

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Administration and Financial Management

4 (Amended After Comments)

5 907 KAR 1:604. 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, Social Security Act  
10 1902(a)(10)(A), 1902(a)(52), 1902(aa), 1902(l)(1)(B),(C),(D), 1905(a)(4)(C), 1905(o),  
11 1931, 2006 GA HB 380 [2005 GA HB 267]

12 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3),  
13 205.6312(5), 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.51, 447.53, 447.54, 447.55,  
14 447.57, 457.535, 457.560, 42 U.S.C. 1396r-6(b)(5), Public Law 109-171

15 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family  
16 Services, Department for Medicaid Services has responsibility to administer the Medi-  
17 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to  
18 comply with any requirement that may be imposed, or opportunity presented, by federal  
19 law for the provision of medical assistance to Kentucky's indigent citizenry. KRS  
20 205.6312(5) requires the cabinet to promulgate administrative regulations that imple-  
21 ment copayments or other similar charges for Medicaid recipients. KRS 205.6485(1) re

1 requires the cabinet to establish, by administrative regulation, premiums for families with  
2 children in the Kentucky Children's Health Insurance Program. 42 U.S.C. 1396r-6(b)(5)  
3 allows for a monthly premium in the second six (6) months of transitional medical assis-  
4 tance. This administrative regulation establishes the provisions, including those author-  
5 ized by Public Law 109-171, relating to imposing and collecting copayments, coinsur-  
6 ance and premiums from certain recipients.

7 Section 1. Definitions.

8 (1) [~~“Caretaker relative” means a relative:~~

9 ~~—(a) With whom a child is, or shall be, placed by the Cabinet for Health and Family~~  
10 ~~Services; and~~

11 ~~—(b) Who is seeking to qualify as a kinship caregiver.~~

12 ~~—(2) “Categorically needy children” means individuals under eighteen (18) years of age~~  
13 ~~receiving Title IV-E benefits, SSI, or SSP, or who would have been eligible to receive Ti-~~  
14 ~~tle IV-A benefits prior to July 16, 1996.~~

15 ~~(3)~~ “Coinsurance” means a percentage of the cost of a Medicaid benefit that a re-  
16 ipient is required to pay.

17 ~~(2)~~ ~~(4)~~ “Comprehensive choices” is defined in 907 KAR 1:900, Section 1. [a benefit  
18 package for individuals who meet the nursing facility patient status criteria established in  
19 907 KAR 1:022, receive services through either a nursing facility in accordance with 907  
20 KAR 1:022, the acquired brain injury waiver program in accordance with 907 KAR  
21 3:090, the home and community based waiver program in accordance with 907 KAR  
22 1:160 or the model waiver II program in accordance with 907 KAR 1:595.]

23 ~~(3)~~ ~~(5)~~ “Copayment” means a dollar amount [that] portion of the cost of a Medicaid

1 benefit [service] that a recipient is required to pay.

2 ~~(4) [(6)] [(2)]~~ “Department” means the Department for Medicaid Services or its desig-  
3 nee.

4 ~~(5) [(7)] [(3)]~~ "Drug" means a covered drug provided in accordance with 907 KAR  
5 1:019 for which the Department for Medicaid Services provides reimbursement.

6 ~~(6) [(8)]~~ “Family choices” is defined in 907 KAR 1:900, Section 1. [~~a benefit package for~~  
7 ~~individuals covered pursuant to Section 1902(a)(10)(A)(i)(I) and 1931 of the Social Secu-~~  
8 ~~rity Act, Section 1902(a)(52) and 1925 of the Social Security Act (excluding children eli-~~  
9 ~~gible under Part A or E of title IV), Section 1902 (a)(10)(A)(i)(IV) as described in~~  
10 ~~1902(I)(1)(B) of the Social Security Act, Section 1902(a)(10)(A)(i)(VI) as described in~~  
11 ~~1902 (I)(1)(C) of the Social Security Act, Section 1902 (a)(10)(A)(i)(VII) as described in~~  
12 ~~1902 (I)(1)(D) of the Social Security Act, and 42 CFR 457.310.]~~

13 ~~(7) [(9)]~~ “Global choices” is defined in 907 KAR 1:900, Section 1. [~~the department’s de-~~  
14 ~~fault benefit package and shall be for the following populations:~~

15 ~~(a) Caretaker relatives of children who:~~

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

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

18 ~~—3. Do not receive K-TAP and are deprived due to unemployment;~~

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

20 ~~—1. But do not meet nursing facility patient status criteria in accordance with 907 KAR~~

21 ~~1:022; or~~

22 ~~—2. And receive SSP but do not meet nursing facility patient status criteria in accordance~~  
23 ~~with 907 KAR 1:022;~~

- 1 ~~—(c) Blind individuals who receive SSI:~~  
2 ~~1. Who do not meet nursing facility patient status criteria in accordance with 907 KAR~~  
3 ~~1:022;~~  
4 ~~—2. And SSP but do not meet nursing facility patient status criteria in accordance with~~  
5 ~~907 KAR 1:022;~~  
6 ~~—(d) Disabled individuals who receive SSI:~~  
7 ~~—1. Who do not meet nursing facility patient status criteria in accordance with 907 KAR~~  
8 ~~1:022, including children;~~  
9 ~~2. And SSP but do not meet nursing facility patient status criteria in accordance with~~  
10 ~~907 KAR 1:022;~~  
11 ~~—(e) Individuals aged sixty five (65) and over who have lost SSI or SSP benefits and are~~  
12 ~~eligible for “pass through” Medicaid benefits but do not meet nursing facility patient status~~  
13 ~~criteria in accordance with 907 KAR 1:022;~~  
14 ~~—(f) Blind individuals who have lost SSI or SSP benefits and are eligible for “pass~~  
15 ~~through” Medicaid benefits but do not meet nursing facility patient status in accordance~~  
16 ~~with 907 KAR 1:022; or~~  
17 ~~—(g) Disabled individuals who have lost SSI or SSP benefits and are eligible for “pass~~  
18 ~~through” Medicaid benefits but do not meet nursing facility patient status in accordance~~  
19 ~~with 907 KAR 1:022.]~~

20 [(4) "Emergency condition" means a condition which requires an emergency service  
21 pursuant to 42 C.F.R. 447.53.

22 (5) "General ophthalmological service" means a service or procedure listed under this  
23 heading in the American Medical Association's Current Procedure Terminology (CPT).

1 ~~(6) "Long-term care facilities" is defined by KRS 216.510(1).]~~

2 ~~(8) [(10)] [(7)]~~ "KCHIP" means the Kentucky Children's Health Insurance Program.

3 ~~(9) [(11)]~~ "KCHIP Children – Medicaid Expansion Program" means a health benefit  
4 program for individuals with eligibility determined in accordance with 907 KAR 4:020.  
5 [department program established in 907 KAR 4:020.]

6 ~~(10) [(12)] [(8)]~~ "KCHIP Children – Separate CHIP Program" [~~Separate Insurance~~  
7 ~~Program~~] means a health benefit program for individuals with eligibility determined in  
8 accordance with 907 KAR 4:030, Section 2.

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

12 ~~(11) [(14)]~~ "K-TAP" means Kentucky's version of the federal block grant program of  
13 Temporary Assistance for Needy Families (TANF), a money payment program for chil-  
14 dren who are deprived of parental support or care due to:

15 (a) Death;

16 (b) Continued voluntary or involuntary absence;

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

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

20 ~~[(9) "Mandatory eligibility group" means a group whose coverage is mandatory under~~  
21 ~~42 U.S.C. 1396a(a).]~~

22 ~~(12) [(15)] [(10)]~~ "Nonemergency [~~condition~~]" means a condition which does not re-  
23 quire an emergency service pursuant to 42 C.F.R. 447.53.

1 (13) [(16)] "Non-preferred brand name drug" means a brand name drug that is not on  
2 the department's preferred drug list pursuant to 907 KAR 1:019.

3 (14) [(17)] ["Occupational therapy" means the practice of occupational therapy pursu-  
4 ant to KRS 319A.010, as covered by the department, and provided by an occupational  
5 therapist as defined in KRS 319A.010.

6 (18)] "Optimum choices" is defined in 907 KAR 1:900, Section 1. [a benefit package for  
7 individuals who meet the intermediate care facility for individuals with mental retardation  
8 or a developmental disability patient status criteria established in 907 KAR 1:022, who  
9 receive services through either an intermediate care facility for individuals with mental  
10 retardation or a developmental disability in accordance with 907 KAR 1:022, or who re-  
11 ceive services through the supports for community living waiver program in accordance  
12 with 907 KAR 1:145.]

13 (15) [(19)] "Physical therapy" means physical therapy as defined in KRS 327.010, as  
14 covered by the department, and provided by a physical therapist as defined in KRS  
15 327.010 and as covered by the department.

16 (16) [(20)] "Preferred brand name drug" means a brand name drug for which no ge-  
17 neric equivalent exists and is available via the department's supplemental rebate pro-  
18 gram pursuant to 907 KAR 1:019.

19 [(11) "Optional eligibility group" means a group whose coverage is:

20 (a) Not identified as mandatory under 42 U.S.C. 1396a(a); and

21 (b) Is established as optional pursuant to 42 U.S.C. 1396a(a) or 42 U.S.C. 1396a(a).]

22 (17) [(21)] [(12)] "Premium" means an amount paid periodically to purchase health  
23 care benefits.

1        (18) [(22)] [(13)] "Recipient" is defined in KRS 205.8451 and applies to [means] an  
2 individual who has been determined eligible to receive benefits under the state's Title  
3 XIX or Title XXI program in accordance with 907 KAR Chapters 1 through 4.

4        (19) [(23)] "Speech therapy" means the practice of speech pathology as defined in  
5 KRS 334A.020, as covered by the department, and provided by a speech-language pa-  
6 thologist as defined in KRS 334A.020.

7        [(24)] "SSI" means the Social Security Administration program named supplemental  
8 security income.

9        [(25)] "SSP" means state supplemental payments for individuals who are aged, blind  
10 or disabled and in accordance with 921 KAR 2:015.]

11        (20) [(26)] [(14)] "Transitional medical assistance" or "TMA" means an extension of  
12 Medicaid benefits for up to twelve (12) months for families who lose Medicaid eligibility  
13 solely because of increased earnings or hours of employment of the caretaker relative  
14 or loss of earning disregards in accordance with 907 KAR 1:011, Section 5(8)(b).

15        Section 2. Comprehensive Choices Copayments and Coinsurance.

16        (1) Following is a grid establishing comprehensive choices copayment and coinsur-  
17 ance amounts, except for individuals excluded pursuant to Section 6(1) of this adminis-  
18 trative regulation, and corresponding provider reimbursement deductions:

<u>Benefit</u>	<u>Copayment or</u> <u>Coinsurance</u> <u>Amount</u>	<u>Amount of Copayment or Coinsurance</u> <u>Deducted from Provider</u> <u>Reimbursement</u>
<u>Acute inpatient</u> <u>hospital admission</u>	<u>\$10 copayment</u>	<u>Full amount of the copayment</u>

<u>Outpatient hospital</u> <u>or ambulatory</u> <u>surgical center visit</u>	<u>\$3 copayment</u>	<u>Full amount of the copayment</u>
<u>Generic prescription</u> <u>drug or an atypical</u> <u>anti-psychotic drug</u> <u>if no generic</u> <u>equivalent for the</u> <u>atypical anti-</u> <u>psychotic drug</u> <u>exists for a recipient</u> <u>who does not have</u> <u>Medicare Part D</u> <u>drug coverage</u>	<u>\$1 copayment</u>	<u>Full amount of the copayment</u>
<u>Preferred brand</u> <u>name drug for a</u> <u>recipient who does</u> <u>not have Medicare</u> <u>Part D drug</u> <u>coverage</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>
<u>Non-preferred brand</u> <u>name drug for a</u> <u>recipient who does</u>	<u>Five (5) percent</u> <u>coinsurance, not to</u> <u>exceed \$20 per</u>	<u>Full amount of the coinsurance</u>

<u>not have Medicare Part D drug coverage</u>	<u>non-preferred brand name drug prescription</u>	
<u>Emergency room for a non-emergency visit</u>	<u>Five (5) percent coinsurance</u>	<u>No deduction [Full amount of the coinsurance]</u>
<u>Durable Medical Equipment</u>	<u>Three (3) percent coinsurance up to a maximum of \$15</u>	<u>The amount of the coinsurance or, if applicable, \$15</u>
<u>Podiatry office visit</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>
<u>Vision services, general ophthalmological services, and optometry services</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>

1

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

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

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

5 (3) The maximum amount of cost-sharing shall not exceed five (5) percent of a fam-

6 ily's income for a quarter.

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

Section 3. Family Choices Copayments and Coinsurance.

(1)(a) Only KCHIP Children - Medicaid Expansion Program and KCHIP Children - Separate CHIP Program individuals, except for any individual excluded in accordance with Section 6(1), shall be family choices individuals subject to copayments or coinsurance;

(b) Following is a grid establishing copayment and coinsurance amounts, for individuals referenced in paragraph (a) of this subsection along with corresponding provider reimbursement deductions:

<u>Benefit</u>	<u>Copayment or Coinsurance Amount</u>	<u>Amount of Copayment or Coinsurance Deducted from Provider Reimbursement</u>
<u>Allergy service or testing (no copayment exists for injections)</u>	<u>\$2 copayment</u>	<u>Full amount of copayment</u>
<u>Generic prescription drug or atypical anti-psychotic drug if no generic equivalent exists</u>	<u>\$1 copayment</u>	<u>Full amount of copayment</u>
<u>Preferred brand name drug</u>	<u>\$2 copayment</u>	<u>Full amount of copayment</u>

<u>Non-preferred brand name drug</u>	<u>\$3 copayment</u>	<u>Full amount of the copayment</u>
<u>Emergency room for a non-emergency visit</u>	<u>Five (5) percent coinsurance</u>	<u>No deduction [Full amount of the coinsurance]</u>

1

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

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

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

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

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

10 Section 4. Global Choices Copayments and Coinsurance.

11 (1) Following is a grid establishing global choices copayment and coinsurance  
12 amounts, except for individuals excluded pursuant to Section 6(1) of this administrative  
13 regulation, and corresponding provider reimbursement deductions:

<u>Benefit</u>	<u>Copayment or Coinsurance</u>	<u>Copayment or Coinsurance</u> <u>Amount Deducted from</u> <u>Provider Reimbursement</u>
<u>Acute inpatient hospital admission</u>	<u>\$50 copayment</u>	<u>Full amount of copayment</u>
<u>Outpatient hospital or</u>	<u>\$3 copayment</u>	<u>Full amount of copayment</u>

<u>ambulatory surgical center visit</u>		
<u>Laboratory, diagnostic or radiology service</u>	<u>\$3 copayment</u>	<u>Full amount of copayment</u>
<u>Physician services</u> <del>[Physician office visit]</del>	<u>\$2 copayment</u>	<u>No deduction</u>
<u>Visit to a rural health clinic, a primary care center, or a federally qualified health center</u>	<u>\$2 copayment</u>	<u>Full amount of copayment</u>
<u>Dental office visit</u>	<u>\$2 copayment</u>	<u>No deduction</u>
<del>[Occupational therapy]</del>	<del>[<u>\$2 copayment</u>]</del>	<del>[<u>Full amount of the copayment</u>]</del>
<u>Physical therapy</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>
<u>Speech therapy</u>	<u>\$1 copayment</u>	<u>Full amount of the copayment</u>
<u>Chiropractic office visit</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>
<u>Generic prescription drug or an atypical anti-psychotic drug if no generic</u>	<u>\$1 copayment</u>	<u>Full amount of the copayment</u>

<u>equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage</u>		
<u>Preferred brand name drug for a recipient who does not have Medicare Part D drug coverage</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>
<u>Non-preferred brand name drug for a recipient who does not have Medicare Part D drug coverage</u>	<u>Five (5) percent coinsurance, not to exceed \$20 per non-preferred brand name drug prescription</u>	<u>Full amount of the coinsurance</u>
<u>Emergency room for a non-emergency visit</u>	<u>Five (5) percent coinsurance</u>	<u>No deduction [<del>Full amount of the coinsurance</del>]</u>
<u>Durable medical equipment</u>	<u>Three (3) percent coinsurance not to exceed \$15</u>	<u>The amount of the coinsurance or, if applicable, \$15</u>
<u>Podiatry office visit</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>
<u>Optometry services</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>

<u>General ophthalmological services</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>
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1 (2)(a) Physician services includes [A physician office visit includes an office visit for]  
2 care provided by a physician, a certified pediatric and family nurse practitioner, a nurse  
3 midwife, an advanced registered nurse practitioner, or a physician assistant.

4 (b) A physician office visit excludes a visit to a federally-qualified health center, rural  
5 health clinic, or a primary care center.

6 (3) [Behavioral health services include mental health rehabilitation or stabilization,  
7 behavioral support, psychological services and inpatient psychiatric services.

8 (4) A recipient shall not be liable for more than:

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

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

11 (4) [(5)] The maximum amount of cost-sharing shall not exceed five (5) percent of a  
12 family's income for a quarter.

13 (5) If a service or benefit is not listed in the global choices cost-sharing grid, the cost-  
14 sharing obligation shall be \$0 for that service or benefit for an individual in the global  
15 choices benefit plan.

16 Section 5. Optimum Choices Copayments and Coinsurance.

17 (1) Following is a grid establishing optimum choices copayment and coinsurance  
18 amounts, except for individuals excluded pursuant to Section 6(1) of this administrative  
19 regulation, and corresponding provider reimbursement deductions:

<u>Benefit</u>	<u>Copayment or</u> <u>Coinsurance</u>	<u>Amount of Copayment or Coinsurance</u> <u>Deducted from Provider</u>

	<u>Amount</u>	<u>Reimbursement</u>
<u>Acute inpatient hospital admission</u>	<u>\$10 copayment</u>	<u>Full amount of the copayment</u>
<u>Outpatient hospital or ambulatory surgical center visit</u>	<u>\$3 copayment</u>	<u>Full amount of the copayment</u>
<u>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</u>	<u>\$1 copayment</u>	<u>Full amount of the copayment</u>
<u>Preferred brand name drug for a recipient who does not have Medicare Part D drug coverage</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>

<u>Non-preferred brand name drug for a recipient who does not have Medicare Part D drug coverage</u>	<u>Five (5) percent coinsurance, not to exceed \$20 per non-preferred brand name drug prescription</u>	<u>Full amount of the coinsurance</u>
<u>Emergency room for a non-emergency visit</u>	<u>Five (5) percent coinsurance</u>	<u>No deduction [Full amount of the coinsurance]</u>
<u>Durable Medical Equipment</u>	<u>Three (3) percent coinsurance up to a maximum of \$15</u>	<u>The amount of the coinsurance or, if applicable, \$15</u>
<u>Podiatry office visit</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>
<u>Vision services, general ophthalmological services, and optometry services</u>	<u>\$2 copayment</u>	<u>Full amount of the copayment</u>

1

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

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

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

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

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

6 Section 6. Copayment, Coinsurance and Premium General Provisions and Exclu-  
7 sions.

8 (1) The department shall impose no cost sharing for the following:

9 (a) A service furnished to an individual under eighteen (18) years of age required  
10 to be provided medical assistance under Social Security Act 1902(a)(10)(A)(i),  
11 including services furnished to an individual with respect to whom aid or assistance is  
12 made available under Title IV, Part B to children in foster care and individuals with re-  
13 spect to whom adoption or foster care assistance is made available under Title IV, Part  
14 E, without regard to age;

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

17 (c) A service furnished to a pregnant woman[, if the service relates to the pregnancy  
18 or to any other medical condition which may complicate the pregnancy];

19 (d) A service furnished to a terminally ill individual who is receiving hospice care as  
20 defined in Social Security Act 1905(o);

21 (e) A service furnished to an individual who is an inpatient in a hospital, nursing facil-  
22 ity, intermediate care facility for individuals with mental retardation or a developmental  
23 disability, or other medical institution, if the individual is required, as a condition of re-

1 ceiving services in the institution under the State plan, to spend for costs of medical  
2 care all but a minimal amount of the individual's income required for personal needs;

3 (f) An emergency service as defined by 42 CFR 447.53;

4 (g) A family planning service or supply as described in Social Security Act  
5 1905(a)(4)(C); or

6 (h) A service furnished to a woman who is receiving medical assistance via the appli-  
7 cation of Social Security Act 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

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

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

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

12 (3) A provider shall not waive a copayment, coinsurance amount or premium obliga-  
13 tion as imposed by the department for a recipient.

14 (4) A pharmacy provider or supplier, including a pharmaceutical manufacturer as de-  
15 finied in 42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor  
16 or agent of a pharmaceutical manufacturer, shall not make a copayment or coinsurance  
17 amount for a recipient.

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

20 (6) Provisions regarding a provider's ability to deny a service or benefit based on a  
21 recipient's failure to make a required copayment or coinsurance payment shall be as es-  
22 tablished in KRS 205.6312(4) and House Bill 380 of the 2006 Session of the General  
23 Assembly and in accordance with Public Law 109-171.

1 (7) A provider:

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

5 (b) Not waive a copayment, coinsurance amount or premium obligation as imposed  
6 by the department for a recipient; and

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

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

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

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

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

17 (10) The department shall not increase its reimbursement to a provider to offset an  
18 uncollected copayment, coinsurance amount or premium from a recipient.

19 ~~[(11) The copayment and coinsurance provisions established in this administrative~~  
20 ~~regulation shall supersede any copayment or coinsurance provision in any other de-~~  
21 ~~partment administrative regulation if any contradiction exists.] [Prescription Drug Co-~~  
22 ~~payments.~~

23 ~~(1) Except as excluded in Section 4 of this administrative regulation, the department~~

1 shall require a prescription drug copayment from a Medicaid recipient in a mandatory  
2 eligibility group as follows:

3 (a) ~~One (1) dollar for a generic drug prescription and the department shall reduce the~~  
4 ~~provider's reimbursement by one (1) dollar;~~

5 (b) ~~One (1) dollar for an atypical anti-psychotic drug prescription if the atypical anti-~~  
6 ~~psychotic drug has no generic equivalent. The department shall reduce the provider's~~  
7 ~~reimbursement by one (1) dollar;~~

8 (c) ~~Two (2) dollars for a brand name drug prescription if the brand name drug has no~~  
9 ~~generic equivalent and the brand name drug is available under the supplemental rebate~~  
10 ~~program. The department shall reduce the provider's reimbursement by one (1) dollar;~~

11 (d) ~~Three (3) dollars for a nonpreferred brand name drug prescription and the de-~~  
12 ~~partment shall reduce the provider's reimbursement by one (1) dollar.~~

13 (2) ~~Except as excluded in Section 4 of this administrative regulation, the department~~  
14 ~~shall require a prescription drug copayment from a Medicaid recipient in an optional eli-~~  
15 ~~gibility group as follows:~~

16 (a) ~~Three (3) dollars for a generic drug prescription and the department shall reduce~~  
17 ~~the provider's reimbursement by three (3) dollars;~~

18 (b) ~~Three (3) dollars for an atypical anti-psychotic drug prescription if the atypical anti-~~  
19 ~~psychotic drug has no generic equivalent. The department shall reduce the provider's~~  
20 ~~reimbursement by three (3) dollars;~~

21 (c) ~~Ten (10) dollars for a brand name drug prescription if the brand name drug has no~~  
22 ~~generic equivalent and the brand name drug is available under the supplemental rebate~~  
23 ~~program. The department shall reduce the provider's reimbursement by ten (10) dollars;~~

1       ~~(d) Twenty (20) dollars for a nonpreferred brand name drug prescription and the de-~~  
2 ~~partment shall reduce the provider's reimbursement by twenty (20) dollars.~~

3       ~~Section 3. Service Copayments.~~

4       ~~Except as excluded in Section 4 of this administrative regulation, the department~~  
5 ~~shall require a service copayment from a Medicaid recipient as follows:~~

6       ~~(1) Two (2) dollars per recipient per visit for a visit to a physician office, advanced~~  
7 ~~registered nurse practitioner office, physician assistant office, rural health clinic, primary~~  
8 ~~care center or federally qualified health center regardless of the type of provider that~~  
9 ~~provides a service during the visit. The department shall not reduce the provider's reim-~~  
10 ~~bursement by the amount of the copayment;~~

11       ~~(2)(a) Two (2) dollars per recipient per visit to any of the following types of providers:~~

12       ~~1. An audiologist;~~

13       ~~2. A chiropractor;~~

14       ~~3. A dentist;~~

15       ~~4. A hearing aid dealer;~~

16       ~~5. An optician;~~

17       ~~6. A podiatrist;~~

18       ~~7. A general ophthalmologist; or~~

19       ~~8. An optometrist for a general ophthalmological service; and~~

20       ~~(b) The department shall reduce the provider's reimbursement by two (2) dollars for~~  
21 ~~each visit or service identified in paragraph (a) of this subsection;~~

22       ~~(3) Three (3) dollars per recipient per provider per date of service for a visit to an out-~~  
23 ~~patient hospital, excluding a visit for treatment of an emergency condition. The depart-~~

1 ~~ment shall reduce the provider's reimbursement by three (3) dollars;~~

2 ~~(4) Three (3) dollars per recipient per visit to an inpatient hospital or outpatient hospi-~~  
3 ~~tal for treatment of a nonemergency condition. The department shall not reduce the pro-~~  
4 ~~vider's reimbursement by three (3) dollars; and~~

5 ~~(5) Fifty (50) dollars per recipient for an inpatient hospital admission including a direct~~  
6 ~~admission as well as any admission resulting from a transfer.~~

7 ~~(a) The copayment shall be due to the admitting hospital.~~

8 ~~(b) The department shall reduce the provider's reimbursement by fifty (50) dollars.~~

9 ~~Section 4. Copayment Exclusions and Limits and Recipient and Provider Respon-~~  
10 ~~sibilities.~~

11 ~~(1) The following annual copayment limits, based on a calendar year, shall apply:~~

12 ~~(a) A recipient shall not be liable for more than \$225 in prescription drug copayments~~  
13 ~~per calendar year; and~~

14 ~~(b) A recipient shall not be liable for more than \$225 in service copayments per cal-~~  
15 ~~endar year.~~

16 ~~(2) The following shall not be subject to copayments:~~

17 ~~(a) Exclusions established in KRS 205.6312, 42 C.F.R. 447.53 or 457.535;~~

18 ~~(b) A service provided to a recipient who has reached his or her 18th birthday but has~~  
19 ~~not turned nineteen (19); or~~

20 ~~(c) A service provided to a recipient residing in a long-term care facility.~~

21 ~~(3) An individual receiving services via any of the department's home and community~~  
22 ~~based waiver service programs shall:~~

23 ~~(a) Be subject to prescription drug copayments; and~~

1       ~~(b) Not be subject to service copayments.]~~

2       ~~(4) Unless excluded in subsection (2) or (3) of this section, the department has de-~~  
3 ~~termined that each Medicaid recipient:~~

4       ~~1. Should be able to pay a required copayment; and~~

5       ~~2. Shall be responsible for a copayment.~~

6       ~~(5) The department shall not increase its reimbursement to a provider to offset an un-~~  
7 ~~collected copayment from a recipient.~~

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

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

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

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

16       ~~Section 5. Provisions for Collection of Copayments.~~

17       ~~(1) A provider shall collect a copayment from a recipient in accordance with Sections~~  
18 ~~2, 3, and 4 of this administrative regulation.~~

19       ~~(2) A provider may collect the copayment at the time a service is provided or at a~~  
20 ~~later date.~~

21       ~~(3) A provider shall not refuse to provide a service if a recipient is unable to pay a re-~~  
22 ~~quired copayment. This provision shall not:~~

23       ~~(a) Relieve a recipient of an obligation to pay a copayment; or~~

1       ~~(b) Prevent a provider from attempting to collect a copayment.~~

2       ~~(4) If it is the routine business practice of a provider to terminate future services to an~~  
3 ~~individual with uncollected debt, the provider may include uncollected copayments un-~~  
4 ~~der this practice.~~

5       ~~(5) A provider shall give advanced notice to a recipient with uncollected debt before~~  
6 ~~services can be terminated.~~

7       ~~(6) A provider shall not waive a copayment obligation as imposed by the department~~  
8 ~~for a recipient.~~

9       ~~(7) A pharmacy provider or supplier, including a pharmaceutical manufacturer as de-~~  
10 ~~finied in 42 U.S.C. 1396R-8(k)(5), or a representative, employee, independent contractor~~  
11 ~~or agent of a pharmaceutical manufacturer, shall not make a copayment for a recipient.~~

12       ~~(8) A parent or guardian shall be responsible for a copayment imposed on a depend-~~  
13 ~~ent child under the age of twenty-one (21).]~~

14       Section 7. ~~[6.]~~ Premiums for KCHIP Children – Separate CHIP Program Recipients.  
15 ~~[Separate Insurance Program Recipients.]~~

16       (1) The department shall require a family with children participating in the KCHIP  
17 Separate Insurance Program to pay a premium of twenty (20) dollars per family, per  
18 month.

19       (2)(a) The family of a new KCHIP Separate Insurance Program eligible shall be re-  
20 quired to pay a premium beginning with the first full month of benefits after the month of  
21 application.

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

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

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

6 (b)1. A KCHIP Separate Insurance Program recipient shall be eligible for reenroll-  
7 ment upon payment of the missed premium.

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

11 Section 8. [~~7~~.] Premiums for Transitional Medical Assistance Recipients.

12 (1) A family receiving a second six (6) months of TMA, whose monthly countable  
13 earned income is greater than 100 percent of the federal poverty limit, shall pay a pre-  
14 mium of thirty (30) dollars per family, per month.

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

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

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

- 1 (c) The caretaker relative was out of town for the payment month; or
- 2 (d) The family moved and reported the move timely, but the move resulted in:
  - 3 1. A delay in receiving the billing notice; or
  - 4 2. Failure to receive the billing notice.

5 Section 9. [~~8~~.] Notices and Collection of Premiums.

6 (1) Premiums shall be collected in accordance with Sections 7 and 8 [~~6 and 7~~] of this  
7 administrative regulation.

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

- 9 (a) Premium amount; and
- 10 (b) Date the premium is due.

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

- 12 (a) In full; and
- 13 (b) In advance.

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

16 Section 10. [~~9~~.] Provisions for Recipients in Medicaid-Managed Care.

17 (1) A managed care entity:

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

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

23 1. A lower copayment, coinsurance or premium than established in this administrative

1 regulation; or

2 2. No copayment, coinsurance or premium. [~~If a copayment is imposed on a recipi-~~  
3 ~~ent receiving services through a managed care entity operating in accordance with 907~~  
4 ~~KAR 1:705, it shall be in accordance with the limitations and provisions established in~~  
5 ~~this administrative regulation.~~]

6 (2) The premium provisions pursuant to Sections 7 and 8 [~~6 and 7~~] of this administra-  
7 tive regulation shall apply to a recipient receiving services through a managed-care en-  
8 tity operating in accordance with 907 KAR 1:705.

9 (3) A six (6) month guarantee of eligibility as described in 907 KAR 1:705, Section  
10 3(6) shall not apply to a recipient required to pay a premium pursuant to Section 7 [~~6~~] of  
11 this administrative regulation.

12 Section 11. [~~10.~~] Freedom of Choice. In accordance with 42 C.F.R. 431.51, a recipi-  
13 ent may obtain services from any qualified provider who is willing to provide services to  
14 that particular recipient.

15 Section 12. [~~11.~~] Notice of Discontinuance, Hearings, and Appeal Rights.

16 (1) The department shall give written notice of, and an opportunity to pay, past due  
17 premiums prior to discontinuance of benefits for nonpayment of a premium.

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

20 (b) Following receipt of the documentation, the department shall determine if the fam-  
21 ily is required to pay the premiums established in Section 7 or 8 [~~6 or 7~~] of this adminis-  
22 trative regulation using the new income level.

23 (c) If the family is required to pay the premium and the premium has not been paid,

1 the benefits shall be discontinued in accordance with Section 7(4)(a) or 8(2) [~~6(4)(a) or~~  
2 ~~7(2)~~] of this administrative regulation.

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

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

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

907 KAR 1:604  
(Amended After Comments)

REVIEWED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Glenn Jennings, Commissioner  
Department for Medicaid Services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mike Burnside  
Undersecretary for Administrative and Fiscal Affairs

APPROVED:

\_\_\_\_\_  
Date

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

## REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:604

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Person: Stuart Owen or Stephanie Brammer-Barnes (564-6204)

- (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 is being promulgated to structure Department for Medicaid Services (DMS) cost-sharing in accordance with the Medicaid transformation known as KyHealth Choices. A companion regulation, 907 KAR 1:900E (KyHealth Choices Benefit Packages), will re-design the Kentucky Medicaid program into one tailored to individual needs and circumstances. The benefit packages established via KyHealth Choices are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs.

This initiative, which has already been approved by the Centers for Medicare and Medicaid Services and is being enacted in accordance with the Deficit Reduction Act of 2005, is necessary to maintain the viability of the program, to provide innovative opportunities to Medicaid and Kentucky Children's

Health Insurance Program (KCHIP) beneficiaries, and to promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

The amended after comments regulation removes "occupational therapy" and its corresponding co-payment from the Global Choices grid because occupational therapy will not be a covered service at this time unless it is covered under adult day care for individuals participating in the Home and Community Based Waiver program, or covered under physician services in a situation where the occupational therapist is employed as a full time employee of the physician and the procedure is billed under the physician's provider number. The amended after comments regulation further clarifies that the 5% coinsurance fee for non-preferred brand name drugs will not exceed \$20 per prescription. Additionally, the amended after comments regulation inserts vision cost-sharing provisions inadvertently admitted previously, denotes that the non-emergency coinsurance will not be deducted from the provider's reimbursement, refers to 907 KAR 1:900 benefit plan definitions to ensure uniformity as well as deletes definitions related to benefit plans.

- (b) The necessity of the amendment to this administrative regulation: The amendment and amended after comments regulation is necessary to assist in transforming the Medicaid program in conjunction with a related administration regulation - 907 KAR 1:900E (KyHealth Choices Benefit Packages). This action is necessary to maintain the viability of the Medicaid program and to transform it into a program tailored to beneficiaries' needs. The transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries which will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.
- (c) How the amendment conforms to the content of the authorizing statutes: The amendment and amended after comments regulation conforms to the content of the authorizing statutes, including KRS 205.6312 and Public Law 109-171 (aka the Deficit Reduction Act of 2005), by assisting in transforming the Medicaid program to maintain its viability and to transform it into a program tailored to beneficiaries' needs. The transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries which will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.
- (d) How the amendment will assist in the effective administration of the statutes: The amendment and amended after comments regulation conforms to the content of the authorizing statutes, including KRS 205.6312 and Public Law 109-171 (aka the Deficit Reduction Act of 2005) by assisting in transforming the Medicaid program to maintain its viability and to tailor it to beneficiaries' needs. The transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiar-

ies which will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This amendment and amended after comments regulation will affect all Medicaid and KCHIP program recipients who are not exempt from co-payment or co-insurance fees.
- (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: All recipients who are not exempt from co-payment or co-insurance fees will be responsible for complying with the cost-sharing provisions established in this administrative regulation.
  - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Those recipients who are not exempt from cost sharing charges will pay no more than \$225 per year for prescription drug co-payments and no more than \$225 for medical services. In addition, state rules provide that the maximum amount of cost sharing shall not exceed 5% of a family's income per quarter. The Medicaid Management Information System will track co-payments to ensure that they are correctly applied, and providers may check the Department's automated voice response system at 1-800-807-1301 or KyHealth Net to see whether a member is exempt from co-payments or has reached the cap on out of pocket expenses.
  - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The transformed program, known as *KyHealth Choices*, provides innovative opportunities that will promote healthy lifestyles and personal accountability among Medicaid and Kentucky Children's Health Insurance Program (KCHIP) recipients.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
  - (a) Initially: DMS anticipates that this amendment and amended after comments regulation will generate a savings of approximately \$31.1 million (\$21.1 million federal funds; \$10.0 million state funds) during State Fiscal Year (SFY) 2007.
  - (b) On a continuing basis: DMS anticipates that this amendment and amended after comments regulation will generate a similar but higher level of annual savings in subsequent years.
- (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 adminis-

trative 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: A funding increase is unnecessary; however, an increase in certain designated cost-sharing amounts or imposition of new cost-sharing requirements is necessary to implement this administrative regulation.
- (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 lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

## FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:604

Contact Person: Stuart Owen  
(564-6204)

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 administrative regulation and amended after comments regulation will affect all Medicaid and Kentucky Children's Health Insurance (KCHIP) program recipients who are not exempt from co-payment or co-insurance fees.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 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. Additionally, this administrative regulation and amended after comments regulation comply Public Law 109-171, governing the Medicaid program, and 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. Also, this administrative regulation and amended after comments regulation comply 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.

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? This amendment will not generate any additional revenue for state or local governments during the first year of implementation.

(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? This amendment will not generate any additional revenue for state or local governments during subsequent years of implementation.

(c) How much will it cost to administer this program for the first year? Implementation of this amendment will not result in any additional costs during the first year.

However, DMS anticipates that this amendment and amended after comments regulation will generate a savings of approximately \$31.1 million (\$21.1 million federal funds; \$10.0 million state funds) during State Fiscal Year (SFY) 2007.

- (d) How much will it cost to administer this program for subsequent years? Implementation of this amendment will not result in any additional costs during subsequent years of implementation. However, DMS anticipates that this amendment and amended after comments regulation will generate a similar but higher level of annual savings in subsequent years.

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: No additional expenditures are necessary to implement this amendment.