

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Administration and Financial Management

4 (Amendment)

5 907 KAR 1:900. KyHealth Choices benefit plans.

6 RELATES TO: KRS 205.520, 205.560, 205.6312, 205.6481-6497, 205.8451,
7 319A.010, 327.010, 334A.020, 20 C.F.R. 416.2001, 42 C.F.R. 433.56, 435, 436.3,
8 440.30, 440.40, 440.60, 440.70, 440.110, 440.120, 440.130, 440.170, 441.20, 441.21,
9 441.35, 441.40, 457.310, 45 C.F.R. 233.100, 42 U.S.C. 416, 423, 1382c, 1383c, 1396a,
10 b, c, d, o, r-6, r-8, 1396a(10)(A), 1396a(a)(52), 1396a(aa), 1396a(l)(1)(B), (C), (D),
11 1396d(a)(4)(C), 1396d(o), 1396u-1, 1397aa,

12 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), Pub. L.
13 106-170, Pub.L. 109-171

14 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
15 Services, Department for Medicaid Services has responsibility to administer the Medi-
16 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to
17 comply with any requirement that may be imposed or opportunity presented by federal
18 law for the provision of medical assistance to Kentucky's indigent citizenry. This admin-
19 istrative regulation establishes the Medicaid Program KyHealth Choices benefit plans.

20 Section 1. Definitions. (1) "Benchmark plan" means the Global Choices.

21 (2) "Benefit plan" means the health plan provided to recipients under comprehensive

1 choices, family choices, global choices, and optimum choices.

2 (3) "Caretaker relative" means a relative:

3 (a) With whom a child is, or shall be, placed by the Cabinet for Health and Family
4 Services; and

5 (b) Who is seeking to qualify as a kinship caregiver.

6 (4) "Comprehensive choices" means a benefit plan for an individual who:

7 (a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;

8 (b) Receives services through either:

9 1. A nursing facility in accordance with 907 KAR 1:022;

10 2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;

11 3. The Home and Community Based Waiver Program in accordance with 907 KAR
12 1:160; or

13 4. The Model Waiver II Program in accordance with 907 KAR 1:595; and

14 (c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.

15 (5) "Department" means the Department for Medicaid Services or its designee.

16 (6) "Family choices" means a benefit plan for an individual who:

17 (a) Is covered pursuant to:

18 1. 42 U.S.C. 1396a(a)(10)(i)(I) and 1396u-1;

19 2. 42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E
20 of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

21 3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);

22 4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);

23 5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or

1 6. 42 C.F.R. 457.310; and

2 (b) Has a designated package code of 2, 3, 4, or 5.

3 (7) "Global choices" means the department's default benefit plan, consisting of indi-
4 viduals designated with a package code of A, B, C, D, or E and who are included in one
5 (1) of the following populations:

6 (a) Caretaker relatives who:

- 7 1. Receive K-TAP and are deprived due to death, incapacity, or absence;
- 8 2. Do not receive K-TAP and are deprived due to death, incapacity, or absence; or
- 9 3. Do not receive K-TAP and are deprived due to unemployment;

10 (b) Individuals aged sixty-five (65) and over who receive SSI and:

- 11 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR
12 1:022; or
- 13 2. Receive SSP and do not meet nursing facility patient status criteria in accordance
14 with 907 KAR 1:022;

15 (c) Blind individuals who receive SSI and:

- 16 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR
17 1:022; or
- 18 2. SSP, and do not meet nursing facility patient status criteria in accordance with 907
19 KAR 1:022;

20 (d) Disabled individuals who receive SSI and:

- 21 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR
22 1:022, including children; or
- 23 2. SSP, and do not meet nursing facility patient status criteria in accordance with 907

1 KAR 1:022;

2 (e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are
3 eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient
4 status criteria in accordance with 907 KAR 1:022;

5 (f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through"
6 Medicaid benefits, and do not meet nursing facility patient status in accordance with 907
7 KAR 1:022;

8 (g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass
9 through" Medicaid benefits, and do not meet nursing facility patient status in accordance
10 with 907 KAR 1:022; [øø]

11 (h) Pregnant women; or

12 (i) Medicaid works individuals.

13 (8) "Kinship caregiver" means the qualified caretaker relative of a child with whom the
14 child is placed by the Cabinet for Health and Family Services as an alternative to foster
15 care.

16 (9) "K-TAP" means Kentucky's version of the federal block grant program of Tempo-
17 rary Assistance for Needy Families (TANF), a money payment program for children who
18 are deprived of parental support or care due to:

19 (a) Death;

20 (b) Continued voluntary or involuntary absence;

21 (c) Physical or mental incapacity of one (1) parent or stepparent if two (2) parents are
22 in the home; or

23 (d) Unemployment of one (1) parent if both parents are in the home.

1 (10) "Medicaid works individual" means an individual who:

2 (a) But for earning in excess of the income limit established under 42 U.S.C.

3 1396d(q)(2)(B) would be considered to be receiving supplement security income;

4 (b) Is at least sixteen (16), but less than sixty-five (65), years of age;

5 (c) Is engaged in active employment verifiable with:

6 1. Paycheck stubs;

7 2. Tax returns;

8 3. 1099 forms; or

9 4. Proof of quarterly estimated tax;

10 (d) Meets income standards established in 907 KAR 1:640, Income standards for
11 Medicaid; and

12 (e) Meets resource standards established in 907 KAR 1:645, Resource standards for
13 Medicaid.

14 (11) "Model Waiver II" means a department program established in 907 KAR 1:595.

15 (12)[(44)] "Optimum choices" means a benefit plan for an individual who:

16 (a) Meets the intermediate care facility for individuals with mental retardation or a de-
17 velopmental disability patient status criteria established in 907 KAR 1:022;

18 (b) Receives services through either:

19 1. An intermediate care facility for individuals with mental retardation or a develop-
20 mental disability in accordance with 907 KAR 1:022; or

21 2. The Supports for Community Living Waiver Program in accordance with 907 KAR
22 1:145; and

23 (c) Has a designated package code of S, T, U, V, W, X, Z, 0, or 1.

1 ~~(13)~~~~(42)~~ "Package code" means a unique code which identifies a specific service
2 under each benefit plan.

3 ~~(14)~~~~(43)~~ "Recipient" is defined in KRS 205.8451 and applies to an individual who
4 has been determined eligible to receive benefits under the state's Title XIX or Title XXI
5 Program in accordance with 907 KAR Chapters 1 through 4.

6 ~~(15)~~~~(44)~~ "SSI" means the Social Security Administration program called supplemen-
7 tal security income.

8 ~~(16)~~~~(45)~~ "SSP" means state supplemental payments for individuals who are aged,
9 blind or disabled and in accordance with 921 KAR 2:015.

10 Section 2. Benefit Plan Assignment. (1)(a) The department shall assign each recipi-
11 ent, including those excluded from mandatory participation pursuant to 42 U.S.C.
12 1396u-7(a)(2)(B), to an appropriate benefit package. The four (4) benefit plans shall in-
13 clude: comprehensive choices, family choices, global choices, or optimum choices -
14 pursuant to the definitions established in Section 1(4), (6), (7), and (11)~~[7]~~ and based on
15 the recipient's medical needs or circumstances.

16 (b) An individual excluded from mandatory participation pursuant to 42 U.S.C. 1396u-
17 7(a)(2)(B):

18 1. May enroll in the benchmark plan; and

19 2. Shall be subject to the cost-sharing, service limit, and any other provisions estab-
20 lished for the benchmark plan effective beginning with the date the individual requested
21 to be enrolled in the benchmark plan.

22 (2) If a recipient's medical needs or circumstances evolve to the extent another bene-
23 fit plan is more appropriate change, the department shall assign the recipient to the

1 more appropriate benefit plan.

2 (3) (a) A recipient whose medical needs or circumstances are appropriate for the
3 comprehensive or optimum choices benefit plan may elect to not be assigned to the
4 comprehensive or optimum choices benefit plan.

5 (b) The department shall assign a recipient who elects to not be assigned to the
6 comprehensive or optimum choices benefit plan to the global choices benefit plan,
7 unless the individual elects to opt out of all coverage.

8 (4) (a) A recipient may request to be assigned to a different benefit plan by notifying
9 the department.

10 (b) If a recipient requests to be assigned to a different benefit plan, the department
11 shall examine the recipient's medical needs or circumstances and determine the appro-
12 priateness of placing the individual shall be placed in a different benefit plan.

13 Section 3. Benefit Plan Covered Services and Cost Sharing. (1) Benefit plan covered
14 service provisions shall be as established in the respective program administrative regu-
15 lations located in Title 907 KAR.

16 (2) Benefit plan cost-sharing provisions shall be as established in 907 KAR 1:604,
17 Recipient cost-sharing.

18 Section 4. Appeals. A recipient may appeal a department decision in accordance with
19 907 KAR 1:563, Medicaid covered services hearings and appeals.

907 KAR 1:900

REVIEWED:

Date

Shawn M. Crouch, Commissioner
Department for Medicaid Services

APPROVED:

Date

Mark D. Birdwhistell, Secretary
Cabinet for Health and Family Services

907 KAR 1:900

A public hearing on this administrative regulation shall, if requested, be held on January 21, 2008 at 9:00 a.m. in the Cafeteria on the first floor of the Human Resources Building, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by January 14, 2008, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business January 31, 2008. Please send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, Phone: 502-564-7905, Fax: 502-564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:900

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Person: Stuart Owen (502) 564-6204 or Lisa Lee (502) 564-6890

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes provisions related to KyHealth Choices benefit plans.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish provisions related to KyHealth Choices benefit plans.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing provisions related to KyHealth Choices benefit plans.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing provisions related to KyHealth Choices benefit plans.

- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: This amendment results from a congressional initiative to encourage states to adopt the option of allowing individuals with disabilities to purchase Medicaid coverage that is necessary to enable such individuals to maintain employment. The initiative creates a new Medicaid eligibility group known as Medicaid works individuals. Currently, individuals receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) who choose to work, lose Medicaid health benefits because their income exceeds the allowable limit. This initiative will allow individuals with disabilities who choose to work and whose income is less than or equal to 250% of the federal poverty level the opportunity to purchase Medicaid coverage by paying a premium. Currently individuals who qualify via a spend down option receive benefits for three (3) months and then have to return to a local office and re-apply each time they desire a spend down eligibility card. If these individuals elect to be covered via the Medicaid works option they will simply pay a monthly premium and not have to continue returning to a local office to qualify via spend down. Additionally, this option allows individuals to increase their expendable income by working and maintaining Medicaid eligibility rather than having to choose between working and preserving Medicaid benefits.
 - (b) The necessity of the amendment to this administrative regulation: This amendment is necessary to extend Medicaid coverage to individuals with disabilities who work. Currently individuals who qualify via a spend down option receive benefits for three (3) months and then have to return to a local office and re-apply each time they desire a spend down eligibility card. If these individuals

elect to be covered via the Medicaid works option they will simply pay a monthly premium and not have to continue returning to a local office to qualify via spend down. Additionally, this option allows individuals to increase their expendable income by working and maintaining Medicaid eligibility rather than having to choose between working and preserving Medicaid benefits.

- (c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by ensuring that provisions relating to eligibility requirements are within the limits established in 42 USC 1396a(r)(2) and 42 USC 1396a(a)(10), 42 USC 1396b(f), 42 USC 1396d(q)(2)(B) and Public Law 106-170.
 - (d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the authorizing statutes by ensuring that provisions relating to eligibility requirements are within the limits established in 42 USC 1396a(r)(2) and 42 USC 1396a(a)(10), 42 USC 1396b(f), 42 USC 1396d(q)(2)(B) and Public Law 106-170.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect individuals with disabilities between the ages of sixteen (16) and sixty-five (65) who choose to work and whose income is less than or equal to 250% of the federal poverty level.
- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Individuals choosing Medicaid coverage via this option must pay a monthly premium in order to receive benefits under this program. In addition, recipients must pay nominal co-payments for specified services.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Members eligible via the Medicaid works option will be subject to pharmacy and medical co-payments that are capped at \$225 each per year per recipient. Therefore, recipients the maximum amount of co-payments per recipient will be \$450 per year. In addition, recipients will be responsible for a monthly premium based on income levels. Premiums range from thirty-five (35) dollars to fifty-five (55) dollars.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals eligible via the Medicaid works option will receive pharmacy and medical benefits through the Medicaid program. Currently individuals who qualify via a spend down option receive benefits for three (3) months and then have to return to a local office and re-apply each time they desire a spend down eligibility card. If these individuals elect to be covered via the Medicaid works option they will simply pay a monthly premium and not have to continue returning to a local office to qualify via spend down. Additionally, this option allows individuals to increase their expendable income by working and

maintaining Medicaid eligibility rather than having to choose between working and preserving Medicaid benefits.

- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: The Department for Medicaid Services (DMS) anticipates that the system modifications will cost \$36,275.
 - (b) On a continuing basis: DMS anticipates medical and pharmaceutical costs to be approximately \$912,000 during the first year; however, this amount will be offset by cost sharing in the form of premiums totaling \$108,000. Additionally, DMS anticipates that sixty-five (65) percent of recipients expected to enroll for coverage via the Medicaid works option will already be enrolled in another Medicaid program. Considering all factors, DMS projects total annual costs to be \$211,200, of which \$147,840 would be federal funds.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act, matching funds from general fund appropriations, and monthly premium payments made by recipients participating in the program.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in funding will be necessary as DMS anticipates any increased cost will be absorbed within the existing Medicaid budget.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This amendment establishes monthly premium fees for recipients eligible via the Medicaid works option.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering is applied to monthly premium amounts. The monthly premium is based on income brackets in order to make the program affordable to individuals in the lower income brackets. Recipients whose monthly income is below 100% of the federal poverty level will pay no premium while recipients above this level will vary with each increase of fifty (50) percent or more.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:900

Agency Contact: Stuart Owen (502) 564-6204 or Lisa Lee (502) 564-6890

1. Federal statute or regulation constituting the federal mandate.

The Centers for Medicare and Medicaid Services (CMS) does not mandate that state Medicaid programs cover working individuals who are disabled; however, relevant provisions for states who choose to offer this coverage are established in 42 USC 1396a(r)(2) and 42 USC 1396a(a)(10), 42 USC 1396b(f), 42 USC 1396d(q)(2)(B) and Public Law 106-170.

2. State compliance standards.

KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

3. Minimum or uniform standards contained in the federal mandate.

CMS does not mandate that state Medicaid programs cover working individuals who are disabled; however, relevant provisions for states who choose to offer this coverage are established in 42 USC 1396a(r)(2) and 42 USC 1396a(a)(10), 42 USC 1396b(f) and 42 USC 1396d(q)(2)(B) and Public Law 106-170. Provisions established in this administrative regulation conform to the federal requirements.

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

This administrative regulation does not impose stricter, than federal, requirements.

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

This administrative regulation does not impose stricter, than federal, requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:900

Contact Person: Stuart Owen (502) 564-6204 or Lisa Lee (502) 564-6890

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

Yes X No _____

If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect an organization that chooses to hire an individual with a disability.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. Relevant provisions for states who choose to offer this coverage are established in 42 USC 1396a(r)(2) and 42 USC 1396a(a)(10), 42 USC 1396b(f) and 42 USC d(q)(2)(B) and Public Law 106-170. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

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

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amount of revenue this administrative regulation will generate for state or local government is contingent upon the number of individuals who enroll via the Medicaid works option. Individuals who meet criteria established by this amendment will be allowed to enter the workforce, increase their earnings and remain eligible to receive benefits. State revenue is contingent upon the number of hours of worked per individual and the rate of pay each receives.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amount of revenue this administrative regulation will generate for state or local government is contingent upon the number of individuals who enroll via the Medicaid works option. Individuals who meet criteria established by this amendment will be allowed to enter the workforce,

increase their earnings and remain eligible to receive benefits. State revenue is contingent upon the number of hours of worked per individual and the rate of pay each receives.

- (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) anticipates that the Medicaid Management Information System (MMIS) modifications associated with this initiative will cost approximately \$36,275.

- (d) How much will it cost to administer this program for subsequent years? DMS anticipates the enhanced coverage may result in additional cost; however, the measures are necessary to enhance access to health services. DMS anticipates medical and pharmaceutical costs to be approximately \$912,000 during the first year. However, this amount will be offset by cost sharing in the form of premiums totaling \$108,000. In addition, research shows that sixty-five (65) percent of individuals expected to participate in this option were already enrolled in another Medicaid program. DMS anticipates offsets in premiums and, due to the fact that approximately sixty-five (65) percent of recipients in this program would move from another Medicaid program, total annual costs are expected to be \$211,200, of which \$147,840 would be federal funds.

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

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