CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Audrey Tayse Haynes
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January 9, 2014

TO: Medicaid Providers
General Provider Letter # A-95

RE: Affordable Care Act Changes

Greetings for 2014 Kentucky Medicaid Provider,

In May 2013, Governor Steve Beshear announced his decision to expand Medicaid in the Commonwealth of Kentucky to 138% of the Federal Poverty Level (FPL) beginning January 1, 2014 under the Affordable Care Act (ACA). With this decision to expand Medicaid, the Kentucky Department for Medicaid Services (DMS) modified elements of its Medicaid program, including changes to benefits and cost-sharing. Changes made to the program were done with the goals of simplifying and streamlining the Medicaid program, and also more closely aligning the Medicaid program with the benefit plans sold on kynect, the Kentucky Health Benefit Exchange (HBE). This notice is intended to inform providers of the changes to the Medicaid program that were implemented beginning January 1, 2014.

Benefit Plans
The Kentucky Medicaid program previously segmented its members into four unique alternative benefit plans – Global Choices, Family Choices, Optimum Choices, and Comprehensive Choices – depending on member eligibility characteristics. Starting January 1, 2014, all members, both those eligible prior to the expansion of Medicaid and those newly eligible through the expansion of Medicaid, will be in a single alternative benefit plan and receive the same benefits.

Benefit Changes
Kentucky is making the following changes to benefits for all Medicaid members, beginning January 1, 2014:

Benefit	Change
Private Duty Nursing	Adds private duty nursing services as a new benefit and limits it to 2,000 hours per year
Allergy Services	Clarifies benefit to include adults (children were already covered)
Prescription Drugs	Eliminates limit of four prescriptions per month
Preventive Services	Expands benefits provided under preventive services
Eyeglasses	Eliminates annual dollar limit of $200 or $400 for eyeglasses (depending on previous benefit plan) and sets a limit of one pair of eyeglasses per year (with an additional pair covered if the first pair is lost or the individual's prescription changes)
Physical, Occupational, Speech Therapy	Aligns the number of visits across eligibility groups to be 20 visits per year per therapy for all members (combined for rehabilitative and habilitative)
Mental Health Services	Expands benefit to offer the following services (list includes existing mental health services offered): • Screening • Assessment • Individual Outpatient Therapy • Group Outpatient Therapy

	• Psychological Testing • Crisis Intervention • Mobile Crisis • Residential Crisis Stabilization • Day Treatment • Peer Support • Parent/Family Peer Support • Intensive Outpatient Program • Family Outpatient Therapy • Collateral Outpatient Therapy • Partial Hospitalization • Service Planning • Assertive Community Treatment • Comprehensive Community Support • Therapeutic Rehabilitation Program
Substance Use Services	Expands benefit beyond current coverage scope of pregnant women and children to include all categories of Medicaid recipients and expands scope of substance use services to include the following services (list includes existing substance use services offered): • Screening • Assessment • Psychological Testing • Crisis Intervention • Mobile Crisis • Residential Crisis Stabilization • Day Treatment • Peer Support • Parent/Family Peer Support • Intensive Outpatient Program • Individual Outpatient Therapy • Group Outpatient Therapy • Family Outpatient Therapy • Collateral Outpatient Therapy • Partial Hospitalization • Service Planning • Residential Services for Substance Use Disorders • Screening, Brief Intervention and Referral to Treatment • Medication Assisted Treatment

All benefits provided must be medically necessary

Additional details of these changes are available in the Kentucky State Plan Amendments posted on the DMS website at http://www.chfs.ky.gov/dms/State+Plan+Amendments.htm#2013 or in Kentucky regulation located at http://www.chfs.ky.gov/dms/Regs.htm.

Cost Sharing
The following are the cost sharing amounts for Medicaid beneficiaries (except for the exempted individuals listed further below) beginning January 1, 2014:

Outpatient Services
- $4 - Outpatient hospital or surgery
- $3 – Health professional office visit
- $3 – Physical therapy, occupational therapy, speech therapy
- $3 - Laboratory, diagnostic, radiology services

Durable Medical Equipment
- $4 - durable medical equipment (the cost sharing applies per date of service)

Inpatient Hospital Stay
- $50 - inpatient hospital stay

Drugs
- $1 – generic drug
- $4 – preferred brand name drug
- $8 – non-preferred drug
- Exceptions:
    - Family planning, no copays
    - Tobacco cessation, no copays
    - 2nd Generation Antipsychotics and Injectable Antipsychotics, $1 copay
    - Anticonvulsants, non-preferred bands, $4 copay
    - Oral oncology, non-preferred brands, $4 copay

- Diabetic supplies
  - Meters, no copays
  - Test strips, control solutions, insulin needles, lancets, etc. $4 copay with no more than one copay per calendar day being charged

Non-Emergency Care in an Emergency Room

- $8 -non-emergency care/services in an emergency room

Total cost sharing cannot exceed an aggregate of 5% of a family's income per calendar quarter (3 months). Kentucky's Medicaid Management Information System (MMIS) will track cost sharing aggregation and allow providers to determine when members have reached the aggregate limit for the quarter. Members will also be notified by the Department when they have reached their aggregate limit and are no longer required to pay cost sharing for the quarter.

Exempt from Cost Sharing (Except for the $8 Non-preferred Drug Cost Sharing Obligation)
All Medicaid beneficiaries are obligated to pay the $8 cost sharing for a non-preferred drug as a condition of receiving the item. Providers may waive or reduce cost sharing on a case by case basis at their discretion.

The following Medicaid beneficiaries and/or services are excluded from other cost sharing charges:

- *Children.*—Services furnished to individuals under 18 years of age (and, services provided to individuals who are part of an optional group, such as foster care and remain on Medicaid, who have reached their 18th birthday but have not turned 19) are excluded from cost sharing.
- *Pregnant women.*—Services furnished to pregnant women are excluded from cost sharing.
- *Institutionalized individuals.*—Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if the individual is required (pursuant to §435.725, 435.733, 435.832, or 436.832), as a condition of receiving services in the institution, to spend all but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.
- *Emergency services*—Services as defined at section 1932(b)(2) of the Act and §438.114(a) are excluded from cost sharing.
- *Family planning.*—Family planning services and supplies furnished to individuals of child-bearing age are excluded from cost sharing.
- *American Indians.*—Items and services furnished to an American Indian directly by an American Indian health care provider or through referral under contract health services are excluded from cost sharing.
- Services furnished to an individual who is receiving hospice care are excluded from cost sharing.
- Preventive services are excluded from cost sharing.

Managed Care
Any managed care organization participating in Kentucky's Medicaid program is allowed to impose cost sharing on beneficiaries up to, but not exceeding, the cost sharing amounts established by DMS. A managed care organization is required to exempt the same individuals and services from cost sharing that DMS exempts.

Paying Cost Sharing/Receipt of Services Based on Cost Sharing
A beneficiary is expected to pay the cost sharing obligation at the time of receiving the health care service, drug, or item/supply. If a beneficiary is unable to pay a cost sharing amount at the time of receiving a service, the provider cannot deny the service to the beneficiary. However, being unable to pay a cost sharing amount at the time of receiving a service shall not excuse the recipient from liability for payment of the charge.

Thank you for your time and attention to this correspondence. Should you have any questions or concerns, please contact the Department for Medicaid Services at 800-635-2570.

Sincerely,

Lawrence Kissner, Commissioner
Kentucky Department for Medicaid Services