communities, with the ultimate goal of empowering individuals and providing them with the necessary tools to seek and obtain employment and transition to commercial insurance coverage. Kentucky HEALTH’s community engagement and employment initiative will incentivize members to steadily increase their community involvement and eventually develop the tools and skills to seek and obtain lasting employment. The Kentucky Cabinet for Health and Family Services will collaborate with the Cabinet for Education and Workforce Development to implement a graduated system to ease new members into the community engagement participation requirement so that, after the first year, all able-bodied working age adult Kentucky HEALTH members will be performing at least twenty hours of community engagement or employment activities each week. Notwithstanding the foregoing, children, pregnant women, individuals determined medically frail, and adults who are the primary caregiver of a dependent (including a minor child or a disabled adult dependent) are exempt from the community engagement and employment requirement. To clarify, caregivers for individuals other than a dependent will not be exempt. However, those individuals providing caregiving services for a non-dependent relative or other person with a chronic, disabling health condition will be permitted to count those caregiving hours towards fulfilling the hour requirements of this section.

Table 2.2: Escalated Community Engagement & Employment Hours

Eligibility Period	Required Engagement Hours
1-3 months	0 hours per week
4-6 months	5 hours per week
6-9 months	10 hours per week
9-12 months	15 hours per week
12+ months	20 hours per week

³³ CARMEN DENAVAS-WALT & BERNADETTE D. PROCTOR, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, PUB. NO. P60-252, INCOME AND POVERTY IN THE UNITED STATES: 2014 (2015), *available at* <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf>.

³⁴ Letter from Paul Leparulo, Deputy Director, Main Office of Policy and Management, to Mary Mayhew, Commissioner Main Department of Health and Human Services (April 19, 2016), *available at* http://www.maine.gov/economist/econdemo/ABAWD%20analysis_final.pdf.

Beginning after three months of program eligibility, participation in the community engagement and employment initiative will be a condition of eligibility for all able-bodied working age adult Kentucky HEALTH members without dependents (including minor children or disabled adult dependents). Failure to meet required engagement hours will result in a suspension of benefits until the member satisfies the requirement for a full month. Kentucky HEALTH members who are full-time students or employed and working at least 20 hours per week satisfy the requirements of this initiative and would not be impacted by this change.

Qualifying community engagement and employment hours include a variety of activities beyond standard employment and may include:

- Job skills training;
- Job search activities;
- Education related to employment;
- General education (i.e. GED, community college);
- Vocational education/ training;
- Subsidized or unsubsidized employment;
- Community work experience;
- Community service/ public service; and
- Caregiving services for a non-dependent relative or other person with a chronic, disabling health condition.

The requirements of the community engagement and employment initiative are not limited to volunteer and employment related activities, but can also be met through investing in one's education and job training. It is well understood that increased education is directly associated with higher wages. In Kentucky, there is a 33% difference in median annual earnings between individuals with and without high school diplomas.³⁵ To encourage Kentucky HEALTH members to improve their educational attainment, participation in the free General Educational Development (GED) certification exam prep classes available in every county will count as a credit towards the community engagement and employment initiative requirements. In addition, to respond to the recent 76% decrease in Kentucky GED participation rates in the last year, this waiver will also seek to cover the out-of-pocket costs associated with taking the GED exam, as described in more detail in *Section 3.1.4*.³⁶

By encouraging impoverished individuals to engage more fully in their education, training, and communities through completion of even five hours of community engagement and employment each week, Kentucky HEALTH seeks to increase the employment rate and reduce the poverty level of individuals participating in the program. However, to ensure appropriate resources are available and to monitor the impact of this new requirement, the State may implement a regional or county based rolling implementation of the community engagement and employment initiative.

³⁵ KENTUCKY CENTER FOR ECONOMIC POLICY, FACING CHALLENGES WITH THE NEW GED TEST IN KENTUCKY (2015), available at <http://kypolicy.org/dash/wp-content/uploads/2015/12/2015-KY-GED-Report3.pdf>.

³⁶ *Id.*

2.3 Projected Enrollment

Projected enrollment in Kentucky HEALTH is based on calendar year 2015 member enrollment data of the eligibility groups that will transition to the waiver. The projections for the future demonstration years consider the impact of the new program features contained within this waiver. Further, Kentucky HEALTH does not propose to apply any enrollment limits on the number of individuals that may enroll in the program.

Table 2.3: Kentucky HEALTH Projected Enrollment by Eligibility Group

Eligibility Group	Project Enrollment by Demonstration Year (DY)				
	DY 1	DY 2	DY3	DY4	DY 5
Children	532,250	549,917	568,187	587,000	606,500
Non-Expansion Adults	133,333	130,417	127,583	124,833	122,083
Expansion Group	489,000	477,583	466,333	455,417	444,750

Note: Values shown have been rounded and represent average monthly enrollment.

2.4 Other Eligibility Policies

One of the primary goals of the Kentucky HEALTH program is to encourage individuals to become active consumers of healthcare who are prepared to use commercial health insurance. As such, Kentucky HEALTH will implement key commercial market and Marketplace policies in order to introduce these critical concepts to Kentucky HEALTH members. Notwithstanding the foregoing, children, pregnant women, and individuals determined medically frail will be excluded from many of these commercial market reforms.

2.4.1. Coverage Effective Date & Retroactive Coverage

Similar to the commercial market, members (excluding children and pregnant women) will be required to make their first month's required premium payment prior to the start of benefits. Individuals will have sixty days from the date of their eligibility determination to pay the premium payment. Once an individual pays the premium, benefits will begin the first day of the month in which the payment was received. In order to provide individuals with the opportunity to begin coverage as expeditiously as possible, the State will develop a process by which applicants (not yet determined eligible for Kentucky HEALTH) will be permitted to make an initial premium pre-payment in order to expedite coverage. Once determined eligible, benefits would begin effective the first day of the month in which the pre-payment was made, which could be as early as the first day of the month in which the application was submitted.

Despite the pre-payment option, all initial premium contributions must be made within sixty calendar days from the date of the initial invoice. Individuals who do not pay the initial premium payment within the sixty-day payment period will be subject to the penalties detailed in *Section 4.2.1*. Accordingly, individuals with income above 100% FPL will not be enrolled in the program and will be required to reapply should they wish to participate in the program. Whereas, individuals at or below 100% FPL who fail to pay the initial premium will be enrolled effective the first day of the month in which the sixty-day payment period expired. However, once enrolled, these individuals will be required to pay Medicaid allowable copayments for all

services in the first six months of enrollment and will not have access to a *My Rewards Account*, the enhanced benefits available through the account, or the potential \$500 reward available to members after leaving Medicaid.

In addition, the State will not provide retroactive coverage and benefits to newly enrolled individuals, except for pregnant women and children. Instead, consistent with the commercial market and federal Marketplace policies, coverage and benefits will only begin after the member's initial premium payment is made. Eliminating Medicaid retroactivity encourages individuals to obtain and maintain health insurance coverage, even when the individual is healthy. In addition, due to Medicaid expansion and the availability of tax credits, affordable healthcare coverage options have been available for two years to Kentuckians who have complied with the individual mandate, eliminating the need for retroactive coverage. However, to provide the opportunity for expedited enrollment for individuals in a time of need, the State will minimize the potential impact of this policy revision through the expansion of presumptive eligibility sites to include county health departments and qualifying safety net providers, such as community mental health centers, federally qualified health centers, and rural health centers.

2.4.2 Open Enrollment

Consistent with private market health plans, Kentucky HEALTH will implement a modified member-specific annual open enrollment period (with exceptions for certain vulnerable populations, including pregnant women and children) to help familiarize Kentucky HEALTH members with this commercial market policy. All Kentucky HEALTH members will be required to complete the annual redetermination process within a specific timeframe to avoid coverage gaps. The open enrollment period will vary for each member depending on when they enrolled in the program, and will begin approximately three months prior to the expiration of their twelve-month benefit period. Individuals that do not complete the re-enrollment process prior to the expiration of their twelve-month benefit period will be disenrolled from the program.

Following disenrollment, individuals will have an additional three-month period in which to submit their redetermination paperwork to be reenrolled in Kentucky HEALTH. However, after the expiration of the six-month redetermination period (including three months prior to coverage expiration and three months following), individuals will be required to wait six months until their next open enrollment period before being permitted to re-enroll in the program. This open enrollment policy will not apply to pregnant women, children, and individuals determined medically frail. In addition, the State will create certain exceptions for individuals who experienced a change in circumstances preventing completion of redetermination, such as gaining and subsequently losing commercial health insurance coverage or moving out of state and having returned.

Compared to Kentucky HEALTH's six-month period, individuals on the Marketplace who miss the open enrollment period are generally required to wait up to nine months prior to re-enrolling in coverage, with limited exceptions. By comparison, all Kentucky HEALTH eligible individuals will be provided the opportunity for early re-entry at any time prior to their next open enrollment period by completing a financial or health literacy course. Once the course is completed, the member may re-enroll in Kentucky HEALTH at any time and pay their first month's premium contribution to begin coverage.

3 Kentucky HEALTH Benefits

Kentucky HEALTH seeks to provide its members with a commercial health insurance experience in order to better prepare members to transition to commercial health insurance coverage. Consistent with this goal, Kentucky HEALTH will provide a benefit package consistent with the commercial market for the expansion population. The Kentucky HEALTH benefit plan for the expansion population will be equivalent to the Kentucky State Employees’ Health Plan, which provides a comprehensive commercial insurance benefit package. All current mental health and SUD services will be preserved. Additional benefits such as dental services, vision services, and over the counter medications will be provided via the member’s *My Rewards Account*. Further, consistent with the goal of offering a commercial market experience, the State will not provide coverage for non-emergency medical transportation (NEMT) to the newly eligible adult group, and will seek a waiver of this non-commercial benefit.

Children, pregnant women, medically frail individuals, and any individuals eligible for Medicaid prior to the passage of the Affordable Care Act will be eligible to receive Medicaid State Plan benefits. There will be no changes to the current State Plan benefits. The eligibility groups listed in *Table 3.1* below receiving State Plan benefits will continue to receive non-emergency transportation, as well as access to covered vision and dental services, in accordance with the State Plan rather than through the *My Rewards Account*. In addition, all children receiving services through the waiver will continue to receive all early and periodic screening, diagnostic, and treatment (EPSDT) services.

3.1 Kentucky HEALTH Benefit Package

Table 3.1: Benefit Package Chart

Eligibility Group	Benefit Package
Adult Group	Kentucky HEALTH Alternative Benefit Plan
Section 1931	Kentucky State Plan
TMA	
Pregnant Women	
Newborn Children	
Children under 19	
CHIP	

3.1.1 Section 1937 Alternative Benefit Plan

The alternative benefit plan (ABP) coverage provided to the new adult group will be based on the current State Employees’ Health Plan, which is a consumer-driven health plan administered by Anthem Blue Cross and Blue Shield of Kentucky, Inc. In accordance with this waiver request, the State will modify and update its ABP to benchmark benefits to the Kentucky State Employees’ Plan for the expansion population.

3.1.2 Benefit Detail

Kentucky HEALTH benefits for the expansion population will be aligned with the commercial market State Employees’ Health Plan. All current mental health and SUD services will be maintained for all populations. A high level summary of the covered benefits in each of the ten essential health benefit categories is provided below, and includes benefits that may differ from the Kentucky Medicaid State Plan in amount, duration, or scope.

The chart below details only the benefits for the new adult group. Benefits will remain consistent with the existing State Plan for all children, pregnant women, medically frail, and other traditional low-income (non-expansion) Medicaid populations transitioning to Kentucky HEALTH. Additional details regarding the ABP benefits will be included in the State’s ABP Medicaid State Plan amendments.

Table 3.1.2(A): Benefits Provided*

Benefit	Description of Amount, Duration and Scope	Reference
Outpatient Services (Ambulatory Patient Services)		
Physician Services	Coverage for office visits and physician services, specialists may require prior authorization.	Mandatory 1905(a)(5)
Outpatient Hospital Services	Coverage for outpatient hospital and clinic services. Prior authorization is required for some services.	Mandatory 1905(a)(2)
Rural Health Clinic Services	Same limitations when provided by the rural health clinic as when provided by the usual ambulatory care provider.	Mandatory 1905(a)(2)
Home Health Care	Limited to 60 visits per year. Prior authorization requirements may apply.	Mandatory for certain individuals - 1905(a)(7)
Telehealth	Complies with Kentucky benefit mandate to not exclude a service from coverage solely because the service is provided through telehealth.	Kentucky Benefit Mandate
Chiropractic	Limited to 1 visit per day and 26 visits per covered person per benefit year.	Optional 1905(a)(6)
Podiatry	Covered but limited to medically necessary care i.e. diabetes care.	Optional 1905(a)(6)
Emergency Services		
Emergency Transportation	Transportation to an emergency department for medical emergencies.	Optional 1905(a)(29), 42 CFR 440.170(e)
Emergency Services	Covers emergency physicians and facilities.	Optional 1905(a)(29), 42 CFR 440.170(e)
Hospitalization		
Inpatient Hospital Services	Covered.	Mandatory 1905(a)(1)
Inpatient Physician Services	Covered.	Mandatory 1905(a)(5)
Maternity and newborn care		
Prenatal and postpartum care	Covered.	Mandatory 1905(a)(5)
Delivery and inpatient maternity services	Covered.	Mandatory 1905(a)(1)
Nurse-midwife services	Covered.	Mandatory 1905(a)(17)
Expanded Services for Pregnant Women –	Services for pregnant women are covered at the level of the Kentucky State Plan.	Optional 1902(e)(5)

Benefit	Description of Amount, Duration and Scope	Reference
Additional pregnancy-related and postpartum services for a 60-day period after the pregnancy ends		
Mental health services and addiction treatment		
Inpatient mental health and addiction treatment	Includes behavioral health services.	Mandatory 1905(a)(1)
Outpatient mental health and addiction treatment	Includes behavioral health services.	Mandatory 1905(a)(2), Mandatory 1905(a)(5)
Prescription drugs		
Prescribed Drugs	Covered.	Optional 1905(a)(12)
Rehabilitative and habilitative services and devices		
Physical Therapy	30 visits per calendar year limit.	Optional 1905(a)(11)
Occupational Therapy	30 visits per calendar year limit.	Optional 1905(a)(11)
Services for individuals with speech, hearing and language disorders	30 visits per calendar year limit.	Optional 1905(a)(11)
Cardiac Rehabilitation	30 visits per calendar year limit.	Optional 1905(a)(11)
Skilled Nursing Facility	Limited to 30 days per benefit period.	Mandatory 1905(a)(4)
Laboratory services		
Laboratory and X-Ray Services	Some imaging services require a prior authorization.	Mandatory 1905(a)(3)
Preventive services		
Preventive Services	"A" and "B" services recommended by the United States Preventive Services Task Force, including recommended smoking cessation services; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children, and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).	Optional 1905(a)(13)
Weight Loss programs	Limited to telephonic and online health coaching.	Optional 1905(a)(13)

Benefit	Description of Amount, Duration and Scope	Reference
Pediatric services		
EPSDT	Limited to children under 21 years of age; Prior Authorization required for orthodontia. Provided in accordance with benefits documented in the State Plan.	Mandatory 1905(a)(4)

* Prior Authorization Requirements may apply to benefits in accordance with standard industry practice.

Table 3.1.2(B): Benefits Not Provided

Benefit	Description of Amount, Duration and Scope	Reference
Private Duty Nursing	Not Covered.	Optional 1905(a)(8)
Non-Emergency Medical Transportation	Not Covered. Waiver requested.	Optional 1905(a)(29)
Hearing Exams	Not covered except for coverage provided via EPSDT benefit for those under age 21.	Optional 1905(a)(13)
Hearing Aids	Not Covered except for coverage provided via EPSDT benefit for those under age 21.	Optional 1905(a)(29)

3.1.3 My Rewards Account Benefit

Kentucky HEALTH carves out vision and dental services for the new adult group; however, this benefit change will occur three months following the initial program implementation date of the program to allow members additional time to accrue funds in their *My Rewards Account*, as these benefits are only provided through this account. Additional optional benefits, including over the counter medications and gym membership, can also be accessed via this account. The *My Rewards Account* provides a benefit incentive program for individuals that meet health and community engagement goals as discussed in *Section 4.1.2*.

Table 3.1.3: My Rewards Account Vision and Dental Carve-out and Additional Benefits

Additional services available through My Rewards Account		
Vision Services	Benefits available as a carve-out for the adult group using their <i>My Rewards Account</i> . These services will be provided in accordance with the State Plan for all other Kentucky HEALTH populations.	Optional 1905(a)(6)
Dental Services		Optional 1905(a)(10)
Over the counter medications	Benefits available for adults eligible for the waiver through their <i>My Rewards Account</i> .	Optional 1905(a)(12)
Gym memberships		1115

3.1.4 Educational Support

Educational attainment is a predictive indicator of health and economic security. However, Kentucky ranks 46th in the nation for percentage of adults 25 or older with a high school diploma

or equivalency.³⁷ In addition, GED certification attainment rates in Kentucky have declined dramatically in recent years, by more than 76%.³⁸ Recognizing that costs may be a significant barrier to GED attainment, Kentucky HEALTH will seek to cover the costs of the member's out of pocket expenses associated with completion of the GED exam for any adult Kentucky HEALTH member without a high school diploma. This benefit will be available to the expansion adult group, as well as other adults on Kentucky HEALTH receiving State Plan benefits, as described in *Table 3.1* above.

3.2 Employer Premium Assistance Program

The State currently operates a small Health Insurance Premium Payment (HIPP) program providing premium assistance to eligible individuals with access to employer-sponsored insurance (ESI). The Kentucky HEALTH employer premium assistance program builds upon this existing program, which will be modified to include all Kentucky HEALTH eligible members through the introduction of family coverage, mandatory participation for members with ESI participating in Kentucky HEALTH longer than one year, and member cost-sharing requirements aligned with Kentucky HEALTH premium contributions.

Eligible employer plans must be cost-effective for the State. The State will ensure that the employer-sponsored plan is cost-effective in accordance with the current methodology for HIPP established in the State Plan. Specifically, a plan will be determined cost-effective when the cost of paying the premiums, coinsurance, deductibles and other cost-sharing obligations, as well as additional administrative costs is estimated to be less than the amount paid for the member's participation in the standard Kentucky HEALTH program. Once determined eligible, the employer premium assistance program will subsidize the member's cost-effective employer plan by paying the member an advance premium reimbursement payment to cover the costs of the employee's share of the premium before it is deducted from the employee's paycheck in accordance with the employer's standard practice. The State will implement a system to ensure members are maintaining coverage before monthly payments are made. Like all other Kentucky HEALTH members, individuals enrolled in their employer-sponsored health plan will be required to pay a sliding scale monthly premium payment based on family income consistent with the amounts established in *Section 4.2*. The advanced reimbursement payment from the State will deduct the individual's required premium contribution.

Once enrolled, the member will have full access to their employer-sponsored health plan benefits and network providers. The Kentucky HEALTH program will act as a secondary payer to the employer plan. Therefore, members will not be subject to additional cost-sharing beyond the flat rate monthly premium required by the State. In addition, the program will wrap-around benefits applicable to their eligibility group to ensure that members have access to all Kentucky HEALTH benefits (and, if applicable, KCHIP specific benefits) not otherwise reimbursed by their employer plan. In addition, the employer premium assistance program will cover all cost-sharing, including copayments and deductibles, required by the

³⁷ Approximately 83.5% of Kentuckians 25 years of age and older have completed high school or high school equivalency. U.S. CENSUS BUREAU, *Educational Attainment, 2010-2014 American Community Survey 5 Year Estimates*, available at:

http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_S1501&src=pt

³⁸ KENTUCKY CENTER FOR ECONOMIC POLICY, *FACING CHALLENGES WITH THE NEW GED TEST IN KENTUCKY* (2015), available at <http://kypolicy.org/dash/wp-content/uploads/2015/12/2015-KY-GED-Report3.pdf>.

employer plan, such that the member will not be exposed to any cost-sharing in excess of their required monthly premium contribution.

As an additional benefit, individuals enrolled in the employer premium assistance program will also be provided a *My Rewards Account*, as described in more detail in *Section 4.1.2*. Individuals in the employer premium assistance program will have the opportunity to earn incentive dollars for the completion of community engagement or health related activities. Members may use the account to purchase enhanced benefits not otherwise covered in the base Kentucky HEALTH benefit package, and therefore will not be wrapped around their employer plan. For example, members enrolled in the employer premium assistance program may use the account to purchase over the counter medication or a membership to a gym.

3.3 Populations Exempt from Alternative Benefits Plans

3.3.1 *Medically Frail*

Individuals in the expansion population who meet the definition of medically frail will be enrolled in Kentucky HEALTH. In accordance with 42 CFR §440.315(f), a person will be determined medically frail if the individual has a disabling mental disorder (including serious mental illness), chronic SUD, serious and complex medical condition, or a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living. For example, medically frail conditions may include, but are not limited to active cancer, aplastic anemia, blood clotting disorders, chronic alcohol or substance abuse, and mental illness, including major depression or bipolar disorder. In addition, individuals otherwise eligible for Kentucky HEALTH who are either receiving hospice care, diagnosed with HIV/AIDs, or eligible for Social Security Disability Insurance (SSDI) will automatically be determined medically frail upon verification of the qualifying condition, and will not be subject to the assessment process described below.

Generally, individuals will be identified as potentially medically frail in several ways: (i) member self-identification to the MCO; (ii) provider identification and referral to MCO; and (iii) MCO identification of high-risk individuals through a standardized state approved health risk assessment and available claims data. Once identified, individuals not otherwise qualifying under one of the automatic medically frail categories will be reviewed and assessed for medically frail. While the MCO will collect the necessary information to complete the assessment, the approval process will be based on objective criteria established by the State. This process will evaluate the severity of the member's health conditions and assign a risk score based on objective criteria, such as specific underwriting guidelines. Individuals with qualifying conditions and scores would be determined medically frail. While this medically frail assessment and determination process will rely primarily on available claims data, new members or newly diagnosed individuals without significant claims history of their health condition will also have the opportunity to submit additional information for consideration. Individuals will have the ability to appeal the medically frail determination in accordance with standard grievance and appeals processes.

Medically frail individuals will receive State plan benefits, which include non-emergency transportation. In addition, medically frail individuals will be exempt from copayments under the Kentucky HEALTH waiver, as detailed in *Section 4.2.1*.

3.3.2 Pregnant Women and Low-Income Families

The following populations covered by Kentucky HEALTH are exempt from the benchmark equivalent benefit package and will be provided the standard Medicaid State Plan benefits, including non-emergency transportation (NEMT) coverage:

- Pregnant women;
- Children under age 19; and
- Parents and caretaker relatives eligible pursuant to Section 1931.

In addition, all children enrolled in Kentucky HEALTH or the employer premium assistance program will continue to be provided full EPSDT benefits.

4 Cost-Sharing

The cost-sharing structure of Kentucky HEALTH differs from the existing State Plan, which currently imposes copayments for services. In lieu of these copayments, Kentucky HEALTH requires all members (except pregnant women, children, and medically frail) to contribute to the cost of their healthcare coverage through the payment of monthly premiums, as detailed in *Section 4.2*.³⁹ While Kentucky HEALTH encourages members to make upfront monthly premium contributions to prepare for commercial market coverage policies, individuals at or below 100% FPL may elect to not make their required premium payments and, instead, continue to be charged copayments for services. The overall Kentucky HEALTH cost-sharing structure is designed to introduce members to critical commercial market features, including making timely monthly premiums, tracking deductibles, and managing a healthcare account.

4.1 Member-Managed Healthcare Accounts

Kentucky HEALTH will be structured as a consumer-driven, high deductible health plan. Members will be provided two member managed healthcare spending accounts, one to cover deductible expenses and the other (the *My Rewards Account*) to accrue savings and earned incentive dollars to purchase optional enhanced benefits. The accounts will work together, creating incentives for members to obtain preventive care, participate in disease management programs, and prudently manage their spending from both accounts. In addition, member oversight and control of the accounts will provide beneficiaries the skills and training to help prepare them to eventually manage health savings accounts or flexible spending accounts available in the private market.

Pregnant women and children enrolled in Kentucky HEALTH will not be required to make monthly premium contributions, nor will their benefit plans include a deductible. Therefore, these covered populations will not be provided a deductible account. However, pregnant women are eligible to earn incentive dollars and utilize the *My Rewards Account*.

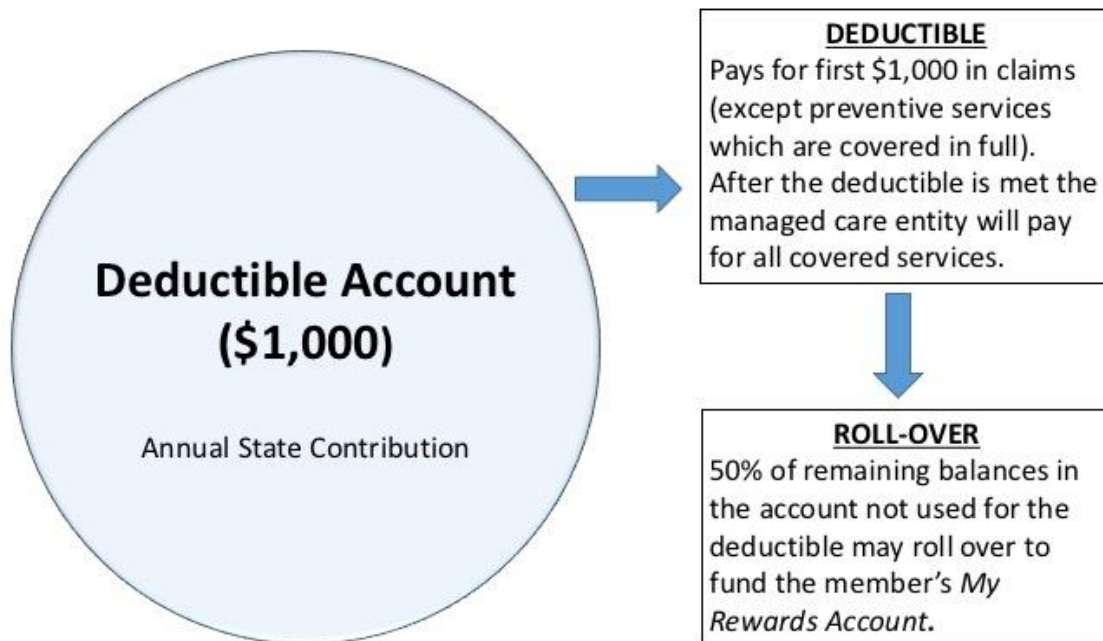
4.1.1 Deductible Account

Similar to most commercial health products and those offered in the Marketplace, Kentucky HEALTH will include a \$1,000 deductible that applies to all non-preventive healthcare services. However, each member will be provided a fully funded deductible account equal to \$1,000,

³⁹ Pregnant women and children are exempt from all cost-sharing requirements of the waiver. However, while medically frail members are not subject to cost-sharing as a condition of participation, monthly premiums will be required for medically frail members to obtain the benefits of the *My Rewards Account*.

which will be immediately available to cover the initial medical expenses for the deductible. Members will receive monthly account statements detailing the cost of each service utilized during the month and the overall account balance so the member may learn about the cost of healthcare services and begin to actively manage the account and their healthcare utilization.

To further encourage this effort, the deductible account will provide financial incentives to prudently manage the State funds in the account. At the end of the benefit period, members who have a balance remaining in their deductible account may transfer 50% of the total remaining balance to their *My Rewards Account* to purchase enhanced benefits. The deductible account exposes members to the cost of healthcare and encourages them to act as consumers of healthcare by evaluating cost and quality as they seek care.



4.1.2 My Rewards Account

All Kentucky HEALTH and employer premium assistance program members, with the exception of children, will be provided a *My Rewards Account*, which may be used to access benefits not covered in the base benefit plan. In addition to the balances carried over from the Kentucky HEALTH deductible account each year, the *My Rewards Account* will also contain incentive dollars that members may earn by completing specified activities. Qualifying activities are designed to improve member health (i.e. disease management class) or to increase community engagement (i.e. volunteer work, public service opportunities, or job search and training activities). In addition, adult Kentucky HEALTH members without a high school diploma will also be rewarded for improving their employability through obtaining a GED. To remove potential cost barriers for taking the exam, Kentucky HEALTH will cover the costs for the out-of-pocket expenses associated with completing the GED exam as a program benefit.

Some activities can be accomplished immediately upon enrollment to quickly bolster the *My Rewards Account*, such as completion of a new member health risk and/or an employment

assessment within the first quarter following plan enrollment. In addition, each reward activity type will be capped so a member must complete different activities in order to receive additional funds in the reward account. Also, for purposes of clarification, community engagement activities listed in the chart below will only qualify for reward activity dollars for hours completed in excess of the minimum requirements established for the community engagement and employment initiative, detailed in *Section 2.2*. For example, individuals who complete work search activities as part of their program eligibility requirements will not be eligible to receive credits to their *My Rewards Account* for the same work search activities. My Rewards Account credits will only be provided for community engagement activities in excess of the minimum amount required to maintain eligibility.

Incentive activities may include any of the activities detailed in the table below, which will be further refined prior to program implementation.⁴⁰ In addition to the general activities below, pregnant women will be able to obtain reward dollars for completion of activities important to promoting healthy babies, such as completion of prenatal care visits.

Table 4.1.2(A): My Rewards Account Earned Incentive Activities

Community Engagement Activities		Health Incentive Activities	
Activity	Earned \$*	Activity	Earned \$*
Register with Career Center and complete job needs assessment	\$150 (one-time only)	Complete health risk assessment with MCO	\$25 (1 st quarter, limit one per year)
Participate in qualifying community service activity (including caretaking services)**	\$10 per event (max \$50 per year)	Complete diabetes, cardiovascular, or other chronic disease management, or weight management course	\$50 per course
Complete job skills training or training with career coach	\$25 per course (max \$50 per year)	No inappropriate ER Visits Within 12 months	\$20 per year
Complete job search activities	\$10 per month	Sign non-smoking pledge & participate in smoking cessation activity	\$50 per course
Employment-related education or GED-prep classes	\$25 per course (max \$50 per year)	Sign drug-free pledge & participate in drug addiction counseling services	\$50 per activity
Passing the GED exam	\$50 (one-time only)	Complete well-child, preventive dental exam, or vision screening for dependent child.	\$10 per activity (max \$40 per year)

In addition to the community engagement and health incentives reward activities, the *My Rewards Account* will also incentivize appropriate healthcare utilization, including appropriate

⁴⁰ *Amounts and listed activities are for illustrative purposes only and may be adjusted.

** Qualifying caregiving services include those provided for a non-dependent relative or other person with a chronic, disabling health condition.

use of hospital emergency departments as well as keeping scheduled appointments for healthcare services.

Kentucky HEALTH encourages all members to seek care in the most appropriate setting possible, including avoiding the use of hospital emergency departments (one of the most costly settings) except in the case of a true emergency. In 2015, nearly 125,000 Medicaid managed care enrollees utilized a hospital emergency room for a non-urgent condition.⁴¹ Therefore, consistent with the plan structure, the Kentucky HEALTH emergency room utilization policy relies on complementing incentives and disincentives. To encourage appropriate emergency room utilization, members will be eligible for a \$20 financial contribution to their *My Rewards Account* for each year in which the member avoids unnecessary emergency room services and seeks appropriate alternative providers for care. In addition, Kentucky HEALTH will simultaneously discourage inappropriate emergency room utilization by deducting funds from the member's *My Rewards Account* for each inappropriate emergency room visit. The amount of the penalty will escalate in accordance with the table below for each subsequent unnecessary emergency room visit. The State will also ensure that hospitals comply with 42 CFR 447.54(d) in educating members about appropriate alternative settings.

Table 4.1.2(B): Escalated *My Reward Account* Penalty for Inappropriate ER Utilization

Inappropriate ER Visit	Account Deduction
1 st Visit	\$20
2 nd Visit	\$50
3 rd Visit or More	\$75

In addition, the State will consider developing a similar complementing incentive and disincentive feature related to excessive missed healthcare appointments, whereby members may earn reward dollars for keeping all scheduled appointments in the benefit period, or, in the alternative, lose dollars from the account for each healthcare appointment missed without adequate cancellation or good cause. The proposed *My Rewards Account* penalty amounts are not member copayments and do not utilize member out-of-pocket funds.

Members maintain the *My Rewards Account* as long as they are enrolled in the program and continue to make their required monthly premium contributions. Each year the full balance of the *My Rewards Account* will roll-over to the subsequent year to be used for the purchase of qualifying enhanced benefits. In addition, as an incentive and reward for members to obtain employment, the balance of the *My Rewards Account* will be transferable to reward members who are successful in finding a path to long-term stable employment and independence from public assistance. Specifically, former members who are able to maintain stable employment and remain commercially insured without Medicaid for at least eighteen months may apply to receive the balance remaining in their *My Rewards Account*, up to \$500.

⁴¹ Kentucky Department for Medicaid Services, CY 2015 Non-Emergent ER Visits (May 26, 2016) (on file with the State).

This reward opportunity not only provides an additional work incentive complementing Kentucky HEALTH community engagement and employment initiative requirements, it also provides members an incentive to accumulate earned incentives dollars in the account and to prudently manage those funds. Members that leave the program but transition back to Kentucky HEALTH prior to eighteen months will have their *My Rewards Account* reactivated at its ending balance and will be able to access the full balance of their account for the purchase of enhanced services.

Ultimately, the two member managed accounts coordinate incentives to drive member behavior in positive ways. The deductible account incentivizes the member to prudently manage the account by obtaining preventive care and seeking price transparency in order to maximize roll-over amounts. Similarly, the *My Rewards Account* encourages members to actively participate in healthy behaviors, such as participation in disease management courses. In addition, the member is incentivized to carefully manage the *My Rewards Account* to maximize the potential cash-out reward. Fundamentally, through these many layered incentives, Kentucky HEALTH empowers members to become active members in their healthcare.

4.2 Member Required Contributions

As a condition of eligibility, all Kentucky HEALTH members, with the exception of medically frail individuals, pregnant women, and children, will be required to make sliding scale flat rate monthly premium payments based on family income. The payment rates are affordable and established to be less than 2% of household income across each income threshold payment band. As these amounts are established based on household income, the premium payment applies towards all Kentucky HEALTH members in the household, such that premiums will not be collected on a per person basis. As long as the required monthly premiums are paid, Kentucky HEALTH will not require additional cost-sharing for services. Except for medically frail members who are exempt, copayments for healthcare services will only be charged for Kentucky HEALTH enrolled adults with income below 100% FPL who fail to pay their required premiums.

Table 4.2(A): Kentucky HEALTH Sliding Scale Premium Contribution Amounts

Federal Poverty Level	Premium Payment
Under 25% FPL	\$1.00 per month
25-50% FPL	\$4.00 per month
51-100% FPL	\$8.00 per month
101-138% FPL	\$15.00 per month

Consistent with the goal of encouraging community engagement, the State will permit third parties to pay required premium payments on behalf of a member. Non-profit organizations, provider groups, and other third parties may assist members in their monthly premium responsibilities. However, these premium payments are critical to member engagement, as studies have shown that making regular monthly premiums may actually lead to better health outcomes for members. In Indiana, where Medicaid eligible adults are required to pay monthly premiums equal to 2% of income, members making

contributions had higher satisfaction rates, higher primary and preventative care utilization, higher drug adherence, and lower emergency room use than those who did not.⁴²

In addition, Kentucky HEALTH is intended to be a temporary stepping stone for able-bodied low-income adults. It seeks to encourage employment and assist individuals as they move from dependence on public assistance to independence. To avoid “coverage cliffs” and help prepare members to transition to Marketplace coverage, individuals with income greater than 100% FPL will be subject to gradually increasing premium contributions beginning in the member’s third year of enrollment. The cost-sharing will increase incrementally by 50% of the original base premium amount each year the individual remains on Kentucky HEALTH, in accordance with the table below. The escalating payment rates continue to be affordable, and even at the maximum premium amount of \$37.50, the payment represents less than 4% of income (below Medicaid’s 5% of income maximum allowable cost-sharing amount). The increasing premium requirement will also be applied to individuals enrolled in employer premium assistance program receiving premium assistance to participate in their employer-sponsored health plan. Ultimately, the increased cost-sharing requirements bring the premium amounts more in line with the premiums required in the Marketplace, and discourages Medicaid dependency by preparing individuals for the costs associated with commercial or Marketplace coverage.

Table 4.2(B): Sliding Scale Increased Premium Amounts for Individuals Over 100% FPL

FPL	Year 1-2 Premium	Year 3 Premium	Year 4 Premium	Year 5+ Premium
101-138% FPL	\$15.00	\$22.50	\$30.00	\$37.50

4.2.1 Non-Payment Penalties

Members will be provided a 60-day grace period to make their required monthly premium payment. Similar to commercial plans, Kentucky HEALTH will impose consequences for non-compliance in order to help educate members about standard commercial market policies. Therefore, individuals who do not elect to pay a required premium payment within sixty calendar days from the due date will face a six-month non-payment penalty. The non-payment penalty varies based on whether the member has income above or below federal poverty in accordance with the table below. However, recognizing that Kentucky HEALTH is intended to educate and ease individuals into commercial market policies, members will have the opportunity to end their non-payment penalty period sooner than six months, as detailed below in *Section 4.2.2*.

Table 4.2.1: Non-Payment Penalty

Member FPL	Non-Payment Penalty	Early Re-Entry Option
Above 100% FPL	<ul style="list-style-type: none"> Disenrolled from Kentucky HEALTH Re-enrollment waiting period of six months 	<ul style="list-style-type: none"> Pay past debt; Pay premium for reinstatement month; and
At or below 100% FPL	<ul style="list-style-type: none"> State Plan copayments required for all services \$25 is deducted from the <i>My Rewards Account</i> <i>My Rewards Account</i> is suspended 	

⁴² THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), available at http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

	<ul style="list-style-type: none"> ○ Not able to use funds in account ○ Not able to accrue funds in account ● No impact to eligibility 	<ul style="list-style-type: none"> ● Participate in financial or health literacy course
Medically Frail	<ul style="list-style-type: none"> ● <i>My Rewards Account</i> is suspended <ul style="list-style-type: none"> ○ Not able to use funds in account ○ Not able to accrue funds in account ● No impact to eligibility ● No copayments required 	
Pregnant Women and Children	Not applicable. Exempt from all cost-sharing requirements.	Not applicable

Members with annual income above 100% FPL, who are not medically frail or otherwise exempt from cost-sharing, will be disenrolled from Kentucky HEALTH for non-payment following the sixty-day grace period. Further, consistent with the commercial market, members terminated from Kentucky HEALTH due to non-payment will be required to wait six months to re-enroll, unless they meet the criteria for early re-entry as detailed below in *Section 4.2.2*. This policy helps prepare individuals for Marketplace policies, which suspend claims payment after thirty-day payment delinquency, terminate coverage after ninety days, and prevent reenrollment until the next annual open enrollment period.

Individuals who are determined medically frail in accordance with *Section 3.3.1* are not subject to disenrollment due to non-payment of premium, even if income is greater than 100% FPL. In addition, medically frail individuals are exempt from the imposition of copayments following non-payment of premium, however, access to the member’s *My Rewards Account* will continue to be conditioned on payment of premiums.

Individuals below the FPL that choose not to make payments will not lose coverage. However, in lieu of disenrollment, individuals with annual income at or below 100% FPL will be subject to a six-month non-payment penalty period in which they will be subject to copayments. Required copayments during the member’s non-payment penalty period will be equal to the current copayments scheduled in the Kentucky Medicaid State Plan, which range from \$3.00 for physician office visits and up to \$50.00 for hospital inpatient services. A detailed copayment schedule is set forth in 907 Kentucky Administrative Regulations 1:604. In addition to copayments, \$25.00 will be deducted from the member’s *My Rewards Account*, and the account will be suspended for six months, thus prohibiting access to the enhanced benefits. During this period, the account is effectively “frozen” and members will not be permitted to use the account or earn additional contributions to the account. The potentially increased cost-sharing along with the reduced benefits create an incentive for members to make consistent monthly premium payments to maintain health insurance coverage, while also maintaining a safety net for individuals who are below the FPL or medically frail.

4.2.2. Early Re-Entry Opportunity

While the penalties above are created to encourage compliance, Kentucky HEALTH ensures that members have opportunities to return to full benefits at any time. All members in a non-

payment penalty period will be provided the opportunity to re-enter the standard program with full access to their plan and the *My Rewards Account* benefits prior to the expiration of the six-month non-payment penalty period. Early re-entry requires the individual to pay outstanding premium payments and complete a financial or health literacy course. Specifically, the individual would be required to pay a one-time payment equal to three months of premium contributions. This re-entry premium amount would effectively cover the two months of debt in which the member received healthcare coverage during the 60-day grace period prior to the effective date of the non-payment penalty, as well as the advance premium payment required to restart coverage.

In addition to the re-entry payment, individuals seeking early re-entry will be required to attend a financial or health literacy course. The financial literacy course will educate members on the basics of money management to assist individuals in increasing income, paying debt, and achieving financial stability, while the health literacy course will educate members on enrollment policies, managing healthcare expenditures, and appropriate use of healthcare services. Completion of a course is voluntary but will allow members to regain eligibility prior to the end of the six-month non-payment penalty period.

4.3 Cost-Sharing Exemption

Pregnant women and children will be exempt from all cost-sharing required under the waiver. In addition, medically frail members will not be required to pay premiums as a condition of participation in Kentucky HEALTH. However, premium payment will be a condition to access the member’s *My Reward Account*. In the event of non-payment, all medically frail members will be exempt from the imposition of copayments. In addition, Kentucky HEALTH covers several other populations exempt from alternative benefit plan (ABP) enrollment, and these populations will be subject to modified cost-sharing as detailed in the table below.

Table 4.3: Cost-Sharing for Exempt Populations

Applicable Policies	Children	Pregnant Women	Section 1931 Parents	Medically Frail
Premiums	No premiums	No premiums	Yes	Optional
Copayments	Consistent with current State Plan	No copayments	Copayments only if fail to pay premium	No copayments
Deductible Account	No	No	Yes	Yes
My Rewards Account	No	Yes	Yes	Yes
Non-Payment Penalty	Not applicable	Not applicable	Copayments and Suspension of <i>My Rewards Account</i>	Suspension of <i>My Rewards Account</i>

5 Delivery System and Payment Rates for Services

Consistent with the current Medicaid expansion program, Kentucky HEALTH will continue to be operated through a managed care delivery system. In addition to the new requirements for members, Kentucky HEALTH will also increase accountability of the healthcare system by adding new payment

incentives aimed at furthering the “Triple Aim” of improving the patient experience, improving population health, and lowering costs.

5.1 Delivery System Reforms

The creation of the Kentucky HEALTH program is just one part of an overall Medicaid transformation initiative being undertaken by the State to improve quality, access, efficiency and value in healthcare. Through this demonstration project, Kentucky will make significant delivery system reforms to improve quality and outcomes, including efforts related to substance use disorders, chronic disease management, and general managed care reforms. Further, to support each of these delivery system initiatives, the State will continue to strengthen its data collection efforts. The State will implement an initiative to improve data collection, including appropriate interoperability of data, and ensure that data driven decisions are aligned with overall goals to further improve quality and outcomes across the delivery system.

5.1.1 Substance Use Disorder Delivery System Reform Pilot Program

A report from the Substance Abuse and Mental Health Services Association (SAMHSA) estimated the prevalence of SUD among Medicaid eligible adults at 21%.⁴³ Applied to Kentucky’s expansion population, it is estimated that nearly 90,000 newly enrolled Kentuckians may have a SUD requiring treatment. In 2014 with the expansion of Medicaid, Kentucky greatly expanded coverage to mental health and SUD treatment options, allowing Medicaid recipients to receive coverage for the full spectrum of inpatient and outpatient SUD services. However, coverage of benefits means little without access to providers.

Federal law generally prohibits federal financial participation for medically necessary Medicaid services provided to adults aged 21 through 64 in certain facilities that meet the federal definition of an institution for mental disease (IMD), specifically, free-standing psychiatric hospitals with more than 16 beds. In Kentucky, there are 26 qualified mental health facilities capable of providing covered mental health and SUD services to Medicaid recipients with SUD, however, they are prohibited from doing so due to the IMD exclusion. Instead, individuals in need of mental health or SUD inpatient services must either travel long distances out of their communities to access services and/or experience long wait times for a bed to open, putting the individual at risk of experiencing a crisis and ending up in either the criminal justice system or high-cost hospital emergency departments.

Kentucky currently faces a drug abuse epidemic, and access to the Medicaid program’s comprehensive mental health and SUD benefits is critical. In July 2015, CMS issued a letter indicating a willingness to offer states a waiver of the IMD exclusion, provided the State also develops broad based reforms regarding the provision of SUD services to Medicaid recipients. The State will explore this opportunity through pilot programs in ten to twenty select high-risk counties. Counties will be identified based on the recent CDC HIV/hepatitis C outbreak study

⁴³ SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, BEHAVIORAL HEALTH TREATMENT NEEDS ASSESSMENT TOOLKIT FOR STATES, PUB. NO. SMA13-4757 (2013), *available at* <https://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf>.

described in *Section 1*, the State's existing Shaping Our Appalachian Region (SOAR) initiative,⁴⁴ and public input received during the demonstration waiver public notice and comment period.

The pilot program will seek to increase access to mental health and SUD services through a waiver of the IMD exclusion to allow federal financial participation for covered services provided to Medicaid eligible adults ages 21 through 64 residing in an IMD for short-term residential stays of up to thirty days. The pilot programs are intended to evaluate the impact of increased access to treatment in IMD's. The State will work with CMS in the design of the pilot project, examining the current mental health and SUD delivery system for best practice improvements related to standards of care, inclusion of recommended SUD as well as HIV quality indicators, care coordination between levels and settings of care, and strategies to address prescription drug abuse and opioid use disorder.

In addition, Kentucky intends to align standards of care for SUD treatment with the national best practice criteria set forth by the American Society of Addiction Medicine in the pilot counties. To further improve the quality and consistent delivery of these services, the State will also require certain SUD treatment providers to become accredited.

5.1.2 Chronic Disease Management

Several Kentucky HEALTH program components have been designed to support existing statewide efforts to improve chronic disease prevention and management. For example, the Kentucky HEALTH *My Rewards Account*, described in *Section 4.1.2*, will incentivize members to participate in a variety of health activities including health risk assessments, chronic disease or weight management courses, and smoking cessation programs, many of which are already offered through State and local health departments across Kentucky.

The State will also explore encouraging, through its contracts, MCO participation in existing initiatives designed to drive public health outcomes and focused on Kentucky Department for Public Health (DPH) key priorities, which currently include, but are not limited to, diabetes, obesity, cardiovascular disease, lung cancer, and substance use disorder. State-based programs include, but are not limited to, the Kentucky Diabetes Prevention and Control Program and the Kentucky Tobacco Prevention and Cessation Program.

In addition, the State will continue participation in existing federal programs, such as the National Diabetes Prevention Program (DPP), a Centers for Disease Control and Prevention (CDC)-supported program aimed at preventing or delaying type two diabetes for at-risk individuals. The DPP consists of a series of group counseling sessions focused on nutrition and physical activity targeted to individuals that meet specific at-risk diagnostic criteria, including body mass index greater than 24 and elevated blood sugar levels within pre-diabetic range. The DPP has been evaluated and shown effective at preventing the development of type 2 diabetes by the National Institutes of Health and the CDC.

5.1.3 Managed Care Reforms

All of the populations that will transition to Kentucky HEALTH currently receive medical benefits through an MCO. Kentucky HEALTH will continue to provide services through the current MCOs.

⁴⁴ The SOAR initiative seeks to expand job creation, enhance regional opportunity, innovation, and identity, improve the quality of life, and support all those working to achieve these goals in Appalachian Kentucky.

However, in order to implement the programmatic changes resulting from this Section 1115 demonstration project, the State will update existing managed care contracts. While the State has already taken a critical look at its managed care rates, it will continue to make several additional contract reforms to reduce the inflated managed care profits which are nearly five times the national average.⁴⁵ The contracts will be further revised to control the rate of growth and trends, ensure that the MCOs are spending more of their capitation on medical benefits, and incorporate other contract efficiencies to ensure value. In addition, MCOs will no longer be able to waive copayments.

In addition, the Kentucky HEALTH contract revisions will seek to further the “Triple Aim” of improving the patient experience, population health goals, and lowering costs. First, this waiver will add initiatives to the managed care program consistent with industry standards and aligned with CMS quality payment guidelines. The MCOs will be contractually required to develop innovative provider contracting strategies aimed at transitioning from a reimbursement model that rewards providers solely based on volume, to a model that aligns payment incentives with quality performance and outcomes. Through this initiative each MCO will be required to ensure a meaningful portion of its total Medicaid population is participating in a purchasing arrangement that aims to achieve improvements in population health outcomes and decrease total costs of care for the participating population.

In addition, the State will introduce new MCO payment incentives for quality performance and outcomes for both the MCOs and providers participating in Kentucky HEALTH. The MCOs operating Kentucky HEALTH will be subject to a quality withhold, in which a portion of the capitation payment is withheld and eligible to be paid to the MCO following achievement of specified quality health outcomes. The outcome measures will be designed to align with the overall Kentucky HEALTH program goals, such as increasing the number of members who receive preventive services, reduced smoking rates, and demonstrated improvement in health of members participating in disease management programs (e.g., diabetes programs).

MCOs will also be required to implement a provider bonus program, in which providers may earn a quality bonus from the MCO. The bonus will be aligned to encourage provider participation and support of the same member health activities incentivized by the *My Rewards Account*. By ensuring that the MCO, provider, and member incentives are aligned, Kentucky HEALTH seeks to make a measurable impact on member health over the course of the five-year demonstration period. Further, the State will pursue several additional managed care system reform measures aimed at improving the efficiency and responsiveness of the current managed care delivery system. For example, on the enrollee level, the State will look to implement strategies to improve MCO call center performance. For providers, the State will include MCO contract provisions aimed at aligning processes and establishing consistencies in administrative

⁴⁵ The average underwriting ratio (profit margin) for Kentucky’s five Medicaid MCOs was reported at 11.3%, significantly above the national average of 2.6% (3.3% for expansion states). JEREMY D. PALMER & CHRISTOPHER T. PETTIT, MILLIMAN, MEDICAID RISK-BASED MANAGED CARE: ANALYSIS OF FINANCIAL RESULTS FOR 2015 (2016), available at <http://www.milliman.com/uploadedFiles/insight/2016/medicaid-risk-based-managed-care-analysis-2015.pdf>.

requirements across the contracted MCOs, such as formulary alignment efforts and uniform credentialing processes.

5.2 Managed Care Delivery System

Kentucky HEALTH will utilize a statewide mandatory managed care delivery system for all populations covered under this demonstration waiver. Only eligible members participating in the employer premium assistance program will be exempted from mandatory managed care enrollment under this demonstration.

Table 5.2: Managed Care Enrollment Table

Eligibility Group	Managed Care Enrollment	Note
New adult population	Mandatory	Freedom of Choice Waiver Requested
Parents and other caretaker relatives		
Transitional medical assistance		
Pregnant women		
Newborn Children		
Infants and Children Under Age 19		
Title XXI Separate CHIP Program		

The State currently contracts with MCOs previously selected through a competitive procurement process. The State intends to renegotiate and amend the existing contracts to implement Kentucky HEALTH. Therefore, since Kentucky HEALTH will be built off of the State’s well-established statewide managed care program, the Kentucky HEALTH managed care implementation will not be phased in, but will rather roll-out on a statewide basis. The MCOs operating in the State are compliant with provider network adequacy standards. However, prior to the implementation of Kentucky HEALTH, the State will conduct readiness review to ensure operational readiness for Kentucky HEALTH.

5.3 Health Plan Choice

Consistent with current processes, Kentucky HEALTH applicants will be able to select one of the MCOs operating statewide at the time they apply. If a member does not actively choose an MCO, the individual will be auto-assigned to a health plan. The member will be provided the opportunity to select a new MCO until such time that the individual makes their first premium contribution. However, once the individual is fully enrolled and begins coverage under Kentucky HEALTH, the member must remain with the selected MCO for the duration of the member’s twelve-month benefit period. The State will seek a waiver of the ninety-day managed care choice period in order to mirror commercial market policies, which do not permit health plan selection changes outside of annual open enrollment periods. Notwithstanding the foregoing, Kentucky HEALTH members will be permitted to change MCOs at any time during the benefit period due to one of the “for cause” reasons described in 42 CFR 438.56(d)(2), such as poor quality of care.

5.4 Excluded services

All Kentucky HEALTH covered services will be provided through a managed care delivery system, except for long-term care services. Consistent with the current processes, the MCO will not be responsible for a member’s nursing facility costs during the first thirty days; however, if a member is admitted to a nursing facility, the MCO will be required to cover the costs of any health services provided to the member while the member resides in the nursing facility, for up to thirty days, until the individual is

disenrolled from the MCO. In addition, all covered benefits that will be wrapped around an employer premium assistance program member's employer-sponsored health plan will be excluded from managed care, and will be reimbursed on a fee-for-service basis.

5.6 Fee-for-service

The only covered services that will be provided under fee for services are benefits that are wrapped around employer-sponsored health insurance for individuals enrolled in the employer premium assistance program. Member premiums for such individuals will be paid to the employer, and services not covered by the employer plan will be paid on a fee for service basis to the rendering provider. Such payments will not deviate from State Plan provider payment rates. In addition, the State may carve out the services provided through the *My Rewards Account* from managed care, and reimburse on a fee-for-service basis.

5.7 Capitated payments

As the State updates the contracts with the existing MCOs, the State will also adjust the capitation rates to reflect program changes resulting from this demonstration program. All risk-based capitation rates will be developed based on federal regulations and actuarial standards of practice, as well as reflect the historical experience of all populations with eligibility under this program. The capitation rate development process will not deviate from the payments and contracting requirements under 42 CFR 428.

5.8 Quality

All quality initiatives and quality related payments will be detailed in the Scope of Work with the MCOs, as well as the State's quality strategy. Quality related withhold incentives will be included in the updated MCO contracts, as described in *Section 5.1.2* of this demonstration application. In addition, all MCOs will continue to be required to submit Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. Further, MCOs will be required to report on additional quality measures and data targeted by the State and required for the evaluation of the Kentucky HEALTH waiver.

6 Implementation of Demonstration

The State will implement the Kentucky HEALTH program on a statewide basis on or about six months post-approval, however, this date may vary depending on the approval date from CMS. Notwithstanding the foregoing, the Kentucky HEALTH community engagement and employment initiative may be phased in on a county basis. Prior to implementation and enforcement of the initiative, each county will be assessed to ensure adequate resources are available to members residing in the county seeking to fulfill the community engagement, job training, and employment hour requirements. Further, staggered implementation of this new demonstration initiative will allow for measured review of the policy impact. In addition, the changes to the current vision and dental coverage will be implemented three months after the Kentucky HEALTH waiver is implemented. This three month delay will provide members the opportunity to maintain existing vision and dental coverage while accumulating available funds in their *My Rewards Account*. During this time, the State will work with various provider and stakeholder groups as well as the MCOs to aggressively communicate and educate members about the *My Rewards Account* and changes to the benefits.

Implementation of Kentucky HEALTH will require the State to amend existing managed care contracts, modify systems and other operational procedures, and conduct readiness review with the various State

vendors. In addition to these tasks, the State will also have to amend the State Plan, amend the ABP, develop State, MCO and member education materials, and prepare to transition existing members.

6.1 Enrollment

Due to the significant enrollment in the State's Medicaid program following the implementation of Medicaid expansion, the State anticipates that most eligible individuals already have Medicaid coverage, and will transition to Kentucky HEALTH from their existing Medicaid coverage. However, the State will initiate an effort to educate members about changes and will partner with stakeholder groups throughout the implementation process to ensure all potential members are notified of upcoming program changes.

The State will begin targeting formal communication and education activities to enrollees and stakeholders beginning at least ninety days prior to the anticipated implementation date. All current Medicaid populations transitioning to Kentucky HEALTH will be notified in writing at least sixty days prior to the implementation of changes to their benefits. At this time, members will also be notified of their new required monthly premium amount. Upon the implementation date, all covered populations will transition to coverage under Kentucky HEALTH, and will be provided their initial premium invoice, which will be due no later than sixty days from the date of implementation. The State and MCOs will be trained and prepared to assist members with questions regarding program changes, premium requirements, and methods of making payments. Efforts will be made to allow for use of a variety of payment methods, including money order, personal check, credit card, bank debit card, prepaid debit card, and cash. During the initial transition, the MCOs will make outbound calls to all transitioning members who are at risk of missing the initial payment date to encourage and assist them in making a contribution.

6.2 Managed Care

Kentucky HEALTH will utilize existing MCOs to provide benefits to Kentucky HEALTH enrollees. The State will not conduct procurement action prior to implementation, but will rather amend current contracts and conduct readiness review with the MCOs prior to final implementation of Kentucky HEALTH. However, current managed care contracts will expire during the course of the five-year demonstration and the State will conduct re-procurement activities as necessary.

7 Demonstration Financing and Budget Neutrality

A detailed financing and budget neutrality narrative is attached as **Attachment II** to this demonstration waiver application, and the detailed budget neutrality worksheet template prepared by Milliman Inc. is attached as **Attachment III**.

8 List of Proposed Waivers and Expenditure Authorities

8.1 Title XIX Waivers

Below is a list of proposed waivers necessary to implement Kentucky HEALTH:

1. Eligibility: Section 1902(a)(10)(A)

- To the extent necessary to enable Kentucky to not provide medical coverage until the first day of the month in which the Kentucky HEALTH member pays their first premium payment,

or for members below 100% FPL who fail to make an initial premium payment, the first day of the month following the expiration of the sixty-day payment period.

- To the extent necessary to enable Kentucky to require Kentucky HEALTH members, as a condition of eligibility, to complete specified community engagement hours.

2. Retroactive Eligibility: Section 1902(a)(34)

- To the extent necessary to enable Kentucky to not provide medical coverage for any month prior to the month in which the member finalized enrollment in Kentucky HEALTH.

3. Cost-Sharing: Section 1902(a)(14) insofar as it incorporates 1916 and 1916A

- To the extent necessary to enable Kentucky to require monthly premium payments not to exceed 5% of income, but no less than \$1.00 per month, for all Kentucky HEALTH members.

4. Amount, Duration, and Scope: Section 1902(a)(10)(B)

- To the extent necessary to enable Kentucky to vary cost-sharing requirements, such that premium contribution amounts increase each year for members with income above 100% FPL who remain on Kentucky HEALTH, not to exceed 5% of income, and to charge copayments in lieu of premiums for individuals at or below 100% FPL who fail to make their premium payment within the sixty-day payment period.
- To the extent necessary to allow Kentucky HEALTH members who continue to pay premium contributions to use their *My Rewards Account* to purchase specified enhanced benefits not otherwise available in the base Kentucky HEALTH benefit package.
- To the extent necessary to enable Kentucky to allow individuals to receive the benefits provided through their employer-sponsored plan.

5. Reasonable Promptness: Section 1902(a)(3)/Section 1902(a)(8)

- To the extent necessary to enable Kentucky to delay benefits, such that benefits do not begin until a member makes a premium contribution, or until the expiration of a sixty-day payment period for members below 100% FPL who fail to make a premium contribution.
- To the extent necessary to enable Kentucky to prohibit re-enrollment for up to six months for Kentucky HEALTH members above 100% FPL who are disenrolled for failure to make their required premium contributions within sixty days of the due date.
- To the extent necessary to enable Kentucky to implement an open enrollment period for Kentucky HEALTH, such that members who are disenrolled for failure to complete the redetermination process will be required to wait until their next open enrollment period to re-enroll (up to six months).

6. Freedom of Choice: Section 1902(a)(23)

- To the extent necessary to enable Kentucky to restrict the freedom of choice of providers for demonstration eligibility groups.

7. Non-Emergency Transportation: Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53

- To the extent necessary to relieve Kentucky of the requirement to assure non-emergency medical transportation to and from medical providers for Kentucky HEALTH members.

8.2 Costs Not Otherwise Matchable

The State requests that expenditures related to providing services in an IMD, in participating pilot project counties, as well as costs associated with providing GED testing fees as a covered benefit for

Kentucky HEALTH enrolled adults without a high school diploma, be regarded as expenditures under the State's Medicaid Title XIX State Plan.

9 Public Notice & Public Comment

Kentucky Department for Medicaid Services provided the public the opportunity to review and provide input on this §1115 demonstration waiver in accordance with the requirements set forth at 42 CFR §431.408. Governor Bevin publically announced the Kentucky HEALTH waiver application on June 22, 2016. Public notice was also provided the same day to formally open the 30-day public comment period, which ended at 5:00 p.m. on July 22, 2016. However, in response to the volume of comments that were submitted on the final day of the comment period, including after the 5:00 p.m. deadline, the State extended the comment period through 11:59 p.m. on August 14, 2016. The extension allowed for the numerous comments that came in after the official deadline to be incorporated, as well as allowed any individual who was unable to comment previously the opportunity to do so.

A copy of the full public notice that announced the three public hearings is included in **Attachment IV** of this waiver application. The notice was posted on the Cabinet for Health and Family Services website at the web address of the Section 1115 waiver program's homepage: <http://chfs.ky.gov/kentuckyhealth>. In addition, the formal public notice was also published in newspapers in the Commonwealth which serve a population of at least 50,000 (which included more areas than the minimum threshold required under the federal regulation). Electronic copies of all documents related to the Kentucky HEALTH waiver application were also available on the above listed waiver website throughout the comment period.

Although federal regulations only require two public hearings, the Commonwealth held three formal public hearings in geographically distinct areas of the state during the public comment period. In accordance with the notice, three public hearings were held on the following dates and locations as scheduled and publicized: (1) June 28, 2016 in Bowling Green, Kentucky; (2) June 29, 2016 at the Advisory Council for Medical Assistance (MAC) Special Meeting in Frankfort, Kentucky; and (3) July 6, 2016 in Hazard, Kentucky. In addition, although federal regulations do not require telephonic and/or web conference capabilities be made available if at least two public hearings were held in geographically distinct areas of the state, a toll-free conference call line was made available for the June 28th hearing, and live internet streaming was available for both the June 28th and July 6th hearing dates. All of the public hearings followed the same format, beginning with an overview of the Kentucky HEALTH waiver proposal, a brief question and answer session, followed by the collection of formal public comments. A court reporter transcribed and entered into the public record all verbal comments presented during each of the public hearings.

On June 29, 2016, a special Medicaid Advisory Committee (MAC) meeting was held to provide an overview of the waiver to the committee members and receive comments from the public. Prior to taking public comment at this meeting, committee members were provided the opportunity to raise questions or concerns about the waiver. The questions raised spanned a variety of topics and were primarily technical in nature. For example, committee members sought clarification on how CHIP children will be impacted, what requirements are in place for the community engagement program, how the *My Rewards Account* will function, medically frail premium requirements, MCO contract term questions and how many individuals will be impacted by the waiver. They also posed questions about the benefit package and how the SUD program will operate. Representatives from the State provided clarification to the questions.

In addition to the MAC meeting, the Kentucky HEALTH waiver was also presented to several public legislative committee hearings throughout the course of the public comment period. Specifically, the waiver was presented to the Interim Joint Committee on Health and Welfare on July 20, the Interim Joint Committee on Appropriations and Revenue on July 23, and the Budget Review Subcommittee on Human Resources on August 1. Each of these legislative hearings was open to the public, and members of the legislative committees were able to ask questions and comment on the waiver.

Following both the initial public comment period as well as the extension thereof, all comments were cataloged, summarized, and organized. In total, the State received 1,428 public comments during the entire public comment period, including 1,342 unduplicated written comments, and 86 verbal testimonies at the three public hearings. In addition to these, several organizations gathered input and statements from their constituencies which were synthesized within the organization's overall submission. The below summary combines the testimony offered at the public hearings as well as the formal comments received by the State via mail and email.

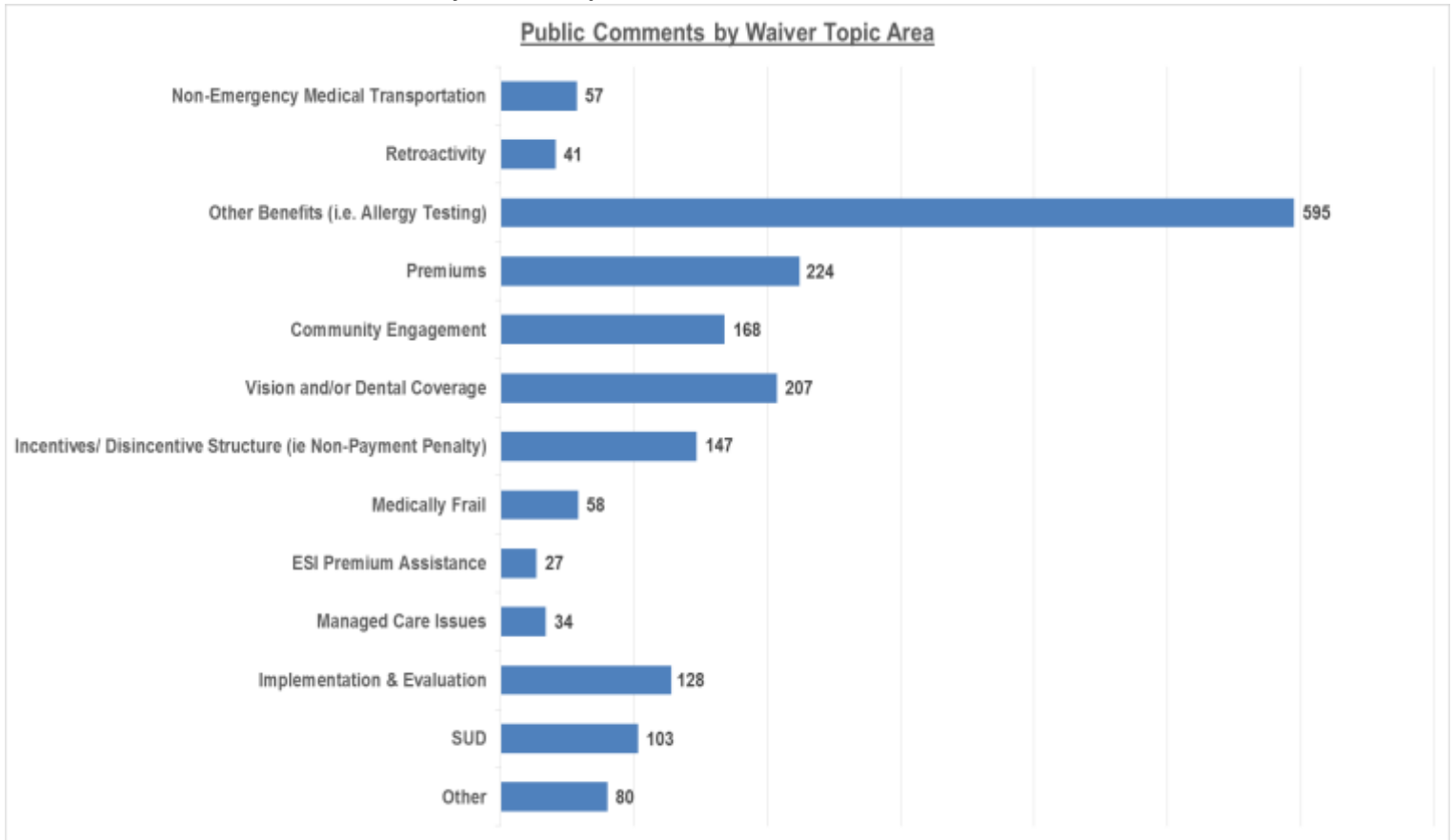
9.1 Summary of Public Comments and State Response

A significant portion of the public comments targeted the waiver proposal as a whole. These comments shared either general support of the waiver initiative or general opposition to any changes to the existing Medicaid expansion program, without offering substantive comments on any particular aspect of the proposal. However, the majority of comments received were robust and touched on a broad range of topics that generally fell into the following categories:

- Changes to benefits;
- Premiums and cost sharing;
- Community engagement and employment initiative;
- *My Rewards Account* and the proposed changes to vision and dental coverage;
- Incentive and disincentive structure of Kentucky HEALTH (i.e. non-payment penalties);
- Medically frail;
- Employer-sponsored insurance (ESI) premium assistance program;
- Managed care and implementation of the waiver program; and
- Substance use disorder (SUD) waiver pilot project.

The frequency with which each of these topics were raised within the comments is listed below in [*Table 9.1*](#). Further, each topic area theme is summarized and discussed in more detail below.

Table 9.1 Public Comment by Waiver Topic Area



1. Changes to Covered Benefits

- a. **Summary of Comments:** Over 40% of the total comments received during the public comment period (or roughly 595 comments) were specific to the proposed state plan amendment, primarily the elimination of allergy testing. Generally, commenters encouraged continued coverage of allergy testing, and shared personal anecdotes of how they had personally benefitted from the service. Other commenters noted that allergy testing is a critical component of diagnosis, establishing appropriate treatment plans, and educating patients about potential triggers to avoid. Several of the allergy and asthma providers and interest groups cited high rates of allergies and asthma in the Commonwealth, and provided detailed evidence that allergy testing and treatment is a highly effective and cost efficient benefit for the Medicaid program. Further, several commenters suggested that appropriate allergy testing and treatment can increase productivity and reduce missed days of school and work, therefore, supporting the overall goals of the Kentucky HEALTH waiver.

A relatively few number of comments were received related to proposed changes to non-emergency medical transportation and retroactivity, which received 57 comments (4% of total comments) and 41 comments (3% of total comments) respectively. Half of the comments received on these topics were from impacted providers and advocacy groups, many of which expressed concern with the potential negative economic impact these

changes would have on providers through missed appointments and uncompensated care. In addition, many commenters expressed concern about the potential impact that lack of NEMT services would have on access to care, particularly on the State's more vulnerable clients living in rural areas.

Ultimately, the overwhelming majority of comments received during the public comment period were related to proposed changes in allergy testing services. Most of the benefit related comments were submitted by impacted provider groups and their patients. Several commenters supported efforts to make Kentucky HEALTH benefits equal to the Kentucky State Employees' Health Plan, as well as efforts to maintain the current robust Medicaid mental health and substance use disorder benefits.

- b. **State Response:** Based on the overwhelming public response and significant evidence provided related to the cost effectiveness of the allergy testing benefit, the State will not pursue a state plan amendment to remove the additional benefits added in 2014, including allergy testing and private duty nursing.

In regards to comments related to non-emergency medical transportation, the Division of Medicaid Services data indicates that utilization for this benefit among expansion adults has been extremely low. From June 2014 through June 2015, the expansion adult population of more than 400,000 individuals utilized less than 140,000 non-emergency trips.⁴⁶ In addition, data from Iowa and Indiana, two states currently operating Medicaid expansion programs without NEMT benefits, indicates that members have not experienced any meaningful obstruction of member access to care. In fact, two independent evaluation surveys of Indiana members found that those without NEMT benefits missed fewer appointments than members with NEMT benefits (whether those benefits were provided by the State or as an enhancement through MCOs).⁴⁷ Due to this research as well as the under-utilization of this benefit among the expansion population in Kentucky, no changes were made to the waiver resulting from these comments, and the State will continue to seek a waiver of the NEMT benefit for the adult expansion group only. However, for purposes of clarification, NEMT will remain a covered service for the more vulnerable populations participating in Kentucky HEALTH, including children, pregnant women, medically frail individuals, and any individuals eligible for Medicaid prior to the passage of the Affordable Care Act.

In addition, the State has opted not to modify the waiver related to retroactive coverage. One of the main goals of Kentucky HEALTH is to "encourage individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance." A waiver of retroactive eligibility is consistent with this goal, as commercial market coverage begins after payment of a premium. In addition, Medicaid expansion has been in effect since 2014, therefore, most individuals are already covered, eliminating the

⁴⁶ Kentucky Department for Medicaid Services, Non-Emergency Medical Transportation Utilization of Adult Expansion Population from June 2014 through May 2015 (May 23, 2016) (on file with the State).

⁴⁷ Indiana NEMT Waiver Amendment Request to the Healthy Indiana Plan (HIP) 2.0 Medicaid Section 1115 Demonstration Waiver (2016) available at: <http://in.gov/fssa/hip/files/Indiana%20HIP%202.0%20NEMT%20Waiver%20Amendment%20Request%20-%2008%2001%2016.pdf>

need for retroactive coverage—as demonstrated by the relatively few comments on this policy (approximately 2%). Further, retroactivity has been widely waived by CMS in other states. However, in recognition of the concerns in the provider community, the Kentucky HEALTH waiver proposed to expand the presumptive eligibility program to allow more providers the opportunity to facilitate expedited enrollment for their uninsured patients in a time of need. This policy should address the few concerns related to increased uncompensated care.

2. Premiums and Other Cost Sharing

- a. **Summary of Comments:** Approximately 16% of all comments received (or 224 comments) addressed member cost-sharing components of the waiver. The State received several supportive comments, with even one Medicaid recipient indicating they would be willing to pay more for coverage. Several individuals indicated that the collection of even one dollar helps members engage in their own care as well as appropriately manage utilization and cost. In contrast, many commenters expressed general concern related to the affordability of the cost-sharing provisions for this population. Several commenters suggested there was no evidence that charging premiums would increase patient engagement. In addition, several stakeholder groups cited various studies indicating that any form of cost-sharing would negatively impact access to care and reduce coverage. In addition, several commenters opposed increasing premiums for individuals with income greater than the poverty level.

Other commenters focused on potential logistical difficulties that many low income individuals would face in making regular premium payments, particularly those individuals with mental disorders and those without a checking account or stable address. These concerns were most pronounced in regards to individuals determined medically frail. Many advocates and other stakeholders expressed concern with applying any form of cost-sharing (premiums or copayments) to the medically frail population. While many supported exempting these individuals from disenrollment for failing to pay premiums, many commenters requested the policy go further and simply exempt individuals determined medically frail from all cost-sharing obligations. These commenters noted that individuals who miss premiums will instead be subject to copayments which may be very expensive for medically frail individuals with extensive health care needs, which could lead to pharmaceutical noncompliance and other reductions in utilization.

State Response: In regards to concerns about copayments, all Medicaid copayments are subject to the federal maximum cost-sharing limit equal to 5% of income. CMS regulations allow states to charge copayments up to this limit without a waiver. However, stakeholder feedback expressed support for predictable, lower premiums as an alternative to standard Medicaid copayments up to 5% of income, as low-income working families are better able to budget for the expense. CMS has recently approved several similar 1115 waivers that implemented premium requirements equal to 2% of income. The flat rate premium amounts proposed in this waiver are all equal to or less than 2% of income, while the increasing premium amounts for individuals with income over 100% FPL never exceed the CMS threshold of 5% of income. Therefore, the cost-sharing provisions in the waiver are consistent with federal regulations and current CMS policy.

In addition, the studies cited by a few commenters were not specific to the new adult group category. Recent data from Indiana's Healthy Indiana Plan (HIP), also a Section 1115 waiver, indicated that premiums equal to 2% of income are affordable.⁴⁸ Approximately 87% of HIP members reported they would pay more than 2% of income premiums to remain enrolled in the program and that affordability was not an issue for people that left the program.⁴⁹ Only 5% of people surveyed who left the program indicated they did so for affordability reasons.⁵⁰ In addition, individuals who made regular payments had better outcomes, higher satisfaction, higher primary and preventive care, higher drug adherence, and lower ER use.⁵¹ The State will not seek changes to the premium amounts set forth in the original waiver draft.

While there were a relatively small number of comments (approximately 16%) related to cost-sharing and premiums, the State has adjusted the plan based on a few recommendations. A couple of commenters suggested that the State implement family caps on premium requirements, such that the monthly premium equal to 2% of household income was not charged individually to all adults in the household. Based on this feedback, the Kentucky HEALTH waiver has been updated to clarify that premiums will be charged on a household basis rather than an individual basis. For example, for a married couple with household income equal to 75% FPL, the couple would be required to pay only \$8.00 per month (rather than \$16.00 per month).

In regards to the collection of premium payments, the State will ensure a variety of payment collection methods are available, including cash, money order, personal checks, credit card or debit card (including prepaid Visa debit cards). The Kentucky HEALTH program will seek to provide ample opportunity for members to make a premium payment in a method most convenient to their situation.

Finally, based on the comments received, the waiver has been updated to exempt medically frail individuals from the imposition of both premiums and copayments. The waiver was updated to allow medically frail members to choose to make premiums in order to maintain access to the My Rewards Account, however, in the event of non-payment of premium, such individuals will not be disenrolled and will not be subject to copayments for services.

3. Community Engagement & Employment Initiative

- a. **Summary of Comments:** Relatively few comments (168, or approximately 12% of the total comments) addressed the community engagement and employment initiative. Several commenters supported the idea of requiring individuals who are able to work or volunteer for their tax funded benefit, noting that the majority of Americans also have to work to obtain employer sponsored health coverage. Of the individuals opposed to the imposition of the community engagement and employment initiative, many had questions about who would be subject to the requirements, as well as what types of activities would satisfy the

⁴⁸ The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

requirements. Specifically, several individuals expressed concern that Kentucky HEALTH would increase burdens on low-income working families that are already struggling and would have little time for extra-curricular activities, such as community service. Further, several advocacy groups, including the AARP, requested that the exemption for caretakers of a dependent child be expanded to include other forms of caretaking activities. In addition, several organizations posed very detailed operational questions related to the implementation of this initiative.

- b. **State Response:** With respect to comments concerned about the increased burden on low-income working families, the proposed waiver as originally drafted indicated that employment satisfies the requirement. However, the waiver has been updated to provide further emphasis that the community engagement and employment initiative would not impact working families. Specifically, individuals who are already working more than 20 hours per week will meet the requirement of the initiative, and will not be required to perform community service or other job training activities as a condition of continued enrollment. This point is clarified in *Section 2.3* of the waiver.

In regards to caretakers, the State recognizes the value and critical role of the countless Kentuckians who serve as caretakers for aging or disabled individuals. Therefore, in response, the waiver will be amended in two ways. First, the community engagement and employment exemption will be expanded to exempt not only primary caregivers of a dependent minor child, but also primary caregivers of a disabled adult dependent. Secondly, caregiving activities for non-dependents, such as caregiving services provided to elderly parents, will be counted as a qualifying activity for the community engagement and employment initiative.

4. **My Rewards Account and Changes to Vision and Dental Coverage**

- a. **Summary of Comments:** Slightly over 200 comments (approximately 14%) were submitted in regards to the proposed changes to vision and dental coverage. Many commenters expressed concern over the elimination of dental and vision services, as well as concern that the *My Rewards Account* limits access to care through the requirement to complete reward activities in order to purchase benefits. In addition, some raised concerns over the perception that vision and dental benefits were classified in the same category as a gym membership. However, several commenters wrote in support of the *My Rewards Account* structure and related benefit change, indicating that asking a person to participate in beneficial activities in exchange for vision and dental services promotes ownership and teaches responsibility.

A significant portion of comments related to vision and dental coverage were from impacted providers and their professional organizations. Dentists and other oral health professionals expressed concern that reduction in access to dental services would lead to increased emergency room visits and increased opioid use due to tooth pain. Similarly, many optometrists opposed removing vision screenings from the base benefit package, since these preventive visits often lead to early detection of other chronic diseases. Overall, the provider communities advocated for inclusion of vision and dental in the base benefit package, as cost effective methods of addressing the overall health of the member.

Further, several commenters indicated concern that the change in dental and vision coverage for adults could negatively impact utilization of these services for children resulting from potential misunderstanding that the parents and children have different covered benefits. In addition, a few commenters indicated that, as currently structured, it would be impossible for a person to accumulate enough funds to pay for basic dental and vision services. These individuals urged inclusion of additional and more inclusive opportunities to earn rewards. In addition, several individuals recommended that coverage for eyeglasses and contacts be added to the *My Rewards Account*.

- b. **State Response:** Many of the comments indicated a misunderstanding of the waiver and additional clarifying language has been added. The Kentucky HEALTH program will continue to cover all of the vision and dental services currently covered in Medicaid. It does not propose to “eliminate” or add new coverage, but rather transition existing vision and dental services (both considered optional Medicaid services under federal law) to the *My Rewards Account*. Vision and dental benefits will be maintained in the standard benefits for children, pregnant women, medically frail individuals, and any individuals eligible for Medicaid prior to the passage of the Affordable Care Act.

The *My Rewards Account* is structured to give participants flexibility and ownership of their own benefits and healthcare spending. The State recognizes that some members may only need one dental cleaning and vision screening in a year. Rather than a one-size-fits-all approach, the *My Rewards Account* creates flexibility and tailors benefits to the individual, allowing the participant to make choices about how to spend additional funds, which may be on a gym membership or additional dental work. It is up to the individual to decide what benefit they value most and use of the account is flexible based on individual needs.

In responding to the comments, the State will delay the implementation of this benefit change by three months, to allow current members additional time to accumulate dollars in their *My Rewards Account*. In addition, the State is committed to ensuring that the structure of the account provides meaningful access to covered vision and dental benefits. The table of qualifying activities provided in the waiver is illustrative, but not definitive, and several additional opportunities will be made available for achievement of rewards. For example, parents will also be able to earn dollars in their *My Rewards Account* for obtaining prenatal and/or preventive care for their children, including recommended well-child visits, dental cleanings, and vision screenings. This will serve to educate and encourage parents to utilize the full array of children’s preventive services.

In addition, Kentucky HEALTH will also seek to encourage members to complete their GED not only by rewarding members who pass the exam with a *My Rewards Account* incentive, but also by helping to pay for the out of pocket costs associated with taking the exam. The State will seek a waiver to pay for this service as part of the Medicaid package in order to further promote independence. *Section 4.1.2* of the waiver has been updated to reflect these additions.

5. Incentive & Disincentive Program Structure

- a. **Summary of Comments:** Another set of commenters (approximately 10%) discussed various aspects of the incentive and disincentive structure of the Kentucky HEALTH waiver proposal. Several comments were received praising the use of incentives to drive healthy behaviors, as well as rewarding members for taking educational classes, health assessments, and engaging in their community. In addition, numerous commenters expressed concern about the non-payment penalty provisions of the waiver, particularly the impact of the six month disenrollment period for individuals with income greater than 100% FPL. Specifically, commenters are concerned that this policy will increase emergency room utilization and uncompensated care during coverage gaps. In addition, several providers, particularly substance use disorder (SUD) providers, stated that a disenrollment penalty would disrupt continuity of care, which is particularly important for individuals in active mental health and SUD treatment programs. In addition, a few commenters opposed the emergency room penalty, and noted that the non-emergency use of a hospital emergency department penalty is much higher than the \$8.00 federally allowable copayment amount.
- b. **State Response:** The intent of the penalties is not punitive in nature, but rather is intended to familiarize members with the requirements of private insurance to help make their eventual transition easier. Further, the disenrollment non-payment penalty does not apply to individuals with income below the poverty line or individuals determined medically frail, which would include those individuals actively participating in SUD treatment programs. Further, Indiana's Healthy Indiana Plan waiver also includes a similar six month non-payment disenrollment period for individuals with income greater than 100% FPL. According to program data, less than 6% of the individuals (2,677) were disenrolled for non-payment, and the majority (56%) were able to obtain health insurance during this six month period.⁵² While the Kentucky waiver contains similar disincentives to encourage key behaviors, it is also designed to create a way for individuals to minimize or eliminate the penalty. As drafted, the waiver provides disenrolled members the opportunity to take a financial or health literacy class, as well as pay owed premiums for the months they received coverage but did not pay, in order to regain coverage prior to the expiration of the six month disenrollment period.

In regards to the non-emergency use of hospitals emergency department penalty, the penalty is not an actual member copayment and does not use member out-of-pocket funds. Instead, it reduces reward dollars from the *My Rewards Account* that were gained through positive behavior, which may also include reward contributions for avoiding inappropriate emergency room use. In addition, the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations at 42 CFR §489.24, which sets special responsibilities for hospitals in emergency cases, including definitions of emergency conditions, will apply and members may not be refused treatment.

⁵² The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf

6. Medically Frail

- a. **Summary of Comments:** Approximately 4% of comments (or 58 comments) were received specific to medically frail. Many of the commenters sought additional detail regarding the state-specific definition of “medically frail.” Several commenters asked that certain populations be explicitly identified and included in the definition, including those receiving Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). In addition, the American Academy of HIV medicine specifically recommended that individuals with HIV be automatically considered medically frail due to the critical importance of medication adherence and continuity of care. Further, several commenters also requested additional information regarding the medically frail determination process.
- b. **State Response:** The State concurs with the commenters that providing a clear, concise, and objective definition of medically frail will be critical to ensuring that the most vulnerable members participating in Kentucky HEALTH are quickly and appropriately identified. In response to several comments received about the urgency in quickly identifying specific segments of the medically frail population, the State will modify the waiver to create specific populations that automatically will be considered medically frail, including (1) individuals in hospice care, (2) individuals living with HIV/ AIDS, and (3) individuals receiving SSDI.

The waiver also has been updated to provide additional clarification that individuals with SSI are not included under the Kentucky HEALTH waiver and will retain traditional disability Medicaid benefits. By contrast, individuals otherwise eligible for Kentucky HEALTH who also receive SSDI will be automatically determined medically frail under this waiver program. Further, in response to the requests that additional detail be provided regarding the medically frail determination process, *Section 3.2* of the waiver was modified to provide additional detail about the process, as well as the role of the MCOs in providing information to the State for medically frail determinations.

7. ESI Premium Assistance

- a. **Summary of Comments:** Only 27 comments (approximately 2% of the total received) expressed concerns that employer sponsored insurance (ESI) is too expensive and individuals will not qualify for the employer premium assistance program due to their part-time employment status. Two comments were received requesting input from stakeholders, including MCOs, in the design and operationalization of the program.
- b. **State Response:** As stated in *Section 3.2* of the original waiver proposal, individuals eligible for the employer premium assistance program will not be subject to out-of-pocket expenses in excess of the Kentucky HEALTH required premiums. Additionally, enrollment in ESI will only be required to the extent an individual qualifies and the employer plan is cost-effective to the State. Therefore, no changes were made to the waiver in response to comments received, as the concerns raised were due to a misinterpretation of the program requirements.

8. Managed Care and Implementation Concerns

- a. **Summary of Comments:** Many commenters discussed the implementation of Kentucky HEALTH, including comments about changes to managed care (34 comments or 2%) and the administration of the plan more generally (128 comments or approximately 9% of the total comments). Several commenters indicated that they appreciated the proposed MCO reforms contained within Kentucky HEALTH and indicated they have struggled with the administrative burden of working with multiple MCOs. These commenters encouraged reducing the number of MCOs in future contracting. In addition, many commenters also explicitly supported efforts to implement a single formulary, consistent prior authorization processes and standardized forms, as well as uniform credentialing. More generally, a number of comments were received that expressed various concerns with perceived administrative complexities built into the program that will impact the Commonwealth, the MCOs and their members, as well as increase overall program costs. In addition, a few commenters were concerned that the program would be too difficult for members to understand and navigate.
- b. **State Response:** No additional revisions to the waiver were made resulting from these comments, except that the State removed specific references to “five” MCOs, as the state is making a number of reforms to its contracting and cannot affirmatively state that the program will continue to be administered by five MCOs for the duration of the waiver. The State intends to build on existing infrastructure within the SNAP program to operationalize the community engagement initiative and will explore existing technology solutions to track engagement. Ultimately, the investment in developing the workforce in the Commonwealth is important for not only to reduce unemployment, but also to improve health outcomes. As detailed in the waiver, there is a known link between health and employment, and CMS states it is “essential to individual's economic self-sufficiency, self-esteem and well-being.”⁵³ Kentucky HEALTH aims to work across the various Cabinets in the Commonwealth to leverage existing health and employment-related programs and focus efforts on assisting Kentucky HEALTH members achieve improved health and self-sufficiency. The State intends to partner with stakeholder groups and initiate a strong communications effort to educate members about changes to the program throughout the implementation process to ensure all members and potential members are notified of upcoming program changes.

9. SUD Pilot Project

- a. **Summary of Comments:** Nearly all of the 103 comments received related to the proposed SUD pilot project were supportive. Commenters described the devastating impact of addiction and commended the State for addressing this issue and increasing access to critical services through the proposed pilot project. Many commenters took the opportunity to ask questions related to the specific details of the program, and provided detailed suggestions for the design of the pilot project. Suggestions included specific quality measures to study, provider qualifications for telehealth and partial hospitalization

⁵³ Medicaid Employment Initiatives, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 7, 2016).

programs and expansion of the IMD waiver on a statewide basis. Commenters also requested specific counties be included in the pilot project and provided suggested criteria for determining which counties to include.

- b. **State Response:** The State will utilize the comments received in the development of the operational components of the SUD pilot project. Additionally, regarding expansion of the IMD exclusion, the State intends to permit MCOs to utilize IMDs for up to fifteen (15) days as an in-lieu of service, as available under 42 CFR §438.6(e). In accordance with these new federal regulations, this will be accomplished through the MCO contracting and rate setting process and does not require a modification to the waiver proposal. Further information on this change will be provided at a later time. By contrast to the 15 day IMD stay permitted under the new managed care rule, the IMD waiver sought for the SUD pilot project would allow Medicaid to reimburse for IMD stays up to 30 days in length.

10. Questions and Misconceptions

- a. **Summary of Comments:** During the public comment process, many individuals took the opportunity to ask specific questions related to the program generally, including how it will impact specific individuals, details regarding how it will be operationalized and which vendors will be utilized. Also, several comments were based on misunderstandings of various aspects of the waiver. For example, several comments were received related to perceived reductions in the coverage of smoking cessation benefits or perceived elimination of hearing aid coverage. In addition, others were concerned about estimated reductions in enrollment of children over the 5 year demonstration period.
- b. **State Response:** To clarify, in regards to the smoking cessation benefit, there are no changes to benefits related to the coverage of smoking cessation counseling and medication. The State will continue to cover all services (including smoking cessation services) given an "A" or "B" from the United States Preventive Services Task Force (USPSTF), at no cost to the recipient. All preventive services are covered by the managed care organization outside of the member's deductible account.

Many of the questions asked specific operational questions that will be helpful in the future as the State works to operationalize and further refine the program. In addition, the State plans to use the comments to develop member and stakeholder communication material prior to implementation. However, as these types of questions did not provide specific feedback on the waiver, no modifications were made to the waiver as a result.

In addition, the enrollment figures for children contained in the initial waiver draft were mistakenly transposed with the enrollment numbers for expansion adults in the table on Page 18 of the waiver. The correct enrollment figures were available on Page 3 of Attachment III. To clarify, the State does not anticipate that enrollment for children will decrease, rather it may actually increase under the waiver.

9.2 Summary of Waiver Changes Following Public Comment

The State appreciates the massive public response to its 30-day request for public comments. Due to the robust and thoughtful input, the State took additional time to thoroughly review and give due consideration to each comment. While the broad themes are summarized and discussed above, each

comment received during the public comment period helps inform not only the development of the waiver, but also future discussions with CMS, the design of the program evaluation, member communication strategies, and other operational considerations. In addition, the State has chosen to directly respond to a number of significant concerns and specific recommendations suggested during this process, and has made changes and modifications to the waiver as a direct result of public input. These changes were discussed above and are also summarized in the below table:

Section	Description of Change	Page #
Kentucky Health Overview (Section 1.2.2)	<p>Several updates and clarifications were added to the program overview section, including:</p> <ul style="list-style-type: none"> • Clarified that benefits will not change for children, pregnant women, medically frail, and adults eligible for Medicaid before expansion. • Listed eligibility groups excluded from waiver. • Added language that premiums will only be applied on a family basis. • Clarified that members may choose how to use the <i>My Rewards Account</i> benefits. • Added language about Medicaid policy goals in support of services to support independence. • Added caretaking as community engagement & employment activity, and clarified list of exempt individuals. 	Pages 9, 10, 12, & 13
Demonstration Area and Timeframe (Section 1.5)	The implementation of changes to the dental and vision benefit will be delayed by three months to allow members time to accrue funds in the <i>My Rewards Account</i> .	Page 14
Impact to Medicaid and Chip (Section 1.6)	Clarification was added to explain that this waiver primarily only impacts “non-disabled” individuals in traditional Medicaid populations.	Page 14
Eligibility (Sections 2 and 2.1)	<ul style="list-style-type: none"> • Added description and chart describing groups excluded from the waiver: <ul style="list-style-type: none"> ○ Former foster children up to age 26; ○ Individuals on a 1915(c) waiver; ○ Individuals in an institution; and ○ Individuals eligible for Medicaid on the bases of age, blindness, or disability, including individuals eligible for social security income (SSI). • Made technical correction to listed income levels for Section 1931 parents and caretakers in <i>Table 2.1(A)</i> 	Pages 15-16
Community Employment & Engagement (Section 2.2)	<p>Several revisions and clarifications were made to this section, including:</p> <ul style="list-style-type: none"> • Added language about Medicaid policy goals in support of services to support independence. • Extended community engagement & employment exemption for primary caretakers of minor children as well as disabled adult dependents. 	Pages 16-18

	<ul style="list-style-type: none"> Clarified that students or individuals employed more than 20 hours a week meet the requirements of this section, and no additional community engagement activities are required to maintain benefits. Added “caregiving services for a family member or other person with a chronic, disabling health condition” as a qualifying activity. Added clarification around education component of the initiative, and added GED benefit. 	
Projected Enrollment (Section 2.3)	Made a technical correction to the enrollment chart.	Page 19
Kentucky HEALTH Benefits (Sections 3 & 3.1.2)	<p>Made changes to proposed benefit changes as follows:</p> <ul style="list-style-type: none"> <u>Allergy Testing</u>: Removed proposed amendment to the Medicaid State Plan, as allergy testing and private duty nursing will continue to be covered services. <u>Smoking Cessation</u>: Clarified that current smoking cessation benefits will continue to be covered as an “A” and “B” service recommended by the United States Preventive Services Task Force. 	Pages 21 & 23
<i>My Rewards Account</i> Benefit (Section 3.1.3)	The dental and vision benefit change will be delayed by three months to allow members time to accrue funds in the <i>My Rewards Account</i> .	Page 24
Educational Support (Section 3.1.4)	Added GED testing costs as an additional covered benefit for Kentucky HEALTH members.	Pages 24 & 25
Medically Frail (Section 3.3.1)	<p>Clarified the definition and process</p> <ul style="list-style-type: none"> Certain populations will be determined automatically medically frail, including individuals receiving hospice care, persons with HIV/AIDS, and individuals receiving SSDI. Added additional detail regarding the medically frail identification, determination and appeal process. Medically frail individuals will be exempt from copayments. 	Page 26
<i>My Rewards Account</i> (Section 4.1.2)	<p>Clarified and added the following:</p> <ul style="list-style-type: none"> Added description of educational support benefit Community engagement related activities will only qualify for a reward deposit if in excess of hours required to maintain coverage as set forth in <i>Section 2.2</i>. Expanded the reward activity chart to include caretaking responsibilities, passing the GED, and completion of child preventive services. Clarified that the inappropriate emergency room penalty is not a member copayment. Added an incentive and disincentive option for excessive missed healthcare appointments 	Pages 28-30
Member Required Contributions (Section 4.2)	<p>Clarified and added the following:</p> <ul style="list-style-type: none"> Added an explanation that premiums will be paid on a household basis rather than per person. 	Pages 31-33

	<ul style="list-style-type: none"> Added an exemption for medically frail from the imposition of premiums and copayments. Included study results supporting positive impact premium payment has on member health outcomes. 	
Cost-Sharing Exemption (Section 4.3)	Clarified that medically frail members will be exempt from the imposition of premiums and copayments. However, premiums are still required to maintain the member's <i>My Rewards Account</i> .	Page 34
SUD Pilot Program (Section 5.1.1)	Added that the pilot project will include measurement of specific recommended SUD and HIV quality indicators.	Page 35
Managed Care Reforms (Section 5.1.3)	Removed references to 5 MCOS, as the State is not committed to maintaining this number of MCOs in the future.	Page 38
Fee for Service (Section 5.6)	Clarified that the State may carve out the services provided through the <i>My Rewards Account</i> from managed care.	Page 38
Implementation (Section 6)	The implementation of changes to the dental and vision benefit will be delayed by three months to allow members time to accrue funds in the <i>My Rewards Account</i> .	Page 39
Costs Not Otherwise Matchable (Section 8.2)	Added a request that GED testing fees be regarded as a Medicaid expenditure.	Page 41
Evaluation Plan (Attachment I)	Added a new evaluation metric related to measuring GED participation rates.	Page 61
Financing & Budget Neutrality Summary (Attachment II)	<ul style="list-style-type: none"> Eliminated reference to removal of private duty nursing. Added GED certification fees for expansion and non-expansion adults as a covered benefit. Clarified premiums will be collected on a household basis. Made allowance for a three month delay in changes to the vision and dental benefit in the first year of the waiver. 	Pages 67 & 68

Other than the changes noted above, the content of this application is identical to the copy of the application initially posted on the Cabinet for Health and Family Services website on June 22, 2016.

10 Demonstration Administration

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ATTACHMENT I: Evaluation plan

The table below presents an overview of a preliminary plan for how the State may evaluate the Kentucky HEALTH program. This evaluation plan is subject to change and will be further defined to reflect operational details as the program is implemented.

#	Hypothesis	Methodology	Data Sources and Metrics
Goal 1: Improve member’s health and help them be responsible for their health			
1.1	Kentucky HEALTH policies will promote member use of preventive and primary care.	Track and compare health service utilization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.	Claims data: <ul style="list-style-type: none"> • Primary care encounters; • Specialist care encounters; • ED visits; and • Preventive care codes.
		Track preventive care utilization rates and trends among different age and gender groups.	Claims data: <ul style="list-style-type: none"> • Number, type, and frequency of preventive care services used; and • Gender- and age-specific rates of pre-determined preventive service utilization.
1.2	Kentucky HEALTH policies will promote member compliance with chronic disease management.	Track and compare chronic disease management compliance rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.	Claims data: <ul style="list-style-type: none"> • Chronic disease management codes; and • Participation in disease management program.
1.3	Kentucky HEALTH policies will reduce member hospitalization of ambulatory care sensitive conditions (ACSCs).	Track and compare ACSCs hospitalization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.	Claims data: <ul style="list-style-type: none"> • Ambulatory care sensitive conditions (ACSCs) codes.
1.4	Kentucky HEALTH will increase access to substance use disorder (SUD) services with special focus on Institutions for Mental Diseases (IMD).	Track and compare inpatient specialty care/SUD utilization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.	Claims data: <ul style="list-style-type: none"> • Specialist care encounters. Administrative data and MCO reported data: <ul style="list-style-type: none"> • Network adequacy; • Number of certified providers; • Change in ED utilization and costs; and

			<ul style="list-style-type: none"> Change in inpatient utilization and costs. <p>Member survey:</p> <ul style="list-style-type: none"> Percentage of members who report the wait times for SUD services.
Goal 2: Encourage individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance			
2.1	Kentucky HEALTH policies will provide incentives to monitor and manage the two member managed account funds.	Track and compare remaining balances in member deductible accounts at the end of each benefit period.	Administrative data: <ul style="list-style-type: none"> Percentage of deductible accounts that have a balance at the end of a benefit period.
		Track and compare balances in member <i>My Rewards</i> accounts at the end of each benefit period.	Administrative data: <ul style="list-style-type: none"> Percentage of <i>My Rewards Accounts</i> that have a balance at the end of the benefit period.
		Track account balances transferred from the deductible account to the <i>My Rewards Account</i> at the end of each benefit period. <ul style="list-style-type: none"> Number of members with unused deductible account balances at the end of each benefit period; and Average amount transferred to <i>My Rewards Account</i> at the end of each benefit period. 	Administrative data: <ul style="list-style-type: none"> Average deductible account balance amount at the end of each benefit period; and Average <i>My Rewards Account</i> balance at the end of each benefit period.
		Track number of people checking their account balances: <ul style="list-style-type: none"> Weekly; Monthly; Semi-Annually; Annually. 	MCO administrative data.
2.2	Kentucky HEALTH policies will encourage healthy behaviors and increase member access to enhanced health services (such	Track and compare <i>My Reward Account</i> expenditures on enhanced health services.	Administrative data: <ul style="list-style-type: none"> Percentage of <i>My Reward Accounts</i> that have expenditures for

	as dental, vision, gym memberships and over-the-counter medications).		<p>enhanced health services at the end of each benefit period;</p> <ul style="list-style-type: none"> • Average <i>My Reward Account</i> expenditures for enhanced health services at the end of each benefit period; and • Percent of <i>My Reward Account</i> expenditures for enhanced health services at the end of each benefit period.
		Track and compare member achievement of healthy incentives contributions to the <i>My Rewards Account</i> .	<p>Administrative data:</p> <ul style="list-style-type: none"> • Members receiving any healthy incentive contributions; • Type/source of healthy incentive contribution (e.g., avoidance of inappropriate ER visits, completed job search, GED, etc.); • Average number of healthy incentive contributions earned; • Total dollar amount of healthy incentive contributions received; and • Average dollar amount of healthy incentive contributions received.
		Track and compare type of enhanced health services used by member <i>MY Rewards</i> accounts.	<ul style="list-style-type: none"> • Enhanced services used, by percent of total enhanced services offered (e.g., 40% of all enhanced services used for gym memberships; 30% of all enhanced services used for OTC medications, etc.); • Enhanced services used, by number of services (e.g., 4,000 total gym memberships received; 3,000 total OTC

			<p>medications received, etc.);</p> <ul style="list-style-type: none"> • Total dollar amount spent on enhanced services; and • Average amount spent on enhanced services.
2.3	Kentucky HEALTH policies will promote member compliance with making premium payments.	<p>Track premium initial and ongoing premium payments.</p> <ul style="list-style-type: none"> • Overall; • Above 100% FPL; • At or below 100% FPL; and • Medically Frail Status. 	<p>Health plan contribution and enrollment data:</p> <ul style="list-style-type: none"> • Number and percentage making premium payments within allowed time; • Number and percentage disenrolled from Kentucky HEALTH due to non-payment of premium (above 100% FPL); • Number and percentage suspended with copayments applied (below 100% FPL) due to non-payment of premium; • Number and percentage reinstated early (before 6 months) into Kentucky HEALTH after disenrollment (above 100% FPL) or suspension (at or below 100%) due to non-payment of premium; and • Number and percentage reinstated on-time (after 6 months) into Kentucky HEALTH following non-payment of premium.
2.4	Kentucky HEALTH open enrollment policy will increase member compliance with redetermination process.	<p>Track member compliance with redetermination.</p> <ul style="list-style-type: none"> • Overall; • Above 100% FPL; • At or below 100% FPL; and • Medically Frail Status 	<ul style="list-style-type: none"> • Number and percentage disenrolled from Kentucky HEALTH due to failure to comply with redetermination process; • Number and percentage reinstated prior to next open enrollment period; and

			<ul style="list-style-type: none"> • Number and percentage reinstated at next open enrollment period (after six months).
2.5	<p>Kentucky HEALTH’s incentive and disincentive policies related to non-emergency use of hospital emergency room will reduce inappropriate utilization among Kentucky HEALTH members.</p>	<p>Compare annual rates of inappropriate emergency department utilization between Kentucky Medicaid populations for the years <i>before waiver</i> (prior to 2017) and <i>after waiver</i> (2017 and beyond).</p>	<p>Claims data:</p> <ul style="list-style-type: none"> • Annual overall emergency department utilization rates (percent of members and visits/100,000 members); and • Annual non-emergency emergency department utilization rates (percent of members and visits/100,000 members).
		<p>Survey Kentucky HEALTH members on whether the incentives and disincentives related to the <i>My Rewards Account</i> for appropriate emergency room utilization caused them to seek services with their primary care physician or in an alternative urgent care setting.</p>	<p>Member survey:</p> <ul style="list-style-type: none"> • Percentage of members who report the disincentive caused them to seek services with their primary care physician or in an alternative urgent care setting in lieu of the emergency department. • Percentage of members who report the incentive caused them to seek services with their primary care physician or in an alternative urgent care setting in lieu of the emergency department.
		<p>Compare annual rates of members subject to the escalating <i>My Rewards Account</i> disincentive based on repeated inappropriate hospital emergency department utilization.</p>	<p>MCO reported data:</p> <ul style="list-style-type: none"> • Number of members that utilized inappropriate emergency services: <ul style="list-style-type: none"> ○ Only once; ○ Two times; ○ Three times; and ○ More than three times.

Goal 3: Empower people to seek employment and transition to commercial health insurance coverage			
3.1	Kentucky HEALTH policies will encourage members to increase community engagement.	Track and compare member achievement of community engagement and employment contributions to the <i>My Rewards Account</i> .	Administrative data: <ul style="list-style-type: none"> • Members receiving any community engagement and employment related contributions to their <i>My Rewards Account</i>; and • Average number of such contributions earned.
3.2	Kentucky HEALTH policies will encourage members to obtain their GED certification.	Track members preparing for, taking and passing the GED exam.	Administrative data: <ul style="list-style-type: none"> • Members receiving contributions to their <i>My Rewards Account</i> for GED related activities • Members reporting GED related activities for their required community engagement hour requirements • Members who utilize the GED exam fee benefit
3.3	Kentucky HEALTH policies will encourage members to seek employment.	Track members participating in job search activities.	Administrative data: <ul style="list-style-type: none"> • Number and percent of members who register with Career Center and complete job needs assessment; • Number and percent of members who participate in qualifying community service activity; • Number and percent of members who complete job skills training (i.e. vocational education, training); and • Number and percent of members who complete job search activities.

3.4	Kentucky HEALTH policies will encourage members to earn employment and ultimately transition to commercial health insurance coverage.	Track number of former Medicaid members successfully transitioning to commercial health insurance coverage and accessing the <i>My Rewards Account</i> bonus after eighteen months.	Administrative data: <ul style="list-style-type: none"> • Number of former members able to receive a cash reward after transitioning to commercial health insurance coverage; • Average <i>My Rewards Account</i> balance payoff; and • Number of individuals that reenter program prior to achieving a full eighteen months of commercial health insurance coverage.
		Track number of individuals employed over twenty hours per week.	Administrative data: <ul style="list-style-type: none"> • Number of members who move from part-time employment to full-time employment; • Number of members who move from unemployment to part-time employment; and • Number of members who move from unemployment to full-time employment.
		Track earnings of members who earn employment.	Administrative data: <ul style="list-style-type: none"> • % FPL of individual income; and • % FPL of household income.
3.5	The employer premium assistance program will increase the proportion of Kentucky residents under 138% FPL covered by employer-sponsored insurance (ESI).	Track the number of Kentucky residents with income under 138% FPL covered by ESI over the demonstration period.	Current Population Survey & American Community Survey: <ul style="list-style-type: none"> • ESI coverage rate estimates, all ages.
		Track employer premium assistance program member enrollment.	Kentucky HEALTH enrollment and premium assistance records: <ul style="list-style-type: none"> • Number of Kentucky HEALTH members who are eligible for the

			<p>employer premium assistance program;</p> <ul style="list-style-type: none"> • Number of Kentucky HEALTH members who enroll into the employer premium assistance program. • Percentage of total demonstration enrollees participating in the employer premium assistance program—monthly and annually; and • Number of employer premium assistance program enrollees who receive premium assistance to purchase ESI—monthly and annually.
		Track employer premium assistance program employer enrollment.	<p>Employer premium assistance program administrative data:</p> <ul style="list-style-type: none"> • Number of employers who enroll in the employer premium assistance program, by employer size (e.g., small, medium, large).
		Track employer premium assistance program wrap-around coverage expenditures.	<p>Claims data:</p> <ul style="list-style-type: none"> • Number, type, and frequency of wrap-around service used; • Average cost of wrap-around service used; and • Total cost of wrap-around service used.
3.6	Kentucky HEALTH’s sliding scale increased premium payment amounts will discourage dependency on public assistance and encourage members to transition to commercial health insurance coverage.	Compare annual rates of Medicaid enrollment between Kentucky Medicaid populations for the years <i>before waiver</i> (prior to 2017) and <i>after waiver</i> (2017 and beyond).	<p>Administrative data:</p> <ul style="list-style-type: none"> • Monthly Medicaid enrollment; and • Annual Medicaid enrollment.
		Survey Kentucky HEALTH members on whether the	Member survey:

		sliding scale increased premium payment amount caused them to seek employment and/or other forms of health insurance coverage.	<ul style="list-style-type: none"> Percentage of members who report the sliding scale increased premium payment amount caused them to seek employment and/or other forms of health insurance coverage.
		Compare annual rates of members paying increased premium amounts based on continued annual enrollment in Kentucky HEALTH.	MCO reported data: <ul style="list-style-type: none"> Premium payment amounts, by year of coverage.
Goal 4: Implement delivery system reforms to improve quality and outcomes			
4.1	Kentucky HEALTH policies will promote high quality healthcare delivered by providers.	Track MCO ability to meet quality and outcome benchmarks within their service contracts.	Claims data: <ul style="list-style-type: none"> Kentucky HEALTH outcomes compared to MCO benchmark requirements: <ul style="list-style-type: none"> Primary care; Preventive care; Specialist care; Emergency care; and Ambulatory care sensitive conditions.
		Track Kentucky providers receiving bonus payments from MCOs for meeting quality and outcomes standards.	MCO reported data: <ul style="list-style-type: none"> Bonus payments paid to provider.
Goal 5: Ensure fiscal sustainability			
5.1	Kentucky HEALTH will remain budget-neutral for both the federal and State governments.	Conduct a budget neutrality analysis and document adherence to waiver margin.	<ul style="list-style-type: none"> Calculation of the waiver margin (annual and cumulative); Documentation of all State and federal costs; and Demonstration of budget neutrality.

ATTACHMENT II: Financing and Budget Neutrality Summary

Milliman, Inc. (Milliman) was engaged to develop the response to the Budget Neutrality Form section for the Section 1115 Medicaid Demonstration Waiver Application (1115 Waiver). The Centers for Medicare and Medicaid Services (CMS) requires all 1115 Waivers to demonstrate budget neutrality. Budget neutrality is a comparison of without waiver expenditures (WoW) to with waiver expenditures (WW). CMS recommends two potential methodologies of demonstrating budget neutrality:

1. Per Capita Method: Assessment of the per member per month (PMPM) cost of the Demonstration
2. Aggregate Method: Assessment of both the number of members and PMPM cost of the Demonstration

Budget neutrality for the Kentucky HEALTH 1115 Waiver will be demonstrated through the use of the aggregate method. The budget neutrality projections were developed using CMS budget neutrality requirements. A detailed budget neutrality worksheet is attached as **Attachment III**.

Milliman has relied upon certain data and information provided by the Kentucky Department for Medicaid Services in the development of the estimates contained in the Budget Neutrality Worksheet. Milliman has relied upon the Kentucky Department for Medicaid Services for the accuracy of the data and accepted it without audit. Additionally, Milliman relied on data and other information from the Current Population Survey and Medical Expenditure Panel Survey. To the extent that the data provided is not accurate, the results of this analysis may need to be modified to reflect revised information.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. It should be emphasized that the values in the Budget Neutrality Form are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this analysis.

Appendix III illustrates the 1115 Waiver Budget Neutrality spreadsheet. The rest of this section documents the supporting data included in the spreadsheet using guidance provided by CMS in the Budget Neutrality Form.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual Data

We have provided actual historical data separately for three Medicaid populations contained in the waiver: Children (Age 18 and Under), Adults: Non-Expansion, and Adults: Expansion.

For both the Children and Adult Non-Expansion populations, we have provided historical data for calendar years 2011 through 2015. For the Adult Expansion population, we have provided historical data for the program's first two years, calendar year (CY) 2014 through 2015. For each eligibility group, the historical data includes capitation payments and fee-for-service experience for members who were enrolled in program that will be eligible for Kentucky HEALTH.

B. Bridge Period

The bridge period is January 1, 2016 to December 31, 2016 (12 months).

C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification

For the Children and Adult Non-Expansion populations, we developed annual trend rates for member months based on CY 2011 to CY 2015 eligible member months. For PMPM cost trend, we used observed 5-year average trends developed based on the CY 2011 through CY 2015 historic data.

We were unable to observe reasonable enrollment and PMPM cost trends for the Expansion eligibility group due to the infancy of the program. Therefore, we used eligible member months and PMPM cost trend rates equal to the observed 5-year average trend rate for the Adult Non-Expansion eligibility group.

D. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

To project with-waiver PMPM cost and member months, we estimated the impact of key features of Kentucky HEALTH for each eligibility group. PMPM cost and enrollment changes were estimated through the use of data and information provided by the Kentucky Department for Medicaid Services. Additionally, we relied on data and other information from the Current Population Survey and Medical Expenditure Panel Survey. We also relied on data and other information from similar Medicaid programs to develop with-waiver projection estimates as appropriate.

Key features of Kentucky HEALTH reflected in the with-waiver projections include the following:

Benefit Package Changes. Specific benefit changes reflected in the with-waiver projections for the Expansion eligibility group include:

- Removal of non-emergency medical transportation (NEMT) for non-medically frail expansion eligibility group;
- Modification of service limits for PT/OT/ST; and,
- Addition of GED certification fees for Expansion and non-Expansion adults.

We relied on data and other information provided by consultants to the Kentucky Department for Medicaid Services in developing estimated impacts for these benefit package changes. Please note that no benefit package changes were assumed for the Children and Adult Non-Expansion eligibility groups.

Coverage Effective Date & Retroactive Coverage. For non-exempted eligibility groups, we assumed that retroactive eligibility will no longer apply. We anticipate that presumptive eligibility will be introduced at additional providers corresponding with this program change. The removal of retroactive eligibility is expected to have an impact to both enrollment and per capita claims. With no retroactive eligibility, we expect to see anywhere from zero to three months of enrollment removed for newly eligible beneficiaries. We assumed a different level of cost on a PMPM basis for these retroactive months, relative to non-retroactive eligibility months, as the members are not fully acclimated to Medicaid and may not fully utilize Medicaid covered services. Aggregate expenditures are estimated to be reduced due to the removal of retroactive eligibility months.

To estimate the impact of this change, we compared base medical member months and PMPMs with and without retroactive months for a similar Medicaid population. We reviewed the changes in enrollment and cost between the two scenarios by eligibility group segment to estimate the impact of removing retroactive eligibility. In developing these estimates, we considered the impact of presumptive eligibility at additional providers, a provision which will partially offset the removal of retroactive eligibility.

Employer Premium Assistance Program. We estimated the impact associated with the premium assistance program through the use of Medical Expenditure Panel Survey data from the Agency for Healthcare Research and Quality (AHRQ), along with the 2014 Current Population Survey. We expect membership levels to increase under the premium assistance program as members with existing Employer Sponsored Insurance (ESI) coverage apply for Medicaid ESI assistance. We developed enrollment projections through the use of take up rates which varied by eligibility and age group.

Additionally, we estimated that the PMPM cost for the eligibility groups will decrease as the average cost of ESI premium and cost sharing assistance is estimated to be lower than that of a traditional Medicaid beneficiary. We estimated the impact of this by reviewing the employee premium and cost sharing amounts for an ESI member as compared to Medicaid capitation rates and wrap around coverage, stratified by quartile and eligibility group.

Premium Contributions and My Rewards Account Benefit. To estimate the impact of the introduction of premiums on a household basis, we valued required premium contributions by income band and assumed varying payment rates by eligibility group. Premium amounts were compared to existing copayment requirements to estimate the net impact of member premium contributions.

To estimate the impact of the *My Rewards Account*, we modeled the PMPM cost or savings of each program component by eligibility group. We estimated the impact of the eligible benefits (dental, vision, and OTC drugs) based on PMPM cost estimates for these services, with allowances made for the delayed implementation of vision and dental benefits in the first year of the waiver. We valued the impact of deductible rollover by modeling the distribution of remaining year-end deductible levels based on data and other information from a similar Medicaid program. We estimated the penalty assessed for non-emergent emergency room use and the incentive for proper emergency room use by reviewing the distribution of non-emergent and emergent emergency room utilization based on data provided by the Kentucky Department for Medicaid Services.

Managed Care Reforms. We estimated that requiring the managed care organizations to align payment incentives with quality performance and outcomes has the potential to reduce annualized trends by 0.5% on a PMPM basis.

Community Engagement and Employment. Kentucky HEALTH is structured to encourage employment and community engagement by requiring a graduated weekly commitment from all able bodied adults. We utilized data from the 2014 Current Population Survey to model employment rates in Kentucky while adjusting for children, pregnant women, medically frail, and adults with primary caretaking responsibility for a dependent, which are exempt from the community engagement and employment initiative. We modeled enrollment changes and the corresponding morbidity effects based on a 2 year program phase in for community engagement requirements.

E. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

The impact of each feature of Kentucky HEALTH is fully reflected in the trend rates displayed in **Appendix III**. The development and justification for these rates is described in *Section D* above.

II. Cost Projections for New Populations

Not applicable

III. Disproportionate Share Hospital Expenditure Offset

Not applicable

IV. Summary of Budget Neutrality

Appendix III illustrates the 1115 Waiver Budget Neutrality spreadsheet, which includes the following applicable tabs:

- i. Historic Data
- ii. WOW (Without-Waiver)
- iii. WW (With-Waiver)
- iv. Summary (of Budget Neutrality)

V. Additional Information to Demonstrate Budget Neutrality

We do not believe there is any other information necessary for CMS to complete its analysis of the budget neutrality submission.

ATTACHMENT III: Budget Neutrality Worksheets

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

<u>Children (Age 18 and Under)</u>	2011	2012	2013	2014	2015	5-YEARS
TOTAL EXPENDITURES	\$ 1,278,702,725	\$ 1,310,253,249	\$ 1,376,613,845	\$ 1,477,821,840	\$ 1,618,128,571	\$ 7,061,520,230
ELIGIBLE MEMBER MONTHS	5,265,504	5,273,555	5,271,564	5,623,907	5,986,896	
PMPM COST	\$ 242.85	\$ 248.46	\$ 261.14	\$ 262.77	\$ 270.28	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE		2.47%	5.06%	7.35%	9.49%	6.06%
ELIGIBLE MEMBER MONTHS		0.15%	-0.04%	6.68%	6.45%	3.26%
PMPM COST		2.31%	5.10%	0.63%	2.86%	2.71%

<u>Adults: Non-Expansion</u>	2011	2012	2013	2014	2015	5-YEARS
TOTAL EXPENDITURES	\$ 667,466,616	\$ 717,268,238	\$ 749,662,818	\$ 808,989,927	\$ 892,510,877	\$ 3,835,898,476
ELIGIBLE MEMBER MONTHS	1,592,467	1,585,041	1,612,831	1,554,892	1,626,900	
PMPM COST	\$ 419.14	\$ 452.52	\$ 464.81	\$ 520.29	\$ 548.60	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE		7.46%	4.52%	7.91%	10.32%	7.53%
ELIGIBLE MEMBER MONTHS		-0.47%	1.75%	-3.59%	4.63%	0.54%
PMPM COST		7.96%	2.72%	11.93%	5.44%	6.96%

<u>Adults: Expansion</u>	2011	2012	2013	2014	2015	5-YEARS
TOTAL EXPENDITURES	\$ -	\$ -	\$ -	\$ 2,316,349,837	\$ 3,118,683,205	\$ 5,435,033,042
ELIGIBLE MEMBER MONTHS	-	-	-	4,422,028	5,977,024	
PMPM COST	\$ -	\$ -	\$ -	\$ 523.82	\$ 521.78	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE		0.00%	0.00%	0.00%	34.64%	34.64%
ELIGIBLE MEMBER MONTHS		0.00%	0.00%	0.00%	35.16%	35.16%
PMPM COST		0.00%	0.00%	0.00%	-0.39%	-0.39%

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					DY 01	DY 02	DY 03	DY 04	DY 05	
Children (Age 18 and Under)										
Pop Type: Medicaid										
Eligible Member Months	3.3%	12	6,182,069	3.3%	6,383,604	6,591,709	6,806,599	7,028,494	7,257,623	
PMPM Cost	2.7%	12	\$ 277.60	2.7%	\$ 285.12	\$ 292.85	\$ 300.79	\$ 308.94	\$ 317.31	
Total Expenditure					\$ 1,820,093,153	\$ 1,930,382,104	\$ 2,047,356,958	\$ 2,171,383,023	\$ 2,302,916,416	\$ 10,272,131,654
Adults: Non-Expansion										
Pop Type: Medicaid										
Eligible Member Months	0.5%	12	1,635,685	0.5%	1,644,518	1,653,398	1,662,326	1,671,303	1,680,328	
PMPM Cost	7.0%	12	\$ 586.78	7.0%	\$ 627.62	\$ 671.30	\$ 718.02	\$ 767.99	\$ 821.44	
Total Expenditure					\$ 1,032,132,205	\$ 1,109,926,148	\$ 1,193,583,641	\$ 1,283,544,004	\$ 1,380,288,676	\$ 5,999,474,674
Adults: Expansion										
Pop Type: Medicaid										
Eligible Member Months	0.5%	12	6,009,300	0.5%	6,041,750	6,074,376	6,107,177	6,140,156	6,173,313	
PMPM Cost	7.0%	12	\$ 558.09	7.0%	\$ 596.93	\$ 638.48	\$ 682.92	\$ 730.45	\$ 781.29	
Total Expenditure					\$ 3,606,502,037	\$ 3,878,367,462	\$ 4,170,713,612	\$ 4,485,077,089	\$ 4,823,147,740	\$ 20,963,807,940

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01	DY 02	DY 03	DY 04	DY 05	
Children (Age 18 and Under)								
Pop Type:	Medicaid							
Eligible Member Months	6,182,069	3.3%	6,387,155	6,599,045	6,817,965	7,044,147	7,277,833	
PMPM Cost	\$ 277.60	2.2%	\$ 283.62	\$ 289.77	\$ 296.05	\$ 302.47	\$ 309.02	
Total Expenditure			\$ 1,811,524,938	\$ 1,912,205,384	\$ 2,018,458,538	\$ 2,130,643,184	\$ 2,248,995,873	\$ 10,121,827,918
Adults: Non-Expansion								
Pop Type:	Medicaid							
Eligible Member Months	1,635,685	-2.2%	1,600,019	1,565,130	1,531,003	1,497,619	1,464,964	
PMPM Cost	\$ 586.78	6.9%	\$ 627.17	\$ 670.35	\$ 716.50	\$ 765.82	\$ 818.54	
Total Expenditure			\$ 1,003,483,850	\$ 1,049,185,216	\$ 1,096,963,509	\$ 1,146,906,800	\$ 1,199,131,380	\$ 5,495,670,754
Adults: Expansion								
Pop Type:	Medicaid							
Eligible Member Months	6,009,300	-2.3%	5,868,387	5,730,779	5,596,397	5,465,167	5,337,013	
PMPM Cost	\$ 558.09	7.4%	\$ 599.55	\$ 644.09	\$ 691.94	\$ 743.34	\$ 798.56	
Total Expenditure			\$ 3,518,391,637	\$ 3,691,137,353	\$ 3,872,371,048	\$ 4,062,476,931	\$ 4,261,925,309	\$ 19,406,302,278

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Children (Age 18 and Under)	\$ 1,820,093,153	\$ 1,930,382,104	\$ 2,047,356,958	\$ 2,171,383,023	\$ 2,302,916,416	\$ 10,272,131,654
Adults: Non-Expansion	\$ 1,032,132,205	\$ 1,109,926,148	\$ 1,193,583,641	\$ 1,283,544,004	\$ 1,380,288,676	\$ 5,999,474,674
Adults: Expansion	\$ 3,606,502,037	\$ 3,878,367,462	\$ 4,170,713,612	\$ 4,485,077,089	\$ 4,823,147,740	\$ 20,963,807,940
TOTAL	\$ 6,458,727,395	\$ 6,918,675,714	\$ 7,411,654,210	\$ 7,940,004,116	\$ 8,506,352,832	\$ 37,235,414,268

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Children (Age 18 and Under)	\$ 1,811,524,938	\$ 1,912,205,384	\$ 2,018,458,538	\$ 2,130,643,184	\$ 2,248,995,873	\$ 10,121,827,918
Adults: Non-Expansion	\$ 1,003,483,850	\$ 1,049,185,216	\$ 1,096,963,509	\$ 1,146,906,800	\$ 1,199,131,380	\$ 5,495,670,754
Adults: Expansion	\$ 3,518,391,637	\$ 3,691,137,353	\$ 3,872,371,048	\$ 4,062,476,931	\$ 4,261,925,309	\$ 19,406,302,278
TOTAL	\$ 6,333,400,425	\$ 6,652,527,953	\$ 6,987,793,094	\$ 7,340,026,915	\$ 7,710,052,562	\$ 35,023,800,949

VARIANCE	\$ 125,326,970	\$ 266,147,762	\$ 423,861,116	\$ 599,977,201	\$ 796,300,270	\$ 2,211,613,318
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ATTACHMENT IV: Public Notice

**NOTICE OF KENTUCKY DEPARTMENT FOR MEDICAID SERVICES
PUBLIC HEARINGS AND COMMENT PERIOD FOR
§1115 DEMONSTRATION WAIVER**

Pursuant to 42 CFR 431.408, notice is hereby given that the Kentucky Department for Medicaid Services will provide the public the opportunity to review and provide input on a §1115 demonstration waiver that will be submitted to the Centers for Medicare and Medicaid Services (CMS) to implement Kentucky HEALTH. This notice provides details about the waiver submission and serves to open the 30-day public comment period, which closes on Friday, July 22, 2016 at 5:00 p.m.

In addition to the 30-day public comment period in which the public will be able to provide written comments to the agency via the US postal service or electronic mail, the Commonwealth will also host two public hearings in which the public may provide verbal comments directly to the Agency. The public hearings will be held on the following dates and times at the following geographically distinct locations:

Tuesday, June 28, 2016, 10:00 AM – 12:00 PM (CST)

Western Kentucky University
Knicey Conference Center Auditorium
2355 Nashville Road
Bowling Green, KY 42101

Wednesday, June 29, 2016, 1:00 PM – 2:00 PM (EST)

Advisory Council for Medical Assistance (MAC) Special Meeting
Kentucky Capitol Annex
702 Capital Avenue
Frankfort, KY 40601

Wednesday, July 6, 2016, 11:00 AM – 1:00 PM (EST)

Hazard Community and Technical College Campus
Room 208, Jolly Classroom Center
1 Community College Drive
Hazard, KY 41701

Prior to finalizing the proposed waiver, the Commonwealth will consider all of the public comments received during the public comment period, both written and verbal. The comments will be summarized and addressed in the final draft of the waiver to be submitted to CMS.

WAIVER PROPOSAL SUMMARY

The §1115 demonstration waiver seeks to secure the long-term viability of Medicaid expansion in Kentucky, and introduce reforms intended to tailor the program to a non-disabled working-age adult population. The §1115 demonstration waiver creates an innovative, transformative healthcare program designed to not only improve health outcomes for members, but also improve their overall quality of life by addressing some of the underlying social determinants of health and helping to break the cycle of poverty. The §1115 demonstration waiver includes the

creation of the Kentucky HEALTH program and introduces comprehensive delivery system reforms targeting substance use disorder (SUD), chronic disease management, and managed care to improve quality and outcomes.

Kentucky HEALTH offers eligible individuals two pathways to coverage: (i) an employer premium assistance program, which assists individuals in purchasing their employer-sponsored health insurance plan; and (ii) a consumer-driven health plan option, which offers members a high-deductible health plan with commercial market benefits.

1. Employer Premium Assistance Program: Members who currently have access to health insurance through their employer will have the option to enroll their family into their employer-sponsored health insurance plan. Participation in the premium assistance program in lieu of the standard Kentucky HEALTH consumer driven health plan is optional during their first year of enrollment, but mandatory after the member's second year of eligibility, provided the member has been employed with their employer at least one year. The employer premium assistance program will subsidize the member's employer-sponsored health insurance plan.
2. Consumer-Driven Health Plan: This innovative, transformative healthcare program introduces commercial market health insurance features and encourages members to become active consumers of healthcare. Kentucky HEALTH will be managed through a managed care delivery system and will offer a new benefit package modeled after the Kentucky State Employees' Health Plan, while maintaining current mental health and substance use disorder benefits. In addition, Kentucky HEALTH provides a consumer-driven, high-deductible health plan paired with two member controlled healthcare spending accounts: (i) the deductible account, to cover deductible expenses; and (ii) the *My Rewards Account*, to accrue savings and earned incentive dollars that can be used to purchase enhanced benefits not covered in the base benefit package.

Kentucky HEALTH is designed to improve member health, prepare them for employment, and provide them with the tools to successfully transition to commercial market insurance coverage. First, the program focuses on engaging people to improve their overall health and wellbeing by creating incentives for preventive care, participation in disease management programs, and healthy lifestyles. Second, the program embraces commercial market policies and principles to familiarize participants with commercial market coverage by requiring member premiums and establishing an open enrollment period. Finally, the program actively assists members in transitioning to commercial market insurance coverage by requiring participation in minimum community engagement activities, incentivizing employment, and rewarding members who are successfully able to obtain employment and commercial health insurance for at least eighteen months.

GOALS & OBJECTIVES

The Kentucky HEALTH seeks to comprehensively transform Medicaid and accomplish the following goals:

1. Improve participants' health and help them be responsible for their health;

2. Encourage individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance;
3. Empower people to seek employment and transition to commercial health insurance coverage;
4. Implement delivery system reforms to improve quality and outcomes; and
5. Ensure fiscal sustainability.

ELIGIBILITY

Kentucky HEALTH is designed specifically for able-bodied working age adults and their families. Currently, the Commonwealth has expanded Medicaid to cover this new adult group up to 138% of the federal poverty level (FPL). This expansion will be maintained through Kentucky HEALTH. In addition, the Commonwealth will seek to transition all other non-disabled adult Medicaid recipients to Kentucky HEALTH. Finally, Kentucky HEALTH will seek to provide seamless coverage for families by including children covered under the KCHIP program.

Kentucky HEALTH will include the following eligibility categories:

- Individuals eligible in the new adult group pursuant to Section 1902(a)(10)(i)(VIII) of the Social Security Act (the Act);
- Low-income parents and caretaker relatives pursuant to Section 1931 of the Act;
- Individuals eligible for transitional medical assistance pursuant to Section 1925 of the Act;
- Women eligible in the pregnant women category;
- Newborn children;
- Medicaid eligible infants and children under age 19; and
- Children eligible under Title XXI CHIP Program.

Kentucky HEALTH may also affect member eligibility due to the introduction of several commercial market policies as well as the community engagement and employment initiative.

- Commercial Market Policies: Similar to the commercial health insurance market, individuals determined eligible for Kentucky HEALTH (excluding children and pregnant women) will be required to make their first month's required premium payment (as described in the Cost Sharing section below) prior to the start of benefits. Notwithstanding the foregoing, individuals with income at or below 100% FPL who do not make an initial premium payment within sixty calendar days from the date of the invoice, will begin benefits but subject to the non-payment penalty described below in the "Member Cost Sharing" section of this notice. In addition, Kentucky HEALTH will establish a client-specific open enrollment period. That is, if an individual is disenrolled from the program in accordance with current practice for failing to comply with annual eligibility redetermination requirements, the individual will be required to wait six months for a new open enrollment period. This policy will educate members of the importance of meeting commercial health insurance market open enrollment deadlines. Members may rejoin the program at any time prior to the six-month date by completing a financial or health literacy course.
- Community Engagement & Employment Initiative: To further the goal of helping members transition to commercial health insurance coverage, Kentucky HEALTH will implement a

community engagement and employment initiative. After three months of program eligibility, all able-bodied working age adult Kentucky HEALTH members will be required to participate in a community engagement activity, such as volunteer work, employment or job training, and job search activities. To help transition members into this requirement, the hour requirement will gradually increase to require at least twenty hours of community engagement activities each week after the first year. Children, pregnant women, individuals determined medically frail, and individuals who are the primary caregiver of a dependent will be exempt from this requirement.

Escalated Community Engagement & Employment Hours

Eligibility Period	Required Engagement Hours
1-3 months	0 hours per week
4-6 months	5 hours per week
6-9 months	10 hours per week
9-12 months	15 hours per week
12+ months	20 hours per week

ENROLLMENT & FISCAL PROJECTIONS

It is anticipated that enrollment in Kentucky HEALTH will fluctuate for a variety of reasons, including program non-compliance. Members may have health coverage temporarily suspended for not meeting the community engagement and employment initiative requirements or for failing to pay required monthly premiums. However, all individuals will have the opportunity to regain coverage at any time through compliance with the community engagement requirements, or by completing a health or financial literacy class and paying premiums. In addition, initial enrollment may fluctuate as individuals with little to no claims activity choose to leave the program rather than pay premiums, however, over time this will settle as individuals become familiar with the advantages of the program. Finally, in later demonstration years, more participants are expected to transition to commercial coverage.

The following table illustrates the State’s enrollment projections by total member months.

Estimated Enrollment Projections

Year	Without Waiver	KENTUCKY HEALTH	Difference
1 (2017)	14,070,000	13,856,000	(214,000)
2 (2018)	14,319,000	13,895,000	(424,000)
3 (2019)	14,576,000	13,945,000	(631,000)
4 (2020)	14,840,000	14,007,000	(833,000)
5 (2021)	15,111,000	14,080,000	(1,031,000)

Note: Values shown have been rounded and represent member months.

Over the five-year demonstration period, Kentucky HEALTH will save a total of approximately \$2.2 billion. The table below provides the estimated State and federal costs divided by year.

Estimated Fiscal Projections

Demonstration Year	Expenditures			State Share of Expenditure Difference
	Without Waiver	Kentucky HEALTH	Difference	
1 (2017)	\$ 6,458,700,000	\$ 6,332,300,000	\$ (126,500,000)	\$ (15,500,000)
2 (2018)	\$ 6,918,700,000	\$ 6,650,100,000	\$ (268,600,000)	\$ (34,900,000)
3 (2019)	\$ 7,411,700,000	\$ 6,983,900,000	\$ (427,700,000)	\$ (58,500,000)
4 (2020)	\$ 7,940,000,000	\$ 7,334,700,000	\$ (605,300,000)	\$ (95,600,000)
5 (2021)	\$ 8,506,400,000	\$ 7,703,000,000	\$ (803,300,000)	\$ (126,800,000)

Note: Values have been rounded.

BENEFITS

Kentucky HEALTH seeks to provide its members with a commercial health insurance experience in order to better prepare members to transition to commercial insurance. The Kentucky HEALTH benefit plan for the expansion population will align with the Kentucky State Employees' Health Plan, which provides a comprehensive commercial health insurance benefit package. Kentucky HEALTH will preserve all current mental health and SUD services. Further, additional benefits including dental services, vision services, over the counter medications, and gym membership reimbursement will be available through the member's *My Rewards Account*. Further, consistent with the goal of offering a commercial health insurance market experience, the Commonwealth will not provide coverage for non-emergency medical transportation (NEMT) to the newly eligible adult group, and will seek a waiver of this non-commercial health insurance benefit.

Children, pregnant women, medically frail individuals, and individuals eligible for Medicaid prior to the passage of the Affordable Care Act will be eligible to receive standard Medicaid State Plan benefits, including NEMT, vision services, and dental services. In addition, all children receiving services through the waiver will continue to receive all early and periodic screening, diagnostic, and treatment (EPSDT) services. The Commonwealth will make several minor modifications to the current State Plan covered services via State Plan Amendment to remove certain non-traditional Medicaid benefits that were added in 2014 with expansion, such as private duty nursing and allergy testing.

In addition, this §1115 demonstration waiver seeks to implement a new employer premium assistance program, which will allow eligible members to purchase their employer-sponsored health insurance plan in lieu of participating in Kentucky HEALTH. Members participating in the employer premium assistance option will have full access to the benefits and network of the employer plan; however, the Commonwealth will provide wrap-around benefits to ensure that members have access to all Kentucky HEALTH benefits not otherwise covered by the employer-sponsored health insurance plan.

MEMBER COST SHARING

All Kentucky HEALTH members, with the exception of pregnant women and children, will be required to pay a monthly premium amount, increasing on a sliding scale based on family income, ranging from \$1.00 per month up to a maximum of \$15.00 per month.

Kentucky HEALTH Sliding Scale Premium Contribution Amounts

Federal Poverty Level	Premium Payment
Under 25% FPL	\$1.00 per month
25-50% FPL	\$4.00 per month
51-100% FPL	\$8.00 per month
101-138% FPL	\$15.00 per month

To discourage long-term program dependency and to prepare higher income members for Marketplace coverage, premium requirements will gradually increase for individuals with income greater than 100% FPL each year the member remains Kentucky HEALTH, in accordance with the table below.

Increased Premium Amounts for Individuals Over 100% FPL

FPL	Year 1-2 Premium	Year 3 Premium	Year 4 Premium	Year 5+ Premium
101-138%	\$15.00	\$22.50	\$30.00	\$37.50

In addition to monthly premiums, Kentucky HEALTH will include a deductible (equal to \$1,000), and each member (except pregnant women and children who are exempt from all cost sharing) will be provided a fully funded deductible account to pay for the deductible. Preventive services, such as annual examinations, are covered without charge to the member and are not included in the plan deductible amount. After the \$1,000 deductible is met through the utilization of the member’s deductible account, the managed care plan will pay for all covered services in full.

Members who consistently make their required premium contributions will have access to the *My Rewards Account*. The *My Rewards Account* will contain incentive dollars which members may earn by completing specified activities designed to improve member health (i.e. participation in disease management course) and increase community engagement (i.e. volunteer work, participation in job search or training, etc.). In addition, members may transfer up to 50% of any unused balance in their deductible account to the *My Rewards Account* at the end of the benefit period. As funds accumulate in the *My Rewards Account*, the member may purchase additional benefits (as described in the Benefits section above).

Members will have a sixty-day grace period to make their required monthly premium payment contribution to the deductible account. Similar to commercial plans, Kentucky HEALTH will impose consequences for non-compliance in order to help educate members about standard commercial health insurance market policies. Therefore, individuals that do not pay a required premium payment within sixty calendar days from the due date will face a six-month non-payment penalty, as detailed in the table below. However, all individuals will have the ability to end their non-payment penalty period by completing one of the early re-entry options outlined in the table below.

Non-Payment Penalty

Member FPL	Non-Payment Penalty	Early Re-Entry Option
Above 100% FPL	<ul style="list-style-type: none"> Disenrolled from Kentucky HEALTH Re-enrollment waiting period of six months 	<ul style="list-style-type: none"> Pay past debt; Pay premium for reinstatement month; and Participate in financial or health literacy course
At or below 100% FPL & Medically Frail	<ul style="list-style-type: none"> State Plan copayments required for all services \$25 is deducted from the <i>My Rewards Account</i> <i>My Rewards Account</i> is suspended <ul style="list-style-type: none"> Not able to use funds in account Not able to accrue funds in account 	
Pregnant Women and Children	Not applicable. Exempt from all cost-sharing requirements.	Not applicable

As long as the member is consistently paying their monthly premium, Kentucky HEALTH will not require additional copayments for services. Kentucky HEALTH will only apply copayments to services for individuals with income at or below 100% FPL or for those determined medically frail. Required copayments during the member’s non-payment penalty period will be equal to the current copayments scheduled in the Kentucky Medicaid State Plan, which range from \$3.00 for a physician office visit and up to \$50.00 for hospital inpatient services.

In addition, to incentivize appropriate hospital emergency department utilization, Kentucky HEALTH will implement incentives and disincentive related to the members *My Rewards Account*. Members will be eligible for a \$20 financial contribution to the *My Rewards Account* for each year in which the member avoids unnecessary emergency room services and seeks appropriate alternative providers for care, and be subject to escalating deductions from the *My Rewards Account* for each inappropriate emergency room visit.

Inappropriate Emergency Room Utilization *My Rewards Account* Penalty

Inappropriate ER Visit	Account Deduction
1 st Visit	\$20
2 nd Visit	\$50
3 rd Visit or More	\$75

HEALTH CARE DELIVERY SYSTEM

Kentucky HEALTH will rely on the Commonwealth’s existing managed care delivery system. In addition to the creation of the Kentucky HEALTH program, the §1115 demonstration waiver will also introduce comprehensive delivery system reforms targeting substance use disorder (SUD), chronic disease management, and managed care to improve quality and outcomes.

- Substance Use Disorder: Kentucky HEALTH will maintain all current mental health and substance use disorder (SUD) benefits. However, this §1115 demonstration waiver will also implement a pilot program in ten to twenty select counties to improve access to

mental health and SUD services. Counties will be identified based on a recent CDC HIV/hepatitis C outbreak study, the State's existing Shaping Our Appalachian Region (SOAR) initiative, and public input received during the demonstration waiver public notice and comment period. Specifically, the Commonwealth will request a waiver of the Institutions for Mental Disease (IMD) exclusion to allow Medicaid reimbursement for short-term residential stays of up to thirty days in an IMD. The pilot program will also examine best practice improvements related to standards of care, care coordination between levels and settings of care, and strategies to address prescription drug abuse and opioid use disorder.

- Chronic Disease Management: The waiver will align various Kentucky HEALTH program components to support the Commonwealth's existing public health infrastructure and current efforts to improve chronic disease prevention and management. In addition, the Commonwealth will work with Kentucky's Medicaid managed care organizations to continue implementing best practices from nationally recognized disease management programs, such as the National Diabetes Prevention Program.
- Managed Care Reforms: Prior to implementing Kentucky HEALTH, the Commonwealth will align incentives across the delivery system by introducing mechanisms to control spending, as well as payment incentives for providers and the managed care organizations to improve quality and align with member incentives. In addition, the Kentucky Department for Medicaid Services will continue to seek improvements and administrative efficiencies in the existing Medicaid managed care program, such as uniform credentialing and formulary alignment.

IMPLEMENTATION

The Commonwealth will implement the Kentucky HEALTH program on a statewide basis on or about six months post-§1115 demonstration waiver approval; however, this date may vary depending on the approval date from CMS. The Kentucky HEALTH community engagement and employment initiative will be phased in on a county-by-county basis and may take longer. Implementation of this 1115 demonstration waiver will require the Commonwealth to amend the existing managed care contracts, modify systems and other operational procedures, and conduct a readiness review of various vendors. In addition to these tasks, the Commonwealth will also have to amend the Medicaid State Plan, amend the Alternative Benefit Plan, develop education materials, and prepare to transition existing members.

HYPOTHESES & EVALUATION

This Section 1115 demonstration waiver will investigate the following research hypotheses related to each program goal:

Goal 1: Improve participant's health and help them be responsible for their health

- Hypothesis: Kentucky HEALTH policies will promote member use of preventive and primary care.
 - Track and compare health service utilization rates between current Kentucky HEALTH members and their previous Medicaid enrollment category.

- Track preventive care utilization rates and trends among different age and gender groups.
- Hypothesis: Kentucky HEALTH policies will promote member compliance with chronic disease management.
 - Track and compare chronic disease management compliance rates between current Kentucky HEALTH members and their previous Medicaid enrollment category.
- Hypothesis: Kentucky HEALTH policies will reduce member hospitalization of ambulatory care sensitive conditions (ACSCs).
 - Track and compare ACSCs hospitalization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.
- Hypothesis: Kentucky HEALTH policies will increase access to substance use disorder (SUD) services with special focus on Institutions for Mental Diseases (IMD).
 - Track and compare inpatient specialty care/SUD utilization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.

Goal 2: Transform individuals from passive beneficiaries to active participants and consumers of healthcare who are prepared to use commercial health insurance

- Hypothesis: Kentucky HEALTH policies will provide incentives to monitor and managed the two member managed account funds.
 - Track and compare remaining balances in member deductible accounts at the end of each benefit period.
 - Track and compare balance in member *My Rewards Accounts* at the end of each benefit period.
 - Track account balances transferred from the deductible account to the *My Rewards Account* at the end of each benefit period, including number of members with unused deductible account balances at the end of each benefit period and the average amount transferred to the *My Rewards Account* at the end of each benefit period.
 - Track number of people checking their account balances, as well as how often they are checked (i.e. weekly, monthly, semi-annually, and annually).
- Hypothesis: Kentucky HEALTH policies will encourage healthy behaviors and increase member access to enhanced health services (such as gym memberships and over-the-counter medications).
 - Track and compare *My Reward Account* expenditures on enhanced health services.
 - Track and compare member achievement of healthy incentives contributions to the *My Rewards Account*.
 - Track and compare type of enhanced health services used by member *MY Rewards* accounts.
- Hypothesis: Kentucky HEALTH policies will promote member compliance with making premium payments.
 - Track premium initial and ongoing premium payments.
- Hypothesis: Kentucky HEALTH open enrollment policy will increase member compliance with redetermination process.

- Track member compliance with redetermination.
- Hypothesis: Kentucky HEALTH's incentive and disincentive policies related to non-emergency use of hospital emergency room will reduce inappropriate utilization among Kentucky HEALTH members.
 - Compare annual rates of inappropriate emergency department utilization between Kentucky Medicaid populations for the years *before waiver* (prior to 2017) and *after waiver* (2017 and beyond).
 - Survey Kentucky HEALTH members on whether the incentives and disincentives related to the *My Rewards Account* for appropriate emergency room utilization caused them to seek services with their primary care physician or in an alternative urgent care setting.
 - Compare annual rates of members subject to the escalating *My Rewards Account* disincentive based on repeated inappropriate hospital emergency department utilization.

Goal 3: Empower people to seek employment and transition to commercial health insurance coverage

- Hypothesis: Kentucky HEALTH policies will encourage members to increase community engagement.
 - Track and compare member achievement of community engagement and employment contributions to the *My Rewards Account*.
- Hypothesis: Kentucky HEALTH policies will encourage members to seek employment.
 - Track members participating in job search activities.
- Hypothesis: Kentucky HEALTH policies will encourage members to earn employment and ultimately transition to commercial health insurance coverage.
 - Track number of individuals successfully transitioning to commercial health insurance coverage and accessing the *My Rewards Account* bonus after eighteen months.
 - Track number of individuals employed over twenty hours per week.
 - Track earnings of members who earn employment.
- Hypothesis: The employer premium assistance program will increase the proportion of Kentucky residents under 138% FPL covered by employer sponsored insurance.
 - Track the number of Kentucky residents with income under 138% FPL covered by ESI over the demonstration.
 - Track employer premium assistance program member enrollment.
 - Track employer premium assistance program employer enrollment.
 - Track employer premium assistance program wrap-around coverage expenditures.
- Hypothesis: Kentucky HEALTH's sliding scale increase premium payment amounts will discourage dependency on public assistance and encourage members to transition to commercial health insurance coverage.
 - Compare annual rates of Medicaid enrollment between Kentucky Medicaid populations for the years *before waiver* (prior to 2017) and *after waiver* (2017 and beyond).

- Survey Kentucky HEALTH members on whether the sliding scale increased premium payment amount caused them to seek employment and/or other forms of health insurance coverage.
- Compare annual rates of members paying increased premium amounts based on continued annual enrollment in Kentucky HEALTH.

Goal 4: Implement Delivery System Reform to Improve Quality and Outcomes

- Hypothesis: Kentucky HEALTH policies will promote high quality healthcare delivered by providers.
 - Track managed care organizations ability to meet quality and outcome benchmarks within their service contracts.
 - Track Kentucky providers receiving bonus payments from the managed care organizations for meeting quality and outcomes standards.

Goal 5: Ensure fiscal sustainability

- Hypothesis: Kentucky HEALTH will remain budget-neutral for both the federal and State governments.
 - Conduct a budget neutrality analysis and document adherence to waiver margin.

WAIVER & EXPENDITURE AUTHORITIES

Below is a list of proposed waivers the Commonwealth will seek from CMS to implement Kentucky HEALTH:

- 1. Eligibility: Section 1902(a)(10)(A)**
 - To the extent necessary to enable Kentucky to not provide medical coverage until the first day of the month in which the Kentucky HEALTH member pays their first premium payment, or for members below 100% FPL who fail to make an initial premium payment, the first day of the month following the expiration of the 60-day payment period.
 - To the extent necessary to enable Kentucky to require Kentucky HEALTH members, as a condition of eligibility, to complete specified community engagement hours.
- 2. Retroactive Eligibility: Section 1902(a)(34)**
 - To the extent necessary to enable Kentucky to not provide medical coverage for any month prior to the month in which the member finalized enrollment in Kentucky HEALTH.
- 3. Cost-Sharing: Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**
 - To the extent necessary to enable Kentucky to require monthly premium payments not to exceed 5% of income, but no less than \$1.00 per month, for all Kentucky HEALTH members.
- 4. Amount, Duration, and Scope: Section 1902(a)(10)(B)**
 - To the extent necessary to enable Kentucky to vary cost-sharing requirements, such that premium contribution amounts increase each year members with income above 100% FPL remain on Kentucky HEALTH, not to exceed 5% of income, and to charge copayments in lieu of premiums for individuals at or below 100% FPL who fail to make their premium payment within the sixty-day payment period.

- To the extent necessary to allow Kentucky HEALTH members who continue to pay premium contributions to use their *My Rewards Account* to purchase specified enhanced benefits not otherwise available in the base Kentucky HEALTH benefit package.
 - To the extent necessary to enable Kentucky to allow individuals to receive the benefits provided through their employer-sponsored plan.
- 5. Reasonable Promptness: Section 1902(a)(3)/Section 1902(a)(8)**
- To the extent necessary to enable Kentucky to delay benefits, such that benefits do not begin until a member makes a premium contribution, or until the expiration of a 60-day payment period for members below 100% FPL who fail to make a premium contribution.
 - To the extent necessary to enable Kentucky to prohibit re-enrollment for up to six months for Kentucky HEALTH members above 100% FPL who are disenrolled for failure to make their required premium contributions within 60 days of the due date.
 - To the extent necessary to enable Kentucky to implement an open enrollment period for Kentucky HEALTH, such that members who are disenrolled for failure to complete redetermination process will be required to wait until their next open enrollment period to re-enroll (up to six months).
- 6. Freedom of Choice: Section 1902(a)(23)**
- To the extent necessary to enable Kentucky to restrict the freedom of choice of providers for demonstration eligibility groups.
- 7. Non-Emergency Transportation: Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**
- To the extent necessary to relieve Kentucky of the requirement to assure non-emergency medical transportation to and from medical providers for Kentucky HEALTH members.

In addition, the Commonwealth requests that expenditures related to providing services in an Institution for Mental Disease (IMD), in participating pilot project counties, be regarded as expenditures under the Commonwealth's Medicaid Title XIX State Plan.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

All information regarding the Kentucky HEALTH §1115 demonstration waiver, including this public notice, the waiver application, and other documentation regarding the proposal are available at: <http://chfs.ky.gov/kentuckyhealth>. In addition, the Kentucky HEALTH §1115 demonstration waiver application is available for in-person public review at Cabinet for Health and Family Services, Office of the Secretary, 275 E. Main St., Frankfort, KY 40621.

Written comments regarding the Kentucky HEALTH waiver application may be mailed to Commissioner Stephen Miller, Department for Medicaid Services, 275 E. Main Street, Frankfort, KY 40621. Comments may also be sent via electronic mail to kyhealth@ky.gov. All comments must be received by Friday, July 22, 2016 at 5:00 p.m.

NOTICE OF KENTUCKY DEPARTMENT FOR MEDICAID SERVICES PUBLIC COMMENT PERIOD FOR §1115 DEMONSTRATION WAIVER

Notice is hereby given that the Kentucky Department for Medicaid Services (DMS) will extend the public comment period on the §1115 demonstration waiver that will be submitted to the Centers for Medicare and Medicaid Services (CMS) to implement Kentucky HEALTH. This notice provides details about the waiver submission and serves as formal notice of the public comment period extension through Friday, August 12, 2016 at 5:00 p.m.

DMS previously held open a 30-day public comment period on the same Kentucky HEALTH waiver from June 22, 2016 through July 22, 2016. In response to the volume of comments that were submitted on the final day of the comment period, including after the 5:00 p.m. deadline, DMS is extending the comment period through 5:00 p.m. on August 12, 2016. This will allow for the numerous comments that came in after the official deadline to be incorporated, as well as allow any individual who was unable to comment previously the opportunity to do so.

Prior to finalizing the proposed waiver, the Commonwealth will consider all comments received on the Kentucky HEALTH waiver, including the original 30-day public comment period as well as this extended public comment period. All comments will be summarized and addressed in the final waiver to be submitted to CMS.

WAIVER PROPOSAL SUMMARY

The §1115 demonstration waiver seeks to secure the long-term viability of Medicaid expansion in Kentucky, and introduce reforms intended to tailor the program to a non-disabled working-age adult population. The §1115 demonstration waiver creates an innovative, transformative healthcare program designed to not only improve health outcomes for members, but also improve their overall quality of life by addressing some of the underlying social determinants of health and helping to break the cycle of poverty. The §1115 demonstration waiver includes the creation of the Kentucky HEALTH program and introduces comprehensive delivery system reforms targeting substance use disorder (SUD), chronic disease management, and managed care to improve quality and outcomes.

Kentucky HEALTH offers eligible individuals two pathways to coverage: (i) an employer premium assistance program, which assists individuals in purchasing their employer-sponsored health insurance plan; and (ii) a consumer-driven health plan option, which offers members a high-deductible health plan with commercial market benefits.

1. Employer Premium Assistance Program: Members who currently have access to health insurance through their employer will have the option to enroll their family into their employer-sponsored health insurance plan. Participation in the premium assistance program in lieu of the standard Kentucky HEALTH consumer driven health plan is optional during their first year of enrollment, but mandatory after the member's second year of eligibility, provided the member has been employed with their employer at least one year. The employer premium assistance program will subsidize the member's employer-sponsored health insurance plan.

2. Consumer-Driven Health Plan: This innovative, transformative healthcare program introduces commercial market health insurance features and encourages members to become active consumers of healthcare. Kentucky HEALTH will be managed through a managed care delivery system and will offer a new benefit package modeled after the Kentucky State Employees' Health Plan, while maintaining current mental health and substance use disorder benefits. In addition, Kentucky HEALTH provides a consumer-driven, high-deductible health plan paired with two member controlled healthcare spending accounts: (i) the deductible account, to cover deductible expenses; and (ii) the *My Rewards Account*, to accrue savings and earned incentive dollars that can be used to purchase enhanced benefits not covered in the base benefit package.

Kentucky HEALTH is designed to improve member health, prepare them for employment, and provide them with the tools to successfully transition to commercial market insurance coverage. First, the program focuses on engaging people to improve their overall health and wellbeing by creating incentives for preventive care, participation in disease management programs, and healthy lifestyles. Second, the program embraces commercial market policies and principles to familiarize participants with commercial market coverage by requiring member premiums and establishing an open enrollment period. Finally, the program actively assists members in transitioning to commercial market insurance coverage by requiring participation in minimum community engagement activities, incentivizing employment, and rewarding members who are successfully able to obtain employment and commercial health insurance for at least eighteen months.

GOALS & OBJECTIVES

The Kentucky HEALTH seeks to comprehensively transform Medicaid and accomplish the following goals:

1. Improve participants' health and help them be responsible for their health;
2. Encourage individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance;
3. Empower people to seek employment and transition to commercial health insurance coverage;
4. Implement delivery system reforms to improve quality and outcomes; and
5. Ensure fiscal sustainability.

ELIGIBILITY

Kentucky HEALTH is designed specifically for able-bodied working age adults and their families. Currently, the Commonwealth has expanded Medicaid to cover this new adult group up to 138% of the federal poverty level (FPL). This expansion will be maintained through Kentucky HEALTH. In addition, the Commonwealth will seek to transition all other non-disabled adult Medicaid recipients to Kentucky HEALTH. Finally, Kentucky HEALTH will seek to provide seamless coverage for families by including children covered under the KCHIP program.

Kentucky HEALTH will include the following eligibility categories:

- Individuals eligible in the new adult group pursuant to Section 1902(a)(10)(i)(VIII) of the Social Security Act (the Act);
- Low-income parents and caretaker relatives pursuant to Section 1931 of the Act;
- Individuals eligible for transitional medical assistance pursuant to Section 1925 of the Act;
- Women eligible in the pregnant women category;
- Newborn children;
- Medicaid eligible infants and children under age 19; and
- Children eligible under Title XXI CHIP Program.

Kentucky HEALTH may also affect member eligibility due to the introduction of several commercial market policies as well as the community engagement and employment initiative.

- Commercial Market Policies: Similar to the commercial health insurance market, individuals determined eligible for Kentucky HEALTH (excluding children and pregnant women) will be required to make their first month’s required premium payment (as described in the Cost Sharing section below) prior to the start of benefits. Notwithstanding the foregoing, individuals with income at or below 100% FPL who do not make an initial premium payment within sixty calendar days from the date of the invoice, will begin benefits but subject to the non-payment penalty described below in the “Member Cost Sharing” section of this notice. In addition, Kentucky HEALTH will establish a client-specific open enrollment period. That is, if an individual is disenrolled from the program in accordance with current practice for failing to comply with annual eligibility redetermination requirements, the individual will be required to wait six months for a new open enrollment period. This policy will educate members of the importance of meeting commercial health insurance market open enrollment deadlines. Members may rejoin the program at any time prior to the six-month date by completing a financial or health literacy course.
- Community Engagement & Employment Initiative: To further the goal of helping members transition to commercial health insurance coverage, Kentucky HEALTH will implement a community engagement and employment initiative. After three months of program eligibility, all able-bodied working age adult Kentucky HEALTH members will be required to participate in a community engagement activity, such as volunteer work, employment or job training, and job search activities. To help transition members into this requirement, the hour requirement will gradually increase to require at least twenty hours of community engagement activities each week after the first year. Children, pregnant women, individuals determined medically frail, and individuals who are the primary caregiver of a dependent will be exempt from this requirement.

Escalated Community Engagement & Employment Hours

Eligibility Period	Required Engagement Hours
1-3 months	0 hours per week
4-6 months	5 hours per week
6-9 months	10 hours per week
9-12 months	15 hours per week
12+ months	20 hours per week

ENROLLMENT & FISCAL PROJECTIONS

It is anticipated that enrollment in Kentucky HEALTH will fluctuate for a variety of reasons, including program non-compliance. Members may have health coverage temporarily suspended for not meeting the community engagement and employment initiative requirements or for failing to pay required monthly premiums. However, all individuals will have the opportunity to regain coverage at any time through compliance with the community engagement requirements, or by completing a health or financial literacy class and paying premiums. In addition, initial enrollment may fluctuate as individuals with little to no claims activity choose to leave the program rather than pay premiums, however, over time this will settle as individuals become familiar with the advantages of the program. Finally, in later demonstration years, more participants are expected to transition to commercial coverage.

The following table illustrates the State’s enrollment projections by total member months.

Estimated Enrollment Projections

Year	Without Waiver	KENTUCKY HEALTH	Difference
1 (2017)	14,070,000	13,856,000	(214,000)
2 (2018)	14,319,000	13,895,000	(424,000)
3 (2019)	14,576,000	13,945,000	(631,000)
4 (2020)	14,840,000	14,007,000	(833,000)
5 (2021)	15,111,000	14,080,000	(1,031,000)

Note: Values shown have been rounded and represent member months.

Over the five-year demonstration period, Kentucky HEALTH will save a total of approximately \$2.2 billion. The table below provides the estimated State and federal costs divided by year.

Estimated Fiscal Projections

Demonstration Year	Expenditures			State Share of Expenditure Difference
	Without Waiver	Kentucky HEALTH	Difference	
1 (2017)	\$ 6,458,700,000	\$ 6,332,300,000	\$ (126,500,000)	\$ (15,500,000)
2 (2018)	\$ 6,918,700,000	\$ 6,650,100,000	\$ (268,600,000)	\$ (34,900,000)
3 (2019)	\$ 7,411,700,000	\$ 6,983,900,000	\$ (427,700,000)	\$ (58,500,000)
4 (2020)	\$ 7,940,000,000	\$ 7,334,700,000	\$ (605,300,000)	\$ (95,600,000)
5 (2021)	\$ 8,506,400,000	\$ 7,703,000,000	\$ (803,300,000)	\$ (126,800,000)

Note: Values have been rounded.

BENEFITS

Kentucky HEALTH seeks to provide its members with a commercial health insurance experience in order to better prepare members to transition to commercial insurance. The Kentucky HEALTH benefit plan for the expansion population will align with the Kentucky State Employees’ Health Plan, which provides a comprehensive commercial health insurance benefit package. Kentucky HEALTH will preserve all current mental health and SUD services. Further, additional benefits including dental services, vision services, over the counter medications, and gym membership reimbursement will be available through the member’s *My Rewards Account*.

Further, consistent with the goal of offering a commercial health insurance market experience, the Commonwealth will not provide coverage for non-emergency medical transportation (NEMT) to the newly eligible adult group, and will seek a waiver of this non-commercial health insurance benefit.

Children, pregnant women, medically frail individuals, and individuals eligible for Medicaid prior to the passage of the Affordable Care Act will be eligible to receive standard Medicaid State Plan benefits, including NEMT, vision services, and dental services. In addition, all children receiving services through the waiver will continue to receive all early and periodic screening, diagnostic, and treatment (EPSDT) services. The Commonwealth will make several minor modifications to the current State Plan covered services via State Plan Amendment to remove certain non-traditional Medicaid benefits that were added in 2014 with expansion, such as private duty nursing and allergy testing.

In addition, this §1115 demonstration waiver seeks to implement a new employer premium assistance program, which will allow eligible members to purchase their employer-sponsored health insurance plan in lieu of participating in Kentucky HEALTH. Members participating in the employer premium assistance option will have full access to the benefits and network of the employer plan; however, the Commonwealth will provide wrap-around benefits to ensure that members have access to all Kentucky HEALTH benefits not otherwise covered by the employer-sponsored health insurance plan.

MEMBER COST SHARING

All Kentucky HEALTH members, with the exception of pregnant women and children, will be required to pay a monthly premium amount, increasing on a sliding scale based on family income, ranging from \$1.00 per month up to a maximum of \$15.00 per month.

Kentucky HEALTH Sliding Scale Premium Contribution Amounts

Federal Poverty Level	Premium Payment
Under 25% FPL	\$1.00 per month
25-50% FPL	\$4.00 per month
51-100% FPL	\$8.00 per month
101-138% FPL	\$15.00 per month

To discourage long-term program dependency and to prepare higher income members for Marketplace coverage, premium requirements will gradually increase for individuals with income greater than 100% FPL each year the member remains Kentucky HEALTH, in accordance with the table below.

Increased Premium Amounts for Individuals Over 100% FPL

FPL	Year 1-2 Premium	Year 3 Premium	Year 4 Premium	Year 5+ Premium
101-138%	\$15.00	\$22.50	\$30.00	\$37.50

In addition to monthly premiums, Kentucky HEALTH will include a deductible (equal to \$1,000), and each member (except pregnant women and children who are exempt from all cost

sharing) will be provided a fully funded deductible account to pay for the deductible. Preventive services, such as annual examinations, are covered without charge to the member and are not included in the plan deductible amount. After the \$1,000 deductible is met through the utilization of the member’s deductible account, the managed care plan will pay for all covered services in full.

Members who consistently make their required premium contributions will have access to the *My Rewards Account*. The *My Rewards Account* will contain incentive dollars which members may earn by completing specified activities designed to improve member health (i.e. participation in disease management course) and increase community engagement (i.e. volunteer work, participation in job search or training, etc.). In addition, members may transfer up to 50% of any unused balance in their deductible account to the *My Rewards Account* at the end of the benefit period. As funds accumulate in the *My Rewards Account*, the member may purchase additional benefits (as described in the Benefits section above).

Members will have a sixty-day grace period to make their required monthly premium payment contribution to the deductible account. Similar to commercial plans, Kentucky HEALTH will impose consequences for non-compliance in order to help educate members about standard commercial health insurance market policies. Therefore, individuals that do not pay a required premium payment within sixty calendar days from the due date will face a six-month non-payment penalty, as detailed in the table below. However, all individuals will have the ability to end their non-payment penalty period by completing one of the early re-entry options outlined in the table below.

Non-Payment Penalty

Member FPL	Non-Payment Penalty	Early Re-Entry Option
Above 100% FPL	<ul style="list-style-type: none"> • Disenrolled from Kentucky HEALTH • Re-enrollment waiting period of six months 	<ul style="list-style-type: none"> • Pay past debt; • Pay premium for reinstatement month; and • Participate in financial or health literacy course
At or below 100% FPL & Medically Frail	<ul style="list-style-type: none"> • State Plan copayments required for all services • \$25 is deducted from the <i>My Rewards Account</i> • <i>My Rewards Account</i> is suspended <ul style="list-style-type: none"> ○ Not able to use funds in account ○ Not able to accrue funds in account 	
Pregnant Women and Children	Not applicable. Exempt from all cost-sharing requirements.	Not applicable

As long as the member is consistently paying their monthly premium, Kentucky HEALTH will not require additional copayments for services. Kentucky HEALTH will only apply copayments to services for individuals with income at or below 100% FPL or for those determined medically frail. Required copayments during the member’s non-payment penalty period will be equal to the

current copayments scheduled in the Kentucky Medicaid State Plan, which range from \$3.00 for a physician office visit and up to \$50.00 for hospital inpatient services.

In addition, to incentivize appropriate hospital emergency department utilization, Kentucky HEALTH will implement incentives and disincentive related to the members *My Rewards Account*. Members will be eligible for a \$20 financial contribution to the *My Rewards Account* for each year in which the member avoids unnecessary emergency room services and seeks appropriate alternative providers for care, and be subject to escalating deductions from the *My Rewards Account* for each inappropriate emergency room visit.

Inappropriate Emergency Room Utilization *My Rewards Account* Penalty

Inappropriate ER Visit	Account Deduction
1 st Visit	\$20
2 nd Visit	\$50
3rd Visit or More	\$75

HEALTH CARE DELIVERY SYSTEM

Kentucky HEALTH will rely on the Commonwealth’s existing managed care delivery system. In addition to the creation of the Kentucky HEALTH program, the §1115 demonstration waiver will also introduce comprehensive delivery system reforms targeting substance use disorder (SUD), chronic disease management, and managed care to improve quality and outcomes.

- **Substance Use Disorder:** Kentucky HEALTH will maintain all current mental health and substance use disorder (SUD) benefits. However, this §1115 demonstration waiver will also implement a pilot program in ten to twenty select counties to improve access to mental health and SUD services. Counties will be identified based on a recent CDC HIV/hepatitis C outbreak study, the State’s existing Shaping Our Appalachian Region (SOAR) initiative, and public input received during the demonstration waiver public notice and comment period. Specifically, the Commonwealth will request a waiver of the Institutions for Mental Disease (IMD) exclusion to allow Medicaid reimbursement for short-term residential stays of up to thirty days in an IMD. The pilot program will also examine best practice improvements related to standards of care, care coordination between levels and settings of care, and strategies to address prescription drug abuse and opioid use disorder.
- **Chronic Disease Management:** The waiver will align various Kentucky HEALTH program components to support the Commonwealth’s existing public health infrastructure and current efforts to improve chronic disease prevention and management. In addition, the Commonwealth will work with Kentucky’s Medicaid managed care organizations to continue implementing best practices from nationally recognized disease management programs, such as the National Diabetes Prevention Program.
- **Managed Care Reforms:** Prior to implementing Kentucky HEALTH, the Commonwealth will align incentives across the delivery system by introducing mechanisms to control spending, as well as payment incentives for providers and the managed care organizations to improve quality and align with member incentives. In addition, the

Kentucky Department for Medicaid Services will continue to seek improvements and administrative efficiencies in the existing Medicaid managed care program, such as uniform credentialing and formulary alignment.

IMPLEMENTATION

The Commonwealth will implement the Kentucky HEALTH program on a statewide basis on or about six months post-§1115 demonstration waiver approval; however, this date may vary depending on the approval date from CMS. The Kentucky HEALTH community engagement and employment initiative will be phased in on a county-by-county basis and may take longer. Implementation of this 1115 demonstration waiver will require the Commonwealth to amend the existing managed care contracts, modify systems and other operational procedures, and conduct a readiness review of various vendors. In addition to these tasks, the Commonwealth will also have to amend the Medicaid State Plan, amend the Alternative Benefit Plan, develop education materials, and prepare to transition existing members.

HYPOTHESES & EVALUATION

This Section 1115 demonstration waiver will investigate the following research hypotheses related to each program goal:

Goal 1: Improve participant's health and help them be responsible for their health

- Hypothesis: Kentucky HEALTH policies will promote member use of preventive and primary care.
 - Track and compare health service utilization rates between current Kentucky HEALTH members and their previous Medicaid enrollment category.
 - Track preventive care utilization rates and trends among different age and gender groups.
- Hypothesis: Kentucky HEALTH policies will promote member compliance with chronic disease management.
 - Track and compare chronic disease management compliance rates between current Kentucky HEALTH members and their previous Medicaid enrollment category.
- Hypothesis: Kentucky HEALTH policies will reduce member hospitalization of ambulatory care sensitive conditions (ACSCs).
 - Track and compare ACSCs hospitalization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.
- Hypothesis: Kentucky HEALTH policies will increase access to substance use disorder (SUD) services with special focus on Institutions for Mental Diseases (IMD).
 - Track and compare inpatient specialty care/SUD utilization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.

Goal 2: Transform individuals from passive beneficiaries to active participants and consumers of healthcare who are prepared to use commercial health insurance

- Hypothesis: Kentucky HEALTH policies will provide incentives to monitor and managed the two member managed account funds.

- Track and compare remaining balances in member deductible accounts at the end of each benefit period.
- Track and compare balance in member *My Rewards Accounts* at the end of each benefit period.
- Track account balances transferred from the deductible account to the *My Rewards Account* at the end of each benefit period, including number of members with unused deductible account balances at the end of each benefit period and the average amount transferred to the *My Rewards Account* at the end of each benefit period.
- Track number of people checking their account balances, as well as how often they are checked (i.e. weekly, monthly, semi-annually, and annually).
- Hypothesis: Kentucky HEALTH policies will encourage healthy behaviors and increase member access to enhanced health services (such as gym memberships and over-the-counter medications).
 - Track and compare *My Reward Account* expenditures on enhanced health services.
 - Track and compare member achievement of healthy incentives contributions to the *My Rewards Account*.
 - Track and compare type of enhanced health services used by member *MY Rewards* accounts.
- Hypothesis: Kentucky HEALTH policies will promote member compliance with making premium payments.
 - Track premium initial and ongoing premium payments.
- Hypothesis: Kentucky HEALTH open enrollment policy will increase member compliance with redetermination process.
 - Track member compliance with redetermination.
- Hypothesis: Kentucky HEALTH's incentive and disincentive policies related to non-emergency use of hospital emergency room will reduce inappropriate utilization among Kentucky HEALTH members.
 - Compare annual rates of inappropriate emergency department utilization between Kentucky Medicaid populations for the years *before waiver* (prior to 2017) and *after waiver* (2017 and beyond).
 - Survey Kentucky HEALTH members on whether the incentives and disincentives related to the *My Rewards Account* for appropriate emergency room utilization caused them to seek services with their primary care physician or in an alternative urgent care setting.
 - Compare annual rates of members subject to the escalating *My Rewards Account* disincentive based on repeated inappropriate hospital emergency department utilization.

Goal 3: Empower people to seek employment and transition to commercial health insurance coverage

- Hypothesis: Kentucky HEALTH policies will encourage members to increase community engagement.
 - Track and compare member achievement of community engagement and employment contributions to the *My Rewards Account*.

- Hypothesis: Kentucky HEALTH policies will encourage members to seek employment.
 - Track members participating in job search activities.
- Hypothesis: Kentucky HEALTH policies will encourage members to earn employment and ultimately transition to commercial health insurance coverage.
 - Track number of individuals successfully transitioning to commercial health insurance coverage and accessing the *My Rewards Account* bonus after eighteen months.
 - Track number of individuals employed over twenty hours per week.
 - Track earnings of members who earn employment.
- Hypothesis: The employer premium assistance program will increase the proportion of Kentucky residents under 138% FPL covered by employer sponsored insurance.
 - Track the number of Kentucky residents with income under 138% FPL covered by ESI over the demonstration.
 - Track employer premium assistance program member enrollment.
 - Track employer premium assistance program employer enrollment.
 - Track employer premium assistance program wrap-around coverage expenditures.
- Hypothesis: Kentucky HEALTH's sliding scale increase premium payment amounts will discourage dependency on public assistance and encourage members to transition to commercial health insurance coverage.
 - Compare annual rates of Medicaid enrollment between Kentucky Medicaid populations for the years *before waiver* (prior to 2017) and *after waiver* (2017 and beyond).
 - Survey Kentucky HEALTH members on whether the sliding scale increased premium payment amount caused them to seek employment and/or other forms of health insurance coverage.
 - Compare annual rates of members paying increased premium amounts based on continued annual enrollment in Kentucky HEALTH.

Goal 4: Implement Delivery System Reform to Improve Quality and Outcomes

- Hypothesis: Kentucky HEALTH policies will promote high quality healthcare delivered by providers.
 - Track managed care organizations ability to meet quality and outcome benchmarks within their service contracts.
 - Track Kentucky providers receiving bonus payments from the managed care organizations for meeting quality and outcomes standards.

Goal 5: Ensure fiscal sustainability

- Hypothesis: Kentucky HEALTH will remain budget-neutral for both the federal and State governments.
 - Conduct a budget neutrality analysis and document adherence to waiver margin.

WAIVER & EXPENDITURE AUTHORITIES

Below is a list of proposed waivers the Commonwealth will seek from CMS to implement Kentucky HEALTH:

1. Eligibility: Section 1902(a)(10)(A)

- To the extent necessary to enable Kentucky to not provide medical coverage until the first day of the month in which the Kentucky HEALTH member pays their first premium payment, or for members below 100% FPL who fail to make an initial premium payment, the first day of the month following the expiration of the 60-day payment period.
- To the extent necessary to enable Kentucky to require Kentucky HEALTH members, as a condition of eligibility, to complete specified community engagement hours.

2. Retroactive Eligibility: Section 1902(a)(34)

- To the extent necessary to enable Kentucky to not provide medical coverage for any month prior to the month in which the member finalized enrollment in Kentucky HEALTH.

3. Cost-Sharing: Section 1902(a)(14) insofar as it incorporates 1916 and 1916A

- To the extent necessary to enable Kentucky to require monthly premium payments not to exceed 5% of income, but no less than \$1.00 per month, for all Kentucky HEALTH members.

4. Amount, Duration, and Scope: Section 1902(a)(10)(B)

- To the extent necessary to enable Kentucky to vary cost-sharing requirements, such that premium contribution amounts increase each year members with income above 100% FPL remain on Kentucky HEALTH, not to exceed 5% of income, and to charge copayments in lieu of premiums for individuals at or below 100% FPL who fail to make their premium payment within the sixty-day payment period.
- To the extent necessary to allow Kentucky HEALTH members who continue to pay premium contributions to use their *My Rewards Account* to purchase specified enhanced benefits not otherwise available in the base Kentucky HEALTH benefit package.
- To the extent necessary to enable Kentucky to allow individuals to receive the benefits provided through their employer-sponsored plan.

5. Reasonable Promptness: Section 1902(a)(3)/Section 1902(a)(8)

- To the extent necessary to enable Kentucky to delay benefits, such that benefits do not begin until a member makes a premium contribution, or until the expiration of a 60-day payment period for members below 100% FPL who fail to make a premium contribution.
- To the extent necessary to enable Kentucky to prohibit re-enrollment for up to six months for Kentucky HEALTH members above 100% FPL who are disenrolled for failure to make their required premium contributions within 60 days of the due date.
- To the extent necessary to enable Kentucky to implement an open enrollment period for Kentucky HEALTH, such that members who are disenrolled for failure to complete redetermination process will be required to wait until their next open enrollment period to re-enroll (up to six months).

6. Freedom of Choice: Section 1902(a)(23)

- To the extent necessary to enable Kentucky to restrict the freedom of choice of providers for demonstration eligibility groups.

7. Non-Emergency Transportation: Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53

- To the extent necessary to relieve Kentucky of the requirement to assure non-emergency medical transportation to and from medical providers for Kentucky HEALTH members.

In addition, the Commonwealth requests that expenditures related to providing services in an Institution for Mental Disease (IMD), in participating pilot project counties, be regarded as expenditures under the Commonwealth's Medicaid Title XIX State Plan.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

All information regarding the Kentucky HEALTH §1115 demonstration waiver, including this public notice, the waiver application, and other documentation regarding the proposal are available at: <http://chfs.ky.gov/kentuckyhealth>. In addition, the Kentucky HEALTH §1115 demonstration waiver application is available for in-person public review at Cabinet for Health and Family Services, Office of the Secretary, 275 E. Main St., Frankfort, KY 40621.

Written comments regarding the Kentucky HEALTH waiver application may be mailed to Commissioner Stephen Miller, Department for Medicaid Services, 275 E. Main Street, Frankfort, KY 40621. Comments may also be sent via electronic mail to kyhealth@ky.gov.

All comments must be received by **Friday, August 12, 2016 at 5:00 p.m.**



COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

MATTHEW G. BEVIN
GOVERNOR

700 CAPITOL AVENUE
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FRANKFORT, KY 40601
(502) 564-2611
FAX: (502) 564-2517

July 3, 2017

Mr. Brian Neale
Director, Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Re: Kentucky HEALTH §1115 Demonstration Modification Request

Dear Mr. Neale,

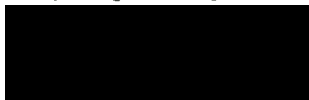
The Commonwealth appreciates CMS' continued consideration of the Kentucky HEALTH 1115 demonstration application, submitted on August 24, 2016. As Kentucky continues to plan for successful implementation of the Kentucky HEALTH program, the Commonwealth has identified several opportunities for program modifications to support ease of administering program operations. Attached please find a description of the requested modifications to the original demonstration application for your consideration.

Although our proposed changes are a logical outgrowth of the original waiver application resulting from the Commonwealth's ongoing program development efforts and continued negotiations with your team, the Commonwealth wishes to continue the transparency with which we have been developing 1115-related policy. Per our conversations, although these modifications do not meet the standard for requiring public input as set forth at 42 CFR 431.408, we have decided to voluntarily take public comment on the proposed revisions. However, to prevent delay in our active negotiations, the Commonwealth wishes to accept CMS' offer to run a voluntary federal comment period concurrently with our state comment period.

We look forward to your review of this request. Please note, the Commonwealth will submit a revised version of the modification request incorporating public comments at the conclusion of the 30-day public comment period. Please do not hesitate to contact me if you have any questions with the submission.

Again, thank you for your continued partnership as we work to transform Medicaid in Kentucky.

Very respectfully,



Adam Meier
Deputy Chief of Staff for Policy
Governor's Office





Helping to Engage and Achieve Long Term Health

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Section 1: Overview of Kentucky HEALTH Operational Modification Request

Kentucky HEALTH is the Commonwealth of Kentucky's Section 1115 demonstration project focused on "Helping to Engage and Achieve Long Term Health (HEALTH)." The proposed demonstration project is part of an overall initiative to transform the Kentucky Medicaid program to empower individuals to improve their health. The program offers opportunities for individuals to take control of their life through taking an active role in not only their health, but also in their communities by working to gain skills needed for long-term independence and success. Only by helping members engage in their healthcare and their communities will the Commonwealth achieve long term improvements in the health of its citizens and improved fiscal health for the Commonwealth and its Medicaid program. To this end, the Commonwealth continues to seek a five-year Section 1115 waiver from the Centers for Medicare & Medicaid Services (CMS) to implement and evaluate Kentucky HEALTH, a demonstration project designed to provide dignity to individuals as they move towards self-reliability, accountability, and ultimately independence from public assistance.

The Commonwealth appreciates CMS' continued consideration of the Kentucky HEALTH 1115 waiver application, submitted on August 24, 2016. As Kentucky continues to plan for successful implementation of the Kentucky HEALTH program, the Commonwealth continuously seeks to identify areas in which the program can be enhanced to streamline program implementation and operation for the Commonwealth, its federal partners at CMS, members, providers, and other key stakeholders. Because of continued negotiations with CMS, feedback from current vendors and other stakeholders, and after further technical development of the program, the Commonwealth formally submits the following operational modifications to the August 24, 2016 application:

1. **Static Community Engagement and Employment Hours:** The original waiver application requested graduated hours for community engagement that increased by five hours for every quarter the member was enrolled in Kentucky HEALTH. However, due to the various exceptions to the community engagement and employment requirements and the various penalties applicable to members in Kentucky HEALTH, tracking these hour increases by each member's unique set of circumstances and variable factors will be challenging for both IT systems and member communications. To mitigate these administrative complexities, Kentucky seeks to replace the graduated hour requirements with a stable and unchanging participation requirement that aligns with existing public programs. Specifically, Kentucky HEALTH seeks to align with the Supplemental Nutrition Assistance Program (SNAP) by requiring 20 hours per week (80 hours per month) for non-exempt individuals.
2. **Disenrollment for Failure to Report a Change in Circumstance:** To mirror the commercial market, the original waiver application included a provision requesting a six-month member disenrollment period for members who fail to complete their redetermination paperwork. Timely and accurate eligibility information is critical for the administration of Kentucky HEALTH, where there are a variety of factors that impact eligibility. Several of the eligibility factors rely on members providing information on changes in income that could impact the premium amount, changes in employment status that could impact access to employer sponsored insurance, and self-attestation of community engagement and employment hours. To dissuade members from failing to timely report changes in income and/or employment or falsely reporting community engagement or employment hours, the Commonwealth would like to apply the same six-month disenrollment penalty for intentional fraudulent actions that would undermine the integrity of the Kentucky HEALTH program.

3. **Maintenance of Current Presumptive Eligibility Sites:** The original waiver application contemplated expansion of presumptive eligibility (PE) sites with the implementation of Kentucky HEALTH. However, after further review, the Commonwealth has determined that implementation would be burdensome for members and PE providers. Furthermore, expansion of PE is not necessary to ensure timely enrollment into Kentucky HEALTH due to implementation of the fast track enrollment option. Therefore, Kentucky no longer wishes to seek the expansion of PE sites originally contemplated in the Kentucky HEALTH demonstration application.

Section 2: Discussion of Proposed Modifications to Original 1115 Application

2.1 Static Community Engagement and Employment Hours

As noted above, the original Kentucky HEALTH waiver application requested graduated hours for the community engagement and employment initiative. The original design included a five-hour increase in community engagement hours for every quarter the member was enrolled in the program. However, since submission of the original request, Kentucky has determined that tracking these hour increases by each member's unique set of circumstances and variable factors proves extremely challenging for member communications and program IT systems.

To mitigate these administrative complexities, the State proposes to align the number of required community engagement and employment hours to the requirements of the SNAP program at 20 hours per week (80 hours per month) for non-exempt individuals. There is significant overlap between Medicaid and SNAP eligibility, and many SNAP beneficiaries will transition to Kentucky HEALTH. For this reason, alignment of the requirements will assist in messaging to members and support clear communication of the requirements.

First time Kentucky HEALTH members will be given a three-month notice period of the community engagement and employment initiative prior to being subject to the 20 hour per week (80 hour per month) requirement. The three-month notice period after initial enrollment will allow time for new members to become educated about program requirements, seek healthcare services to address any urgent health needs, and allow time for the managed care organizations (MCOs) to screen for medically frail conditions that may exempt the individual from the community engagement and employment requirements. After their third month of enrollment in Kentucky HEALTH, all non-exempt members will be required to complete 20 hours of qualifying activities per week (80 hours per month) to maintain Kentucky HEALTH benefits.

Eligibility for the three-month notice period will be calculated by determining how many months total over a 5-year period the member has been enrolled in Kentucky HEALTH with a non-exempt community engagement status. If more than three months, the member (even new applicants) will be subject to the community engagement and employment requirements effective the first day of the first full month of enrollment. For purposes of clarification, if a member has previously been enrolled in Kentucky HEALTH in a non-exempt community engagement status for more than three months within the last 5 years, the member will be immediately subject to the community engagement and employment requirement effective the first full month of coverage. An example of how this policy would function is as follows: a previously enrolled individual who completes a new application and pays their first month premium payment on May 15th would have Kentucky HEALTH coverage that would date back to May 1st, while their community engagement and employment requirement would not begin until June 1st.

For current members who will transition to Kentucky HEALTH, Kentucky does not propose to provide a notice period for community engagement and employment initiative requirements. Because the implementation of the initiative will be phased in by regions, all current members will not only be educated about the general requirements of Kentucky HEALTH, but will receive detailed communications and formal notice prior to the roll-out in their region. Additionally, if a member moves from a non-rolled out region to a region with an active community engagement and employment initiative, the member will be provided a good cause exemption from the requirement for their first full transitional month in the roll-out region. Lastly, for members moving from community engagement exempt status to a non-exempt status, the requirement to complete the community engagement and employment initiative will be effective the next administratively feasible month following their change in circumstance.

The proposed change is limited to eliminating the increasing scale for the community engagement and employment hour requirements. Suspensions for community engagement and employment non-compliance and all exemptions will remain unchanged. Specifically, the Commonwealth continues to seek an exemption of the community engagement and employment initiative for the following individuals:

- Children under the age of 19 enrolled in Kentucky HEALTH;
- Pregnant women;
- Primary caregivers of a dependent, including either a dependent minor child or disabled adult dependent (limited to only one exemption per household);
- Individuals identified as medically frail; and
- Full time students.

In addition, the following individuals will be deemed to meet the community engagement and employment initiative requirements and no additional participation will be required of the following members:

- Individuals meeting the requirements of SNAP and/or TANF employment initiatives;
- Individuals enrolled in the Kentucky HEALTH premium assistance program; and
- Individuals employed for more than 30 hours per week.

2.2 Disenrollment for Failure to Report a Change in Circumstance

Similar to an individual in the commercial marketplace being required to wait for an open enrollment period, the original waiver application included a provision requesting a six-month disenrollment for members who fail to complete their redetermination paperwork. As our partners at CMS are aware, timely and accurate eligibility information is imperative for the administration of traditional Medicaid. However, this information is arguably even more critical for Kentucky HEALTH, where there are a variety of factors impacting eligibility. Many of the Kentucky HEALTH eligibility factors rely on receiving updated information from the member. This information could include: changes in income that would be substantial enough to impact the member's premium amount; changes in employment status that could impact access to employer sponsored insurance, and; self-attestation of community engagement and employment hours. To deter members from failing to timely report changes in income or employment or from falsely reporting community engagement hours, Kentucky now seeks to apply the same six-month disenrollment penalty for these intentionally fraudulent member actions. As with the disenrollment for failure to complete redetermination paperwork, individuals disenrolled for failure to report a change in circumstance would be required to wait six months before being permitted to re-enroll in the program.

Members would be notified of their obligation to timely report changes at both application and recertification through the rights and responsibility documents. Further, Kentucky will develop additional materials documenting this requirement, including all premium invoices and communications on community engagement or via the Community Engagement portal. In conjunction with this policy, the Commonwealth would implement good cause exceptions through which members would not be disenrolled for failure to report changes under defined circumstances. The proposed exception circumstances will include the following: (i) the member was out of town for the entire reporting period; (ii) an immediate family member living in the home was institutionalized or died during the reporting period; (iii) the member was a victim of a natural disaster, such as a flood, storm, earthquake, or serious fire; (iv) the individual obtained and subsequently lost private insurance; (v) the individual was evicted from their home or became homeless; or (vi) the individual was a victim of domestic violence.

Currently, there is a requirement for Medicaid enrollees to report all changes to the State within ten (10) days; however, there is no enforcement mechanism for failure to comply. The Kentucky HEALTH disenrollment period will be used as a learning tool for enrollees regarding the importance of maintaining accurate information to maintain insurance coverage, helping further prepare enrollees for commercial market insurance policies.

Like all Kentucky HEALTH program disincentives, this proposed disenrollment period would be paired with a critical “on-ramp” to help support enrollees in successfully returning to the Kentucky HEALTH program and accessing its benefits, resources, and tools. Specifically, all Kentucky HEALTH eligible individuals will be provided the opportunity for early re-entry at any time prior to the expiration of the disenrollment period by completing a financial or health literacy course. Once the individual has completed a financial or health literacy course and an updated certification of the eligibility information is on file, the individual may re-enroll in Kentucky HEALTH and pay their first month’s premium contribution to begin coverage. The individual would not be required to complete a full Medicaid application to re-enroll under this circumstance.

2.3 Maintenance of Current Presumptive Eligibility Sites

The original Kentucky HEALTH waiver application contemplated expansion of presumptive eligibility (PE) sites. However, in developing the PE requirements for Kentucky HEALTH, it has been determined that operationalizing this proposed expansion would be particularly onerous for PE qualified providers and enrollees. For example, it would be challenging to implement Kentucky HEALTH cost sharing during an individual’s PE period. If Kentucky were to attempt to mitigate these types of issues by implementing divergent policies during the PE period, this would create potential member confusion and ultimately undermine the Kentucky HEALTH policy goals. Additionally, the State will be providing individuals an alternative opportunity to expedite enrollment into Kentucky HEALTH through the Fast Track process. Through this process, enrollees will be able to pre-pay their premium obligation and activate coverage as early as the first of the month of application. Therefore, expansion of PE is not necessary to ensure timely enrollment into Kentucky HEALTH.

Section 3: Title XIX Waiver Requests

In addition to the Title XIX waivers requested in the August 24, 2016, Kentucky HEALTH application, the Commonwealth seeks the following revisions and additions:

1. Reasonable Promptness

Section 1902(a)(3)/Section 1902(a)(8)

To the extent necessary to enable Kentucky to prohibit re-enrollment for up to six months for Kentucky HEALTH members who are disenrolled for failure to timely report a change in income and/or employment or falsely reporting community engagement or employment hours, or for any other actions that would fall under the definition of Medicaid fraud.

Section 4: Budget Neutrality Impact

Please see the attached the updated 1115 budget neutrality spreadsheet, which has been updated to reflect the impact of the proposed operational modifications to the Kentucky HEALTH demonstration application. Specifically, the revised spreadsheet includes estimated enrollment changes and the impact to per member per month cost by Medicaid population attributable to the following proposed policy modifications:

- Community Engagement and Employment. The proposed policy revision seeks to remove the graduated, required weekly commitment in exchange for a static, weekly commitment that becomes effective after an initial 3-month grace period. The original model was updated to estimate the impact of this change while still accounting for the exempt eligibility groups (children, pregnant women, caregivers, and medically frail).
- Disenrollment for Failure to Report Changes in Circumstances. The original projections were revised to account for the proposed implementation of a 6-month disenrollment for members who fail to report a change in circumstances. To estimate the impact of all activities that would result in a lockout, disenrollment rates were modeled separately for each action, while participation rates of the early re-entry opportunity were also factored in. The impact of the disenrollment causes was modeled for each year of the demonstration.

Section 5: Public Notice and Public Comment

These proposed program operational modifications are a logical outgrowth of the original waiver application, and are minor revisions resulting from the Commonwealth's ongoing program development efforts and continued negotiations with CMS. However, although these slight modifications do not meet the standard for requiring public input as set forth at 42 CFR 431.408, the Kentucky Department for Medicaid Services will voluntarily hold a 30-day public comment period from July 3, 2017 to August 2, 2017 and two public hearings during this time to gather public input on the proposed operational modifications.

A copy of the full public notice that announced the two public hearings and opened the 30-day public comment period is included in *Attachment B* of this application. The notice is also posted on the Cabinet for Health and Family Services website at the web address of the Section 1115 waiver program's homepage: <http://chfs.ky.gov/kentuckyhealth>. In addition, the formal public notice will also be published in various newspapers in the Commonwealth. The public notice provides the option for any individual, regardless of whether he or she attended the public hearing, to submit written feedback to the Commonwealth by email or by USPS mail. Electronic copies of all documents related to the Kentucky HEALTH waiver are also available on the above listed waiver website throughout the comment period. Kentucky will also notify stakeholders and the public of its intent to submit these program modifications to CMS and opportunities to comment via notification to an electronic mailing list. The Commonwealth will hold two formal public hearings in geographically distinct areas of the state during the public comment period. In accordance with the notice, public hearings will be held on the following dates and locations as scheduled and publicized:

Friday, July 14, 2017, 10:00 AM – 12:00 PM (EST)
The Center for Rural Development
2292 South Highway 27
Suite 300
Somerset, KY 42501

Monday, July 17, 2017, 10:00 AM – 12:00 PM (EST)
Interim Joint Committee on Health and Welfare
Kentucky Capitol Annex
702 Capital Avenue
Frankfort, KY 40601

In addition, telephonic conference capabilities will be made available for the July 14th public hearing.

Section 6: Conclusion

The Commonwealth of Kentucky appreciates CMS' ongoing willingness to support the proposed goals of the Kentucky HEALTH program and continued discussions to obtain approval of the demonstration. We believe that the operational modifications requested through this submission are necessary to reduce program complexity for stakeholders, ease administrative burdens for both the Commonwealth and CMS, and support effective communication to members. These program alterations will provide the opportunity to further the Kentucky HEALTH program goals of comprehensively transforming Medicaid by improving members' health and helping them take responsibility for their health; encouraging individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance; empowering members to seek employment and transition to commercial health insurance coverage; implementing delivery system reforms to improve quality and outcomes; and ensuring long-term fiscal sustainability, while easing administrative burden and alleviating program complexity concerns. Therefore, the Commonwealth of Kentucky respectfully requests that CMS consider approval of these program operational revisions as it continues to review the Kentucky HEALTH waiver application.

Attachment A: Budget Neutrality

Interim Section 1115 Demonstration Application Budget Neutrality Table Shell

	A	B	C	D	E	F	G
1	5 YEARS OF HISTORIC DATA						
2							
3	SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:						
4							
5	Children (Age 18 and Under)	2011	2012	2013	2014	2015	5-YEARS
6	TOTAL EXPENDITURES	\$ 1,278,702,725	\$ 1,310,253,249	\$ 1,376,613,845	\$ 1,477,821,840	\$ 1,618,128,571	\$ 7,061,520,230
7	ELIGIBLE MEMBER MONTHS	5,265,504	5,273,555	5,271,564	5,623,907	5,986,896	
8	PMPM COST	\$ 242.85	\$ 248.46	\$ 261.14	\$ 262.77	\$ 270.28	
9	TREND RATES						5-YEAR
10				ANNUAL CHANGE			AVERAGE
11	TOTAL EXPENDITURE		2.47%	5.06%	7.35%	9.49%	6.06%
12	ELIGIBLE MEMBER MONTHS		0.15%	-0.04%	6.68%	6.45%	3.26%
13	PMPM COST		2.31%	5.10%	0.63%	2.86%	2.71%
14							
15	Adults: Non-Expansion	2011	2012	2013	2014	2015	5-YEARS
16	TOTAL EXPENDITURES	\$ 667,466,616	\$ 717,268,238	\$ 749,662,818	\$ 808,989,927	\$ 892,510,877	\$ 3,835,898,476
17	ELIGIBLE MEMBER MONTHS	1,592,467	1,585,041	1,612,831	1,554,892	1,626,900	
18	PMPM COST	\$ 419.14	\$ 452.52	\$ 464.81	\$ 520.29	\$ 548.60	
19	TREND RATES						5-YEAR
20				ANNUAL CHANGE			AVERAGE
21	TOTAL EXPENDITURE		7.46%	4.52%	7.91%	10.32%	7.53%
22	ELIGIBLE MEMBER MONTHS		-0.47%	1.75%	-3.59%	4.63%	0.54%
23	PMPM COST		7.96%	2.72%	11.93%	5.44%	6.96%
24							
25	Adults: Expansion	2011	2012	2013	2014	2015	5-YEARS
26	TOTAL EXPENDITURES	\$ -	\$ -	\$ -	\$ 2,316,349,837	\$ 3,118,683,205	\$ 5,435,033,042
27	ELIGIBLE MEMBER MONTHS	-	-	-	4,422,028	5,977,024	
28	PMPM COST	\$ -	\$ -	\$ -	\$ 523.82	\$ 521.78	
29	TREND RATES						5-YEAR
30				ANNUAL CHANGE			AVERAGE
31	TOTAL EXPENDITURE		0.00%	0.00%	0.00%	34.64%	34.64%
32	ELIGIBLE MEMBER MONTHS		0.00%	0.00%	0.00%	35.16%	35.16%
33	PMPM COST		0.00%	0.00%	0.00%	-0.39%	-0.39%

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION COST DATA

	A	B	C	D	E	F	G	H	I	J	K
1	DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS										
2											
3											
4	ELIGIBILITY	TREND	MONTHS	BASE YEAR	TREND	DEMONSTRATION YEARS (DY)					TOTAL
5	GROUP	RATE 1	OF AGING	DY 00	RATE 2	DY 01	DY 02	DY 03	DY 04	DY 05	WOW
6											
7	Children (Age 18 and Under)										
8	Pop Type:	Medicaid									
9	Eligible Member Months	3.3%	12	6,182,069	3.3%	6,383,604	6,591,709	6,806,599	7,028,494	7,257,623	
10	PMPM Cost	2.7%	12	\$ 277.60	2.7%	\$ 285.12	\$ 292.85	\$ 300.79	\$ 308.94	\$ 317.31	
11	Total Expenditure					\$ 1,820,093,153	\$ 1,930,382,104	\$ 2,047,356,958	\$ 2,171,383,023	\$ 2,302,916,416	\$ 10,272,131,654
12											
13	Adults: Non-Expansion										
14	Pop Type:	Medicaid									
15	Eligible Member Months	0.5%	12	1,635,685	0.5%	1,644,518	1,653,398	1,662,326	1,671,303	1,680,328	
16	PMPM Cost	7.0%	12	\$ 586.78	7.0%	\$ 627.62	\$ 671.30	\$ 718.02	\$ 767.99	\$ 821.44	
17	Total Expenditure					\$ 1,032,132,205	\$ 1,109,926,148	\$ 1,193,583,641	\$ 1,283,544,004	\$ 1,380,288,676	\$ 5,999,474,674
18											
19	Adults: Expansion										
20	Pop Type:	Medicaid									
21	Eligible Member Months	0.5%	12	6,009,300	0.5%	6,041,750	6,074,376	6,107,177	6,140,156	6,173,313	
22	PMPM Cost	7.0%	12	\$ 558.09	7.0%	\$ 596.93	\$ 638.48	\$ 682.92	\$ 730.45	\$ 781.29	
23	Total Expenditure					\$ 3,606,502,037	\$ 3,878,367,462	\$ 4,170,713,612	\$ 4,485,077,089	\$ 4,823,147,740	\$ 20,963,807,940

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01	DY 02	DY 03	DY 04	DY 05	
Children (Age 18 and Under)								
Pop Type: Medicaid								
Eligible Member Months	6,182,069	3.3%	6,387,155	6,599,045	6,817,965	7,044,147	7,277,833	
PMPM Cost	\$ 277.60	2.2%	\$ 283.62	\$ 289.77	\$ 296.05	\$ 302.47	\$ 309.02	
Total Expenditure			\$ 1,811,524,938	\$ 1,912,205,384	\$ 2,018,458,538	\$ 2,130,643,184	\$ 2,248,995,873	
							\$ 10,121,827,918	
Adults: Non-Expansion								
Pop Type: Medicaid								
Eligible Member Months	1,635,685	-2.5%	1,595,225	1,555,766	1,517,282	1,479,751	1,443,148	
PMPM Cost	\$ 586.78	6.9%	\$ 627.35	\$ 670.73	\$ 717.11	\$ 766.70	\$ 819.72	
Total Expenditure			\$ 1,000,764,335	\$ 1,043,498,652	\$ 1,088,058,342	\$ 1,134,525,107	\$ 1,182,977,332	
							\$ 5,449,823,767	
Adults: Expansion								
Pop Type: Medicaid								
Eligible Member Months	6,009,300	-2.7%	5,849,182	5,693,330	5,541,631	5,393,974	5,250,251	
PMPM Cost	\$ 558.09	7.5%	\$ 599.72	\$ 644.46	\$ 692.54	\$ 744.20	\$ 799.72	
Total Expenditure			\$ 3,507,871,439	\$ 3,669,123,619	\$ 3,837,801,258	\$ 4,014,195,548	\$ 4,198,731,059	
							\$ 19,227,722,923	

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Children (Age 18 and Under)	\$ 1,820,093,153	\$ 1,930,382,104	\$ 2,047,356,958	\$ 2,171,383,023	\$ 2,302,916,416	\$ 10,272,131,654
Adults: Non-Expansion	\$ 1,032,132,205	\$ 1,109,926,148	\$ 1,193,583,641	\$ 1,283,544,004	\$ 1,380,288,676	\$ 5,999,474,674
Adults: Expansion	\$ 3,606,502,037	\$ 3,878,367,462	\$ 4,170,713,612	\$ 4,485,077,089	\$ 4,823,147,740	\$ 20,963,807,940
TOTAL	\$ 6,458,727,395	\$ 6,918,675,714	\$ 7,411,654,210	\$ 7,940,004,116	\$ 8,506,352,832	\$ 37,235,414,268

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Children (Age 18 and Under)	\$ 1,811,524,938	\$ 1,912,205,384	\$ 2,018,458,538	\$ 2,130,643,184	\$ 2,248,995,873	\$ 10,121,827,918
Adults: Non-Expansion	\$ 1,000,764,335	\$ 1,043,498,652	\$ 1,088,058,342	\$ 1,134,525,107	\$ 1,182,977,332	\$ 5,449,823,767
Adults: Expansion	\$ 3,507,871,439	\$ 3,669,123,619	\$ 3,837,801,258	\$ 4,014,195,548	\$ 4,198,731,059	\$ 19,227,722,923
TOTAL	\$ 6,320,160,712	\$ 6,624,827,655	\$ 6,944,318,138	\$ 7,279,363,839	\$ 7,630,704,264	\$ 34,799,374,608

VARIANCE	\$ 138,566,683	\$ 293,848,059	\$ 467,336,073	\$ 660,640,277	\$ 875,648,568	\$ 2,436,039,660
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Attachment B: Public Notice

NOTICE OF KENTUCKY DEPARTMENT FOR MEDICAID SERVICES PUBLIC COMMENT PERIOD TO MODIFY THE KENTUCKY HEALTH WAIVER APPLICATION

Notice is hereby given that the Kentucky Department for Medicaid Services will provide the public the opportunity to review and provide input on operational modifications to the 1115 Kentucky HEALTH demonstration waiver application that is currently pending approval from the Centers for Medicare and Medicaid Services (CMS). This notice provides details about the proposed program modifications and serves to open a 30-day public comment period, which closes on August 2, 2017 at 11:59 pm.

In addition to the 30-day public comment period in which the public will be able to provide written comments to the agency via US postal service or electronic mail, the Commonwealth will also host two public hearings in which the public may provide verbal comments. Hearings will be held at the following dates, times, and locations:

Friday, July 14, 2017, 10:00 AM – 12:00 PM (EST)¹

The Center for Rural Development
2292 South Highway 27
Suite 300
Somerset, KY 42501

Monday, July 17, 2017, 10:00 AM – 12:00 PM (EST)²

Interim Joint Committee on Health and Welfare
Kentucky Capitol Annex
702 Capital Avenue
Frankfort, KY 40601

Prior to finalizing the proposed submission, the Commonwealth will consider all written and verbal public comments received. The comments will be reviewed and considered in the state's ongoing negotiations with CMS regarding the proposed Kentucky HEALTH demonstration project. Following the close of the public comment period, the Kentucky Department for Medicaid Services will summarize and address the comments received. The final summary will be submitted to CMS to support ongoing negotiations and will be posted to the Kentucky HEALTH website at <http://chfs.ky.gov/kentuckyhealth>.

PROPOSAL SUMMARY

The original 1115 demonstration waiver seeks to secure the long-term viability of Medicaid expansion in Kentucky, and introduce reforms intended to tailor the program to a non-disabled working-age adult population. The 1115 demonstration waiver creates an innovative, transformative healthcare program designed to not only improve health outcomes for members, but also improve their overall quality of life by addressing some of the underlying social determinants of health and helping to break the cycle of poverty. The program offers opportunities for individuals to take control of their life through an active role in not only their health, but also in their communities by working to gain skills needed for long-term independence and success. Only by helping members engage in their healthcare and their communities, will the Commonwealth achieve long term improvements in the health of its citizens and improved fiscal health for the Commonwealth and its Medicaid program. To this end, the Commonwealth continues to seek a five-year Section 1115 waiver from the Centers for Medicare & Medicaid Services (CMS) to implement and evaluate Kentucky HEALTH, a demonstration project designed to provide dignity to individuals as they move towards self-reliability, accountability, and ultimately independence from public assistance.

However, upon further analysis of operational program design, the Commonwealth has identified several program revisions that will be submitted to CMS to further the goals of the Kentucky HEALTH program.

1. Community Engagement & Employment Initiative. The original waiver application requested graduated hours for

¹ Teleconference capabilities will be provided. The dial-in information will be updated on the Kentucky HEALTH website.

² Public comments on the waiver will be taken upon adjournment of the Interim Joint Committee on Health and Welfare meeting.

community engagement that increased every quarter the member was enrolled in Kentucky HEALTH. To aid in clear communication to members and mitigate program complexity, the Commonwealth seeks to align the number of required community engagement and employment hours to the Supplemental Nutrition Assistance Program (SNAP) at 20 hours per week (80 hours per month) for non-exempt individuals.

2. Disenrollment. The original waiver application included a provision requesting a six-month member disenrollment for members who fail to complete their redetermination paperwork. Accurate member reporting of information is crucial to the success of Kentucky HEALTH, so similar to disenrollment for failure to complete redetermination paperwork, the Commonwealth would like to apply a six-month disenrollment period for failing to timely report changes in income and/or employment that impact eligibility, falsely reporting community engagement or employment hours, or any other action that would fall under Medicaid fraud.
3. Presumptive Eligibility. Additionally, the original application considered expansion of presumptive eligibility (PE) sites with Kentucky HEALTH implementation; however, since PE expansion is not necessary to ensure timely enrollment in Kentucky HEALTH, the Commonwealth no longer seeks to expand these sites due to anticipated burden for members and providers.

GOALS AND OBJECTIVES

The proposed revisions are intended to further the goals and objectives of Kentucky HEALTH, which seeks to comprehensively transform Medicaid and accomplish the following goals:

1. Improve participants' health and help them be responsible for their health;
2. Encourage individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance;
3. Empower people to seek employment and transition to commercial health insurance coverage;
4. Implement delivery system reforms to improve quality and outcomes; and
5. Ensure fiscal sustainability.

ELIGIBILITY

The eligibility categories for Kentucky HEALTH will remain unchanged from those included in the original Kentucky HEALTH 1115 waiver.

As with the original Kentucky HEALTH program design, the proposed program modifications may also affect member eligibility due to the introduction of several commercial market policies as well as the community engagement and employment initiative.

- Commercial Market Policies: As originally proposed and similar to the commercial health insurance market, individuals determined eligible for Kentucky HEALTH (excluding children and pregnant women) will be required to make their first month's required premium payment prior to the start of benefits. Notwithstanding the foregoing, individuals with income at or below 100% FPL who do not make an initial premium payment within sixty (60) calendar days from the date of the invoice, will begin benefits but subject to the originally proposed non-payment penalty. Also, as originally proposed, Kentucky HEALTH will establish a client-specific open enrollment period. An individual is disenrolled from the program for failure to comply with redetermination requirements and will be required to wait six months for a new open enrollment period. Similarly, the Commonwealth now proposes to disenroll members for failing to timely report changes in income and/or employment, falsely reporting community engagement or employment hours, or any other action that would fall under Medicaid fraud. Members may rejoin the program at any time prior to the six-month date by completing a financial or health literacy course.
- Community Engagement & Employment Initiative: As originally proposed, to further the goal of helping members transition to commercial health insurance coverage, Kentucky HEALTH will implement a community engagement and employment initiative. After three months of program eligibility, all able-bodied working age adult Kentucky HEALTH members will be required to participate in a community engagement activity, such as volunteer work, employment or job training, and job search activities. However, instead of the originally proposed ramp up period for community engagement hours, in order to simplify communication and processes, the

Commonwealth proposes a set requirement of at least 20 hours per week (80 hours per month) after three months of eligibility for non-exempt individuals.

ENROLLMENT & FISCAL PROJECTIONS

It is anticipated that enrollment in Kentucky HEALTH will fluctuate for a variety of reasons, including program non-compliance. Members may have health coverage temporarily suspended for not meeting the community engagement and employment initiative requirements, failing to pay required monthly premiums, or failing to report a change in circumstances. However, all individuals will have the opportunity to regain coverage at any time through compliance with the community engagement requirements, or by completing a health or financial literacy class and paying premiums. In addition, initial enrollment may fluctuate as individuals with little to no claims activity choose to leave the program rather than pay premiums; however, over time this will settle as individuals become familiar with the advantages of the program. Finally, in later demonstration years, more participants are expected to transition to commercial coverage.

The following table illustrates the State's enrollment projections by total member months, updated to reflect the proposed operational modifications.

Estimated Enrollment Projections

Demonstration Year	Without Waiver	Kentucky HEALTH	Difference
1 (2017)	14,070,000	13,832,000	(238,000)
2 (2018)	14,319,000	13,848,000	(471,000)
3 (2019)	14,576,000	13,877,000	(699,000)
4 (2020)	14,840,000	13,918,000	(922,000)
5 (2021)	15,111,000	13,971,000	(1,140,000)

Note: Values shown have been rounded and represent member months.

Over the five-year demonstration period, Kentucky HEALTH will have budget neutrality margins of approximately \$2.4 billion in aggregate. The table below provides the estimated State and federal costs divided by year.

Estimated Fiscal Projections

Demonstration Year	Expenditures			State Share of Expenditure Difference
	Without Waiver	Kentucky HEALTH	Difference	
1 (2017)	\$ 6,458,700,000	\$ 6,320,200,000	\$ (138,500,000)	\$ (16,800,000)
2 (2018)	\$ 6,918,700,000	\$ 6,624,800,000	\$ (293,900,000)	\$ (37,700,000)
3 (2019)	\$ 7,411,700,000	\$ 6,944,300,000	\$ (467,400,000)	\$ (63,300,000)
4 (2020)	\$ 7,940,000,000	\$ 7,279,400,000	\$ (660,600,000)	\$ (103,600,000)
5 (2021)	\$ 8,506,400,000	\$ 7,630,700,000	\$ (875,700,000)	\$ (137,200,000)

Note: Values have been rounded.

BENEFITS, COST SHARING, AND DELIVERY SYSTEM

The proposed revisions do not propose any changes in benefits, cost sharing or delivery system. These will remain as proposed in the original Kentucky HEALTH 1115 application.

WAIVER AUTHORITY

In addition to the Title XIX waivers requested in the August 24, 2016, Kentucky HEALTH waiver application, the Commonwealth seeks the following revisions and additions:

1. Reasonable Promptness Section 1902(a)(3)/Section 1902(a)(8)
To the extent necessary to enable Kentucky to prohibit re-enrollment for up to six months for Kentucky HEALTH members who are disenrolled for failure to timely report a change in income and/or employment or falsely reporting community engagement or employment hours, or for any other actions that would fall under the definition of Medicaid fraud.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

All information regarding these proposed revisions, including this public notice, the waiver modification, and other documentation regarding the proposal are available at <http://chfs.ky.gov/kentuckyhealth>. To reach all stakeholders, non-electronic copies will be made available for review at Cabinet for Health and Family Services, Office of the Secretary, 275 E. Main St., Frankfort, KY 40621.

Written comments may be addressed to Commissioner Stephen Miller, Department of Medicaid Services, 275 E. Main Street, Frankfort, KY 40621. Comments may also be sent via electronic mail to kyhealth@ky.gov. All comments must be received by August 2, 2017 at 11:59 pm.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00306/4 and 21-W-00067/4
TITLE: KY HEALTH Section 1115 Demonstration
AWARDEE: Kentucky Cabinet for Health and Family Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the Commonwealth of Kentucky for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, must, for the period beginning January 12, 2018, through September 30, 2023, unless otherwise specified, be regarded as matchable expenditures under the state's Title XIX plan but are further limited by the special terms and conditions (STCs) for the KY HEALTH section 1115 demonstration.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the KY HEALTH Section 1115 demonstration, including the granting of the waiver and expenditure authorities described below, is likely to assist in promoting the objectives of title XIX of the Social Security Act.

The following expenditure authorities shall enable Kentucky to implement the KY HEALTH section 1115 demonstration:

1. Expenditures to the extent necessary to enable Kentucky to align a beneficiary's annual redetermination with their employer sponsored insurance (ESI) open enrollment period, including any children enrolled in Medicaid and covered by a parent or caretaker's ESI, in a manner inconsistent with requirements under section 1943 of the Act as implemented in 42 CFR 435.916(a).
2. Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD).

The following expenditure authorities shall enable Kentucky to implement the Kentucky HEALTH program within the KY HEALTH section 1115 demonstration:

3. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A)(vi) of the Act insofar as that provision requires compliance with requirements in section 1932(a)(4) of the Act, including as it is implemented and interpreted in 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period to disenroll without cause, in order to permit the state to restrict this right except in situations that are described in these STCs.

4. Expenditures for My Rewards Account incentives, which are limited to vision services, dental services, over-the-counter medications, and limited fitness-related services, to the extent that they are not included for beneficiaries receiving benefits under the alternative benefit plan for Kentucky HEALTH program beneficiaries and/or in the Medicaid state plan (state plan), and which are either determined by the Secretary to fall within the definition of “medical assistance” at section 1905(a) of the Act, or are found by the Secretary to be necessary for the proper and efficient administration of the state plan, to be federally matched at the applicable matching rate under section 1903(a)(1) or 1903(a)(7) of the Act.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00306/4 and 21-W-00067/4
TITLE: KY HEALTH Section 1115 Demonstration
AWARDEE: Kentucky Cabinet for Health and Family Services

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities and/or these STCs, shall apply to the demonstration project beginning January 12, 2018, through September 30, 2023. In addition, these waivers may only be implemented consistent with the approved STCs.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted for the KY HEALTH section 1115 demonstration, subject to these STCs.

1. Methods of Administration

**Section 1902(a)(4) insofar
as it incorporates 42 CFR
431.53**

To the extent necessary to relieve Kentucky of the requirement to assure non-emergency medical transportation to and from providers for all Medicaid beneficiaries to the extent the non-emergency medical transportation is for methadone treatment services. The waiver does not apply with respect to pregnant women or former foster care youth, and also does not apply if the service is subject to early and periodic screening, diagnostic, and treatment (EPSDT).

2. Provision of Medical Assistance

**Section 1902(a)(8)
and 1902(a)(10)**

To the extent necessary to permit Kentucky to limit the provision of medical assistance (and treatment as eligible) for individuals described in the eligibility group under section 1902(a)(10)(A)(ii)(XX) of the Act and the state plan to only former foster care youth who are under 26 years of age, were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as the state has elected), and who were enrolled in Medicaid on that date.

The following waivers of state plan requirements contained in section 1902 of the Act are granted for the Kentucky HEALTH program within the KY HEALTH demonstration, subject to these STCs.

3. Retroactive Eligibility **Section 1902(a)(34)**

To enable the state not to provide three months of retroactive eligibility for beneficiaries receiving coverage through the Kentucky HEALTH program, except for pregnant women and former foster care youth.

4. Premiums **Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A**

To the extent necessary to enable Kentucky to require monthly premium payments, as described in these STCs.

5. Comparability **Sections 1902(a)(10)(B) and 1902(a)(17)**

To the extent necessary to enable Kentucky to vary premium requirements for different Kentucky HEALTH program beneficiaries based on income and/or length of time enrolled in Medicaid, and on other factors consistent with how premiums are permitted to vary in the commercial insurance market in Kentucky, and in a manner consistent with all otherwise applicable law, except that all beneficiaries, unless excepted, will be required to contribute, at a minimum, a monthly \$1 premium contribution as described in these STCs.

To enable the state to exempt Kentucky HEALTH program beneficiaries who pay premiums from the cost sharing described in the state plan, and to enable the state to require Kentucky HEALTH program beneficiaries with income under 100 percent of the federal poverty level (FPL) to incur state plan cost sharing in lieu of paying premiums if they do not pay premiums, (except former foster care youth, the medically frail, and pregnant women), as described in these STCs.

To enable the state to offer different state plan benefits for different Kentucky HEALTH program beneficiaries as described in these STCs.

6. Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary to enable Kentucky to start enrollment in the Kentucky HEALTH program on the first day of the month in which a beneficiary makes his or her initial premium payment, or, for beneficiaries at or below 100 percent of the FPL who fail to make an initial premium payment within sixty (60) days following the date of invoice, the first day of the month in which the sixty (60) day payment period expires, except for pregnant women, beneficiaries determined medically frail, former foster care youth, and beneficiaries found eligible through presumptive eligibility, as described in these STCs.

7. Provision of Medical Assistance

**Section 1902(a)(8)
and 1902(a)(10)**

To the extent necessary to enable Kentucky to suspend eligibility for, and not make medical assistance available to, Kentucky HEALTH beneficiaries who fail to comply with community engagement requirements, as described in these STCs, unless the beneficiary is exempted as described in STCs 44 or 47(a).

8. Eligibility

**Section 1902(a)(10)
and (a)(52)**

To the extent necessary to enable Kentucky to require community engagement as described in these STCs.

To the extent necessary to enable Kentucky to prohibit re-enrollment, and deny eligibility, for up to six months for Kentucky HEALTH program beneficiaries with income above 100 percent of the FPL who are disenrolled for failure to make their required premium contributions within sixty (60) days of the date of invoice, subject to the exceptions and qualifying events described in these STCs.

To the extent necessary to enable Kentucky to prohibit re-enrollment, and deny eligibility, for up to six months following the end of the ninety (90) day reconsideration period for Kentucky HEALTH program beneficiaries who are disenrolled for failure to provide the necessary information for the state to complete an annual redetermination, subject to the exceptions and qualifying events described in these STCs.

To the extent necessary to enable Kentucky to prohibit re-enrollment, and deny eligibility, for up to six months for Kentucky HEALTH program beneficiaries who are disenrolled for failure to timely and accurately report a change in circumstance affecting eligibility only in such circumstances where a beneficiary would no longer be eligible for Medicaid under any MAGI or Non-MAGI categories, subject to the exceptions and qualifying events described in these STCs.

9. Methods of Administration

**Section 1902(a)(4) insofar
as it incorporates 42 CFR
431.53**

To the extent necessary to relieve Kentucky of the requirement to assure non-emergency medical transportation to and from providers for the new adult group, as defined in 42 CFR 435.119, except that the state must provide non-emergency medical transportation for beneficiaries who are medically frail; who are 19 or 20 years old and entitled to early and period screening, diagnostic, and treatment (EPSDT); who are former foster care youth; or who are pregnant women.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00306/4 and 21-W-00067/4
TITLE: KY HEALTH Section 1115 Demonstration
AWARDEE: Kentucky Cabinet for Health and Family Services

Title XXI Waiver Authority

All requirements of the Medicaid or Children’s Health Insurance Program (CHIP) program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities and/or these STCs, shall apply to the demonstration project beginning January 12, 2018, through September 30, 2023. In addition, these waivers may only be implemented consistent with the approved STCs.

Under the authority of section 1115(a)(1) of the Act, the following waivers of the CHIP state plan requirements contained in title XXI of the Act are granted for the KY HEALTH section 1115 demonstration, subject to these STCs.

1. Continuous Eligibility

Section 2107(e)(1)(R)

To the extent necessary to enable Kentucky to align a beneficiary’s annual redetermination with their employer sponsored insurance (ESI) open enrollment period, including any children enrolled in CHIP and covered by a parent or caretaker’s ESI, in a manner inconsistent with requirements under section 1943 of the Act as implemented in 42 CFR 457.343 and 42 CFR 435.916(a).

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00306/4 and 21-W-00067/4

TITLE: KY HEALTH 1115 Demonstration

AWARDEE: Kentucky Cabinet for Health and Family Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the “KY Helping to Engage and Achieve Long Term Health” (KY HEALTH) demonstration under section 1115(a) of the Social Security Act (hereinafter “demonstration”) to enable Kentucky to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities and waivers of requirements under section 1902(a) and section 2107 of the Social Security Act (the Act). These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The KY HEALTH demonstration will be statewide and is approved from January 12, 2018 through September 30, 2023. The demonstration includes a program entitled Kentucky HEALTH, which will begin July 1, 2018, although roll out for portions of the Kentucky HEALTH program, including the ability to earn credit for My Rewards activities, will begin April 1, 2018.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Kentucky HEALTH Populations Affected
- V. Benefits
- VI. Beneficiary-Managed Healthcare Accounts
- VII. Beneficiary-Required Contributions
- VIII. Community Engagement Initiative
- IX. Delivery System
- X. General Reporting Requirements
- XI. General Financial Requirements
- XII. Budget Neutrality
- XIII. Evaluation
- XIV. Opioid Use Disorder (OUD)/Substance Use Disorder (SUD)

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A: Developing the Evaluation Design

- Attachment B: Preparing the Interim and Summative Evaluation Reports
- Attachment C: SUD Implementation Protocol
- Attachment D: SUD Monitoring Protocol
- Attachment E: SUD Health Information Technology (Health IT)

At the state's option, additional supplemental protocols describing various operational details of the Kentucky HEALTH program may be submitted to CMS for approval and incorporation by reference into these STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

This section 1115(a) demonstration, KY HEALTH, aims to transform the Kentucky Medicaid program to empower beneficiaries to improve their health. "KY HEALTH" refers to the demonstration collectively, and includes components of the demonstration that may impact additional Kentucky Medicaid beneficiaries along with the eligibility groups specified in STC 17, Table 1. This includes beneficiaries impacted by the SUD program, the waiver of NEMT for methadone treatment, and the alignment of a beneficiary's annual redetermination with their employer sponsored insurance (ESI) open enrollment period (including for any children enrolled in Medicaid or CHIP and covered by a parent or caretaker's ESI). "Kentucky HEALTH" refers specifically to program components detailed in Sections IV through IX of these STCs, which apply to the eligibility groups outlined in STC 17, Table 1.

The Kentucky HEALTH program includes two consumer-driven tools, the My Rewards Account and the Deductible Account, which encourage beneficiaries to maintain and improve their health by providing incentives for healthy behavior. Beneficiaries will receive incentives in their My Rewards Account that can be used to obtain enhanced benefits. Kentucky will implement the Deductible Account as an educational tool to inform beneficiaries about the cost of healthcare.

In addition, Kentucky will implement a community engagement requirement as a condition of eligibility for adult beneficiaries ages 19 to 64 in the Kentucky HEALTH program, with exemptions for various groups, including: former foster care youth, pregnant women, primary caregivers of a dependent (limited to one caregiver per household), beneficiaries considered medically frail, and full time students. To remain eligible for coverage, non-exempt beneficiaries must complete 80 hours per month of community engagement activities, such as employment, education, job skills training, and community service. Beneficiaries will have their eligibility suspended for failure to demonstrate compliance with the community engagement requirement, but will be able to reactivate their eligibility on the first day of the month after they complete 80 hours of community engagement in a 30-day period, or a state-approved health literacy or financial literacy course. Beneficiaries who are in an eligibility suspension for failure to meet the requirement on their redetermination date will have their enrollment terminated, and will be required to submit a new application, unless they can show they meet the requirement or qualify for an exemption in the month of redetermination. Kentucky will provide good cause exemptions in certain circumstances for beneficiaries who cannot meet requirements.

CMS is also authorizing additional waivers and expenditure authorities for the Kentucky HEALTH program, including:

- Premiums for beneficiaries in the new adult group and section 1931 parents and other caretaker relatives (with exceptions for pregnant women, former foster care youth, and those determined medically frail);
- Consequences for beneficiaries who do not pay premiums after a 60 day payment period;
- Six month non-eligibility period for certain populations for failure to comply with the redetermination process;
- Disenrollment and six month non-eligibility period for certain populations for failure to report a change in circumstance affecting eligibility;
- Limit to managed care organization disenrollment without cause; and
- A waiver of retroactive eligibility for certain populations;

CMS is also approving the following additional waiver and expenditure authorities for the KY HEALTH demonstration as a whole:

- A waiver of non-emergency medical transportation (NEMT) for certain populations and services;
- Alignment of a beneficiary's annual redetermination with their employer sponsored insurance (ESI) open enrollment period, including any children enrolled in Medicaid or CHIP and covered by a parent or caretaker's ESI; and
- Extension of coverage to former foster care youth who were the responsibility of another state.

The KY HEALTH demonstration will also include a substance use disorder (SUD) program available to all Kentucky Medicaid beneficiaries to ensure that a broad continuum of care is available to Kentuckians with SUD, which will help improve the quality, care, and health outcomes for Kentucky Medicaid beneficiaries. Additionally, the demonstration also enables the Commonwealth to provide Medicaid coverage to former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Social Security Act), and were enrolled in Medicaid at that time, and are now applying for Medicaid in the Commonwealth.

Over the demonstration period, the state seeks to demonstrate several demonstration goals. The state's goals will inform the state's evaluation design hypotheses, subject to CMS approval, as described in these STCs. The state's goals include, and are not limited to the following:

- The Kentucky HEALTH program will strengthen beneficiary engagement in their personal health care, and will provide incentives for responsible decision making;
- A monthly premium contribution will result in more efficient use of health care services;
- The incentives established in this demonstration for Kentucky HEALTH program beneficiaries to engage in their communities and healthy behaviors will result in better health outcomes, lower overall health care costs, and improved socio-economic conditions for beneficiaries;
- The community engagement requirement will assist Kentucky HEALTH program beneficiaries in obtaining employment and transitioning to commercial health insurance and thereby improve health outcomes; and

- Increased access to certain SUD services through a comprehensive opioid/substance abuse strategy including an expenditure authority covered services provided to Medicaid eligible adults ages 21 through 64 will result in:
 - Increased and improved SUD treatment outcomes and establishment of best practices in treatment and accreditation processes.
 - A reduction of overdose deaths
 - A reduction of overall healthcare utilization (hospitals, urgent, etc.)
 - A reduction of co-morbidities associated with Substance Use Disorder (NAS, HIV, Hepatitis C, Hepatitis, Endocarditis) commodities associated with Substance use disorder

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state shall comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and section 1557 of the Affordable Care Act.
2. **Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
3. **Changes in Federal Law, Regulation, and Policy.** The state shall, within the timeframes specified in the applicable federal law, regulation, or policy, come into compliance with changes in federal law, regulation or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable as described in these STCs. In addition, these STCs may be amended at the request of either CMS or the state to reflect such changes and/or changes that the Secretary determines to be of an operational nature without requiring the submission of an amendment to the demonstration under STC 7. The requesting entity will notify the other 30 calendar days in advance of the expected approval date of the amended STCs to allow for comment.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires a change in federal financial participation (FFP) for expenditures made under this demonstration, the state shall adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration, as well as a modified allotment neutrality worksheet as necessary to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
 - b. If mandated changes in federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day

such state legislation becomes effective, or on the day such legislation was required to be in effect under federal law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

As outlined in CMS' November 21, 2016 CMCS Informational Bulletin, *Section 1115 Demonstration Opportunity to Allow Medicaid Coverage to Former Foster Care Youth Who Have Moved to a Different State*, the state shall submit a conforming amendment to the state plan for the former foster care youth from another state affected by the implementation of this demonstration indicating that the proposed effective date of the SPA will be the effective date of this section 1115 demonstration project. After the associated Medicaid SPA is effectuated, the state will not be required to submit any additional title XIX SPAs for changes affecting this former foster care youth population made eligible solely through this demonstration.

6. **Changes Subject to the Amendment Process.** If not otherwise specified in these STCs, changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, and budget neutrality that are specifically authorized under the demonstration project shall be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state shall not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.
7. **Amendment Process.** Requests to amend the demonstration shall be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests shall include, but are not limited to, the following:
 - a. An explanation of the public process used by the state, consistent with the requirements of STC 14, prior to submission of the requested amendment;
 - b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using

- c. the most recent actual expenditures, as well as summary and detail projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- d. An up-to-date CHIP allotment neutrality worksheet, if necessary;
- e. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design in STC 82; and
- f. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration. No later than twelve (12) months prior to the expiration date of the demonstration, the Governor of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 CFR 431.412(c) or a phase out plan consistent with the requirements of STC 9.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. **Notification of Suspension or Termination.** The state shall promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state shall submit a notification letter and a draft plan to CMS. The state shall submit the notification letter and a draft plan to CMS no less than six months before the effective date of the demonstration’s suspension or termination. Prior to submitting the draft plan to CMS, the state shall publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state shall conduct tribal consultation in accordance with STC 14, if applicable. Once the 30-day public comment period has ended, the state shall provide a summary of the public comments received, the state’s response to the comment and the extent to which the state incorporated the received comment into the revised plan.
- b. **Prior CMS Approval.** The state shall obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities shall be no sooner than 14 calendar days after CMS approval of the plan.
- c. **Transition and Phase-out Plan Requirements.** The state shall include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary’s appeal rights, if any), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.
- d. **Phase-out Procedures.** The state shall comply with all applicable notice requirements found in 42 CFR 431.206, 431.210, and 431.213. In addition, the state shall assure all applicable appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR 431.220 and 431.221. If a

demonstration beneficiary is entitled to and requests a hearing before the date of action, the state shall maintain benefits as required in 42 CFR 431.230. In addition, the state shall conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

- e. **Exemption from Public Notice Procedures 42 CFR 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
 - f. **Federal Financial Participation (FFP).** If the demonstration is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling beneficiaries.
- 10. Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state shall publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. Pursuant to 42 CFR 431.420(c), the state shall include a summary of the comments in the quarterly report associated with the quarter in which the forum was held. The state shall also include the summary in its annual report.
- 11. Expiring Demonstration Authority.** For demonstration authority that expires prior to the demonstration's expiration date, the state shall submit a transition plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:
- a. **Expiration Requirements.** The state shall include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights, if any), the process by which the state shall conduct administrative reviews of Medicaid or CHIP eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
 - b. **Expiration Procedures.** The state shall comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state shall assure all applicable appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration participant requests and is entitled to a hearing before the date of action, the state shall maintain benefits as required in 42 CFR section 431.230. In addition, the state shall conduct administrative renewals for all beneficiaries in

Kentucky HEALTH in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

- c. **Federal Public Notice.** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state shall obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities shall be no sooner than 14 calendar days after CMS approval of the plan.
 - d. **Federal Financial Participation (FFP).** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of dis-enrolling participants.
- 12. Withdrawal of Waiver Authority.** CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX and Title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling participants.
- 13. Adequacy of Infrastructure.** The state shall ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
- 14. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, and/or contained in the state's approved state plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

The state must also comply with the public notice procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **Federal Financial Participation (FFP).** No federal matching for service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter or, if later, as expressly stated within these STCs.
16. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. KENTUCKY HEALTH PROGRAM POPULATIONS AFFECTED

17. **Eligible Populations.** Only individuals eligible for Medicaid under an eligibility group listed in Table 1 are subject to the provisions of the Kentucky HEALTH program within this demonstration.

Table 1. Medicaid Eligibility Groups Affected by the Kentucky HEALTH	
Eligibility Group	Citations
New adult group	1902(a)(10)(A)(i)(VIII) 42 CFR 435.119
Parents and other caretaker relatives	1902(a)(10)(A)(i)(I) 1931(b) and (d) 42 CFR 435.110
Transitional medical assistance	408(a)(11)(A) 1931(c)(2) 1925 1902(a)(52)
Pregnant women	42 CFR 435.116
Former Foster Care Youth	42 CFR 435.150 42 CFR 435.218 1902(a)(10)(A)(i)(IX) 1902(a)(10)(A)(ii)(XX)

18. **Effective Date of Coverage.** All beneficiaries in the Kentucky HEALTH program, with the exception of beneficiaries who are medically frail (under 42 CFR 440.315(f) and as defined in the alternative benefit plan in the state plan), former foster care youth, and

pregnant women, are required to make monthly premium payments as described in STC 34. Individuals determined eligible for Kentucky HEALTH who are not otherwise exempt from premiums will be required to make their first premium payment prior to the start of coverage, except for beneficiaries found eligible through presumptive eligibility who will transition directly to Kentucky HEALTH effective the first day of the month of the state's eligibility determination, with no gap in coverage, as described in STC 21. Individuals will have sixty (60) days from the date of their premium invoice to pay the premium payment. Once an individual pays the premium, coverage will begin the first day of the month in which the payment was received.

- a. Individuals with income above 100 percent of the FPL who do not make an initial premium payment will not be enrolled in Kentucky HEALTH and will be required to reapply should they wish to participate.
- b. Individuals at or below 100 percent of the FPL who do not make an initial premium payment will be enrolled in Kentucky HEALTH effective the first day of the month in which the sixty (60) day payment period expired; however, once enrolled, these beneficiaries will be subject to the requirements and conditions outlined in STC 39(b).

As noted above, beneficiaries who are medically frail, former foster care youth, and pregnant women are not required to make premium payments. As a result, pregnant women and former foster care youth will be enrolled in the Kentucky HEALTH program with effective dates consistent with Medicaid regulations. Beneficiaries who are known to be medically frail at the time of application will be enrolled in Kentucky HEALTH effective the first day of the month in which the beneficiary applied for coverage.

- 19. Expedited Coverage.** Individuals not yet determined eligible for the Kentucky HEALTH program will be permitted to make an initial pre-determined premium pre-payment to expedite coverage on the electronic application or through the member self-service portal. This pre-payment amount shall not exceed the highest monthly premium that could be required under these STCs (for an individual at 133 percent FPL). Once the individual is determined eligible, coverage will begin the first day of the month in which the initial premium pre-payment was made. Once a premium pre-payment has been received, the beneficiary may not change managed care organization (MCOs) except for cause prior to their annual open enrollment opportunity, as specified in STC 51(b). The pre-determined premium pre-payment amount shall be determined by the state, and may be modified in accordance with STC 34(a).

The premium pre-payment is optional and fully refundable if the individual is determined not to be eligible for the Kentucky HEALTH program or if the individual is determined to be in a group for whom premiums are optional and subsequently requests a refund. Beneficiaries will remain responsible for the full amount of the monthly premium payment, as described in STC 34, during the first month of coverage and such amount will be included on the subsequent month invoice. If the beneficiary's monthly premium payment is less than the pre-payment, the remaining pre-payment amount must be credited against the monthly premium due until the full amount of the premium pre-

payment is exhausted. If the premium pre-payment is not exhausted after being credited to the remainder of the benefit period, the beneficiary will be refunded the remainder. If a beneficiary is determined presumptively eligible, s/he will not have the option to obtain expedited coverage through a premium pre-payment, because the beneficiary would receive expedited coverage through the state's presumptive eligibility processes.

20. **Retroactive Eligibility.** The state is not obligated to provide retroactive eligibility in accordance with Section 1902(a)(34) for beneficiaries enrolled in Kentucky HEALTH, except for pregnant women and former foster care youth.
21. **Presumptive Eligibility.** Individuals found eligible through presumptive eligibility will transition directly to the Kentucky HEALTH program copayment plan effective the first day of the month of the state's eligibility determination, with no gap in coverage under which they may be required to make copayments for all services equal to the copayment schedule in the Kentucky Medicaid state plan. Beneficiaries will have sixty (60) days from the date of their premium invoice to pay the premium payment. Beneficiaries who do not pay a premium at the end of the sixty (60) day payment period will be subject to the penalties described in STC 39.
22. **Failure to Complete a Redetermination.** Consistent with Medicaid regulations, beneficiaries failing to provide necessary information or documentation to complete the annual redetermination process will be disenrolled from Kentucky HEALTH. Beneficiaries will be granted an additional ninety (90) day reconsideration period in which to submit their redetermination paperwork to be reenrolled in Kentucky HEALTH. Upon the expiration of the ninety (90) day reconsideration period, Kentucky HEALTH beneficiaries, except those described in this STC 22(d), will be prohibited from re-enrollment in the demonstration for up to six months, unless the individual meets a good cause exception described in STC 23(d).

The state must provide reasonable modifications to the annual redetermination process to beneficiaries with disabilities protected by the ADA, Section 504 of the Rehabilitation Act, and Section 1557 of the Patient Protection and Affordable Care Act to enable and assist them in completing the annual redetermination process.

- a. The state may not terminate eligibility if the beneficiary has provided documentation that the state has not processed yet, provided the beneficiary returned the required documentation no later than the last day of the redetermination period.
- b. The state may not apply the six-month non-eligibility period if the beneficiary has provided documentation that the state has not processed yet, provided the beneficiary returned the required documentation no later than the last day of the ninety (90) day reconsideration period.
- c. Following the ninety (90) day reconsideration period, disenrolled beneficiaries subject to the non-eligibility period will be eligible for early re-enrollment at any time prior to the end of the six month non-eligibility period consistent with STC 41.

- d. Pregnant women, former foster care youth, and beneficiaries determined medically frail are exempt from this non-eligibility period. Any beneficiary who becomes pregnant, is determined to be medically frail or otherwise becomes eligible for Medicaid under an eligibility group not subject to the provisions of this non-eligibility period can reactivate their eligibility with an effective date consistent with the beneficiary's eligibility category.
- e. Beneficiaries who experienced a good cause exception that prevented the completion of the annual redetermination requirements, as described in STC 23(d), will be permitted to re-enroll prior to the expiration of the six-month non-eligibility period by providing verification of the exception.
- f. The state may not terminate eligibility of any individual with a disability under the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act for failure to submit redetermination paperwork if the individual needed and was not provided with reasonable modifications necessary to complete the process.

23. Failure to Complete Redetermination: State Assurances. The state shall:

- a. Maintain an annual renewal process, including ex parte renewals and use of pre-populated forms, consistent with all applicable Medicaid requirements, except that, with respect to individuals receiving premium assistance, (including any children enrolled in Medicaid or CHIP and covered by a parent or caretaker's ESI) Medicaid and CHIP eligibility re-determinations will be aligned with the individual's ESI open enrollment period.
- b. Maintain systems to complete ex parte renewals based on available information for all beneficiaries, achieving successful ex parte renewal for at least 75 percent of their Kentucky HEALTH beneficiaries, not including beneficiaries in a non-eligibility period or suspension at the time of the redetermination.
- c. Maintain timely processing of applications to avoid further delays in accessing benefits once the non-eligibility period is over.
- d. Include good cause exceptions to the non-eligibility period that would allow beneficiaries to re-enroll under certain conditions without completion of early re-enrollment requirements as described in STC 41 or waiting six months, including, at a minimum, the following verified conditions:
 - i. The beneficiary is hospitalized, otherwise incapacitated, or has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and as a result was unable to provide information necessary to complete the redetermination during the entire redetermination and/or reconsideration reporting period, or is a person with a disability who was not provided with reasonable modifications needed to complete the process, or is a person with a disability and there were no reasonable modifications that would have enabled the individual to complete the process;
 - ii. A member of the beneficiary's immediate family who was living in the home with the beneficiary was institutionalized or died during the redetermination reporting period or the immediate family member has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the

- Patient Protection and Affordable Care Act and caretaking or other disability-related responsibilities resulted in an inability to complete redetermination;
- iii. The beneficiary obtained or lost private insurance coverage during the redetermination reporting period;
 - iv. The beneficiary was evicted from home or experienced homelessness during the redetermination reporting period;
 - v. The beneficiary was the victim of a declared natural disaster, such as a flood, storm, earthquake, or serious fire that occurred during the redetermination reporting period; or
 - vi. The beneficiary was a victim of domestic violence during the redetermination reporting period.
- e. Provide beneficiaries written notice of specific activities as described in STC 41 that would qualify them for early re-enrollment during a non-eligibility period and assures that these activities are available during a range of times and through a variety of means (e.g. online, in person) at no cost to the beneficiary.
 - f. Provide written notice to beneficiaries of any non-eligibility period exemptions and good cause exceptions, as described in STC 22(d) and (e), that would allow them to re-enroll during a non-eligibility period without completing early re-enrollment requirements. Such notice must include an explanation of the availability of good cause exceptions, as indicated in this STC.
 - g. Provide notice to beneficiaries, prior to adverse action, regarding the non-eligibility period, and explaining what this status means, including but not limited to: their right to appeal, their right to apply for Medicaid on a basis not affected by this status, what this status means with respect to their ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange), what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category, as well as any implications with respect to whether they have minimum essential coverage.
 - h. Provide beneficiary education and outreach that supports compliance with redetermination requirements, such as through communications or coordination with state-sanctioned assistors, providers, MCOs, or other stakeholders.
 - i. Provide full appeal rights prior to disenrollment and observe all requirements for due process for beneficiaries who will be disenrolled for failing to provide the necessary information to the state to complete their redeterminations to allow beneficiaries the opportunity to raise additional issues in a hearing, including whether the beneficiary should be subject to the non-eligibility period and/or provide additional documentation through the appeals process.
 - j. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable modifications that will assist them in meeting redetermination requirements
 - k. Provide reasonable modifications to the annual redetermination process to beneficiaries with disabilities protected by the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Patient Protection and Affordable Care Act to enable and assist them in completing the annual redetermination process.

- 24. Failure to Report a Change in Circumstance.** Beneficiaries who fail to report changes in circumstance in the required reporting period for changes affecting eligibility for Medicaid under any modified adjusted gross income (MAGI) or non-MAGI rules will be disenrolled. Disenrollment from Medicaid may only occur after the state conducts an administrative renewal for the beneficiary and determines the beneficiary ineligible for all other bases of Medicaid eligibility and reviews him/her for eligibility for other insurance affordability programs in accordance with 42 CFR 435.916(f). Disenrollment will be limited to circumstances in which the failure to report a change affected eligibility; specifically if it led to additional month(s) of Medicaid eligibility during which the member was not otherwise eligible. After disenrollment, the individual will be prohibited from re-enrollment in the demonstration for up to six months.
- a. Pregnant women, former foster care youth, and beneficiaries who are medically frail are exempt from this six-month non-eligibility period. Any beneficiary who becomes pregnant, is determined to be medically frail or otherwise becomes eligible for Medicaid under an eligibility group not subject to the provisions of this non-eligibility period can reactivate their eligibility with an effective date consistent with the beneficiary's eligibility category.
 - b. Disenrolled individuals will be eligible for early re-enrollment at any time prior to the end of the non-eligibility period consistent with STC 25(b) and STC 41.
 - c. The state must provide reasonable modifications to the obligation to report a change in circumstance for beneficiaries with disabilities protected by the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Patient Protection and Affordable Care Act.
- 25. Failure to Report a Change in Circumstance: State Assurances.** The state shall:
- a. Assure that beneficiaries identified as failing to have reported a change in circumstance affecting eligibility for Medicaid under any MAGI or Non-MAGI rules as outlined in STC 24 will have the opportunity to provide additional clarifying information indicating the beneficiary did report the change in circumstance or to support a good cause exception pursuant to 42 CFR 435.916(d)(1)(i) and further assures that it will observe all requirements for due process, including adequate notice and appeal rights, in connection with any non-eligibility period.
 - b. Include good cause exceptions that would allow beneficiaries to re-enroll under certain conditions without completion of early re-enrollment requirements as described in STC 41 or waiting six months, including, at a minimum, the following verified circumstances:
 - i. The beneficiary is out of town, hospitalized, otherwise incapacitated, or has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act, and as a result is unable to report the change during the entire change in circumstance reporting period as defined in the state plan, or is a person with a disability who was not provided with reasonable modifications needed to complete the process, or is a person with a disability and there

- were no reasonable modifications that would have enabled the individual to report the required changes in circumstances;
- ii. A member of the beneficiary’s immediate family who was living in the home with the beneficiary was institutionalized or died during the change in circumstance reporting period or the immediate family member has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act, and caretaking or other disability-related responsibilities resulted in an inability to report the change in circumstance;
 - iii. The beneficiary was the victim of a declared natural disaster, such as a flood, storm, earthquake, or serious fire that occurred during the change in circumstance reporting period as defined in the state plan;
 - iv. The beneficiary obtained or lost private insurance coverage during the change in circumstance reporting period as defined in the state plan;
 - v. The beneficiary was evicted from home or experienced homelessness during the change in circumstance reporting period as defined in the state plan; or
 - vi. The beneficiary was a victim of domestic violence during the change in circumstance reporting period as defined in the state plan.
- c. Assure that the non-eligibility period would only apply to beneficiaries where the unreported change in circumstance would affect eligibility as outlined in STC 24.
 - d. Provide written notice to beneficiaries of specific activities as described in STC 41 that would qualify them for early re-enrollment during a non-eligibility period and assure that these activities are available during a range of times and through a variety of means (e.g. online, in person) at no cost to the beneficiary.
 - e. Provide written notice to beneficiaries of any non-eligibility period exemptions and good cause exceptions, as described in STC 24(a) and 25(b), that would allow them to re-enroll during a non-eligibility period without completing early re-enrollment requirements. Such notice must include an explanation of the availability of good cause exceptions, as indicated in this STC.
 - f. Provide notice to beneficiaries, prior to adverse action, about the non-eligibility period, and explaining what this status means, including but not limited to: their right to appeal, their right to apply for Medicaid on a basis not affected by this status, what this status means with respect to their ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange), what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category, as well as any implications with respect to whether they have minimum essential coverage.
 - g. Provide beneficiary education and outreach that supports compliance with change in circumstance reporting requirements, such as through communications or coordination with state-sanctioned assistors, providers, MCOs, or other stakeholders.
 - h. Assure that disenrollment from Medicaid will only occur after an individual has been screened and determined ineligible for all other bases of Medicaid eligibility

and reviewed for eligibility for insurance affordability programs in accordance with 42 CFR 435.916(f).

- i. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable modifications related to reporting a change in circumstance.
- j. Maintain a system that identifies, validates, and provides reasonable modifications related to the obligation to report a change in circumstance to beneficiaries with disabilities protected by the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Patient Protection and Affordable Care Act.

V. BENEFITS

26. Kentucky HEALTH Program Benefits. Beneficiaries in the new adult group enrolled in Kentucky HEALTH will receive benefits through an Alternative Benefit Plan (ABP) that will be defined in the state plan. Benefits will remain consistent with the existing state plan for all pregnant women, former foster care youth, beneficiaries who are medically frail, and other traditional low-income (i.e., not in the new adult group) Medicaid populations transitioning to Kentucky HEALTH. In these STCs, references to a beneficiary's "base benefit plan" refer either to the ABP or to state plan benefits, depending on the beneficiary's eligibility category. Beneficiaries receiving state plan benefits will continue to receive covered vision services, dental services, and over-the-counter-medications in accordance with the state plan rather than through the My Rewards Account. In addition, all beneficiaries under 21 years of age receiving services through the demonstration will continue to receive all early and periodic screening, diagnostic, and treatment (EPSDT) services.

27. Non-Emergency Medical Transportation (NEMT).

- a. The state is not obligated to provide NEMT for any services provided to beneficiaries enrolled in the new adult group as defined in 42 CFR 435.119 except for beneficiaries who are medically frail, 19 or 20 year old beneficiaries entitled to EPSDT services, former foster care youth, and pregnant women. Most beneficiaries receiving state plan benefits will continue to receive non-emergency transportation for all services, except for methadone treatment. However, children under age 21 who are subject to EPSDT, former foster care youth, and pregnant women will continue to receive NEMT for all services, including methadone treatment, as specified in STC 92.
- b. Offering methadone through the state plan is contingent upon the waiver of NEMT.

VI. BENEFICIARY-MANAGED HEALTHCARE ACCOUNTS

28. General Description. Beneficiaries enrolled in the Kentucky HEALTH program will be provided with two member-managed health care accounts, one of which is a deductible account, and the other of which is a My Rewards Account through which beneficiaries accrue incentives that have a dollar value equivalent that can be used to access certain approved additional items and services.

- 29. Deductible Account.** All Kentucky HEALTH program beneficiaries (except pregnant women, and beneficiaries receiving premium assistance) will have a deductible account. At the beginning of each benefit year, the deductible account will reflect an initial dollar-value equivalent of \$1,000 which is available to cover a \$1,000 value plan deductible that is applicable to all non-preventive healthcare services. The deductible account acts as an educational tool to encourage appropriate health care utilization. Beneficiaries will receive monthly deductible account statements detailing the costs of utilized services and including an account balance. If funds in the deductible account are exhausted before the end of a beneficiary's 12-month benefit period, the beneficiary will still be able to access covered services without unreasonable delay.
- a. **Balance Transfer Incentive.** Beneficiaries with funds remaining in their deductible account at the end of their 12 month benefit period may, at the end of their 12 month benefit period, transfer up to 50 percent of the prorated balance of their deductible account to their My Rewards Account. The amount will be prorated based on the beneficiary's number of active member months (months in which a beneficiary is not disenrolled or in a suspension status) during the 12 month benefit period.
- 30. My Rewards Account.** All adult Kentucky HEALTH beneficiaries, including beneficiaries receiving premium assistance, will be provided with a My Rewards Account to access items and services not covered in a beneficiary's corresponding Kentucky HEALTH base benefit plan, as described in STC 26. The My Rewards Account acts as a mechanism to encourage healthy behaviors and community engagement which earn incentives that have a dollar-value equivalent that can be used to access certain approved additional items and services.
- a. **Eligibility.** My Rewards Accounts are available only to beneficiaries who remain enrolled in Kentucky HEALTH and who continue to make required monthly premium contributions consistent with STC 31 and 39, if applicable. Except for pregnant women, in no event may a Kentucky HEALTH beneficiary have an active My Rewards Account unless they are making monthly premium payments of no less than \$1.00.
- b. **Enhanced Benefits.** Kentucky will assist beneficiaries with an active My Rewards Account by covering benefits not included in the beneficiary's corresponding Kentucky HEALTH base benefits plan with amounts that have accrued in the My Rewards Account. Items and services available through the My Rewards Account will include only the following: vision services, dental services, over-the-counter medications, and limited fitness-related services, such as a gym membership. To help ensure that they have an opportunity to earn My Rewards Account credits to access vision services, dental services, over-the-counter medications, and limited fitness-related services, beneficiaries will be able to accumulate dollars in their My Rewards Account prior to the implementation of the Kentucky HEALTH program. Vision services, dental services, and over-the-counter medications will be covered through the My Rewards Account at the rate in the Medicaid fee-for-service fee schedule. Coverage of vision services, dental

services, and over-the-counter medications through the My Rewards account will be limited in scope to the services that would be covered under the Kentucky state plan if the beneficiary was not receiving the Alternative Benefit Plan.

- i. **State Plan Benefit Exception.** Kentucky HEALTH beneficiaries receiving state plan benefits (i.e. pregnant women, former foster care youth, beneficiaries who are medically frail, and adults who are not in the new adult group) will continue to receive state plan vision, dental, and over-the-counter medication covered under the state plan through their MCO rather than through the beneficiary's My Rewards Account.
- c. **Healthy Behaviors.** The state will provide earned incentives for certain state-specified healthy behaviors.
- d. **Community Engagement Activities.** Completion of community engagement activities will qualify for earned incentives only to the extent the activities exceed the 80 hour per month minimum requirements established for the Kentucky HEALTH community engagement initiative as detailed in STC 46.
- e. **Appropriate Healthcare Utilization.** Beneficiaries will be eligible for an annual contribution to their My Rewards Account for not having a non-emergent visit to the emergency department (including for non-use of the emergency department) during the 12 month benefit period.
- f. **Balance Accrual.** My Rewards Account balances accrue continuously when the account is active and the beneficiary is not otherwise suspended or disenrolled. The My Rewards Account is not subject to any annual limits.
- g. **Balance Deduction.** Deductions from the My Rewards Account will not apply when a beneficiary's My Rewards account is suspended. The My Rewards Account may reflect a negative balance of up to negative \$150 to reflect cumulative deductions. A beneficiary's My Rewards Account balance will be reduced for the following:
 - i. Non-payment of Premiums. Beneficiaries will have dollars deducted from their My Rewards Account each time a beneficiary fails to meet their premium payment obligation outlined in STC 39.
 - ii. Non-emergent Use of the Emergency Department. My Rewards Account dollars will be reduced for each non-emergent visit to the emergency department, and the amount of the reduction may increase for each subsequent non-emergent use. As the My Rewards Account deduction is not a copayment, the amount is not subject to the limitations in 42 CFR 447.54(b). This reduction will be waived for any beneficiary who contacts their MCO's 24-hour nurse hotline prior to utilizing the hospital emergency department. The beneficiary must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA, provision of the Act, before their My Rewards dollars can be deducted. Notwithstanding the fact that the My Rewards Account deduction is not a co-payment, the state will ensure that hospitals comply with the requirements described in 42 CFR 447.54(d)(2) related to educating beneficiaries about appropriate

- alternative settings before the state deducts amounts from the My Rewards Account for non-emergent use of the emergency department.
- iii. Missed Appointments. The state may evaluate whether, as a general matter, beneficiaries participating in Kentucky HEALTH are missing health care appointments. Based on that evaluation, the state may permit beneficiaries to earn incentives for keeping all scheduled appointments in the 12-month benefit period, or may deduct dollars from the My Rewards Account for each healthcare appointment missed without adequate notice of cancellation or good cause.
 - iv. No Actual Charges to Beneficiaries. The state assures that at no time would a beneficiary be required to make a monetary payment to the state as a result of having a negative dollar balance in his or her My Rewards Account.
- h. **Provider Reimbursement from My Rewards Account.** When beneficiaries seek to access benefits or services using the My Rewards Account, a Medicaid-enrolled provider should follow a prior authorization process before providing the benefit or service in order to assess whether the My Rewards Account contains an amount sufficient to cover the cost of the benefit or service. If the provider provides the benefit or service without checking available My Rewards Account funds, the provider will be at risk that the benefit or service is not reimbursable due to insufficient funds. Only if the My Rewards Account contains an amount sufficient to cover the cost of the benefit or service may the provider receive reimbursement under the demonstration. Notwithstanding the foregoing, in limited circumstances where prior authorized benefits or services changed after the hold on the My Rewards Account balance, the account balance will be permitted to go negative in order to reimburse the provider in full for the benefits or services rendered. All payments for My Rewards Account services will also reduce the beneficiary's My Rewards Account by the appropriate published state plan reimbursement rate for the eligible service provided. For items or services for which there is a state plan rate, reimbursement may not exceed the Medicaid fee-for-service rate. For items or services for which there is not a state plan rate, CMS must determine that reimbursement for the items and services is cost effective and efficient. Nothing in this provision would prevent the beneficiary from opting to self-pay the full cost of the benefit or service.

VII. BENEFICIARY-REQUIRED CONTRIBUTIONS

31. **Premiums.** All beneficiaries enrolled in the Kentucky HEALTH program, except pregnant women, former foster care youth, and beneficiaries who are medically frail, are required to pay monthly premiums of no less than one dollar per month, subject to exemptions and limitations in STCs 34, 39, and 42.
32. **Notice.** The state must notify Kentucky HEALTH beneficiaries of premium payment requirements upon eligibility determination. The state must determine the amount of a beneficiary's monthly premium based on the beneficiary's modified adjusted gross income and will notify the beneficiary and MCO of this amount. The MCO must bill for

and collect the premium from beneficiaries. Monthly invoices must include information about how to report any change in income; the time period over which income is calculated (e.g., monthly income); the deadline for reporting changes in circumstances; the consequences of non-payment and failure to report changes in circumstance that could affect eligibility; and that once the payment is made the individual may only change MCOs for cause, except during the beneficiary's annual enrollment opportunity.

33. Beneficiary-Required Contributions: State Assurances. The state shall:

- a. Permit the MCO to attempt to collect the unpaid premiums from the beneficiary, but the MCO may not report the premium amount owed to credit reporting agencies, place a lien on a beneficiary's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the beneficiary's earnings for enrollees at any income level. The state will not "sell" the obligation for collection by a third-party. Further, while the amount is collectible by the state, re-enrollment is not conditioned upon repayment, except in the event of early re-enrollment described in STC 41.
- b. Monitor that beneficiaries do not incur household cost sharing and premiums that, combined, exceed 5 percent of the aggregate household income, in accordance with 42 CFR 447.56(f), without regard to MCO enrollment of members in the household. Once a household reaches the cap, the state assures that no further copayments can be charged to beneficiaries, and the premium amount will be reduced to \$1.00 per month for the remainder of the quarter to retain access to the My Rewards Account, except as outlined in STC 39.
- c. Charge copayment amounts, if applicable, that do not exceed Medicaid cost sharing permitted by federal law and regulation and the terms of this demonstration.
- d. Ensure that the state, or its designee, does not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing are considered an administrative expense by the state.
- e. Ensure that all payments from the beneficiary, or on behalf of the beneficiary, are accurately credited toward unpaid premiums in a timely manner, and provide the beneficiary an opportunity to review and seek correction of the payment history.
- f. Ensure that the state has a process to refund any premiums paid for a month in which the beneficiary is ineligible for Medicaid services for that month.
- g. Ensure that a beneficiary will not be charged a higher premium the following month due to nonpayment or underpayment of a premium in the previous month/s, except that amounts outstanding and due from the previous month/s may be reflected separately on subsequent invoices.
- h. Ensure the state suspends monthly invoices of premiums to beneficiaries whose eligibility has been suspended for failure to meet the community engagement requirement, and provide written notice to prevent overpayment of premiums.
- i. Conduct outreach and education to beneficiaries to ensure that they understand the program policies regarding premiums and associated consequences for nonpayment. Beneficiaries must be informed of how premium payments should

be made; the potential impact of a change in income on premium payments owed; the consequences of failure to report a change in income or circumstances that affect eligibility; the time period over which income is calculated (e.g., monthly income); the deadline for reporting changes in circumstances; and how to re-enroll if disenrolled for non-payment of premiums.

- j. Provide good cause exceptions to the consequences for failure to pay premiums described in STC 39 that would allow beneficiaries to re-enroll under certain conditions without completion of early re-enrollment requirements or waiting the full six (6) months, including, at a minimum, the following:
 - i. The beneficiary was hospitalized, otherwise incapacitated, or has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and as a result is unable to pay premiums during the entire sixty (60) day payment period, or is a person with a disability who was not provided with reasonable modifications needed to pay the premium, or is a person with a disability and there were no reasonable modifications that would have enabled the individual to pay premiums during the entire sixty (60) day payment period;
 - ii. A member of the beneficiary's immediate family who was living in the home with the beneficiary was institutionalized or died during the sixty (60) day payment period, or the immediate family member has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and caretaking or other disability-related responsibilities resulted in an inability to pay the premiums;
 - iii. The beneficiary was evicted from their home or experienced homelessness during the sixty (60) day payment period,
 - iv. The beneficiary was the victim of a declared natural disaster, such as a flood, storm, earthquake, or serious fire that occurred during the sixty (60) day payment period; or
 - v. The beneficiary was a victim of domestic violence during the sixty (60) day payment period.
- k. Provide all applicants and beneficiaries with timely and adequate written notices of any decision affecting their eligibility, including an approval, denial, termination, or suspension of eligibility or a denial or change in benefits and services pursuant to 42 CFR 435.917. The state will also provide availability and accessibility resources to program information in accordance with 42 CFR 435.901 and 435.905. The state will provide beneficiaries with 10 days advance notice for any adverse action prior to the date of action pursuant to 42 CFR 431.211.
- l. Provide beneficiaries written notice of specific activities that would qualify them for early re-enrollment during a non-eligibility period, as described in STC 41, and assure that these activities are available during a range of times and through a variety of means (e.g. online, in person) at no cost to the beneficiary.
- m. Provide notice to beneficiaries, prior to adverse action, about the non-eligibility period, and explaining what this status means, including but not limited to: their

right to appeal, their right to apply for Medicaid on a basis not affected by this status, what this status means with respect to their ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange), what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category, as well as any implications with respect to whether they have minimum essential coverage.

- n. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable modifications related to premium payment.
- o. Maintain a system that identifies, validates, and provides reasonable modifications related to the obligation to pay premiums to beneficiaries with disabilities protected by the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Patient Protection and Affordable Care Act.

34. Premium Amounts. All Kentucky HEALTH beneficiaries, including beneficiaries receiving premium assistance, with the exception of beneficiaries who are medically frail, former foster care youth, and pregnant women, as described in STC 18 and 31, are required to make premium payments at an amount established by the state. A premium amount shall not exceed four (4) percent of household income, except that all beneficiaries will be required to contribute, at a minimum, a monthly \$1 premium payment, unless exempt as described in STC 31. The state may vary premium amounts for beneficiaries, including (but not limited to) based on household income or the length of time a beneficiary is enrolled in Kentucky HEALTH, subject to the 4 percent of household income limit on premiums. Other bases for varying premiums shall be consistent with how premium requirements vary in the commercial insurance market in Kentucky and with all otherwise applicable law. Beneficiaries who meet the 5 percent aggregate household cap on premiums and cost sharing will pay a \$1 premium (the minimum) per month for the remainder of the calendar quarter, unless exempt as described in STC 31.

- a. **Changes in Premium Amount.** The state may reduce a premium amount at any time. The state will annually evaluate the premium rates and amounts, and reserves the right to increase a premium amount within the limitations set forth in these STCs in response to evaluation results on an annual basis. The state will notify CMS of upcoming premium changes through the Annual Report described in these STCs. The state will notify beneficiaries at least 60 days prior to implementing a premium change.

35. Household Limits. Premium payments apply towards all Kentucky HEALTH beneficiaries, as described in STC 31, in the MAGI household enrolled with the same MCO, such that premiums will not be collected on a per person basis, but rather on a per MCO basis and will be applicable to all Kentucky HEALTH members enrolled in the MCO.

36. Recalculation of Premium Payments. At a minimum, at annual redetermination or any time the state is made aware that a beneficiary's household income has changed during

the current eligibility period, the state must determine whether an adjustment to the member's monthly premium payment is necessary. Recalculated premium payments are effective the first day of the month following the recalculation. When a beneficiary has a change in circumstance, including household income, any overpayments made by the member shall reduce the premium contribution obligation for the next month(s).

- 37. Third Party Contributions.** Third parties, except contracted MCOs, are permitted to pay premiums on behalf of Kentucky HEALTH beneficiaries. There are no limits on the amounts third parties can contribute. Such third party contributions offset required beneficiary premium obligations only, and may not be used for any other purpose. Payments that exceed such obligations will be returned to the contributing third party. The payment must be used to offset the beneficiary's required premium payment obligation only, not the state's share. Healthcare providers or provider-related entities making premium payments on beneficiaries' behalf must have criteria for providing assistance that do not distinguish between beneficiaries based on whether or not they receive or will receive services from the contributing provider(s) or class of providers. Providers may not include the cost of such payments in the cost of care for purposes of Medicare and Medicaid cost reporting and such payments cannot be included as part of a Medicaid shortfall or uncompensated care.
- 38. Payment Period.** Kentucky HEALTH beneficiaries will have at least sixty (60) calendar days from the date of the payment invoice to make the required monthly premium payment to avoid non-payment penalties described in STC 39.
- 39. Non-Payment.**
- a. **Beneficiaries with Income Above 100 percent of FPL.**
 - i. Following the sixty (60) day payment period, currently enrolled Kentucky HEALTH members with income above 100 percent FPL who do not make their premium payment will be disenrolled from Kentucky HEALTH and will be prohibited from re-enrollment in the demonstration for up to six months, unless the beneficiary completes the requirements for early re-enrollment as described in STC 41. The state will provide beneficiaries with 10 days advance notice for any adverse action prior to the date of the eligibility action pursuant to 42 CFR 431.211.
 - ii. Beneficiaries who re-enter Kentucky HEALTH after the six month period will not be required to pay past premium debt as a condition of eligibility.
 - iii. Beneficiaries will have dollars deducted from their My Rewards Account pursuant to STC 30(g)(i).
 - iv. Beneficiaries who meet the requirements for good cause exceptions identified in STC 33(j) will be eligible to re-enter Kentucky HEALTH before the end of the six month period without completing the early re-enrollment requirements described in STC 41.
 - b. **Beneficiaries with Income At or Below 100 percent of FPL.**
 - i. Beneficiaries with income at or below 100 percent of the FPL who fail to make premium payments will not be disenrolled.

- ii. Beneficiaries who do not make their premium payment within the sixty (60) day payment period will be required to make copayments for all services equal to the copayments schedule in the Kentucky Medicaid state plan.
 - iii. Beneficiaries will have dollars deducted from their My Rewards Account pursuant to STC 30(g)(i).
 - iv. Beneficiaries will have their My Rewards Account suspended (i.e., may not use or accrue incentive amounts) for up to six months.
 - v. Beneficiaries may complete the requirements as described in STC 41 to end the copayment requirement and reactivate their My Rewards Account prior to the end of the six month period.
 - vi. Beneficiaries whose My Rewards Accounts are reactivated after the six month period will not be required to pay past premium(s) owed to reactivate their account.
 - vii. Beneficiaries who meet the requirements for good cause exceptions identified in STC 33(j) will be eligible to resume premium payments instead of copayments and access their My Rewards Account in the next administratively feasible month without completing the requirements described in STC 41.
- c. **Former Foster Care Youth and Beneficiaries Determined Medically Frail.**
- i. Former foster care youth and Kentucky HEALTH beneficiaries who have been identified as medically frail will have the option to pay premiums.
 - ii. Former foster care youth and beneficiaries who are medically frail will not be subject to copayments for services, and will not be subject to disenrollment for nonpayment.
 - iii. Beneficiaries who choose not to pay premiums (or who do not make a premium payment within the sixty (60) day payment period) will have their My Rewards Account suspended (i.e., may not use or accrue incentive amounts) for up to six months.
 - iv. Former foster care youth and beneficiaries who are medically frail may reactivate their My Rewards Accounts by attending an early re-enrollment educational course as described in STC 41(a)(ii). Former foster care youth and beneficiaries who are medically frail will not be required to pay past premiums owed to reactivate their My Rewards Account.
 - v. Beneficiaries who meet the requirements for good cause exceptions identified in STC 33(j) will be eligible to resume premium payments to access their My Rewards Account in the next administratively feasible month without having to attend an early re-enrollment educational course described in STC 41(a)(ii).

40. Eligibility Review. For each Kentucky HEALTH beneficiary subject to disenrollment for non-payment under STC 39, the state must review that beneficiary's eligibility for all other eligibility categories under the state's Title XIX program including notifying the beneficiary of the option of requesting a medically frail status review, pursuant to 42 CFR 435.916(f). The beneficiary's Medicaid MCO must also provide at least two written notices advising the beneficiary of the delinquent payment, the date by which the

payment must be made to prevent disenrollment, and the option for medical frailty screening. The first notice must be sent to the beneficiary on or before the seventh day of the month of coverage for which the premium payment was to be applied and must describe the consequences of nonpayment of required premiums. Notices must include information about reporting any changes in circumstances, including household income.

41. Early Re-Enrollment or Early Re-Activation of My Rewards Account. Kentucky HEALTH beneficiaries subject to consequences for non-payment of premiums as described in STC 39(a) or (b), for failure to complete a redetermination as described in STC 22, or for failure to report change in circumstance as described in STC 24, will have the opportunity to re-enter the program with full access to their MCO and My Rewards Account benefits, or (in the case of beneficiaries described in STC 39(b)) the opportunity to re-activate their My Rewards Account benefits, prior to the expiration of the applicable six-month period. The early re-enrollment or My Rewards reactivation opportunity is only available one time per 12 month benefit period per consequence type.

a. Beneficiaries seeking early re-enrollment following non-payment of premiums as described in STC 39(a), early re-activation of their My Rewards Account as described in STC 39(b), early re-enrollment following failure to complete a redetermination as described in STC 22, or early re-enrollment following failure to report change in circumstance as described in STC 24, must complete both of the following:

- i. Pay the premium payment required for the first month of coverage to restart benefits. Additionally, if the applicable six-month period is due to premium non-payment, beneficiaries seeking early re-enrollment, or (in the case of beneficiaries described in STC 39(b)) early re-activation of the My Rewards Account, must pay a one-time payment equaling premium payments owed for each month in which the member received healthcare coverage during the sixty (60)-day payment period prior to the effective date of the applicable six-month period.
- ii. Attend an early re-enrollment educational course. The course providers will be certified by the state and offer members course options for early re-enrollment on: (1) health literacy, and (2) financial literacy.

42. Exemptions. Pregnant women will be exempt from all Kentucky HEALTH premiums. Kentucky HEALTH beneficiaries who are medically frail or former foster care youth will not be required to pay premium payments as a condition of participation; however, these beneficiaries must make premium payments in order to access the beneficiary's My Rewards Account, as described in STC 39(c). Kentucky HEALTH beneficiaries with incomes at or below 100 percent FPL will not be disenrolled for non-payment of premiums, but will be required to make copayments and will be subject to the additional actions described in STC 39(b). Beneficiaries who are disenrolled and subject to a non-eligibility period as a result of non-payment of premiums but during that period become pregnant, are determined to be medically frail or otherwise become eligible for Medicaid under an eligibility group not subject to the provisions of this non-eligibility period can reactivate their eligibility with an effective date consistent with the beneficiary's

eligibility category. These beneficiaries may access their My Rewards Account if they otherwise meet the requirements in STC 30.

VIII. COMMUNITY ENGAGEMENT INITIATIVE

43. Overview. Kentucky will implement a community engagement requirement as a condition of eligibility for adult beneficiaries in the Kentucky HEALTH program who are not otherwise subject to an exemption described in STC 44 or 47(a). To maintain program eligibility, non-exempt beneficiaries will be required to participate in specified activities that may include employment, education, or community service.

44. Exempt Populations. The following Kentucky HEALTH beneficiaries are exempt from the community engagement initiative:

- Former Foster Care Youth;
- Pregnant women;
- Primary caregivers of a dependent, including either a dependent minor child or an adult who is disabled (limited to only one exempt beneficiary per household);
- Beneficiaries identified as medically frail (under 42 CFR 440.315(f) and as defined in the alternative benefit plan in the state plan);
- Beneficiaries diagnosed with an acute medical condition that would prevent them from complying with the requirements (as validated by a medical professional);
- Full time students, as determined by the state; and
- Beneficiaries under the age of 19 or over the age of 64.

Beneficiaries meeting one or more of the above listed exemptions will not be required to complete community engagement related activities to maintain eligibility.

45. Qualifying Activities. Kentucky HEALTH beneficiaries may satisfy their community engagement requirements through a variety of activities, including but not limited to:

- Job skills training;
- Job search activities;
- Education related to employment (e.g. management training);
- General education (e.g., high school, GED, college or graduate education, English as a second language, etc.)
- Vocational education and training;
- Self-employment;
- Subsidized or unsubsidized employment;
- Community work experience;
- Community service/ public service;
- Caregiving services for a non-dependent relative or other person with a disabling medical condition; and
- Participation in substance use disorder treatment.

Beneficiaries without an exemption must document their participation in any one or combination of qualifying activities on at least a monthly basis.

Notwithstanding the foregoing, some beneficiaries will be deemed to satisfy community engagement requirements by virtue of their verified participation in the following specified activities: (i) the beneficiary meets the requirements of the Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment initiatives or is exempt from having to meet those requirements, (ii) the beneficiary is enrolled in the state's Medicaid employer premium assistance program (a spouse or dependent of the beneficiary enrolled in the premium assistance program is also exempt), or (iii) the beneficiary is employed at least 120 hours per calendar month. Beneficiaries who are deemed to satisfy the community engagement requirements will not be required to actively document their participation in qualifying activities, although, like all beneficiaries, they will be required to timely report changes in eligibility to the state consistent with the reporting rules under the Kentucky HEALTH Program.

- 46. Hour Requirements.** The community engagement initiative will require beneficiaries to participate in 80 hours of community engagement activities per calendar month. The community engagement requirement will be implemented on a regional basis following implementation of Kentucky HEALTH. Kentucky HEALTH beneficiaries who have not been subject to the Kentucky HEALTH community engagement requirement in the past five years, will be given a three month period before being required to meet the community engagement requirement. All other beneficiaries will be subject to the consequences described in STC 47. Beneficiaries can demonstrate that they meet the requirement, in a manner consistent with 42 CFR 435.945.
- a. **Reasonable modifications:** Kentucky must provide reasonable accommodations related to meeting the community engagement requirement for beneficiaries with disabilities protected by the ADA, Section 504 of the Rehabilitation Act, and Section 1557 of the Patient Protection and Affordable Care Act, when necessary, to enable them to have an equal opportunity to participate in and benefit from the program. The state must also provide reasonable modifications for program protections and procedures, including but not limited to assistance with demonstrating eligibility for good cause exemptions; appealing suspensions; documenting community engagement activities and other documentation requirements; understanding notices and program rules related to community engagement requirements; and other types of reasonable modifications.
 - i. Reasonable modifications must include exemptions from participation where an individual is unable to participate for disability-related reasons, modification in the number of hours of participation required where an individual is unable to participate for the required number of hours, and provision of support services necessary to participate, where participation is possible with supports. In addition, the state must evaluate individuals' ability to participate and the types of reasonable modifications and supports needed.
- 47. Non-Compliance.** Eligibility will be suspended, effective under the time frame described in this STC 47(d), for beneficiaries who fail to meet required community engagement hours for a month, unless the beneficiary requests and meets a good-cause

exemption within the allotted time period or appeals the suspension prior to its effective date, and will remain suspended until the first day of the month after the beneficiary completes 80 hours of community engagement in a 30-day period or completes a state-approved re-enrollment health literacy or financial literacy course. If a Kentucky HEALTH beneficiary is in a suspension for failure to meet the requirement on his or her redetermination date, and does not meet the requirement or qualify for an exemption under STC 44 or 47(a) in the month of redetermination, Kentucky will deny that beneficiary's eligibility and terminate his or her enrollment at that time.

- a. **Good Cause Exemption.** The state will waive the suspension for beneficiaries who failed to meet the community engagement hours due to a good cause exemption for a circumstance that occurred in the month in which the beneficiary failed to meet their required community engagement hours. Beneficiaries may seek a good cause exemption up to 10 days prior to suspension. The recognized good cause exemptions include, but are not limited to, at a minimum, the following verified circumstances:
 - i. The beneficiary has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and was unable to meet the requirement for reasons related to that disability; or has an immediate family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the beneficiary or an immediate family member who was living in the home with the beneficiary experiences a hospitalization or serious illness;
 - ii. The beneficiary experiences the birth, or death, of a family member living with the beneficiary;
 - iii. The beneficiary experiences severe inclement weather (including natural disaster) and therefore was unable to meet the requirement; or
 - iv. The beneficiary has a family emergency or other life-changing event (e.g. divorce or domestic violence).
- b. **Opportunity to Cure.** In the month immediately following the month in which a beneficiary fails to meet the hours requirement, beneficiaries will have the opportunity to avoid Kentucky HEALTH suspension for community engagement non-compliance by being current on all hours for the current month, and, either: (1) making up all deficit hours not completed in the prior month, or (2) completing a state approved re-enrollment health literacy or financial literacy course. The option to take a re-enrollment course to avoid suspension or re-enter from suspension is only available one time per 12-month benefit period.
- c. **Extra Hours.** Unless a beneficiary is completing hours in accordance with paragraph (b) above, beneficiaries who engage in more qualifying activities than required in a month do not have the ability to apply the excess hours to any month other than the current month.
- d. **Suspension Effective Date.** Suspensions for non-compliance with community engagement requirements are effective the first day of the month following the one month opportunity to cure.

- e. **Re-activation Following Non-Compliance.** Following suspension for community engagement non-compliance, beneficiaries can re-activate eligibility at any time during their 12-month benefit period by completing 80 hours of community engagement in a 30-day period or completing a state approved re-enrollment health literacy or financial literacy course. The re-enrollment course to avoid suspension or for reactivation is only available one time per 12-month benefit period. Benefits will be effective the first day of the month following completion of the required hours or health literacy or financial literacy course. During a suspension period, any beneficiary who becomes pregnant; is determined to be medically frail; becomes the primary caregiver of a dependent including either a dependent minor child or adult who is disabled (limited to only one exempt beneficiary per household); becomes a full-time student; becomes diagnosed with an acute medical condition that would prevent them from complying with the requirements (as validated by a medical professional); or otherwise becomes eligible for Medicaid under an eligibility group not subject to the provisions of the community engagement suspension can reactivate their eligibility with an effective date consistent with the beneficiary's new eligibility category or status.

48. Community Engagement: State Assurances. Prior to implementation of the community engagement requirements as a condition of eligibility, the state shall:

- a. Maintain system capabilities to operationalize the suspension and/or denial of eligibility and the lifting of suspensions of eligibility once community engagement requirements are met.
- b. Maintain mechanisms to stop capitation payments to an MCO when a beneficiary's eligibility is suspended and to trigger payment once the suspension is lifted.
- c. Ensure that there are processes and procedures in place to seek data from other sources including SNAP and TANF, and systems to permit beneficiaries to efficiently report community engagement hours, and to permit Kentucky to monitor compliance.
- d. Ensure that there are timely and adequate beneficiary notices provided in writing, including but not limited to:
 - i. When the community engagement requirement will commence for that specific beneficiary;
 - ii. Whether a beneficiary is exempt, and under what conditions the exemption would end;
 - iii. A list of the specific activities that may be used to satisfy community engagement requirements and a list of the specific activities that beneficiaries can engage in to cure an impending suspension, as described in STC 47(b);
 - iv. Information about resources that help connect beneficiaries to opportunities for activities that would meet the community engagement requirement, and information about the community supports that are

- available to assist beneficiaries in meeting community engagement requirements;
 - v. Information about how community engagement hours will be counted and documented;
 - vi. What gives rise to a suspension, what a suspension would mean for the beneficiary, including how it could affect redetermination, and how to avoid a suspension, including how to apply for a good cause exemption and what kinds of circumstances might give rise to good cause;
 - vii. If a beneficiary is not in compliance for a particular month, that the beneficiary is out of compliance, and how the beneficiary can cure the non-compliance in the immediately following month;
 - viii. If a beneficiary has eligibility suspended, how to appeal a suspension, and how to have the suspension lifted, including the number of community engagement hours that must be performed within a 30 day period by the specific beneficiary to have the suspension lifted, and information on the option to take a re-enrollment course to have the suspension lifted; and
 - ix. If a beneficiary has requested a good cause exemption, that the good cause exemption has been approved or denied, with an explanation of the basis for the decision and how to appeal a denial.
- e. Ensure that specific activities that may be used to satisfy community engagement requirements and specific activities that would allow beneficiaries to cure an impending community engagement suspension (as described in STC 47(b)) are available during a range of times and through a variety of means (e.g. online, in person) at no cost to the beneficiary.
 - f. Provide full appeal rights as required under 42 CFR, Part 431, subpart E prior to suspension and observe all requirements for due process for beneficiaries whose eligibility will be suspended, denied, or terminated for failing to meet the community engagement requirement, including allowing beneficiaries the opportunity to raise additional issues in a hearing, including whether the beneficiary should be subject to the suspension, and provide additional documentation through the appeals process.
 - g. Assure that disenrollment or denial of eligibility will only occur after an individual has been screened and determined ineligible for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 42 CFR 435.916(f).
 - h. Establish beneficiary protections, including assuring that Kentucky HEALTH beneficiaries do not have to duplicate requirements to maintain access to all public assistance programs that require community engagement and employment.
 - i. Make good faith efforts to connect Kentucky HEALTH beneficiaries to existing community supports that are available to assist beneficiaries in meeting community engagement requirements, including available non-Medicaid assistance with transportation, child care, language access services and other supports; and make good faith efforts to connect beneficiaries with disabilities as defined in the ADA, section 504 of the Rehabilitation Act, or section 1557 of the

- Patient Protection and Affordable Care Act with services and supports necessary to enable them to meet community engagement requirements.
- j. Ensure the state will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be impossible or unreasonably burdensome for beneficiaries to meet.
 - k. Ensure that the state will assess whether people with disabilities have limited job or other opportunities for reasons related to their disabilities. If these barriers exist for people with disabilities, the state must address these barriers.
 - l. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable modifications related to meeting community engagement requirements.
 - m. Maintain a system that provides reasonable modifications related to meeting the community engagement requirement to beneficiaries with disabilities as defined in the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act.

IX. DELIVERY SYSTEM

- 49. Overview.** Kentucky HEALTH will utilize the current statewide mandatory managed care delivery system for all covered populations under the authority of the Kentucky Managed Care Organization Program 1915(b) waiver. Only eligible members participating in the employer premium assistance program will be exempt from mandatory managed care enrollment.
- 50. Managed Care Organizations (MCO).** Beneficiaries shall be enrolled to receive services through an MCO under contract to the state. The MCOs are subject to the federal laws and regulations as specified in 42 CFR Part 438, unless specified otherwise herein. Beneficiaries will be given an opportunity to select an MCO at the time of application. A beneficiary who does not make an MCO selection at the time of application may be auto-assigned to a MCO by the state.
- 51. Beneficiary’s Right to Change MCOs.**
- a. A beneficiary may change MCOs without cause if the change is requested prior to (i) the date the beneficiary pays their initial premium, or (ii) the date the beneficiary has enrolled in Kentucky HEALTH after the sixty (60) day initial payment period has expired. This does not apply to pregnant women and former foster care youth who will be permitted to change MCOs without cause for 90 days after enrollment.
 - b. **For Cause.** A beneficiary may change MCOs for cause at any time and the state will include this information in all communications about beneficiary contributions. “Cause” is defined in 42 CFR 438.56(d)(2).

- c. The beneficiary must submit his or her request for change either orally or in writing. The beneficiary shall still have access to the state's normal grievance and appeals process required under the managed care regulations.
- d. If the state fails to make a determination by the first day of the second month following the month in which the beneficiary files the request, the request for change will be considered approved and the beneficiary will be transferred into the new MCO.
- e. If a beneficiary is transferred from the MCO, the MCO must refund any balance of the beneficiary's premium (if applicable) to the beneficiary within 30 days of the last date of participation with the MCO.
- f. The deductible account balance will transfer with the beneficiary to the new MCO. The deductible account is a virtual account, and no funds are transferred due to an MCO change. The transferring MCO shall provide the individual's current deductible account balance to the new MCO with the information needed to properly track the beneficiary's account balance for the remainder of the benefit period.
- g. The state shall ensure that all transferring beneficiaries receive coverage from their new MCO promptly, and without any interruption in care
- h. **Excluded Services.** Consistent with the state's Kentucky Managed Care Organization (MCO) Program §1915(b) waiver (KY.0007.R01.00), MCOs will not be responsible for Kentucky HEALTH beneficiary nursing facility costs during the first 30 calendar days the beneficiary is enrolled in the MCO; however, if a member is admitted to a nursing facility, the MCO will be required to cover the costs of any non-nursing facility covered health services provided to the beneficiary while the beneficiary resides in the nursing facility, for up to 30 calendar days, after which, the MCO will not be responsible for the costs of the beneficiary's care for so long as the beneficiary is residing in the nursing facility or enrolled in the MCO..

52. Public Contracts. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, must not exceed the documented costs incurred in furnishing covered services to eligible beneficiaries (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

X. GENERAL REPORTING REQUIREMENTS

53. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of \$5,000,000 (federal share) per deliverable when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)")) are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. Similarly, deferrals of \$5,000,000 per deliverable may be issued when the state does not demonstrate sufficient progress on milestones in the SUD Implementation Protocol, as described in STC 93. Specifically:

- a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
- b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the fiscal quarter in which the deliverable was due must include a Corrective Action Plan (CAP).
 - i. CMS may decline the extension request.
 - ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
 - iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.
- c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
- d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
- e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, and timely and complete submission of required deliverables is necessary for effective testing, the state's failure to submit all required deliverables may preclude the state from renewing a demonstration or obtaining a new demonstration.
- f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example which quarter the deferral applies to, and how the deferral is released.

54. Submission of Post-Approval Deliverables. The state will submit all deliverables using the process stipulated by CMS and within the timeframes outlined within these STCs.

55. General Financial Requirements. The state shall comply with all general financial requirements under Title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section XI of these STCs.

56. Reporting Requirements Related to Budget Neutrality. The state shall comply with all reporting requirements for monitoring budget neutrality set forth in Section XII of these STCs.

57. Periodic Monitoring Calls. CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further Kentucky HEALTH beyond September 30, 2023. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

- 58. Monitoring Reports.** The state will submit to CMS a draft of proposed metrics for quarterly and annual monitoring reports within 120 days after implementation of the demonstration. CMS will then work with the state to jointly identify required metrics for quarterly and annual reports. These metrics will reflect the major elements of the demonstration, including but not limited to data that applies to the waiver and expenditure authorities, and may include (but are not limited to): beneficiary engagement through My Rewards Accounts, community engagement initiatives, and coverage of substance use disorder services. Metrics may be identified through a variety of sources, including but not limited to, the CMS Child and Adult Core Measure sets, HEDIS measures, and NCQA measures, as well as proposed CMS metrics. CMS will combine these programmatic metrics with general metrics aimed at monitoring beneficiary enrollment, access to services, and the overall functioning of the demonstration.

The resulting performance metric set is one part of the quarterly and annual monitoring report framework specified later in this STC. The state will submit three (3) quarterly reports and one (1) compiled annual report each demonstration year (DY). The quarterly reports are due no later than sixty (60) days following the end of each demonstration quarter. The annual report is due no later than ninety (90) days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the report may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and must be provided in a structured manner that supports federal tracking and analysis.

- a. **Operational Updates.** Per 42 CFR 431.428, the monitoring reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The monitoring reports should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.
- b. **Performance Metrics.** Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis. The performance metrics should be included in the first quarterly report following CMS approval of the metrics.
- c. **Budget Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state will provide an updated budget neutrality workbook that

includes established baseline and member months data with every Monitoring Report. The budget neutrality workbook will meet all the reporting requirements for monitoring budget neutrality set forth in Section XI. General Financial Requirements of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state will report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

- d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

59. Compliance with Federal Systems Innovation. As federal systems continue to evolve and incorporate 1115 demonstration reporting and analytics, the state will work with CMS to:

- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
- b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to are provided; and
- c. Submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.

60. Close Out Report. Within 120 days prior to the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

- a. The draft report must comply with the most current guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the Close-Out report.
- c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.
- d. The final Close Out Report is due to CMS no later than thirty (30) days after receipt of CMS' comments.
- e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 6.

XI. GENERAL FINANCIAL REQUIREMENTS

This demonstration is approved for Title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

61. Quarterly Expenditure Reports. The state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

- 62. Reporting Expenditures under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:
- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and state Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in sections 2500 and 2115 of the state Medicaid Manual. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).
 - b. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
 - c. **Kentucky HEALTH Premiums.** Premiums from beneficiaries that are collected by the MCO on behalf of the state from beneficiaries under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.
 - d. **Use of Waiver Forms.** For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted reporting expenditures for beneficiaries enrolled in the demonstration, subject to the budget neutrality limit. The state will complete separate waiver forms for the following benefits/ waiver names:
 - i. “SUD” expenditures
 - ii. “My Rewards” expenditures
- 63. Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state shall separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name State and Local Administration Costs (“ADM”).

- 64. Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) shall be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) shall be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state shall continue to identify separately net expenditures related to dates of services during the operation of the demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.
- 65. Reporting of Member Months.** The following describes the reporting of member months for the demonstration populations:
- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state will provide to CMS, as part of the quarterly report required under STC 58, the actual number of eligible member months for the demonstration populations. The state will submit a statement accompanying the quarterly report, which certifies the accuracy of this information.
 - b. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.
 - c. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.
- 66. Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 calendar days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.
- 67. Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below:
- a. Administrative costs, including those associated with the administration of the demonstration. With respect to expenditures for items and services covered through the My Rewards account, only those items and services that the Secretary

has found to be necessary for the proper and efficient administration of the state plan may be claimed as administrative costs.

- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.
- c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments. With respect to expenditures for items and services covered through the My Rewards account, only those items and services that the Secretary has determined meet the definition of medical assistance in section 1905(a) of the Act may be claimed as medical assistance expenditures.

68. Sources of Non-Federal Share. The state must certify that the matching non-federal share of funds for the demonstration is derived from state/local monies. The state further certifies that such funds must not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the demonstration shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

69. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of the demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS shall approve a cost reimbursement methodology. This methodology shall include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated shall certify to the state the amount of such tax revenue (state or local) used to fund the non-federal share of

demonstration expenditures. The entities that incurred the cost shall also provide cost documentation to support the state's claim for federal match.

- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers shall be made in an amount not to exceed the non-federal share of Title XIX payments.
- e. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XII. BUDGET NEUTRALITY

- 70. Limit on Title XIX Funding.** The state is subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 71. The budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C reports from the CMS-64.
- 71. Risk.** The state will be at risk for exceeding the limits on per capita cost (as determined by the method described below) for the demonstration expenditures, as described in STC 72 and STC 73, and shall not be at risk for costs pertaining to the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.
- 72. Calculation of the Budget Neutrality Limit.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in this STC 72(b). The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of

demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 75. The demonstration expenditures subject to the budget neutrality limit are those reported under the waiver names “My Rewards Expenditures” and “SUD Expenditures”.

- a. The Medicaid Eligibility Group (MEGs) listed in the table below are included in the calculation of the budget neutrality limit for the Kentucky HEALTH demonstration.
- b. The budget neutrality cap is calculated by taking the per member per month (PMPM) cost projection for the below groups in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.
- c. The state will not be allowed to obtain budget neutrality “savings” from these populations.

73. Substance Use Disorder Expenditures. As part of the SUD initiative, the state may receive FFP for the continuum of services specified in Table 2 to treat OUD and other SUDs that are provided to all Medicaid beneficiaries in an IMD as authorized by this demonstration. These are state plan services that would be eligible for reimbursement if not for the IMD exclusion. Therefore, they are being treated as hypothetical. The state may only claim FFP via demonstration authority for the services listed in Table 2 that will be provided in an IMD. However, the state will not be allowed to obtain budget neutrality “savings” from these services. Therefore, a separate expenditure cap is established for SUD services.

- a. The SUD MEG listed in the table below is included in SUD budget neutrality test.
- b. SUD expenditures cap are calculated by multiplying the projected PMPM for each SUD MEG, each DY, by the number of actual eligible SUD member months for the same MEG/DY—and summing the products together across all DYs. The federal share of the SUD expenditure cap is obtained by multiplying those caps by the Composite Federal Share (see STC 75).
- c. SUD budget neutrality test is a comparison between the federal share of SUD expenditure cap and total FFP reported by the state for the SUD MEG.

Eligibility group	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5	DY 6
SUD PMPM	5.0%	\$1,430.18	\$1,501.69	\$1,576.77	\$1,655.61	\$1,738.39	\$1,759.72
My Rewards PMPM	5.0%	\$10.26	\$10.77	\$11.31	\$11.88	\$12.47	\$12.62

74. Former Foster Care Youth. CMS has determined that the provision of benefits and services to this demonstration population is budget neutral based on CMS’ assessment that the waiver authorities granted for this demonstration population are unlikely to result in any increase in federal Medicaid expenditures, and that no expenditure authorities are

associated with this demonstration population. There will be no budget neutrality expenditure limit established for this demonstration population, and no further test of budget neutrality will be required. Accordingly, the state will not be allowed to obtain budget neutrality “savings” from this demonstration population. All expenditures associated with this population will be reported on the CMS-64 base form(s) for Medicaid State Plan populations in accordance with section 2500 of the State Medicaid Manual.

- 75. Composite Federal Share Ratio.** The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 9 and STC 11), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.
- 76. Enforcement of Budget Neutrality.** CMS must enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state shall submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

DY	Cumulative Target Definition	Percentage
DY 1 { Approval }- June 30 2018	Cumulative budget neutrality expenditure cap plus:	2.0%
DY 2 July 1, 2018- June 30, 2019	Cumulative budget neutrality expenditure cap plus:	1.5%
DY 3 July 1, 2019- June 30, 2020	Cumulative budget neutrality expenditure cap plus:	1.0%
DY4 July 1, 2020- June 30, 2021	Cumulative budget neutrality expenditure cap plus:	0.5%
DY5 July 1, 2020- June 30, 2022	Cumulative budget neutrality expenditure cap plus:	0%

DY6 July 1, 2022- September 30, 2023	Cumulative budget neutrality expenditure cap plus:	0%
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77. **Exceeding Budget Neutrality.** If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.
78. **Impermissible DSH, Taxes or Donations.** The CMS reserves the right to adjust the budget neutrality expenditure limit in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if CMS determines that any health care-related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is in violation of the provider donation and health care related tax provisions of Section 1903(w) of the Act. Adjustments to the budget neutrality agreement will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

XIII. EVALUATION

79. **Independent Evaluator.** Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology in the evaluation design, but the state may request, and CMS may agree to, changes in the methodology in the appropriate circumstances.
80. **Draft Evaluation Design.** The draft evaluation design must be developed in accordance with Attachment A of these STCs. The state will submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) days after demonstration approval. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of the independent party in the development of the draft Evaluation Design.
81. **Evaluation Design Approval and Updates.** The state will submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state will implement the evaluation

design and submit evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments. Rapid cycle assessments should include any early or interim findings the evaluators have prior to evaluation reports being due. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

- 82. Evaluation Questions and Hypotheses.** Consistent with Attachments A and B of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
- 83. Evaluation Design Elements.** The following items must be specified for each hypothesis:
- a. Quantitative and qualitative research methodologies;
 - b. Proposed baseline and comparison groups;
 - c. Proposed process and outcome measures and specifications;
 - d. Data sources and collection frequency;
 - e. Cost estimates; and
 - f. Timelines for deliverables.
- 84. Evaluation Data Sources.** The Evaluation Design will incorporate multiple stakeholder perspectives, including (but not limited to), surveys of beneficiaries (both enrolled and those no longer enrolled), claims data, and national survey data (such as CAHPS).
- 85. Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the Evaluation Design, if CMS finds that the Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.
- 86. State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the final Evaluation Design, post approval, in conjunction with these STCs. The state will present on its interim evaluation in conjunction with these STCs. The state will present on its summative evaluation in conjunction with these STCs.
- 87. Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), should CMS undertake a federal evaluation of the demonstration or any component of the

demonstration, the state will cooperate fully and timely with CMS and its contractors' evaluation activities. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state will include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required by the state under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 53.

- 88. Interim Evaluation Report.** The state will submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Interim Evaluation Report should be posted to the state's website with the application for public comment. Also refer to Attachment B for additional information on the Interim Evaluation Report.
- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
 - b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
 - c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration, the research questions, hypotheses and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
 - d. The state will submit the final Interim Evaluation Report sixty (60) days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
 - e. The Interim Evaluation Report must comply with Attachment B of these STCs.
- 89. Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state will submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design. Refer to Attachment B for additional information on the Summative evaluation report.
- a. Unless otherwise agreed upon in writing by CMS, the state will submit the final Summative Evaluation Report within sixty (60) days of receiving comments from CMS.

b. The final Summative Evaluation Report must be posted to the state’s Medicaid website within thirty (30) days of approval by CMS.

90. Public Access. The state shall post the final documents (e.g., Quarterly and Annual Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report(s), and Summative Evaluation Report(s) on the state’s Medicaid website within thirty (30) days of approval by CMS.

91. Additional Publications and Presentations. For a period of twenty-four 24 months following CMS approval of the final reports, CMS will be notified prior to the public release or presentation of these reports and related publications (including, for example, journal articles), by the state, contractor, or any other third party (an entity which is not the state or contractor) over which the state Medicaid agency has control. Prior to release of these reports, articles and other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty (30) days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

XIV. OPIOID USE DISORDER (OUD)/SUBSTANCE USE DISORDER (SUD)

Effective upon CMS’ approval of the SUD Implementation Protocol, as described in STC 93, the demonstration benefit package for all Medicaid beneficiaries as authorized by this demonstration will include OUD/SUD residential treatment, crisis stabilization and withdrawal management services provided in IMDs, which are not otherwise matchable expenditures under section 1903 of the Act. Medicaid beneficiaries residing in IMDs under the terms of this demonstration will have coverage of all benefits that would otherwise be covered if the beneficiary were not residing in an IMD. Effective upon CMS’ approval of this demonstration, methadone treatment services will be a covered service under the state plan for Medicaid beneficiaries.

The coverage of OUD/SUD residential treatment, crisis stabilization, withdrawal management and methadone treatment services will expand Kentucky’s current SUD benefit package available to all Medicaid beneficiaries as outlined in Table 2. Note: room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 2: Kentucky SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Costs Not Otherwise Matchable
Early Intervention (Screening, Brief Intervention and Referral to Treatment)	State plan (Individual services covered)	
Outpatient Therapy (Individual; Group; Family; Collateral)	State plan (Individual)	

	services covered)	
Intensive Outpatient Program	State plan (Individual services covered)	
Partial Hospitalization Treatment (including Day Treatment for children/youth under the age of 21)	State plan (Individual services covered)	
Residential Treatment	State plan (Individual services covered)	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	State plan	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	State plan	Services provided to individuals in IMDs
Methadone treatment for opioid dependence	State Plan (contingent on this 1115 demonstration waiver of NEMT)	Services provided to individuals in IMDs
Peer Support (including Parent/Family Peer Support)	State plan	Services provided to individuals in IMDs
Crisis Intervention (including Mobile Crisis)	State plan (Individual services covered)	
Residential Crisis Stabilization	State plan (Individual services covered)	Services provided to individuals in IMDs

- 92. Methadone Treatment Services.** “Methadone Treatment Services” will be covered in the Medicaid state plan. A waiver of the NEMT assurance is granted for Methadone Treatment Services to allow the state not to provide NEMT for methadone services to all Medicaid beneficiaries, except that NEMT for methadone services will be provided for children under age 21 who are subject to EPSDT, former foster care youth, and for pregnant women. (A waiver of the NEMT assurance for all other Medicaid covered services is granted for beneficiaries eligible through the new adult group, as defined in 42 CFR 435.119, except for beneficiaries in that group who are under age 21 and subject to EPSDT, pregnant, medically frail, or former foster care youth.)

- a. The components of Methadone Treatment Services are defined in the Medicaid state plan.

93. SUD Implementation Protocol. The state must submit a SUD Implementation Protocol within 120 calendar days after approval of this demonstration. The protocol must be approved by CMS. The state may not claim FFP for services provided in IMDs until CMS has approved the SUD Implementation Protocol. Once approved, the SUD Implementation Protocol will be incorporated into these STCs, as Attachment C, and once incorporated, may be altered only with CMS approval. After approval of the SUD Implementation Protocol, FFP will be available prospectively, not retrospectively. Failure to submit a SUD Implementation Protocol or failure to obtain CMS approval will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the IMD expenditure authority. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral or withholding.

At a minimum, the SUD Implementation Protocol will describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones that reflect the key goals and objectives of the SUD component of this demonstration program:

- a. **Access to Critical Levels of Care for OUD and other SUDs:** Service delivery for new benefits, including residential treatment, crisis stabilization and withdrawal management within 24 months of demonstration approval;
- b. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that MCOs and providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 24 months of demonstration approval;
- c. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 24 months of demonstration approval;
- d. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be accredited by the Commission on the Accreditation of Rehabilitation Facilities and must be a licensed organization, pursuant to the residential service provider qualifications described in the Kentucky Medicaid state plan. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of

- clinical care, and credentials of staff for residential treatment settings within 24 months of SUD program demonstration approval;
- e. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;
 - f. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;
 - g. **Sufficient Provider Capacity at Critical Levels of Care including Medication Assisted Treatment for OUD:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under the demonstration including those that offer MAT, within 12 months of SUD program demonstration approval over the course of the demonstration;
 - h. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand access to naloxone;
 - i. **SUD Health IT Plan:** Implementation of the milestones and metrics as described in Attachment E; and
 - j. **Improved Care Coordination and Transitions between levels of care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

94. SUD Monitoring Protocol. The state must submit an SUD Monitoring Protocol within 150 calendar days after approval of the demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Upon approval, the SUD Monitoring Plan Protocol will be incorporated into these STCs, as Attachment D. At a minimum, the SUD Monitoring Protocol will include reporting relevant to each of the program implementation areas listed in STC 93. In addition, the SUD Monitoring Protocol will include regular reporting by the state on access to medication assisted therapy (MAT) in each county of the state, availability of MAT providers in each county, the number of individuals accessing MAT including methadone in each county, as well as the estimated cost of providing NEMT for accessing methadone in each county. The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion in the protocol. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in these STCs. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap

between baseline and target expressed as percentage points. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements.

- 95. Mid-Point Assessment.** The state must conduct an independent mid-point assessment within ninety (90) days after the third year after approval of this demonstration. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and the risk of possibly missing those milestones and performance targets. For each milestone and measure target at medium to high risk of not being achieved, the assessor will provide for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report will be provided to CMS. CMS will be briefed on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Protocol and SUD Monitoring Protocols for ameliorating these risks subject to CMS approval.

- 96. Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Towards Milestones.** Up to \$5M in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in Table 2 and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to \$5M will be deferred in the next calendar quarter and each calendar quarter thereafter until the CMS has determined sufficient progress has been made.
- 97. SUD Evaluation.** The SUD Evaluation will be subject to the same terms as the overall demonstration evaluation, as listed in Section XIII of these STCs.
- 98. SUD Evaluation Design.** The state must submit, for CMS comment and approval, a draft SUD Evaluation Design with implementation timeline, no later than one hundred eighty (180) days after approval of the demonstration. Failure to submit an acceptable and timely evaluation design along with any required monitoring, expenditure, or other

evaluation reporting will subject the state to a \$5 million deferral. The state must use an independent evaluator to design the evaluation.

- a. **Evaluation Design Approval and Updates.** The state must submit a revised draft SUD Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved SUD Evaluation Design within thirty (30) days of CMS approval. The state must implement the SUD Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs.
- b. **Evaluation Questions and Hypotheses Specific to the SUD Program.** The state must follow the general evaluation questions and hypotheses requirements as specified in STC 82. In addition, hypotheses for the SUD program should include an assessment of the objectives of the SUD component of this demonstration, to include (but is not limited to) initiative and compliance with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes such as deaths due to overdose. The SUD Evaluation Design must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. The hypotheses should include an assessment of the objectives of SUD section 1115 demonstrations, to include (but is not limited to): initiation and compliance with treatment; utilization of health services including emergency department and inpatient hospital settings; effectiveness of MAT; interaction of MAT impact and access to NEMT; impact of the demonstration on key outcomes including deaths due to overdose; and cost effectiveness of the demonstration, particularly services provided in IMDs and the waiver of NEMT.

Proposed measures should be selected from nationally-recognized sources and national measure sets, where possible. Measures set could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF). Data to evaluate the NEMT waiver impact on MAT shall include a beneficiary survey to be approved by CMS.

99. **SUD Interim Evaluation Report.** The state must submit a SUD Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the SUD Interim Evaluation Report should be posted to the state's website with the application for public comment.
 - a. The SUD Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.

- b. For demonstration authority that expires prior to the overall demonstration's expiration date, the SUD Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. If the state is seeking to renew or extend the demonstration, the draft SUD Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design will be adapted, should be included. If the state is not requesting a renewal for a demonstration, a SUD Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft SUD Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
- d. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft SUD Interim Evaluation Report and post the document to the state's website.
- e. The SUD Interim Evaluation Report must comply with Attachment B of these STCs.

- 100. SUD Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.
- a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.
 - b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

Attachment A: Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

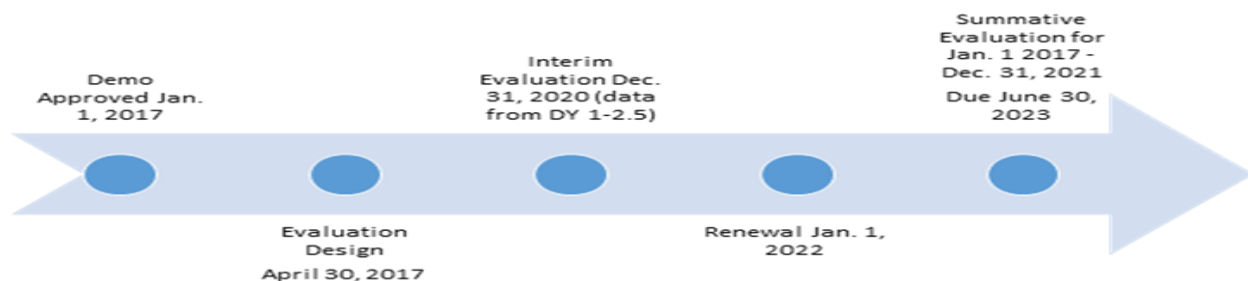
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, the state must follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- A. General Background Information;
- B. Evaluation Questions and Hypotheses;
- C. Methodology;
- D. Methodological Limitations;
- E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state’s Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

- 1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state’s demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

- 2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>
- 3) Identify the state’s hypotheses about the outcomes of the demonstration:
 - a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
 - b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

- 1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
- 2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
- 3) *Evaluation Period* – Describe the time periods for which data will be included.
- 4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

- a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used, and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
 - d. Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
 - e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
 - f. Among considerations in selecting the metrics must be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
- 5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

- 6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
- a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
 - b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
 - c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
 - d. The application of sensitivity analyses, as appropriate, should be considered.
- 7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

- 1) When the state demonstration is:
 - a. Long-standing, non-complex, unchanged, or
 - b. Has previously been rigorously evaluated and found to be successful, or
 - c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

- 2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes; and
 - b. No or minimal appeals and grievances; and
 - c. No state issues with CMS 64 reporting or budget neutrality; and
 - d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

A. Independent Evaluator. This includes a discussion of the state’s process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. This includes “No Conflict of Interest” signed conformation statements.

B. Evaluation Budget. A budget for implementing the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

D. Timeline and Major Milestones. Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design must incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B: Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

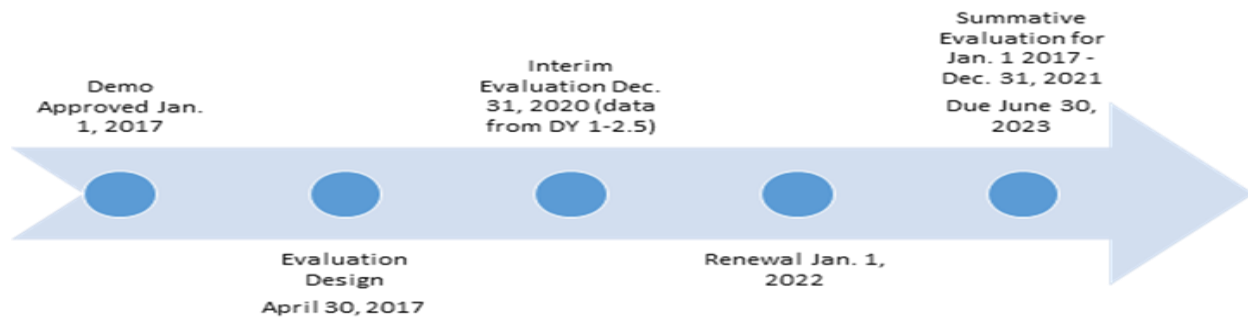
The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;
- D. Methodology;
- E. Methodological Limitations;
- F. Results;

- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

Submission Timelines

There is a specified timeline for the state’s submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state’s website within thirty (30) days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state’s Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state’s submission must include:

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
 - 1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential

- magnitude of the issue, and why the state selected this course of action to address the issues.
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
 - 3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
 - 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
 - 5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state’s demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
- 2) Identify the state’s hypotheses about the outcomes of the demonstration;
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how.

Specifically, this section establishes that the approved Evaluation Design was followed by describing:

- 1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
- 2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
- 3) *Evaluation Period*—Describe the time periods for which data will be collected
- 4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?
- 5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
- 6) *Analytic methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
- 7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results.

- 1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
- 2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives –

In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

- I. Lessons Learned and Recommendations** – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:
1. What lessons were learned as a result of the demonstration?
 2. What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C: SUD Implementation Protocol
[To be incorporated after CMS approval.]

Attachment D: SUD Monitoring Protocol
[To be incorporated after CMS approval.]

ATTACHMENT E: SUD Health Information Technology (Health IT)

Health Information Technology (“Health IT”). The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/“ecosystem” at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This “SUD Health IT Plan,” or assurance, will be included as a section of the state’s “Implementation Plan” (see STC 93) to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

- a. The SUD Health IT section of the Implementation plan will include implementation milestones and dates for achieving them (see Attachment C).
- b. The SUD Health IT Plan must be aligned with the state’s broader State Medicaid Health IT Plan (SMHP) and, if applicable, the State’s Behavioral Health (BH) and/or BH “Health IT” Plan.
- c. The SUD Health IT Plan will describe the state’s goals, each DY, to enhance the state’s prescription drug monitoring program’s (PDMP)¹ ability to engage in interstate data sharing among other state-based PDMPs in order to better track patient-specific prescription data—and support regional law enforcement in cases of controlled substance diversion.²
- d. The SUD Health IT Plan will address how the state’s PDMP will enhance ease of use for prescribers and other state and federal stakeholders.³ This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients’ history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
- e. The SUD Health IT Plan will, as applicable, describe the state’s capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
- f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will: a) support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns; and b) ensure

¹ Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the epidemic and facilitate a nimble and targeted response.

³ *Ibid.*

Medicaid does not inappropriately pay for opioids and that states implement effective controls to minimize the risk.⁴

- g. In developing the Health IT Plan, states shall use the following resources.
 - 1. States may use resources at Health IT.Gov (<https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/>) in “Section 4: Opioid Epidemic and Health IT.”
 - 2. States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
 - 3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration
- h. The state will include in its monitoring Plan (see STC 94) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.
- i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Reports (see STC 58).
- j. As applicable, the state should advance the standards identified in the ‘Interoperability Standards Advisory—Best Available Standards and Implementation Specifications’ (ISA) in developing and implementing the state’s SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
 - 1. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring no other compelling state interest.
 - 2. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling State interest.

⁴ Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.