

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Provider Integrity

4 (Amendment)

5 907 KAR 5:005. Health Insurance Premium Payment (HIPP) Program.

6 RELATES TO: 42 C.F.R. 400.203, 430.10, 26 U.S.C. 4980B, 5000(b)(1), 29 U.S.C. 1161-
7 1169, 42 U.S.C. 1396e(a)-(e)

8 STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3),
9 205.560(2), 42 U.S.C. 1396e(a)-(e)

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Ser-
11 vices, Department for Medicaid Services has responsibility to administer the Medicaid Program.
12 KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a require-
13 ment that may be imposed or opportunity presented by federal law for the provision of medical
14 assistance to Kentucky's indigent citizenry. 42 U.S.C. 1396e(a) through (e) authorizes states to
15 establish a health insurance premium payment, or HIPP, program to provide health insurance
16 coverage outside of Medicaid to Medicaid enrollees, and any family member of Medicaid enrol-
17 lees, if the department determines that HIPP program participation would be cost effective for
18 the department. This administrative regulation establishes the Kentucky integrated health insur-
19 ance premium payment program requirements as authorized by 42 U.S.C. 1396e(a) through (e).

20 Section 1. Definitions.

- 1 (1) "Buying in" means purchasing benefits from Medicare on behalf of an individual.
- 2 (2) "Department" means the Department for Medicaid Services or its designee.
- 3 (3) "Federal financial participation" is defined in 42 C.F.R. 400.203.
- 4 (4) "Group health insurance plan" means any plan, including a self-insured plan, of, or con-
5 tributed to by, an employer to provide health care directly or otherwise to the employer's em-
6 ployees, former employees, or the families of the employees or former employees, if the plan:
- 7 (a) Meets the criteria established in 26 U.S.C. 5000(b)(1); and
- 8 (b) Includes continuation coverage pursuant to 26 U.S.C. 4980B or 29 U.S.C. 1161 to 1169.
- 9 (5) "Income" means:
- 10 (a) Wages, salary, or compensation for labor or services;
- 11 (b) Money received from a statutory benefit including Social Security, Veteran's Administra-
12 tion pension, black lung benefit, or railroad retirement benefit; or
- 13 (c) Money received from any pension plan, rental property, or an investment including inter-
14 est or dividends.
- 15 (6) "Income deduction" means a deduction from an individual's income for the
16 purpose of obtaining or trying to obtain Medicaid eligibility.
- 17 (7) "Kentucky integrated health insurance premium payment program participant" or "KI-
18 HIPP program participant" means an individual receiving health insurance benefits in accordance
19 with this administrative regulation.
- 20 (8) "Medicaid" means the Kentucky Medicaid program.
- 21 (9) "Medicaid enrollee" means an individual eligible for and participating in Medicaid pursu-
22 ant to 907 KAR 1:005, 907 KAR 20:010, 907 KAR 20:020, and 907 KAR 20:025.
- 23 (10) "Spend-down program" means a program by which an individual becomes eligible for

1 Medicaid benefits:

2 (a) By spending down income in excess of the Medicaid income threshold; and

3 (b) In accordance with 907 KAR 20:020.

4 (11) "State plan" is defined in 42 C.F.R. 430.10.

5 (12) "Wrap-around coverage" means coverage of a benefit not covered by an individual's
6 group health insurance plan.

7 Section 2. KI-HIPP Program Eligibility and Enrollment.

8 (1) A Medicaid enrollee, or a person acting on the Medicaid enrollee's behalf, shall cooperate
9 in providing information to the department necessary for the department to establish availability
10 and cost effectiveness of a group health insurance plan by:

11 (a) Completing the Kentucky Health Insurance Premium Payment Program Application; and

12 (b) Submitting the Kentucky Health Insurance Premium Payment Program Application to the
13 individual's local Department for Community Based Services office, the office administering the
14 Kentucky integrated health insurance premium payment program, or on-line via the Kentucky
15 Online Gateway self-service portal.

16 (2) A Medicaid enrollee or beneficiary shall participate in the KI-HIPP program if the de-
17 partment determines in accordance with this administrative regulation that the Medicaid enrollee
18 or beneficiary's participation in the KI-HIPP program would be cost-effective.

19 (3) If a Medicaid enrollee, KI-HIPP program applicant, participant, parent, guardian, or care-
20 taker fails to provide information to the department, within thirty (30) days of the department's
21 request, necessary to determine availability and cost effectiveness of a group health insurance
22 plan, the department shall[:

23 —(a)] not enroll the applicant in the KI-HIPP program unless good cause for failure to cooperate

1 is demonstrated to the department within thirty (30) days of the department's denial[; and

2 —(b) Terminate the individual from the Medicaid program pursuant to 907 KAR 20:060].

3 (4) Good cause for failure to cooperate shall exist if:

4 (a) There was a serious illness or death of the applicant, participant, parent, guardian, or care-
5 taker or of a member of the applicant's, participant's, parent's, guardian's, or caretaker's imme-
6 diate family;

7 (b) There was a fire, tornado, flood, or similar family emergency or household disaster affect-
8 ing the applicant, participant, parent, guardian, or caretaker or member of his or her immediate
9 family;

10 (c) The applicant, participant, parent, guardian, or caretaker demonstrates that a good cause
11 beyond that individual's control has occurred; or

12 (d) There was a failure to receive the department's request for information or notification for a
13 reason not attributable to the applicant, participant, parent, guardian, or caretaker. The lack of a
14 forwarding address shall be attributable to the applicant, participant, parent, guardian, or caretak-
15 er.

16 (5) For a Medicaid enrollee who is a KI-HIPP program participant:

17 (a) The department shall pay all group health insurance plan premiums and deductibles, coin-
18 surance and other cost-sharing obligations for items and services otherwise covered under Medi-
19 caid, up to the Medicaid allowed amount, minus any Medicaid cost-sharing that would normally
20 be paid, including the cost-sharing required under 895 KAR 1:010, 1:015, and 907 KAR 1:604,
21 as applicable; and

22 (b)1. The individual's group health insurance plan shall be the primary payer; and

23 2. The department shall be the payer of last resort.

1 (6) For a KI-HIPP program participating family member who is not a Medicaid enrollee:

2 (a) The department shall pay a KI-HIPP program premium; and

3 (b) The department shall not pay a deductible, coinsurance or other cost-sharing obligation.

4 (7) If an individual who was a Medicaid enrollee at the time the department initiated a KI-
5 HIPP program cost effectiveness review for the individual loses Medicaid eligibility by the time
6 the cost effectiveness review has been conducted, the department shall not enroll the individual
7 or any family member into the KI-HIPP program.

8 Section 3. Wrap-around Coverage.

9 (1) If a service to which a health insurance premium payment program participant would be
10 entitled via Medicaid is not provided by the individual's group health insurance plan, the de-
11 partment shall reimburse for the service.

12 (2) For a service referenced in subsection (1) of this section, the department shall reimburse:

13 (a) The provider of the service; and

14 (b) In accordance with the department's administrative regulation governing reimbursement
15 for the given service. For example, a wrap-around dental service shall be reimbursed in accord-
16 ance with 907 KAR 1:626.

17 Section 4. Cost Effectiveness.

18 (1) Enrollment in a group health insurance plan shall be considered cost effective if the cost of
19 paying the premiums, coinsurance, deductibles and other cost-sharing obligations, and additional
20 administrative costs is estimated to be less than the amount paid for an equivalent set of Medi-
21 caid services.

22 (2) When determining cost effectiveness of a group health insurance plan, the department
23 shall consider the following information:

- 1 (a) The cost of:
- 2 1. The insurance premium,
- 3 2. The coinsurance,
- 4 3. Medicaid's anticipated expenses for the:
- 5 a. KI-HIPP program participant;
- 6 b. KI-HIPP program participant's household; or
- 7 c. KI-HIPP program participant's subdivision of a household, and
- 8 4. The deductible;
- 9 (b) The scope of services covered under the insurance plan, including exclusions for pre-
- 10 existing conditions, exclusions to enrollment, and lifetime maximum benefits imposed;
- 11 (c) The average anticipated Medicaid utilization:
- 12 1. By age, sex, and coverage group for persons covered under the insurance plan; and
- 13 2. Using a statewide average for the geographic component; and
- 14 (d) Annual administrative expenditures of an amount determined by the department per Medi-
- 15 caid participant covered under the group health insurance plan.

16 Section 5. Cost Effectiveness Review.

17 (1) The department shall complete a cost effectiveness review at least annually for an em-

18 ployer-related group health insurance plan or a non-employer-related group health insurance

19 plan.

20 (2) The department shall perform a cost effectiveness re-determination if:

21 (a) A predetermined premium rate, deductible, or coinsurance increases;

22 (b) Any of the individuals covered under the group health insurance plan lose full Medicaid

23 eligibility; or

1 (c) There is a:

- 2 1. Change in Medicaid eligibility;
- 3 2. Loss of employment if the insurance is through an employer; or
- 4 3. Decrease in the services covered under the policy.

5 (3)(a) A health insurance premium payment program participant who is a Medicaid enrollee,
6 or a person on that individual's behalf, shall report all changes concerning health insurance cov-
7 erage to the Third Party Liability Branch office within the Department for Medicaid Services that
8 administers the Kentucky Integrated Health Insurance Premium Payment program, or to the par-
9 ticipant's local Department for Community Based Services (DCBS), Division of Family Support,
10 within thirty (30) days of the change.

11 (b) Except as allowed in subsection (4) of this section, if a Medicaid enrollee who is a health
12 insurance premium payment program participant fails to comply with paragraph (a) of this sub-
13 section, the department shall[:

14 ~~1.] disenroll the KI-HIPP program participating Medicaid enrollee, and any family member~~
15 ~~enrolled in the KI-HIPP program directly through the individual, if applicable, from the KI-HIPP~~
16 ~~program[; and~~

17 ~~2. Terminate the KI-HIPP program participating enrollee, and any family member enrolled in~~
18 ~~the KI-HIPP program directly through the individual from the Medicaid program unless the fam-~~
19 ~~ily member qualifies for Medicaid eligibility independently of the KI-HIPP participating enrol-~~
20 ~~lee].~~

21 (4) The department shall not disenroll [~~or terminate~~] an individual, or any family member en-
22 rolled in the KI-HIPP program directly through the individual, from KI-HIPP program participa-
23 tion if the individual demonstrates to the department, within thirty (30) days of notice of KI-

1 HIPP program disenrollment, good cause for failing to comply with subsection (3) of this sec-
2 tion.

3 (5) Good cause for failing to comply with subsection (3) of this section shall exist if:

4 (a) There was a serious illness or death of the individual, parent, guardian, or caretaker or a
5 member of the individual's, parent's guardian's, or caretaker's immediate family;

6 (b) There was a fire, tornado, flood, or similar family emergency or household disaster affect-
7 ing the applicant, participant, parent, guardian, or caretaker or member of his or her immediate
8 family;

9 (c) The individual, parent, guardian, or caretaker demonstrates that a good cause beyond that
10 individual's control has occurred; or

11 (d) There was a failure to receive the department's request for information or notification for a
12 reason not attributable to the individual, parent, guardian, or caretaker. The lack of a forwarding
13 address shall be attributable to the individual, parent, guardian, or caretaker.

14 Section 6. Kentucky HEALTH participation in KI-HIPP.

15 (1) A Kentucky HEALTH member who has access to employer-sponsored health insurance
16 through an employer shall be eligible for mandatory enrollment within KI-HIPP as follows:

17 (a) After concurrently or consecutively completing:

18 1. Twelve (12) months of Kentucky HEALTH enrollment; and

19 2. Twelve (12) months of employment with access to compatible employer-sponsored health
20 insurance;

21 (b) If the employer-sponsored health insurance is compatible with the KI-HIPP program; and

22 (c) If the employer-sponsored health insurance is cost-effective for the entire household.

23 (2) A Kentucky HEALTH member who is not currently required to participate in KI-HIPP

1 pursuant to subsection (1) of this section may elect to participate in KI-HIPP and submit docu-
2 mentation for an eligibility determination as provided in Section 2 of this administrative regula-
3 tion.

4 (3)(a) A Kentucky HEALTH member may elect to participate in KI-HIPP as an employee if
5 the beneficiary's employer sponsored insurance program is determined to be cost-effective for
6 the employee, but not for the entire household; or

7 (b) A Kentucky HEALTH member may elect to participate in KI-HIPP as a cost-effective
8 subdivision of the beneficiary's household if the employee participates in KI-HIPP but the entire
9 household is determined to not be cost-effective.

10 (4) A Kentucky HEALTH beneficiary participating in the KI-HIPP program shall:

11 (a) Receive a MyRewards Account pursuant to 895 KAR 1:030;

12 (b) Accrue dollars in a MyRewards account by completing any applicable activities pursuant
13 to 895 KAR 1:030;

14 (c) Receive an exemption from the PATH requirement established in 895 KAR 1:020;

15 (d) Receive wrap-around~~[wraparound]~~ services as provided pursuant to 895 KAR 1:010 de-
16 pending on the beneficiary's benefits under the beneficiary's employer sponsored insurance pro-
17 gram; and

18 (e) Comply with any cost-sharing requirement established pursuant to KAR Title 895 or 907
19 KAR 1:604.

20 Section 7. Coverage of Non-Medicaid Family Members.

21 (1) If determined to be cost effective, the department shall enroll a family member who is not
22 a Medicaid enrollee into the KI-HIPP program if the family member has group health insurance
23 plan coverage through which the department can obtain health insurance coverage for a Medi-

1 caid-enrollee in the family.

2 (2) The needs of a family member who is not a Medicaid enrollee shall not be taken into con-
3 sideration when determining cost effectiveness of a group health insurance plan.

4 (3) The department shall:

5 (a) Pay a KI-HIPP program premium on behalf of a KI-HIPP program participating family
6 member who is not a Medicaid enrollee; and

7 (b) Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a KI-HIPP
8 program participating family member who is not a Medicaid enrollee.

9 Section 8. Exceptions. The department shall not pay a premium:

10 (1) For a group health insurance plan if the plan is designed to provide coverage for a period
11 of time less than the standard one-year coverage period;

12 (2) For a group health insurance plan if the plan is a school plan offered on the basis of at-
13 tendance or enrollment at the school;

14 (3) If the premium is used to meet a spend-down obligation and all persons in the household
15 are eligible or potentially eligible only under the spend-down program pursuant to 907 KAR
16 20:020. If any household member is eligible for full Medicaid benefits, the premium shall:

17 (a) Be paid if it is determined to be cost effective when considering only the household mem-
18 bers receiving full Medicaid coverage; and

19 (b) Not be allowed as a deduction to meet the spend-down obligation for those household
20 members participating in the spend-down program.

21 (4) For a group health insurance plan if the plan is an indemnity policy which supplements the
22 policy holder's income or pays only a predetermined amount for services covered under the poli-
23 cy.

1 Section 9. Duplicate Policies.

2 (1) If more than one (1) group health insurance plan or policy is available, the department
3 shall pay only for the most cost-effective plan except as allowed in subsection (2) of this section.

4 (2) If the department is buying in to the cost of Medicare Part A or Part B for an eligible Med-
5 icare beneficiary, the cost of premiums for a Medicare supplemental insurance policy shall also
6 be paid if the department determines that it is likely to be cost effective to do so.

7 Section 10. Discontinuance of Premium Payments.

8 (1) If all Medicaid-enrollee household members covered under a group health insurance plan
9 lose Medicaid eligibility, the department shall discontinue KI-HIPP program payments as of the
10 month of Medicaid ineligibility.

11 (2) If one (1) or more, but not all, of a household's Medicaid-enrollee members covered under
12 a group health insurance plan lose Medicaid eligibility, the department shall re-determine cost
13 effectiveness of the group health insurance plan in accordance with Section 5(2) of this adminis-
14 trative regulation.

15 Section 11. Kentucky Integrated Health Insurance Premium Payment Program Payment Ef-
16 fective Date.

17 (1)(a) KI-HIPP program payments for cost-effective group health insurance plans shall begin
18 with the month the health insurance premium payment program application is received by the
19 department, or the effective date of Medicaid eligibility, whichever is later.

20 (b) If an individual is not currently enrolled in a cost effective group health insurance plan,
21 premium payments shall begin in the month in which the first premium payment is due after en-
22 rollment occurs.

23 (2) The department shall not make a payment for a premium which is used as an income de-

1 duction when determining individual eligibility for Medicaid.

2 Section 12. Premium Refunds. The department shall be entitled to any premium refund due
3 to:

4 (1) Overpayment of a premium; or

5 (2) Payment for an inactive policy for any time period for which the department paid the pre-
6 mium.

7 Section 13. Notice. The department shall inform a Kentucky integrated health insurance pre-
8 mium payment program:

9 (1) Applicant, in writing, of the department's initial decision regarding cost effectiveness of a
10 group health insurance plan and KI-HIPP program payment; or

11 (2) Participating household, in writing:

12 (a) If KI-HIPP program payments are being discontinued due to Medicaid eligibility being
13 lost by all individuals covered under the group health insurance plan;

14 (b) If the group health insurance plan is no longer available to the family; or

15 (c) Of a decision to discontinue KI-HIPP program payment due to the department's determi-
16 nation that the policy is no longer cost effective.

17 Section 14. Federal Financial Participation.

18 (1) The Kentucky integrated health insurance premium program shall be contingent upon the
19 receipt of federal financial participation for the program.

20 (2) If federal financial participation is not provided to the department for the Kentucky inte-
21 grated health insurance premium program, the program shall cease to exist.

22 (3) If the Centers for Medicare and Medicaid Services (CMS) disapproves a provision stated
23 in an amendment to the state plan, which is also stated in this administrative regulation, the pro-

1 vision shall be null and void.

2 Section 15. Incorporation by Reference.

3 (1) "Kentucky Health Insurance Premium Payment Program Application", KIHIPP-100, April
4 2019 edition, is incorporated by reference.

5 (2) This material may be inspected, copied, or obtained, subject to applicable copyright law,
6 at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621,
7 Monday through Friday, 8 a.m. to 4:30 p.m., or from the department's Web site at
8 <http://www.chfs.ky.gov/dms/incorporated.htm>.

907 KAR 5:005

REVIEWED:

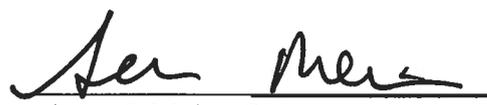
8/23/19
Date



Carol H. Steckel, Commissioner
Department for Medicaid Services

APPROVED:

Oct 9 2019
Date



Adam M. Meier, Secretary
Cabinet for Health and Family Services

PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall, if requested, be held on December 23, 2019, at 9:00 a.m. in Suites A & B, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by December 16, 2019, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until December 31, 2019. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Donna Little, Deputy Executive Director, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, KY 40621; Phone: 502-564-6746; Fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 5:005

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov;
and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services' (DMS's) Kentucky integrated health insurance premium payment (KI-HIPP) program provisions. The KI-HIPP program is a program by which DMS purchases health insurance coverage for an individual by paying the individual's (and family members if applicable) health insurance premiums, deductibles and coinsurance if doing so would be cost effective to DMS. To qualify for the KI-HIPP program, an individual (or at least one individual in the case of a family enrolling in the KI-HIPP program) must be Medicaid eligible; however, the actual benefits are provided by the individual's group health insurance carrier.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to provide cost-effective medical benefits to Medicaid beneficiaries; thus, prudently utilizing DMS's resources.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by providing cost-effective medical benefits to Medicaid individuals.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by providing cost-effective medical benefits to Medicaid beneficiaries.

- (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: The amendments change this administrative regulation by removing a requirement that individuals be terminated from Medicaid coverage if they are eligible for participation in the KI-HIPP program but do not participate. DMS currently does not terminate individuals for failure to participate with Employer Sponsored Insurance (ESI), and is amending this regulation text to conform.
 - (b) The necessity of the amendment to this administrative regulation: The amendments are necessary to reflect the current operation of the KI-HIPP program.
 - (c) How the amendment conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by providing cost-effective medical benefits to Medicaid beneficiaries.
 - (d) How the amendment will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by providing cost-effective medical benefits to Medicaid beneficiaries.

- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation:
Medicaid beneficiaries, MCOs, providers, and employers who employ Medicaid beneficiaries.
- (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: Potential KI-HIPP program enrollees will need to provide all required information, including their health insurance carrier's information, to DMS.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed on the regulated entities.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid beneficiaries who have access to private health insurance via their employers will still receive the full benefits provided through the Medicaid program as well as payment of the premiums for the health insurance through the Medicaid program.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: The Department for Medicaid Services (DMS) estimates savings of \$350 per KI-HIPP participant per month.
 - (b) On a continuing basis: The Department for Medicaid Services (DMS) estimates savings of \$350 per KI-HIPP participant per month.

DMS intends to aggressively educate potential KI-HIPP program participants regarding the benefits of the KI-HIPP program in order to achieve a high participation rate.

- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX, and matching funds from state general fund appropriations.
- (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: Neither an increase in fees nor funding are necessary.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering is applied as children are exempt from Medicaid disenrollment pursuant to 42 USC 1396e(b)(2).

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 5:005

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

1. 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? The Department for Medicaid Services will be affected by this administrative regulation.
2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 205.520(3), 205.560(2), 194A.030(2), 194A.050(1), 194A.010(1), and 42 U.S.C. 1396e(a) through (e).
3. 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 Department for Medicaid Services projects no revenue to be generated by the administrative regulation.
 - (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 Department for Medicaid Services projects no revenue to be generated by the administrative regulation.
 - (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services anticipates no additional costs in the administration of this program in the first year. The Department for Medicaid Services estimates savings of three-hundred and fifty dollars (\$350) per KI-HIPP participant per month.
 - (d) How much will it cost to administer this program for subsequent years? The Department for Medicaid Services anticipates no additional costs in the administration of this program in subsequent years. The Department for Medicaid Services estimates savings of \$350 per KI-HIPP participant per month. The Department for Medicaid Services intends to aggressively educate potential KI-HIPP program participants regarding the benefits of the KI-HIPP program in order to achieve a high participation rate.

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:

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 5:005

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396e(a) through (e).
2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."
3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid).
4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter or different responsibilities than the federal requirements.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter or different responsibilities than the federal requirements.