

## STATEMENT OF EMERGENCY

907 KAR 1:604E

(1) This emergency administrative regulation is being promulgated to amend Medicaid eligibility in order to allow individuals to work and maintain, rather than forfeit, Medicaid eligibility. It is amended in conjunction with four (4) other administrative regulations accomplishing the same goal: 907 KAR 1:011E, Technical eligibility requirements; 907 KAR 1:640E, Income standards for Medicaid; 907 KAR 1:645E, Resource standards for Medicaid; and 907 KAR 1:900E, KYHealth Choices benefit plans.

(2) This action must be taken on an emergency basis to protect the health, safety and welfare of recipients by ensuring access to necessary care.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

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Ernie Fletcher  
Governor

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

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Administration and Financial Management

4 (Emergency Amendment)

5 907 KAR 1:604E. Recipient cost-sharing.

6 RELATES TO: KRS 205.560, 205.6312, 205.6485, 205.8451, 319A.010, 327.010,  
7 334A.020, 42 C.F.R. 430.10, 431.51, 447.15, 447.21, 447.50, 447.52, 447.53, 447.54,

8 447.59, 457.224, 457.310, 457.505, 457.510, 457.515, 457.520, 457.530, 457.535,

9 457.570, 42 U.S.C. 1396a, b, c, d, o, r-6, r-8, 1397aa -1397jj, 42 U.S.C. 1396a(10)(A),

10 1396a(a)(52), 1396a(aa), 1396a(l)(1)(B), (C), (D), 1396d(a)(4)(C), 1396d(o), 1396u-1

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

12 205.6312(5), 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.51, 447.53, 447.54, 447.55,

13 447.57, 457.535, 457.560, 42 U.S.C. 1396r-6(b)(5), Pub. L. 106-170, 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. KRS

19 205.6312(5) requires the cabinet to promulgate administrative regulations that imple-

20 ment copayments or other similar charges for Medicaid recipients. KRS 205.6485(1) re-

21 quires the cabinet to establish, by administrative regulation, premiums for families with

1 children in the Kentucky Children's Health Insurance Program. 42 U.S.C. 1396r-6(b)(5)  
2 allows for a monthly premium in the second six (6) months of transitional medical assis-  
3 tance. This administrative regulation establishes the provisions relating to imposing and  
4 collecting copayments, coinsurance and premiums from certain recipients.

5 Section 1. Definitions. (1) "Coinsurance" means a percentage of the cost of a Medi-  
6 caid benefit that a recipient is required to pay.

7 (2) "Comprehensive choices" means a benefit plan for an individual who:

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

9 (b) Receives services through either:

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

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

12 3. The Home and Community Based Waiver Program in accordance with 907 KAR  
13 1:160; or

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

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

16 (3) "Copayment" means a dollar amount representing the portion of the cost of a  
17 Medicaid benefit that a recipient is required to pay.

18 (4) "Department" means the Department for Medicaid Services or its designee.

19 (5) "Drug" means a covered drug provided in accordance with 907 KAR 1:019 for  
20 which the Department for Medicaid Services provides reimbursement.

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

22 (a) Is covered pursuant to

23 1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u - 1;

1 2. 42 U.S.C. 1396a(a)(52) and 1396r - 6 (excluding children eligible under Part A or E  
2 of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

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

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

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

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

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

8 (7) "Federal Poverty Level" or "FPL" means guidelines that are updated annually in  
9 the Federal Register by the United States Department of Health and Human Services  
10 under authority of 42 U.S.C. 9902(2).

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

14 (a) Caretaker relatives who:

15 1. Receive K-TAP and are deprived due to death, incapacity, or absence;

16 2. Do not receive K-TAP and are deprived due to death, incapacity, or absence; or

17 3. Do not receive K-TAP and are deprived due to unemployment;

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

19 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR

20 1:022; or

21 2. Receive SSP and do not meet nursing facility patient status criteria in accordance  
22 with 907 KAR 1:022;

23 (c) Blind individuals who receive SSI and:

1 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR  
2 1:022; or

3 2. SSP, and do not meet nursing facility patient status criteria in accordance with 907  
4 KAR 1:022;

5 (d) Disabled individuals who receive SSI and:

6 1. Do not meet nursing facility patient status criteria in accordance with 907 KAR  
7 1:022, including children; or

8 2. SSP, and do not meet nursing facility patient status criteria in accordance with 907  
9 KAR 1:022;

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

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

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

19 (h) Pregnant women; or

20 (i) Medicaid works individuals.

21 (9)[(8)] "KCHIP" means the Kentucky Children's Health Insurance Program.

22 (10)[(9)-] "KCHIP - Separate Program" means a health benefit program for individuals  
23 with eligibility determined in accordance with 907 KAR 4:030, Section 2.

1 (11)~~[(40)]~~ "K-TAP" means Kentucky's version of the federal block grant program of  
2 Temporary Assistance for Needy Families (TANF), a money payment program for chil-  
3 dren who are deprived of parental support or care due to:

4 (a) Death;

5 (b) Continued voluntary or involuntary absence;

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

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

9 (12) "Medicaid works individual" means an individual who:

10 (a) But for earning in excess of the income limit established under 42 U.S.C.  
11 1396d(q)(2)(B) would be considered to be receiving supplement security income:

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

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

14 1. Paycheck stubs;

15 2. Tax returns;

16 3. 1099 forms; or

17 4. Proof of quarterly estimated tax;

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

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

22 (13)~~[(41)]~~ "Nonemergency" means a condition which does not require an emergency  
23 service pursuant to 42 C.F.R. 447.53.

1        ~~(14)~~~~(42)~~ "Nonpreferred brand name drug" means a brand name drug that is not on  
2 the department's preferred drug list.

3        ~~(15)~~~~(43)~~ "Optimum choices" means a benefit plan for an individual who:

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

6        (b) Receives services through either:

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

9        2. The Supports for Community Living Waiver Program in accordance with 907 KAR  
10 1:145; and

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

12        ~~(16)~~~~(44)~~ "Preferred brand-name drug" means a brand-name drug for which no ge-  
13 neric equivalent exists which has a more favorable cost to the department and which  
14 prescribers are encouraged to prescribe, if medically appropriate.

15        ~~(17)~~~~(45)~~ "Premium" means an amount paid periodically to purchase health care  
16 benefits.

17        ~~(18)~~~~(46)~~ "Recipient" is defined in KRS 205.8451 and applies to an individual who  
18 has been determined eligible to receive benefits under the state's Title XIX or Title XXI  
19 program in accordance with 907 KAR Chapters 1 through 4.

20        ~~(19)~~~~(47)~~ "Transitional medical assistance" or "TMA" means an extension of Medi-  
21 caid benefits for up to twelve (12) months for families who lose Medicaid eligibility solely  
22 because of increased earnings or hours of employment of the caretaker relative or loss  
23 of earning disregards in accordance with 907 KAR 1:011, Section 5(8)(b).

1 Section 2. Comprehensive Choices Copayments and Coinsurance. (1) Except for an  
 2 individual excluded pursuant to Section 6(1) of this administrative regulation, a recipient  
 3 of the comprehensive choices plan shall pay the copayment or coinsurance amount es-  
 4 tablished in this table, with the corresponding provider reimbursement deductions.

Benefit	Copayment or Coinsurance Amount	Amount of Copayment or Coinsurance Deducted from Provider Reimburse- ment
Acute inpatient hospital admission	\$10 copayment	Full amount of the copayment
Outpatient hospital or ambulatory surgical center visit	\$3 copayment	Full amount of the copayment
Generic prescription drug or an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage	\$1 copayment	Full amount of the copayment
Preferred brand name	\$2 copayment	Full amount of the copayment

drug for a recipient who does not have Medicare Part D drug coverage		
Nonpreferred brand name drug for a recipient who does not have Medicare Part D drug coverage	5% coinsurance, not to exceed \$20 per nonpreferred brand name drug prescription	Full amount of the coinsurance, not to exceed \$20 per nonpreferred brand name drug prescription
Emergency room for a nonemergency visit	5% coinsurance, up to a maximum of \$6	No deduction
DMEPOS	3% coinsurance up to a maximum of \$15 per item	The amount of the coinsurance or, if applicable, \$15
Podiatry office visit	\$2 copayment	Full amount of the copayment
<del>[Ophthalmological or optometric office visit (99000 series evaluation and management codes)]</del>	<del>[\$2 copayment]</del>	<del>[Full amount of the copayment]</del>

- 1 (2) A recipient shall not be liable for more than:
- 2 (a) \$225 per calendar year for prescription drug copayments or coinsurance; or
- 3 (b) \$225 per calendar year for service copayments or coinsurance.
- 4 (3) The maximum amount of cost-sharing shall not exceed five (5) percent of a fam-
- 5 ily's income for a quarter.
- 6 (4) If a service or benefit is not listed in the comprehensive choices cost-sharing grid,
- 7 the cost-sharing obligation shall be \$0 for that service or benefit for an individual in the
- 8 comprehensive choices benefit plan.

9 Section 3. Family Choices Copayments and Coinsurance. (1)(a) Only KCHIP chil-

10 dren, except for any individual excluded in accordance with Section 6(1), shall be family

11 choices individuals subject to copayments or coinsurance.

12 (b) An individual referenced in paragraph (a) of this subsection shall pay the copay-

13 ment or coinsurance amounts established in the following table, along with the corre-

14 sponding provider reimbursement deductions.

Benefit	Copayment or Coin- surance Amount	Amount of Copayment or Coinsur- ance Deducted from Provider Re- imbursement
Allergy service or testing (no copay- ment exists for in- jections)	\$2 copayment	Full amount of copayment
Generic prescrip-	\$1 copayment	Full amount of copayment

tion drug or atypical anti-psychotic drug if no generic equivalent exists		
Preferred brand name drug	\$2 copayment	Full amount of copayment
Nonpreferred brand name drug	\$3 copayment	Full amount of the copayment
Emergency room for a non-emergency visit	5% coinsurance, up to a maximum of \$6	No deduction

1 (2) A recipient shall not be liable for more than:

2 (a) \$225 per calendar year for prescription drug copayments or coinsurance; or

3 (b) \$225 per calendar year for service copayments or coinsurance.

4 (3) The maximum amount of cost-sharing shall not exceed five (5) percent of a fam-  
5 ily's income for a quarter.

6 (4) If a service or benefit is not listed in the family choices cost-sharing grid, the cost-  
7 sharing obligation shall be \$0 for that service or benefit for an individual in the family  
8 choices benefit plan.

9 Section 4. Global Choices Copayments and Coinsurance. (1) Except for an individual  
10 excluded pursuant to Section 6(1) of this administrative regulation, a recipient of the  
11 global choices plan shall pay the copayment or coinsurance amount established in this

1 table, with the corresponding provider reimbursement deductions.

Benefit	Copayment or Coinsurance	Copayment or Coinsurance Amount Deducted from Provider Reimbursement
Acute inpatient hospital admission	\$50 copayment	Full amount of copayment
Outpatient hospital or ambulatory surgical center visit	\$3 copayment	Full amount of copayment
Laboratory, diagnostic or radiology service	\$3 copayment	Full amount of copayment
Physician services	\$2 copayment	No deduction
Visit to a rural health clinic, a primary care center, or a federally	\$2 copayment	Full amount of copayment

qualified health center		
Dental office visit	\$2 copayment	No deduction
Physical therapy	\$2 copayment	Full amount of the copayment
Speech therapy	\$1 copayment	Full amount of the copayment
Chiropractic office visit	\$2 copayment	Full amount of the copayment
Generic prescription drug or an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medi-	\$1 copayment	Full amount of the copayment

care Part D drug cover- age		
Preferred brand name drug for a re- cipient who does not have Medi- care Part D drug cover- age	\$2 copayment	Full amount of the copayment
Nonpreferred brand name drug for a re- cipient who does not have Medi- care Part D drug cover- age	5% coinsurance, not to exceed \$20 per nonpreferred brand name drug prescrip- tion	Full amount of the coinsurance, not to ex- ceed \$20 per nonpreferred brand name drug prescription
Emergency room for a	5% coinsurance, up to a maximum of \$6	No deduction

nonemer- gency visit		
DMEPOS	Three (3) percent co- insurance not to ex- ceed \$15 per item	The amount of the coinsurance or, if appli- cable, \$15
Podiatry of- fice visit	\$2 copayment	Full amount of the copayment
Ophthal- mological or optometric of- fice visit (99000 series evaluation and man- agement codes)	\$2 copayment	Full amount of the copayment

- 1 (2) Physician services shall:
- 2 (a) Include care provided by a physician, a certified pediatric and family nurse practi-
- 3 tioner, a nurse midwife, an advanced registered nurse practitioner, or a physician assis-
- 4 tant; and
- 5 (b) Not include a visit to a federally-qualified health center, rural health clinic, or a
- 6 primary care center.

- 1 (3) A recipient shall not be liable for more than:
- 2 (a) \$225 per calendar year for prescription drug copayments or coinsurance; or
- 3 (b) \$225 per calendar year for service copayments or coinsurance.
- 4 (4) The maximum amount of cost-sharing shall not exceed five (5) percent of a fam-
- 5 ily's income for a quarter.
- 6 (5) If a service or benefit is not listed in the global choices cost-sharing grid, the cost-
- 7 sharing obligation shall be \$0 for that service for an individual in the global choices
- 8 benefit plan.
- 9 Section 5. Optimum Choices Copayments and Coinsurance. (1) Except for an indi-
- 10 vidual excluded pursuant to Section 6(1) of this administrative regulation, a recipient of
- 11 the optimum choices plan shall pay the copayment or coinsurance amount established
- 12 in this table, with the corresponding provider reimbursement deductions.

Benefit	Copayment or Coinsurance Amount	Amount of Copayment or Coinsurance Deducted from Provider Reimburse- ment
Acute inpatient hos- pital admission	\$10 copayment	Full amount of the copayment
Outpatient hospital or ambulatory surgical center visit	\$3 copayment	Full amount of the copayment
Generic prescription drug or an atypical	\$1 copayment	Full amount of the copayment

anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage		
Preferred brand name drug for a recipient who does not have Medicare Part D drug coverage	\$2 copayment	Full amount of the copayment
Nonpreferred brand name drug for a recipient who does not have Medicare Part D drug coverage	5% coinsurance, not to exceed \$20 per non-preferred brand name drug prescription	Full amount of the coinsurance, not to exceed \$20 per nonpreferred brand name drug prescription
Emergency room for a nonemergency visit	5% coinsurance, up to a maximum of \$6	No deduction
DMEPOS	3% coinsurance	The amount of the coinsurance or, if

	up to a maximum of \$15 per item	applicable, \$15
Podiatry office visit	\$2 copayment	Full amount of the copayment
<del>[Ophthalmological or optometric office visit (99000 series evaluation and management codes)]-</del>	<del>[\$2 copayment]</del>	<del>[Full amount of the copayment]</del>

1 (2) A recipient shall not be liable for more than:

2 (a) \$225 per calendar year for prescription drug copayments or coinsurance; or

3 (b) \$225 per calendar year for service copayments or coinsurance.

4 (3) The maximum amount of cost-sharing shall not exceed five (5) percent of a fam-  
5 ily's income for a quarter.

6 (4) If a service or benefit is not listed in the optimum choices cost-sharing grid, the  
7 cost-sharing obligation shall be \$0 for that service or benefit for an individual in the op-  
8 timum choices benefit plan.

9 Section 6. Copayment, Coinsurance and Premium General Provisions and Exclu-  
10 sions. (1) The department shall impose no cost sharing for the following:

11 (a) A service furnished to an individual who has reached his or her 18th birthday, but  
12 has not turned nineteen (19) required to be provided medical assistance under 42  
13 U.S.C. 1396a(a)(10)(A)(i)(I), including services furnished to an individual with respect to  
14 whom aid or assistance is made available under Title IV, Part B (42 U.S.C. 620 to 629i)

1 to children in foster care and individuals with respect to whom adoption or foster care  
2 assistance is made available under Title IV, Part E (42 U.S.C. 670 to 679b), without re-  
3 gard to age;

4 (b) A preventive service (for example, well baby and well child care and immuniza-  
5 tions) provided to a child under eighteen (18) years of age regardless of family income;

6 (c) A service furnished to a pregnant woman;

7 (d) A service furnished to a terminally ill individual who is receiving hospice care as  
8 defined in 42 U.S.C. 1396d(o);

9 (e) A service furnished to an individual who is an inpatient in a hospital, nursing facil-  
10 ity, intermediate care facility for individuals with mental retardation or a developmental  
11 disability, or other medical institution, if the individual is required, as a condition of re-  
12 ceiving services in the institution under Kentucky's Medicaid Program, to spend for  
13 costs of medical care all but a minimal amount of the individual's income required for  
14 personal needs;

15 (f) An emergency service as defined by 42 C.F.R. 447.53;

16 (g) A family planning service or supply as described in 42 U.S.C. 1396d (a)(4)(C); or

17 (h) A service furnished to a woman who is receiving medical assistance via the appli-  
18 cation of 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa).

19 (2) The department has determined that any individual liable for a copayment, coin-  
20 surance amount or premium shall:

21 (a) Be able to pay a required copayment, coinsurance amount or premium; and

22 (b) Be responsible for a required copayment, coinsurance or premium.

23 (3) A pharmacy provider or supplier, including a pharmaceutical manufacturer as de-

1 fined in 42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor  
2 or agent of a pharmaceutical manufacturer, shall not make a copayment or coinsurance  
3 amount for a recipient.

4 (4) A parent or guardian shall be responsible for a copayment, coinsurance amount  
5 or premium imposed on a dependent child under the age of twenty-one (21).

6 (5) Provisions regarding a provider's ability to deny a service or benefit based on a  
7 recipient's failure to make a required copayment or coinsurance payment shall be as es-  
8 tablished in KRS 205.6312(4) and 2006 Ky. Acts ch. 252 and in accordance with Pub.L.  
9 109-171.

10 (6) A provider:

11 (a) Shall collect from a recipient the copayment, coinsurance amount, or premium as  
12 imposed by the department for a recipient in accordance with this administrative regula-  
13 tion;

14 (b) Shall not waive a copayment, coinsurance amount, or premium obligation as im-  
15 posed by the department for a recipient; and

16 (c) May collect a copayment, coinsurance amount or premium at the time a benefit is  
17 provided or at a later date.

18 (7) Cumulative cost sharing for premium payments and copayments for a family with  
19 children who receive benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be lim-  
20 ited to five (5) percent of the annual family income.

21 (8) A monthly premium for a family who receives benefits under 42 U.S.C. 1396r-6(b)  
22 shall not exceed three (3) percent of:

23 (a) The family's average gross monthly income; or

1 (b) The family's average gross monthly income minus the average monthly costs of  
2 child care necessary for the employment of the caretaker relative.

3 (9) The department shall not increase its reimbursement to a provider to offset an un-  
4 collected copayment, coinsurance amount or premium from a recipient.

5 Section 7. Premiums for KCHIP - Separate Program Recipients.

6 (1) A family with children participating in the KCHIP Separate Program shall pay a  
7 premium of twenty (20) dollars per family, per month.

8 (2)(a) The family of a new KCHIP Separate Program eligible shall be required to pay  
9 a premium beginning with the first full month of benefits after the month of application.

10 (b) Benefits shall be effective with the date of application if the premium specified in  
11 paragraph (a) of this subsection has been paid.

12 (3) Retroactive eligibility as described in 907 KAR 1:605, Section 2(3), shall not apply  
13 to a recipient participating in the KCHIP Separate Program.

14 (4)(a) If a family fails to make two (2) consecutive premium payments, benefits shall  
15 be discontinued at the end of the first benefit month for which the premium has not been  
16 paid.

17 (b)1. A KCHIP Separate Program recipient shall be eligible for reenrollment upon  
18 payment of the missed premium.

19 2. If twelve (12) months have elapsed since a missed premium, a KCHIP Separate  
20 Program recipient shall not be required to pay the missed premium before reenrolling.

21 Section 8. Premiums for Transitional Medical Assistance Recipients. (1) A family re-  
22 ceiving a second six (6) months of TMA, whose monthly countable earned income is  
23 greater than 100 percent of the federal poverty limit, shall pay a premium of thirty (30)

1 dollars per family, per month.

2 (2) If a TMA family fails to make two (2) consecutive premium payments, benefits  
3 shall be discontinued at the end of the benefit month for which the premium has not  
4 been paid unless the family has established to the satisfaction of the department that  
5 good cause existed for failure to pay the premium on a timely basis. Good cause shall  
6 exist under the following circumstances:

7 (a) An immediate family member living in the home was institutionalized or died dur-  
8 ing the payment month;

9 (b) The family was victim of a natural disaster including flood, storm, earthquake, or  
10 serious fire;

11 (c) The caretaker relative was out of town for the payment month; or

12 (d) The family moved and reported the move timely, but the move resulted in:

13 1. A delay in receiving the billing notice; or

14 2. Failure to receive the billing notice.

15 Section 9. Premiums for Medicaid Works Individuals. (1)(a) A Medicaid works indi-  
16 vidual shall be required to pay a monthly premium based on income used to determine  
17 eligibility for the program.

18 (b) The monthly premium shall be:

19 1. Thirty-five (35) dollars for an individual whose income is greater than 100% but no  
20 more than 150% of the FPL;

21 2. Forty-five (45) dollars for an individual whose income is greater than 150% but no  
22 more than 200% of the FPL; and

23 3. Fifty-five (55) dollars for an individual whose income is greater than 200% but no

1 more than 250% of the FPL.

2 (2) An individual whose family income is equal to or below 100% of the FPL shall not  
3 be required to pay a monthly premium.

4 (3) A Medicaid works individual shall be required to begin paying a premium with the  
5 first full month of benefits after the month of application.

6 (4) Benefits shall be effective with the date of application if the premium specified in  
7 paragraph (1) of this section has been paid.

8 (5) Retroactive eligibility pursuant to 907 KAR 1:605, Medicaid procedures for deter-  
9 mining initial and continuing eligibility, Section 2(3) shall not apply to a Medicaid works  
10 individual.

11 (6) If a recipient fails to make two (2) consecutive premium payments, benefits shall  
12 be discontinued at the end of the first benefit month for which the premium has not been  
13 paid.

14 (7) A Medicaid works individual shall be eligible for reenrollment upon payment of the  
15 missed premium providing all other technical eligibility, income, and resource standards  
16 continue to be met.

17 (8) If twelve (12) months have elapsed since a missed premium, a Medicaid works  
18 individual shall not be required to pay the missed premium before reenrolling.

19 Section 10. Notices and Collection of Premiums. (1) Premiums shall be collected in  
20 accordance with Sections 7 and 8 of this administrative regulation.

21 (2) The department shall give advance written notice of the:

22 (a) Premium amount; and

23 (b) Date the premium is due.

1 (3) To continue to receive benefits, a family shall pay a premium:

2 (a) In full; and

3 (b) In advance.

4 (4) If a family pays the required premiums semiannually or quarterly in advance, they  
5 shall receive a ten (10) percent discount.

6 Section 11.~~[40.]~~ Provisions for Recipients in Medicaid-Managed Care. (1) A managed  
7 care entity:

8 (a) Shall not impose on a recipient receiving services through a managed-care entity  
9 operating in accordance with 907 KAR 1:705 a copayment, coinsurance or premium  
10 that exceeds a copayment, coinsurance or premium established in this administrative  
11 regulation; and

12 (b) May impose upon a recipient referenced in paragraph (a) of this subsection:

13 1. A lower copayment, coinsurance or premium than established in this administrative  
14 regulation; or

15 2. No copayment, coinsurance or premium.

16 (2) A six (6) month guarantee of eligibility as described in 907 KAR 1:705, Section  
17 3(6) shall not apply to a recipient required to pay a premium pursuant to Section 7 of  
18 this administrative regulation.

19 Section 12.~~[44.]~~ Freedom of Choice. In accordance with 42 C.F.R. 431.51, a recipient  
20 may obtain services from any qualified provider who is willing to provide services to that  
21 particular recipient.

22 Section 13.~~[42.]~~ Notice of Discontinuance, Hearings, and Appeal Rights.

23 (1) The department shall give written notice of, and an opportunity to pay, past due

1 premiums prior to discontinuance of benefits for nonpayment of a premium.

2 (2)(a) If a family's income has declined, the family shall submit documentation show-  
3 ing the decline in income.

4 (b) Following receipt of the documentation, the department shall determine if the fam-  
5 ily is required to pay the premiums established in Section 7 or 8 of this administrative  
6 regulation using the new income level.

7 (c) If the family is required to pay the premium and the premium has not been paid,  
8 the benefits shall be discontinued in accordance with Section 7(4)(a) or 8(2) of this ad-  
9 ministrative regulation.

10 (d) If the family is not required to pay the premium, benefits shall be continued under  
11 an appropriate eligibility category.

12 (3) The department shall provide the recipient with an opportunity for a hearing in ac-  
13 cordance with 907 KAR 1:560 upon discontinuing benefits for nonpayment of premiums.

14 (4) An appeal of a department decision regarding the Medicaid eligibility of an indi-  
15 vidual shall be in accordance with 907 KAR 1:560.

907 KAR 1:604E

REVIEWED:

\_\_\_\_\_

Date

\_\_\_\_\_

Shawn M. Crouch, Commissioner  
Department for Medicaid Services

APPROVED:

\_\_\_\_\_

Date

\_\_\_\_\_

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

## REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:604E

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 cost-sharing provisions for Medicaid and Kentucky Children's Health Insurance Program (KCHIP) recipients.
  - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish cost-sharing provisions for Medicaid and KCHIP recipients.
  - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 205.6312(5) and Public Law 109-171 (aka the Deficit Reduction Act of 2005) by establishing cost-sharing provisions regarding Medicaid and KCHIP recipients.
  - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation currently assists and will continue to assist in the effective administration of the authorizing statutes by establishing the cost-sharing provisions related to Medicaid and KCHIP recipients.
  
- (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. The amendment also establishes premiums which are tiered based on federal poverty levels. In addition to establishing Medicaid works policy this administra-

tive regulation corrects a prior inadvertent mistake by eliminating the ophthalmological and optometric office visit cost sharing for the comprehensive choices and optimum choices individuals.

- (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. The ophthalmological and optometric office visit cost sharing elimination is necessary to correct a prior inadvertent mistake.
  - (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 the Medicaid works eligibility 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: Federal funds authorized under the Social Security Act, Title XIX, and matching funds of general fund appropriations and collections will be used to fund the implementation and enforcement of this administrative regulation.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: 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 administrative regulation increases and imposes certain designated cost-sharing requirements.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)

This administrative regulation includes tiering in order to tailor the cost-sharing provisions to individual medical needs and circumstances and to assist in transforming the Medicaid program in conjunction with a related administration regulation - 907 KAR 1:900 (KyHealth Choices Benefit Packages). The transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries which will promote healthy life-

styles, personal accountability and responsible program governance for a healthier Commonwealth.

## FEDERAL MANDATE ANALYSIS COMPARISON

Reg. No. 907 KAR 1:604E Agency Contact: Stuart Owen (502) 564-6204 or Lisa Lee (502) 564-6890

1. Federal statute or regulation constituting the federal mandate.  
Pursuant to 42 USC 1396a et. seq., the Commonwealth of Kentucky has exercised the option to establish a Medicaid Program for indigent Kentuckians. Having elected to offer Medicaid coverage, the state must comply with federal requirements contained in 42 USC 1396 et. seq.  
  
This administrative regulation complies with federal statutes and regulations, including Public Law 109-171, governing the Medicaid program including the domain of recipient cost sharing.
2. State compliance standards.  
This administrative regulation complies with KRS 205.6312(5) by establishing cost-sharing provisions for Medicaid recipients, their spouses, or parents, under the provisions of Section 1916 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396o. This administrative regulation complies with KRS 205.6485(1) by establishing the premium contribution per family of health insurance coverage available under the Kentucky Children's Health Insurance Program.
3. Minimum or uniform standards contained in the federal mandate.  
This administrative regulation establishes cost-sharing provisions for Medicaid recipients, their spouses, or parents, under the provisions of Section 1916 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396o, and Public Law 109-171.
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 requirements, or additional or different responsibilities or requirements, than those required by the federal mandate.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.  
The amendment is necessary to assist in transforming the Medicaid program in conjunction with a related administration regulation - 907 KAR 1:900 (KyHealth Choices Benefit Packages). This action is necessary to maintain the viability of the Medicaid program, to render it better oriented to recipient individual needs while best utilizing the resources available to the Medicaid program.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:604E      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 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.
- (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: