



Commonwealth of Kentucky
OFFICE OF THE GOVERNOR

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August 24, 2016

The Honorable Sylvia Burwell
Secretary of the Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madame Secretary:

On behalf of the people of the Commonwealth of Kentucky, I am pleased to submit our request for a Section 1115 demonstration waiver for Kentucky HEALTH.

Last year, we began the process of transforming Kentucky's Medicaid program in an effort to produce better health outcomes while ensuring the long-term fiscal sustainability of the program. The need for change is urgent. Almost twenty percent of our residents live in poverty, we are 47th in the nation for median household income, nearly one-third of Kentuckians are on Medicaid, and our workforce participation is among the worst in the nation at less than 60 percent. Kentucky also ranks third in the nation for drug related fatalities. I know, from our conversations, that these facts concern you deeply.

As you are aware, next year we will be required to start paying a portion of the costs of Medicaid expansion for the first time. This is expected to cost Kentucky taxpayers approximately \$1.2 billion in new spending for fiscal years 2017 through 2021. This is an expense Kentucky cannot afford without jeopardizing funding for education, pension obligations, public safety and the traditional Medicaid program for our most vulnerable citizens.

Kentucky HEALTH is a transformative program designed not only to stabilize the program financially, but to improve health outcomes and overall quality of life for its members. Our demonstration waiver seeks to continue health coverage for our existing Medicaid population while evaluating new policies designed to prepare individuals for self-sufficiency and private market coverage. In addition, our proposal seeks to strengthen our behavioral health delivery system, which is critical to addressing Kentucky's substance abuse epidemic.

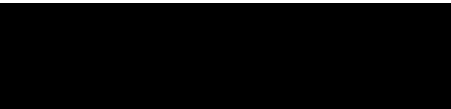
As part of the waiver's development, we had a robust public comment process, which included three public hearings, and an extended comment period to ensure every Kentuckian that wanted to be heard could be included. In total, we received nearly 1,350 comments and made adjustments to our waiver application to address our citizens' most pressing concerns. The resulting waiver request includes the preservation of allergy testing benefits, as well as additional protections for the medically frail population.

The Kentucky HEALTH Section 1115 demonstration application represents our good faith effort to continue Medicaid expansion in a responsible manner. It is within your authority to approve our request as written. This is what I am humbly asking you to do. In fact, most of the features of Kentucky HEALTH have already been approved by your agency in other states. We believe the Commonwealth of Kentucky should be given the same opportunity as others to reform our Medicaid program to meet the unique needs of our Commonwealth. We need a lifeline.

In the interest of the Commonwealth of Kentucky, I hope you will view our application favorably. My team and I stand ready and committed to continue our conversations. By working together in an expeditious manner, Kentucky will have a transformative Medicaid program that will better serve the over 400,000 Kentuckians who are currently receiving healthcare benefits under expanded Medicaid.

Thank you in advance for your thoughtful consideration of our request.

Sincerely,

A black rectangular redaction box covering the signature of Matthew G. Bevin.

Matthew G. Bevin
Governor



Helping to Engage and Achieve Long Term Health

Table of Contents

Section 1: Kentucky HEALTH Program Overview	4
1.1 Historical Narrative and Rationale	4
1.2 Program Summary.....	7
1.2.1 Employer Premium Assistance Program Overview	8
1.2.2 Kentucky HEALTH Overview	9
1.3 Purpose and Goals.....	14
1.4 Hypothesis.....	14
1.5 Demonstration Area and Timeframe.....	14
1.6 Impact to Medicaid and CHIP	14
Section 2: Eligibility	15
2.1 Populations Eligible for Kentucky HEALTH.....	15
2.2 Community Engagement and Employment Initiative	16
2.3 Projected Enrollment.....	19
2.4 Other Eligibility Policies.....	19
2.4.1. Coverage Effective Date & Retroactive Coverage.....	19
2.4.2 Open Enrollment	20
3 Kentucky HEALTH Benefits	21
3.1 Kentucky HEALTH Benefit Package	21
3.1.1 Section 1937 Alternative Benefit Plan	21
3.1.2 Benefit Detail	21
3.1.3 My Rewards Account Benefit	24
3.1.4 Educational Support	24
3.2 Employer Premium Assistance Program.....	25
3.3 Populations Exempt from Alternative Benefits Plans	26
3.3.1 Medically Frail	26
3.3.2 Pregnant Women and Low-Income Families.....	27
4 Cost-Sharing	27
4.1 Member-Managed Healthcare Accounts.....	27
4.1.1 Deductible Account	27
4.1.2 My Rewards Account.....	28
4.2 Member Required Contributions.....	31
4.2.1 Non-Payment Penalties	32

4.2.2. <i>Early Re-Entry Opportunity</i>	33
4.3 Cost-Sharing Exemption.....	34
5 Delivery System and Payment Rates for Services	34
5.1 Delivery System Reforms	35
5.1.1 <i>Substance Use Disorder Delivery System Reform Pilot Program</i>	35
5.1.2 <i>Chronic Disease Management</i>	36
5.1.3 <i>Managed Care Reforms</i>	36
5.2 Managed Care Delivery System	38
5.3 Health Plan Choice	38
5.4 Excluded services	38
5.6 Fee-for-service.....	39
5.7 Capitated payments	39
5.8 Quality.....	39
6 Implementation of Demonstration	39
6.1 Enrollment.....	40
6.2 Managed Care.....	40
7 Demonstration Financing and Budget Neutrality	40
8 List of Proposed Waivers and Expenditure Authorities	40
8.1 Title XIX Waivers	40
8.2 Costs Not Otherwise Matchable	41
9 Public Notice & Public Comment	42
9.1 Summary of Public Comments and State Response	43
9.2 Summary of Waiver Changes Following Public Comment.....	53
10 Demonstration Administration	56
ATTACHMENT I: Evaluation plan	57
ATTACHMENT II: Financing and Budget Neutrality Summary	66
ATTACHMENT III: Budget Neutrality Worksheets	70
ATTACHMENT IV: Public Notice	71

Section 1: Kentucky HEALTH Program Overview

Kentucky HEALTH is the Commonwealth of Kentucky's 1115 demonstration project focused on "Helping to Engage and Achieve Long Term Health (HEALTH)". The proposed demonstration project is part of an overall initiative to transform the Kentucky Medicaid program to empower individuals to improve their health and gain employer sponsored coverage or other commercial health insurance coverage, while simultaneously ensuring the program's long-term fiscal sustainability. Only by helping members engage in their healthcare and their communities, will the Commonwealth achieve long term improvements in the health of its citizens and improved fiscal health for the Commonwealth and its Medicaid program. To this end, the Commonwealth seeks a five-year Section 1115 waiver from the Centers for Medicare & Medicaid Services (CMS) to implement and evaluate Kentucky HEALTH, a demonstration project designed to provide dignity to individuals as they move towards self-reliance, accountability, and ultimately independence from public assistance.

The program seeks to break the cycle of poverty through efforts on several fronts. First, the program encourages members to improve their health by incentivizing preventive care, participation in disease management programs, and healthy lifestyles. Second, the program embraces private market policies and principles to familiarize members with commercial health insurance coverage to prepare them for the commercial market. Third, the program focuses on addressing Kentucky's growing drug abuse epidemic, which based on a recent Centers for Disease Control and Prevention (CDC) study determined that nearly half of all counties in the Commonwealth are at risk for an HIV or hepatitis C outbreak.¹ This risk analysis was based in part on unemployment rates. Addressing employment goes hand in hand with health, and therefore the program will also focus on engaging members in the community, either through employment or preparing for employment, as well as volunteer activities. Further, in addition to creating new requirements for members, the program also raises accountability for the healthcare system by furthering the "Triple Aim" of improving the patient experience, improving population health, and lowering costs.

While Kentucky HEALTH is uniquely designed for the specific challenges facing Kentucky, most of the individual federal authorities necessary to implement this demonstration project have been previously approved in other states. Through this waiver application, the Commonwealth is seeking the opportunity to evaluate these new program components in Kentucky, with the goal of dramatically improving member outcomes. The Kentucky HEALTH program, as outlined below, represents the terms under which the Commonwealth will continue Medicaid expansion.

1.1 Historical Narrative and Rationale

In 2014, as part of the Affordable Care Act (ACA), the Commonwealth of Kentucky expanded its Medicaid program to all newly eligible adults with income below 138% of the federal poverty level (FPL). The expansion placed able-bodied adults into a program designed for disabled individuals, pregnant women and children, and other vulnerable populations likely to be dependent on the State over the long-term. As a result, Kentucky's total Medicaid enrollment has increased dramatically—by April 2016, more than 428,000 low-income non-disabled adults were enrolled in the Medicaid expansion program,

¹ A. Campo-Flores & B. McKay, CDC Identifies Counties at Risk of HIV Outbreaks: Agency Lists Areas Prone to HIV and Hepatitis C Spreading Among Injection-drug Users, WALL STREET JOURNAL (June 3, 2016), <http://www.wsj.com/articles/cdc-identifies-counties-at-risk-of-hiv-outbreaks-1464912264>.

nearly one-third of the State's total Medicaid program enrollment.² Further, due to expansion, the State experienced significant increases in enrollment across all Medicaid eligibility categories. In fact, total Kentucky Medicaid and Children's Health Insurance Program (CHIP) enrollment increased 68% between December 2013 (prior Medicaid expansion) and April 2016.³ Following this dramatic enrollment increase, over 1.35 million Kentuckians (almost a third of the State's entire population) are being served by Medicaid.⁴ However, the expansion has yet to impact the health status of Kentuckians. For example, during the first year following implementation, fewer than 10% of beneficiaries received an annual wellness or physical exam.⁵

In addition, the Commonwealth faces many challenges. Kentucky's rate of unemployment, nearly 6%, and the poverty rate, approximately 19%, are both well above the national average, and workforce participation rates and wages are below the national average and among the worst in the nation.⁶ These factors are known to impact rates of drug use as well as HIV rates. Over the past decade, the number of Kentuckians who die from drug overdoses has steadily climbed to more than 1,200 each year.⁷ Kentucky now ranks third highest in the nation for the number of drug related fatalities.⁸ A June 2016 preliminary report from the Centers for Disease Control & Prevention (CDC) identified 220 counties in the nation at risk for an HIV or hepatitis C outbreak, and 54 of the total at-risk counties were located in Kentucky.⁹ Further, the State also has the seventh highest incarceration rate in the nation, far outpacing the national average.¹⁰

² *Total Monthly Medicaid and CHIP Enrollment: Timeframe Mar 2016*, THE HENRY J. KAISER FAMILY FOUNDATION, <http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/> (last visited June 6, 2016); Stephen P. Miller, Commissioner, Kentucky Department for Medicaid Services, Presentation to the Kentucky Senate Health & Welfare Committee (April 11, 2016).

³ Kentucky Department for Medicaid Services, Comparison of December 2013 member enrollment and April 2016 member enrollment (June 14, 2016) (on file with the State).

⁴ Stephen P. Miller, Commissioner, Kentucky Department for Medicaid Services, Presentation to the Kentucky Senate Health & Welfare Committee (April 11, 2016).

⁵ In 2014, 33,233 individuals received an annual wellness or physical exam. Deloitte, Commonwealth of Kentucky: Medicaid Expansion Report (2014), available at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf

⁶ *Economy at a Glance: Kentucky*, UNITED STATES DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, <http://www.bls.gov/eag/eag.ky.htm> (data extracted June 03, 2016); *Quick Facts: Kentucky*, UNITED STATES CENSUS BUREAU, <http://www.census.gov/quickfacts/table/PST045215/21> (last visited June 6, 2016). Kentucky ranks 45th in the nation for total percent of population age 16+ in civilian labor force, at 59.4%, and 47th in the nation for median household income, at \$43,342. *Id.*

⁷ COMMONWEALTH OF KENTUCKY JUSTICE AND PUBLIC SAFETY CABINET, 2015 OVERDOSE FATALITY REPORT: KENTUCKY OFFICE OF DRUG CONTROL POLICY (2015), available at <http://odcp.ky.gov/Documents/2014-%20ODCP%20Overdose%20Death%20Report%20final1.pdf>.

⁸ Number of deaths due to drug injury of any intent (unintentional, suicide, homicide, or undetermined) per 100,000 population. The 3-year average from 2011-2015 for Kentucky was 24 deaths, while the national average was 13.5. *Drug Deaths: United States*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/all/drugdeaths> (last visited June 6, 2016).

⁹ A. Campo-Flores & B. McKay, CDC Identifies Counties at Risk of HIV Outbreaks: Agency Lists Areas Prone to HIV and Hepatitis C Spreading Among Injection-drug Users, WALL STREET JOURNAL (June 3, 2016), <http://www.wsj.com/articles/cdc-identifies-counties-at-risk-of-hiv-outbreaks-1464912264>.

¹⁰ PRISON POLICY INITIATIVE, <http://www.prisonpolicy.org> (last visited June 6, 2016).

The Commonwealth also consistently ranks near the bottom of the nation in several key population health metrics. For example, over 26% of Kentuckians smoke cigarettes (second highest rate in the nation), 31.6% of adults in the Commonwealth are obese (twelfth highest rate in the nation), and the number of infant deaths per 1,000 live births is 6.8 (seventeenth highest in the nation).¹¹ In addition, Kentucky has both the highest number of cancer deaths, as well as the highest number of preventable hospitalizations, in the nation.¹² Further, Kentucky also faces significant health challenges related to high rates of diabetes and heart disease, ranking 45th and 47th in the nation respectively.¹³ Despite these poor health outcomes, Kentucky's managed care organizations (MCOs) are only spending approximately 80% of their total \$530 per member per month capitation on direct healthcare spending, while the remainder contributed to administrative costs and profit (which on average were the highest profit margins in the nation for Medicaid managed care plans).¹⁴

In addition to poor health outcomes, the Medicaid program is financially unsustainable. To date, the Commonwealth has only covered half the administrative cost of the expansion program and none of the costs associated with the benefits provided to the expansion population. The remaining costs were funded entirely by the federal government. However, over the next five years the federal share of the cost of benefits provided to the expansion population will decline and the required State share will increase. As such, the cost of these benefits to Kentucky taxpayers is estimated to increase from \$74 million in 2017 to approximately \$363 million by 2021, for a total of approximately \$1.2 billion over the next five years.¹⁵ These costs have the potential to challenge the overall state budget and could create funding issues for other programs, such as education, pensions, and infrastructure, as well as also jeopardize funding for the traditional Medicaid program that covers the aged, blind, disabled, pregnant women and children.

When expansion was implemented there was no plan to finance the program long-term, and instead the Kentucky expansion plan counted on increased State revenues. In 2013, prior to the implementation of the Medicaid expansion program, the previous administration commissioned a study of the potential impact of Medicaid expansion under the ACA on the State's anticipated Medicaid population, its budget,

¹¹ *Smoking: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/KY/Smoking/59> (last visited June 6, 2016); *Adult Obesity in the United States*, TRUST FOR AMERICA'S HEALTH AND THE ROBERT WOOD JOHNSON FOUNDATION, <http://stateofobesity.org/adult-obesity/> (last visited June 6, 2016); *Infant Mortality: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/KY/IMR> (last visited June 6, 2016).

¹² AMERICA'S HEALTH RANKINGS, ANNUAL REPORT: KENTUCKY (2015), available at <http://cdnfiles.americashealthrankings.org/SiteFiles/StateProfiles/Kentucky-Health-Profile-2015.pdf>.

¹³ *Diabetes: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/ALL/Diabetes> (last visited June 16, 2016); *Heart Disease: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/IL/CHD> (last visited June 16, 2016).

¹⁴ The average medical loss ratio for Kentucky's five Medicaid MCOs was reported at 80.5%, below the national average of 85.4%. JEREMY D. PALMER & CHRISTOPHER T. PETTIT, MILLIMAN, MEDICAID RISK-BASED MANAGED CARE: ANALYSIS OF FINANCIAL RESULTS FOR 2015 (2016), available at <http://www.milliman.com/uploadedFiles/insight/2016/medicaid-risk-based-managed-care-analysis-2015.pdf>.

¹⁵ Stephen P. Miller, Commissioner, Kentucky Department for Medicaid Services, Presentation to the Kentucky Senate Health & Welfare Committee (April 11, 2016).

and its economy.¹⁶ The actual results of the implementation of Medicaid expansion differ dramatically from the projections set forth in the original study. The reality is, the number of Kentuckians who have enrolled in Medicaid expansion is more than double the number projected, while the number of new jobs created and the economic impact from Medicaid expansion has been significantly lower than forecasted.

Specifically, the 2013 study projected that 147,634 newly eligible members would enroll in the Medicaid expansion program during the period from July 1, 2013 through June 30, 2014, and that number would increase to 187,898 over the next six years.¹⁷ In contrast to these projections, Kentucky's Medicaid expansion population currently exceeds 428,000.¹⁸ In addition, the 2013 study claimed that Medicaid expansion would add 40,000 jobs through June 30, 2021, and would have a positive economic impact of \$802.4 million through that same date.¹⁹ Although difficult to quantify with any appreciable degree of certainty, preliminary economic impact analysis would support a conclusion that the figures cited in the 2013 study were overly optimistic and not likely to be achieved by the cited date of June 30, 2021. The reality is that Medicaid expansion does not pay for itself as envisioned by the prior administration, and the Commonwealth of Kentucky cannot afford the cost of the Medicaid expansion program without this demonstration waiver.

Kentucky HEALTH's design saves taxpayer dollars, critical to ensuring the program's long-term financial viability. In total, Kentucky HEALTH is expected to save taxpayers over \$2.2 billion dollars over the five-year waiver period. While changes to the existing Medicaid program are necessary for the fiscal sustainability of Medicaid expansion, Kentucky HEALTH's primary goal is to improve the health status of Kentuckians and provide members with the tools to develop or enhance their job skills and achieve economic security.

1.2 Program Summary

Kentucky HEALTH is an innovative, transformative healthcare program designed to not only stabilize the program financially, but to also improve the health outcomes and overall quality of life for all members. This demonstration waiver seeks to evaluate new policies and program elements designed to engage members in their healthcare and provide the necessary education and tools required to achieve long term health and an improved quality of life. Ultimately, Kentucky HEALTH seeks to: (1) improve the health of members; (2) engage members in the community and prepare them for employment; and (3) provide members the tools to successfully utilize commercial market health insurance and eventually transition off Medicaid.

¹⁶ Deloitte, Commonwealth of Kentucky: Medicaid Expansion Report (2014), available at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf

¹⁷ Deloitte, Commonwealth of Kentucky: Medicaid Expansion Report (2014), available at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf

¹⁸ Stephen P. Miller, Commissioner, Kentucky Department for Medicaid Services, Presentation to the Kentucky Senate Health & Welfare Committee (April 11, 2016).

¹⁹ Deloitte, Commonwealth of Kentucky: Medicaid Expansion Report (2014), available at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf

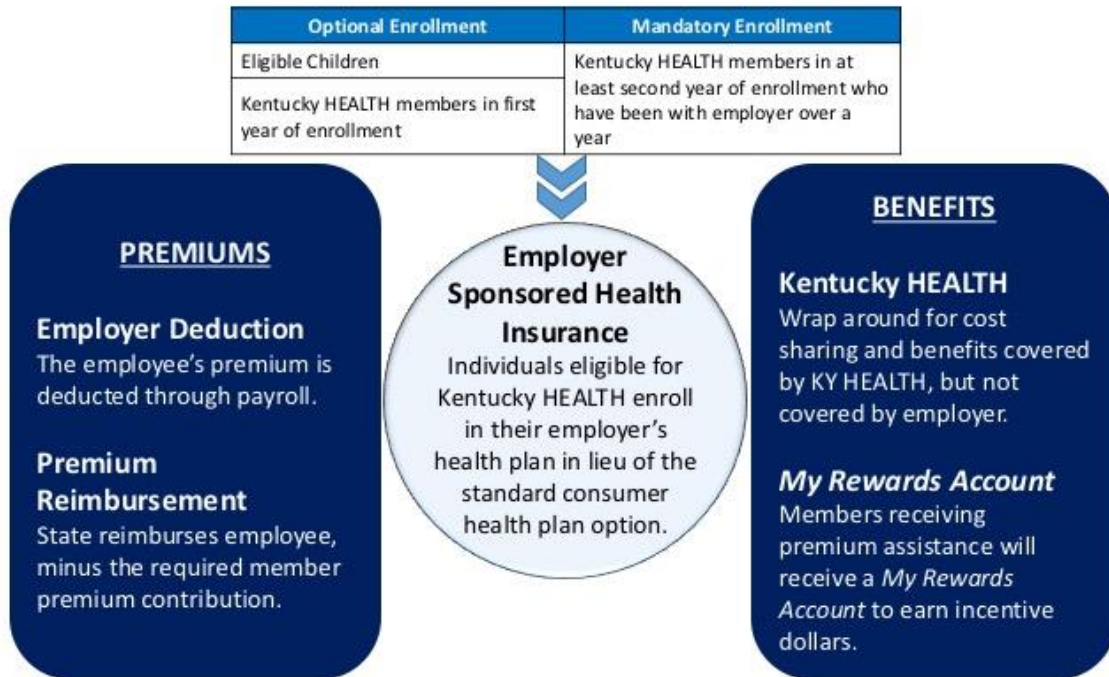
Kentucky HEALTH offers eligible individuals two pathways to coverage: (1) the employer premium assistance program, which offers premium assistance to assist individuals in purchasing employer-sponsored health insurance coverage; and (2) the consumer driven health plan, which offers members a high deductible health plan with commercial market benefits equivalent to the Kentucky State Employees' Health Plan while maintaining current mental health and substance use disorder benefits. In addition, the program includes two member managed accounts, one to fund the deductible, and another to fund enhanced healthcare benefits such as vision, dental, over the counter medications, and gym memberships.

1.2.1 Employer Premium Assistance Program Overview

As part of the overall waiver effort to support and promote employment, eligible members who currently have access to health insurance through their employer will have the option, and ultimately the obligation, to enroll their family into their employer-sponsored health insurance plan. Participation in the member's employer-sponsored health insurance plan in lieu of Kentucky HEALTH is optional during their first year of enrollment, and mandatory for members in their second year of enrollment, provided the member has been with their employer at least one year. In addition, to promote family coverage and keep parents in the same plan as their children, the State will subsidize family-based employer coverage, so that children eligible for the Kentucky Children's Health Insurance Plan (KCHIP) may participate in the same health plan as their parents.

The employer premium assistance program will subsidize the member's employer plan by paying the member an advance premium reimbursement payment to cover the costs of the employee's share of the premium. However, individuals eligible for the employer premium assistance program will be required to also contribute a share of their monthly premium amount equal to the monthly contribution amounts required of Kentucky HEALTH members, as detailed in *Section 4.2*.

Once enrolled, the member will have full access to their employer-sponsored health plan benefits and network providers. To ensure benefit parity, the employer premium assistance program will also wrap-around benefits to ensure that members have access to all Kentucky HEALTH benefits not otherwise reimbursed by their employer plan. Beneficiary out-of-pocket expenses will also be covered. Eligible employer plans must be cost-effective for the State, as further described in *Section 3.2*. The employer premium assistance program provides members with greater choice of coverage and helps prevent crowd-out of private plans, while also encouraging employment.



1.2.2 Kentucky HEALTH Overview

Kentucky HEALTH will continue to be delivered through a managed care delivery system, but will offer a new benefit package modeled after the Kentucky State Employees' Health Plan. However, current Medicaid benefits will be maintained for children, pregnant women, medically frail individuals, and any individuals eligible for Medicaid prior to the passage of the Affordable Care Act. Similar to the employer premium assistance program, Kentucky HEALTH promotes family health coverage by also enrolling the Medicaid eligible children of Kentucky HEALTH participating adults. Single family coverage not only streamlines eligibility processes for the family and the State, it also reduces network and provider fragmentation between adults and children, thus improving access to care. Although children will be included in this Section 1115 demonstration, all children participating in Kentucky HEALTH will maintain their current benefit packages and will be exempt from all Kentucky HEALTH cost-sharing and plan structure changes.

Eligible Populations. Kentucky HEALTH targets the Medicaid expansion populations, specifically adults with income up to 138% FPL. However, the State will also include children and all non-disabled adults currently covered under traditional Medicaid, including low-income parents and caretakers eligible under Section 1931, individuals eligible for transitional medical assistance, and pregnant women. Kentucky HEALTH will not include any of the following: former foster youth up to age 26, individuals eligible for 1915(c) waivers, individuals on Medicaid due to a disability, including those with an SSI determination, individuals over 65 years of age, and individuals residing in an institution, such as a nursing facility.

Beneficiary Responsibility. Kentucky HEALTH will be structured as a consumer-driven, high deductible health plan paired with two member controlled healthcare spending accounts, one to cover deductible expenses and the other to accrue savings that can be used to purchase enhanced benefits not covered in the base benefits. The plan will require that members pay a

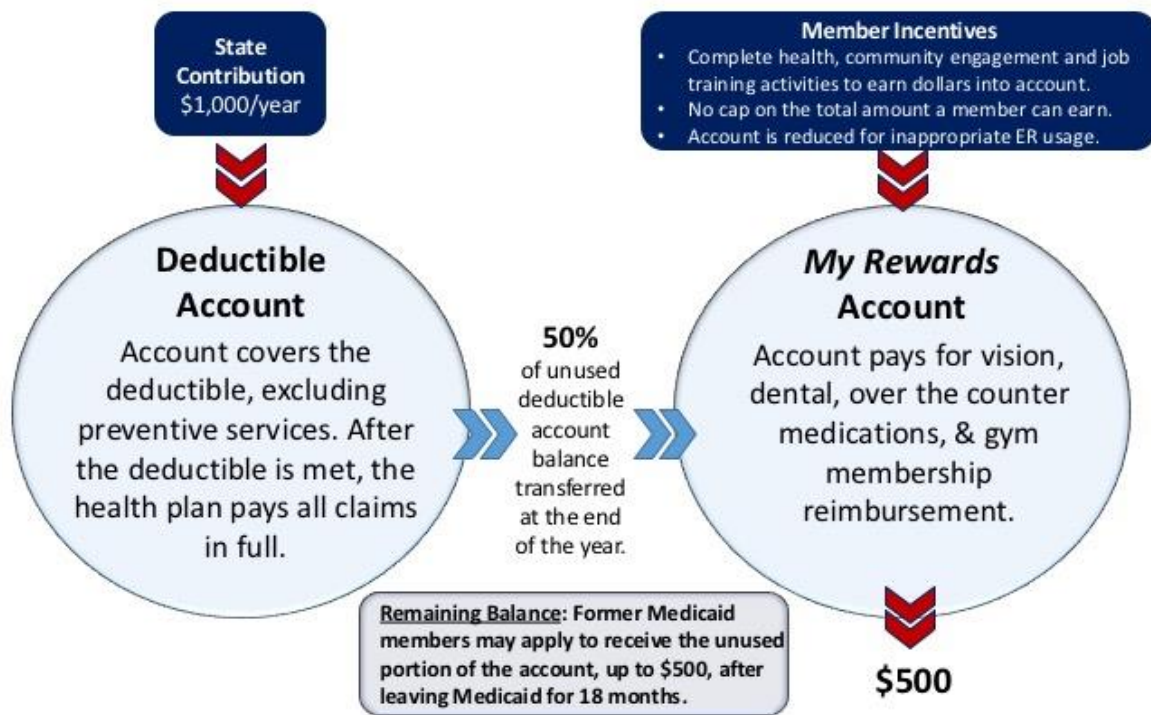
monthly premium amount in lieu of copayments, increasing on a sliding scale based on family income, ranging from \$1.00 per month up to a maximum of \$15.00 per month. The monthly premium will be applied on a family basis, and will not be separately charged to each Kentucky HEALTH member in the household. Please refer to *Section 4.2* for additional information regarding member cost-sharing.

Deductible Account. Each member enrolled in Kentucky HEALTH, with the exception of pregnant women and children, will be provided a deductible account, which will be used to fund the health plan's \$1,000 deductible. The State will fully fund the deductible account to ensure funds are available for the member to cover initial medical expenses for the deductible. The deductible account exposes members to the cost of healthcare and encourages members to be active consumers of healthcare by evaluating cost and quality as they seek care. Please refer to *Section 4.1.1* for additional detail regarding the deductible account.

Rewards Account. In addition to the deductible account, all Kentucky HEALTH members, with the exception of children, will be provided a *My Rewards Account*. Members may use the account to choose from an array of enhanced benefits not otherwise covered in the member's base benefit plan, such as dental benefits, vision services, over the counter medications, and limited reimbursement for the purchase of a gym membership. While these benefits are not required to be offered to beneficiaries under federal Medicaid law, these benefit enhancements will be available through the *My Rewards Account*.

Members will be able to accrue funds in the *My Rewards Account* upon completion of specified health-related or community engagement activities, such as participating in community service or job training activities. Members will be able to utilize these funds to personalize their benefits by selecting from certain enhanced benefit options, up to the accrued balance in their account. To encourage appropriate healthcare utilization, account funds may also be withdrawn from the *My Rewards Account* each time a member utilizes a hospital emergency department for a non-emergency medical condition or excessively misses healthcare appointments without appropriate cancellation. In addition, the account will be utilized to further encourage employment, as members who become employed and successfully transition to commercial health insurance coverage for at least eighteen months will be eligible to receive the balance of their *My Rewards Account* in cash, up to \$500. Please refer to *Section 4.1.2* for additional detail regarding the *My Rewards Account*.

Together, the deductible account and the *My Rewards Account* empower individuals to be active consumers of healthcare and make cost-conscious decisions, while simultaneously providing incentives for members to improve their health and be active members of the community.



Commercial Market Policies. One of the primary goals of Kentucky HEALTH is to educate and familiarize members with commercial market coverage, while creating safeguards to ease the transition to commercial health insurance coverage. This is particularly important given the high rate of movement between coverage options. One study estimated that approximately half of adults with income below 200% FPL will move between Medicaid eligibility and Marketplace coverage at least once a year, while 25% will move between the two programs more than once.²⁰ Policy alignment with commercial market policies is important to avoid beneficiary confusion as members move between programs. Without similar policies, members are unprepared to move to Marketplace or employer-sponsored coverage, and the drastically differing policies have the potential to create a perverse incentive for individuals to remain on Medicaid. Kentucky HEALTH is designed to help educate members about commercial market policies so that members are prepared to eventually transition to commercial health insurance coverage.

Kentucky HEALTH seeks to prepare individuals for commercial health insurance coverage by aligning Medicaid and Marketplace policies in several areas. For example, similar to the standard commercial market policies, Kentucky HEALTH will require monthly member premiums, and benefits will start prospectively from the initial premium payment. Kentucky HEALTH also creates disincentives for program non-compliance, similar to the private market. For example, Kentucky HEALTH will establish a client-specific open enrollment period. Specifically, if an individual is disenrolled from the program in accordance with current practice for failing to comply with annual eligibility redetermination requirements, the individual will be required to

²⁰ B. D. Sommers & S. Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFFAIRS 228 (2011).

wait six months for a new open enrollment period. This policy will educate members of the importance of meeting commercial market open enrollment deadlines, while also allowing members to rejoin the program at any time prior to the six-month date by completing a financial or health literacy course. Each Kentucky HEALTH program disincentive is paired with a critical “on-ramp” to help support individuals to get back on the right path and successfully utilize the Kentucky HEALTH program and access all of its benefits, resources, and tools.

Community Engagement and Employment. The cornerstone of the Kentucky HEALTH program is the introduction of a community engagement and employment initiative aimed at increasing workforce participation rates in Kentucky, which is critical to improving the health status of Kentuckians. The recent study by the Centers for Disease Control identified counties at risk of an HIV epidemic, in part based on county unemployment rates and other factors. Recognizing this important connection between employment and healthy lifestyles, CMS has long supported Medicaid employment initiatives. In fact, Section 1901 of the Social Security Act requires “for the purpose of enabling each State, as far as practicable under the conditions in such State to furnish (1) medical assistance on behalf of . . . individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . . .”²¹ In addition, CMS states on its website that “employment is a fundamental part of life for people with and without disabilities.”²² Meaningful work and participating as a contributing member of society is recognized as part of a healthy lifestyle and “essential to individual’s economic self-sufficiency, self-esteem and well-being.”²³ CMS’s statements support scores of extensive research that has long supported a strong link between community engagement and health.²⁴ In addition to its health benefits, research also indicates that community engagement and volunteerism improves an individual’s employability. One study found that volunteering increased the chances of employment by 51% among individuals without a high school diploma, and by 55% among individuals living in rural areas.²⁵

Therefore, to assist with employment, Kentucky HEALTH will require that all able-bodied working age adult members without dependents participate in the community engagement and employment initiative to maintain enrollment.²⁶ Engagement activities include volunteer work,

²¹ Social Security Act §1901, 42 U.S.C. §1396-1 (2015).

²² Medicaid Employment Initiatives, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 7, 2016).

²³ Medicaid Employment Initiatives, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 7, 2016).

²⁴ Hergenrather K, Zeglin R, McGuire-Kuletz M, and Rhodes S. Employment as a Social Determinant of Health: A Systematic Review of Longitudinal Studies Exploring the Relationship Between Employment Status and Physical Health. *Rehabilitation Research, Policy, and Education*. 2015;29(25):2-26.

²⁵ C. SPERA ET AL., CORPORATION FOR NATIONAL AND COMMUNITY SERVICE, OFFICE OF RESEARCH AND EVALUATION, VOLUNTEERING AS A PATHWAY TO EMPLOYMENT: DOES VOLUNTEERING INCREASE ODDS OF FINDING A JOB FOR THE OUT OF WORK? (2013), *available at* http://www.nationalservice.gov/sites/default/files/upload/employment_research_report.pdf.

²⁶ For purposes of clarification, adults with dependents will only be exempt from the community engagement and employment initiative if the individual has primary caretaking responsibilities for a dependent, including a minor child or a disabled adult dependent.

employment, caretaking, job training, or job search activities. Through a design that gradually increases the requirement for community engagement, individuals increase their connections to potential employment resources and opportunities available in their communities, as well as increase their own self-confidence. While completion of community engagement and/or employment activities is a program expectation for non-disabled working age adult members without dependents, Kentucky HEALTH also offers corresponding incentives to further encourage members to seek employment and successfully transition to commercial health insurance coverage. Children, pregnant women, individuals determined medically frail, and adults who are the primary caregiver of a dependent, including a minor child or a disabled adult dependent, are exempt from the community engagement and employment initiative.

Ultimately, these efforts to improve Kentucky employment rates are critical to addressing the drug abuse epidemic, reducing overall poverty, and sustaining the Medicaid program, as without more robust workforce participation, the State will be unable to continue to financially sustain a Medicaid program that is quickly including nearly one third of the entire State population. Please refer to *Section 2.2* for additional detail regarding Kentucky HEALTH's community engagement and employment initiative.

Substance Use Disorder. This waiver application also seeks delivery system improvements aimed at addressing the drug abuse epidemic facing the State. Kentucky HEALTH will maintain all current mental health and substance use disorder (SUD) benefits. However, this demonstration project will greatly expand access to these robust services available to members by requesting a waiver of the federal exclusion of institutions of mental disease (IMD) providers. Please refer to *Section 5.1.1* for additional detail regarding Kentucky HEALTH's SUD initiative.

Chronic Disease Management. Kentucky faces a series of public health challenges. Not only does the State have exceedingly high infant mortality, obesity, diabetes, heart disease, and smoking rates, as a likely result, it ranks highest in the nation with respect to cancer deaths and preventable hospital conditions.²⁷ While these health indicators are demonstrative of residents' overall health status, they also lead to higher utilization of healthcare services and increased healthcare expenditures, particularly among the State's most vulnerable populations. As such, this demonstration project will align various program components in support of the State's existing public health infrastructure and current efforts to improve chronic disease prevention and management. In addition, the State will work with Kentucky's Medicaid managed care organizations to implement best practices from nationally recognized disease management programs, such as the National Diabetes Prevention Program. Please refer to *Section 5.1.2* for additional information regarding the chronic disease management initiative.

Managed Care Reform. The creation of Kentucky HEALTH is just one piece of a larger transformation aimed at strengthening the existing Medicaid program in the State. The State

²⁷ *Smoking: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/KY/Smoking/59> (last visited June 6, 2016); *Adult Obesity in the United States*, TRUST FOR AMERICA'S HEALTH AND THE ROBERT WOOD JOHNSON FOUNDATION, <http://stateofobesity.org/adult-obesity/> (last visited June 6, 2016); *Infant Mortality: Kentucky*, UNITED HEALTH FOUNDATION, <http://www.americashealthrankings.org/KY/IMR> (last visited June 6, 2016); AMERICA'S HEALTH RANKINGS, ANNUAL REPORT: KENTUCKY (2015), available at <http://cdnfiles.americashealthrankings.org/SiteFiles/StateProfiles/Kentucky-Health-Profile-2015.pdf>.

has already taken a critical look at its managed care contract rates, as Kentucky MCOs have the highest profit margin of any state Medicaid program in the nation.²⁸ Prior to implementing Kentucky HEALTH, the State will continue to align incentives across the delivery system by introducing mechanisms to control spending, as well as payment incentives for providers and MCOs to improve quality and align with member incentives. In addition, the Department for Medicaid Services will continue to seek improvements and administrative efficiencies in the existing Medicaid managed care program, such as uniform credentialing and formulary alignment. Please refer to *Section 5.1.3* for additional detail regarding managed care reforms.

1.3 Purpose and Goals

Kentucky HEALTH seeks to comprehensively transform Medicaid and accomplish the following goals:

1. Improve members' health and help them be responsible for their health;
2. Encourage individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance;
3. Empower people to seek employment and transition to commercial health insurance coverage;
4. Implement delivery system reforms to improve quality and outcomes; and
5. Ensure long-term fiscal sustainability.

1.4 Hypothesis

The State will extensively test and evaluate achievement of the above listed program goals throughout the demonstration approval period. Please see **Attachment I** for the State's proposed hypothesis and preliminary evaluation plan.

1.5 Demonstration Area and Timeframe

The State seeks a five-year waiver approval period. Kentucky HEALTH will operate statewide, however, some program components will be phased in. For example, changes to coverage of vision and dental services will be delayed for three months past the initial program implementation date to allow members a chance to accrue funds in their *My Rewards Account*. In addition, the community engagement and employment initiative may be phased in by county. Please refer to *Section 6* for additional detail regarding program implementation.

1.6 Impact to Medicaid and CHIP

The demonstration is part of the State's overall effort to comprehensively transform Kentucky's Medicaid program. While most of the reforms introduced in this waiver target the expansion population, several new program elements (as detailed in this waiver application) will be introduced to the non-disabled traditional Medicaid population as well. Collectively, the Kentucky HEALTH reforms aim to transform Medicaid from a program that passively provides healthcare coverage to one that educates and empowers members to actively engage in their health.

In addition to eligibility, benefits, cost-sharing and delivery system reforms, each of which is described more fully below, the demonstration will modify Medicaid and CHIP programs to allow families the

²⁸ The average underwriting ratio (profit margin) for Kentucky's five Medicaid MCOs was reported at 11.3%, significantly above the national average of 2.6% (3.3% for expansion states). JEREMY D. PALMER & CHRISTOPHER T. PETTIT, MILLIMAN, MEDICAID RISK-BASED MANAGED CARE: ANALYSIS OF FINANCIAL RESULTS FOR 2015 (2016), available at <http://www.milliman.com/uploadedFiles/insight/2016/medicaid-risk-based-managed-care-analysis-2015.pdf>.

opportunity to enroll in a family plan. This promotes integrated family healthcare by enrolling adults and their KCHIP eligible children in Kentucky HEALTH or, if applicable, the parent’s employer-sponsored health insurance plan through the employer premium assistance program. By providing family coverage, Medicaid eligible families will be able to seek care within the same provider network and with the same health plan, thus reducing administrative burdens and promoting better care integration for all family members.

Section 2: Eligibility

Kentucky HEALTH is designed specifically for able-bodied, working age adults and their families. Currently, the State has expanded Medicaid to cover this new adult group up to 138% FPL. This expansion will be maintained only under this demonstration waiver. In addition, the State will seek to transition all other non-disabled adult Medicaid recipients to the Kentucky HEALTH program, including low-income parents and caretakers eligible under Section 1931, individuals eligible for transitional medical assistance, and pregnant women. Finally, Kentucky HEALTH will seek to provide seamless coverage for entire families through the inclusion of children covered under the KCHIP program.

Only individuals eligible for Medicaid on the basis of an eligibility group listed in *Table 2.1(A)* are subject to the provisions of this waiver. Individuals eligible for 1915(c) waivers, such as Acquired Brain Injury (ABI), Home and Community Based (HCB), Michelle P. (MPW), or the Supports for Community Living (SCL), are excluded from this waiver. In addition, the waiver will also exclude (1) individuals eligible for Medicaid on the basis of blindness or disability, including individuals eligible for Social Security Income (SSI); (2) individuals over 65 years of age; and (3) individuals residing in an institution, such as a nursing facility. Also, Kentucky HEALTH will not impact coverage for former foster children up to age 26, who are also excluded from this waiver.

2.1 Populations Eligible for Kentucky HEALTH

Table 2.1(A): Kentucky HEALTH Eligibility Chart

Eligibility Group Name	Social Security Act and CFR Citations	Income Level	
Adult group	1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	0-138% FPL with a 5% income disregard	
Parents and other caretaker relatives	1902(a)(10)(A)(i)(I) 1931(b) and (d) 42 CFR 435.110	Household Size	Standard
		1	\$235
		2	\$291
		3	\$338
		4	\$419
		5	\$492
		6	\$556
7	\$621		
Transitional medical assistance	408(a)(11)(A) 1931(c)(2) 1925 1902(a)(52)	First 6 months: N/A Additional 6 months: 0-185% FPL	
Pregnant women	42 CFR 435.116	0-195% FPL	
Newborn Children	1902(e)(4) 42 CFR 435.117	N/A – deemed status for newborns whose mother is	

		enrolled in Medicaid on date of birth
Infants and Children Under Age 19	1902(a)(10)(A)(i)(III), (IV), (VI), (VII) 1931(b) and (d) 42 CFR 435.118	Ages 0-1: 0-195% FPL Ages 1-18: 0-159% FPL
Title XXI Separate CHIP Program	Title XXI 42 CFR 457.310	Ages 0-1: >195% - ≤213% FPL Ages 1-18: >159% - ≤213% FPL

Table 2.1(B): Medicaid Populations Not Included In Kentucky HEALTH

1. Individuals qualifying for Medicaid on the basis of blindness.
2. Individuals qualifying for Medicaid on the basis of disability, including, but not limited to: <ul style="list-style-type: none"> a. 1915 (c) waiver recipients; b. Individuals determined eligible for Supplemental Security Income (SSI) on the basis of a disability; c. Medicaid buy-in program for working disabled adults.
3. Individuals qualifying for Medicaid on the basis of age.
4. Institutionalized individuals assessed a patient contribution towards the cost of care.
5. Individuals receiving Medicare.
6. Former foster care children up to age 26.

2.2 Community Engagement and Employment Initiative

Promotion of work through coverage of certain employment supports and vocational rehabilitation for people with disabilities has been a longstanding policy within CMS.²⁹ Kentucky seeks to replicate those priorities for able bodied individuals in the program through the community engagement and employment initiative. As noted earlier, on its website, CMS recognizes that “employment is a fundamental part of life for people with and without disabilities. Employment provides a sense of purpose, how we contribute to our community and are associated with positive physical and mental health benefits.”³⁰ To this end, CMS policy allows states to provide *supported employment benefits* through Home and Community Based Services.³¹ Ultimately, connecting Medicaid recipients to services to help such “families and individuals attain or retain capability for independence or self-care” is one of the fundamental purposes of the Medicaid program, as set forth in the Social Security Act.³²

In addition to health benefits, increasing engagement and employment may reduce poverty. The United States Census Bureau determined that among adults aged 18-64 living in poverty, more than half

²⁹ *Medicaid Employment Initiatives*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 13, 2016).

³⁰ *Medicaid Employment Initiatives*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 13, 2016).

³¹ 42 C.F.R. 440.180(c)(2)(iii) (2015); *Medicaid Employment Initiatives*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 13, 2016).

³² Social Security Act §1901, 42 U.S.C. §1396-1 (2015).

(approximately 61.7%) did not work at least one week in 2014.³³ Government assistance programs can only lessen the burdens of poverty—beneficiaries may only truly escape the bonds of generational poverty and improve their quality of life through obtaining stable employment, as recently demonstrated in Maine following its reinstated work requirement for able-bodied SNAP beneficiaries. The initial evaluation tracked compliant members, non-compliant members that were removed from the program, and members leaving the program due to increased income. The report concluded that implementation of the work requirement rule led to a significant increase in total wages the following year among all three groups, including the non-compliant group.³⁴

In addition to reducing poverty, an initiative to increase employment is imperative to address the drug abuse epidemic facing the State. This complex health crisis requires a multi-faceted solution that not only treats the health related consequences, but also addresses some of the underlying social root causes of the epidemic, including low employment. Kentucky HEALTH seeks to connect beneficiaries with critical vocational skills, job training, education and support to encourage self-sufficiency.

To this end, Kentucky HEALTH will offer several incentives and resources to support members in becoming actively engaged in their communities, with the ultimate goal of empowering individuals and providing them with the necessary tools to seek and obtain employment and transition to commercial insurance coverage. Kentucky HEALTH’s community engagement and employment initiative will incentivize members to steadily increase their community involvement and eventually develop the tools and skills to seek and obtain lasting employment. The Kentucky Cabinet for Health and Family Services will collaborate with the Cabinet for Education and Workforce Development to implement a graduated system to ease new members into the community engagement participation requirement so that, after the first year, all able-bodied working age adult Kentucky HEALTH members will be performing at least twenty hours of community engagement or employment activities each week. Notwithstanding the foregoing, children, pregnant women, individuals determined medically frail, and adults who are the primary caregiver of a dependent (including a minor child or a disabled adult dependent) are exempt from the community engagement and employment requirement. To clarify, caregivers for individuals other than a dependent will not be exempt. However, those individuals providing caregiving services for a non-dependent relative or other person with a chronic, disabling health condition will be permitted to count those caregiving hours towards fulfilling the hour requirements of this section.

Table 2.2: Escalated Community Engagement & Employment Hours

Eligibility Period	Required Engagement Hours
1-3 months	0 hours per week
4-6 months	5 hours per week
6-9 months	10 hours per week
9-12 months	15 hours per week
12+ months	20 hours per week

³³ CARMEN DENAVAS-WALT & BERNADETTE D. PROCTOR, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, PUB. NO. P60-252, INCOME AND POVERTY IN THE UNITED STATES: 2014 (2015), *available at* <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf>.

³⁴ Letter from Paul Leparulo, Deputy Director, Main Office of Policy and Management, to Mary Mayhew, Commissioner Main Department of Health and Human Services (April 19, 2016), *available at* http://www.maine.gov/economist/econdemo/ABAWD%20analysis_final.pdf.

Beginning after three months of program eligibility, participation in the community engagement and employment initiative will be a condition of eligibility for all able-bodied working age adult Kentucky HEALTH members without dependents (including minor children or disabled adult dependents). Failure to meet required engagement hours will result in a suspension of benefits until the member satisfies the requirement for a full month. Kentucky HEALTH members who are full-time students or employed and working at least 20 hours per week satisfy the requirements of this initiative and would not be impacted by this change.

Qualifying community engagement and employment hours include a variety of activities beyond standard employment and may include:

- Job skills training;
- Job search activities;
- Education related to employment;
- General education (i.e. GED, community college);
- Vocational education/ training;
- Subsidized or unsubsidized employment;
- Community work experience;
- Community service/ public service; and
- Caregiving services for a non-dependent relative or other person with a chronic, disabling health condition.

The requirements of the community engagement and employment initiative are not limited to volunteer and employment related activities, but can also be met through investing in one's education and job training. It is well understood that increased education is directly associated with higher wages. In Kentucky, there is a 33% difference in median annual earnings between individuals with and without high school diplomas.³⁵ To encourage Kentucky HEALTH members to improve their educational attainment, participation in the free General Educational Development (GED) certification exam prep classes available in every county will count as a credit towards the community engagement and employment initiative requirements. In addition, to respond to the recent 76% decrease in Kentucky GED participation rates in the last year, this waiver will also seek to cover the out-of-pocket costs associated with taking the GED exam, as described in more detail in *Section 3.1.4*.³⁶

By encouraging impoverished individuals to engage more fully in their education, training, and communities through completion of even five hours of community engagement and employment each week, Kentucky HEALTH seeks to increase the employment rate and reduce the poverty level of individuals participating in the program. However, to ensure appropriate resources are available and to monitor the impact of this new requirement, the State may implement a regional or county based rolling implementation of the community engagement and employment initiative.

³⁵ KENTUCKY CENTER FOR ECONOMIC POLICY, FACING CHALLENGES WITH THE NEW GED TEST IN KENTUCKY (2015), available at <http://kypolicy.org/dash/wp-content/uploads/2015/12/2015-KY-GED-Report3.pdf>.

³⁶ *Id.*

2.3 Projected Enrollment

Projected enrollment in Kentucky HEALTH is based on calendar year 2015 member enrollment data of the eligibility groups that will transition to the waiver. The projections for the future demonstration years consider the impact of the new program features contained within this waiver. Further, Kentucky HEALTH does not propose to apply any enrollment limits on the number of individuals that may enroll in the program.

Table 2.3: Kentucky HEALTH Projected Enrollment by Eligibility Group

Eligibility Group	Project Enrollment by Demonstration Year (DY)				
	DY 1	DY 2	DY3	DY4	DY 5
Children	532,250	549,917	568,187	587,000	606,500
Non-Expansion Adults	133,333	130,417	127,583	124,833	122,083
Expansion Group	489,000	477,583	466,333	455,417	444,750

Note: Values shown have been rounded and represent average monthly enrollment.

2.4 Other Eligibility Policies

One of the primary goals of the Kentucky HEALTH program is to encourage individuals to become active consumers of healthcare who are prepared to use commercial health insurance. As such, Kentucky HEALTH will implement key commercial market and Marketplace policies in order to introduce these critical concepts to Kentucky HEALTH members. Notwithstanding the foregoing, children, pregnant women, and individuals determined medically frail will be excluded from many of these commercial market reforms.

2.4.1. Coverage Effective Date & Retroactive Coverage

Similar to the commercial market, members (excluding children and pregnant women) will be required to make their first month's required premium payment prior to the start of benefits. Individuals will have sixty days from the date of their eligibility determination to pay the premium payment. Once an individual pays the premium, benefits will begin the first day of the month in which the payment was received. In order to provide individuals with the opportunity to begin coverage as expeditiously as possible, the State will develop a process by which applicants (not yet determined eligible for Kentucky HEALTH) will be permitted to make an initial premium pre-payment in order to expedite coverage. Once determined eligible, benefits would begin effective the first day of the month in which the pre-payment was made, which could be as early as the first day of the month in which the application was submitted.

Despite the pre-payment option, all initial premium contributions must be made within sixty calendar days from the date of the initial invoice. Individuals who do not pay the initial premium payment within the sixty-day payment period will be subject to the penalties detailed in *Section 4.2.1*. Accordingly, individuals with income above 100% FPL will not be enrolled in the program and will be required to reapply should they wish to participate in the program. Whereas, individuals at or below 100% FPL who fail to pay the initial premium will be enrolled effective the first day of the month in which the sixty-day payment period expired. However, once enrolled, these individuals will be required to pay Medicaid allowable copayments for all

services in the first six months of enrollment and will not have access to a *My Rewards Account*, the enhanced benefits available through the account, or the potential \$500 reward available to members after leaving Medicaid.

In addition, the State will not provide retroactive coverage and benefits to newly enrolled individuals, except for pregnant women and children. Instead, consistent with the commercial market and federal Marketplace policies, coverage and benefits will only begin after the member's initial premium payment is made. Eliminating Medicaid retroactivity encourages individuals to obtain and maintain health insurance coverage, even when the individual is healthy. In addition, due to Medicaid expansion and the availability of tax credits, affordable healthcare coverage options have been available for two years to Kentuckians who have complied with the individual mandate, eliminating the need for retroactive coverage. However, to provide the opportunity for expedited enrollment for individuals in a time of need, the State will minimize the potential impact of this policy revision through the expansion of presumptive eligibility sites to include county health departments and qualifying safety net providers, such as community mental health centers, federally qualified health centers, and rural health centers.

2.4.2 Open Enrollment

Consistent with private market health plans, Kentucky HEALTH will implement a modified member-specific annual open enrollment period (with exceptions for certain vulnerable populations, including pregnant women and children) to help familiarize Kentucky HEALTH members with this commercial market policy. All Kentucky HEALTH members will be required to complete the annual redetermination process within a specific timeframe to avoid coverage gaps. The open enrollment period will vary for each member depending on when they enrolled in the program, and will begin approximately three months prior to the expiration of their twelve-month benefit period. Individuals that do not complete the re-enrollment process prior to the expiration of their twelve-month benefit period will be disenrolled from the program.

Following disenrollment, individuals will have an additional three-month period in which to submit their redetermination paperwork to be reenrolled in Kentucky HEALTH. However, after the expiration of the six-month redetermination period (including three months prior to coverage expiration and three months following), individuals will be required to wait six months until their next open enrollment period before being permitted to re-enroll in the program. This open enrollment policy will not apply to pregnant women, children, and individuals determined medically frail. In addition, the State will create certain exceptions for individuals who experienced a change in circumstances preventing completion of redetermination, such as gaining and subsequently losing commercial health insurance coverage or moving out of state and having returned.

Compared to Kentucky HEALTH's six-month period, individuals on the Marketplace who miss the open enrollment period are generally required to wait up to nine months prior to re-enrolling in coverage, with limited exceptions. By comparison, all Kentucky HEALTH eligible individuals will be provided the opportunity for early re-entry at any time prior to their next open enrollment period by completing a financial or health literacy course. Once the course is completed, the member may re-enroll in Kentucky HEALTH at any time and pay their first month's premium contribution to begin coverage.

3 Kentucky HEALTH Benefits

Kentucky HEALTH seeks to provide its members with a commercial health insurance experience in order to better prepare members to transition to commercial health insurance coverage. Consistent with this goal, Kentucky HEALTH will provide a benefit package consistent with the commercial market for the expansion population. The Kentucky HEALTH benefit plan for the expansion population will be equivalent to the Kentucky State Employees’ Health Plan, which provides a comprehensive commercial insurance benefit package. All current mental health and SUD services will be preserved. Additional benefits such as dental services, vision services, and over the counter medications will be provided via the member’s *My Rewards Account*. Further, consistent with the goal of offering a commercial market experience, the State will not provide coverage for non-emergency medical transportation (NEMT) to the newly eligible adult group, and will seek a waiver of this non-commercial benefit.

Children, pregnant women, medically frail individuals, and any individuals eligible for Medicaid prior to the passage of the Affordable Care Act will be eligible to receive Medicaid State Plan benefits. There will be no changes to the current State Plan benefits. The eligibility groups listed in *Table 3.1* below receiving State Plan benefits will continue to receive non-emergency transportation, as well as access to covered vision and dental services, in accordance with the State Plan rather than through the *My Rewards Account*. In addition, all children receiving services through the waiver will continue to receive all early and periodic screening, diagnostic, and treatment (EPSDT) services.

3.1 Kentucky HEALTH Benefit Package

Table 3.1: Benefit Package Chart

Eligibility Group	Benefit Package
Adult Group	Kentucky HEALTH Alternative Benefit Plan
Section 1931	Kentucky State Plan
TMA	
Pregnant Women	
Newborn Children	
Children under 19	
CHIP	

3.1.1 Section 1937 Alternative Benefit Plan

The alternative benefit plan (ABP) coverage provided to the new adult group will be based on the current State Employees’ Health Plan, which is a consumer-driven health plan administered by Anthem Blue Cross and Blue Shield of Kentucky, Inc. In accordance with this waiver request, the State will modify and update its ABP to benchmark benefits to the Kentucky State Employees’ Plan for the expansion population.

3.1.2 Benefit Detail

Kentucky HEALTH benefits for the expansion population will be aligned with the commercial market State Employees’ Health Plan. All current mental health and SUD services will be maintained for all populations. A high level summary of the covered benefits in each of the ten essential health benefit categories is provided below, and includes benefits that may differ from the Kentucky Medicaid State Plan in amount, duration, or scope.

The chart below details only the benefits for the new adult group. Benefits will remain consistent with the existing State Plan for all children, pregnant women, medically frail, and other traditional low-income (non-expansion) Medicaid populations transitioning to Kentucky HEALTH. Additional details regarding the ABP benefits will be included in the State’s ABP Medicaid State Plan amendments.

Table 3.1.2(A): Benefits Provided*

Benefit	Description of Amount, Duration and Scope	Reference
Outpatient Services (Ambulatory Patient Services)		
Physician Services	Coverage for office visits and physician services, specialists may require prior authorization.	Mandatory 1905(a)(5)
Outpatient Hospital Services	Coverage for outpatient hospital and clinic services. Prior authorization is required for some services.	Mandatory 1905(a)(2)
Rural Health Clinic Services	Same limitations when provided by the rural health clinic as when provided by the usual ambulatory care provider.	Mandatory 1905(a)(2)
Home Health Care	Limited to 60 visits per year. Prior authorization requirements may apply.	Mandatory for certain individuals - 1905(a)(7)
Telehealth	Complies with Kentucky benefit mandate to not exclude a service from coverage solely because the service is provided through telehealth.	Kentucky Benefit Mandate
Chiropractic	Limited to 1 visit per day and 26 visits per covered person per benefit year.	Optional 1905(a)(6)
Podiatry	Covered but limited to medically necessary care i.e. diabetes care.	Optional 1905(a)(6)
Emergency Services		
Emergency Transportation	Transportation to an emergency department for medical emergencies.	Optional 1905(a)(29), 42 CFR 440.170(e)
Emergency Services	Covers emergency physicians and facilities.	Optional 1905(a)(29), 42 CFR 440.170(e)
Hospitalization		
Inpatient Hospital Services	Covered.	Mandatory 1905(a)(1)
Inpatient Physician Services	Covered.	Mandatory 1905(a)(5)
Maternity and newborn care		
Prenatal and postpartum care	Covered.	Mandatory 1905(a)(5)
Delivery and inpatient maternity services	Covered.	Mandatory 1905(a)(1)
Nurse-midwife services	Covered.	Mandatory 1905(a)(17)
Expanded Services for Pregnant Women –	Services for pregnant women are covered at the level of the Kentucky State Plan.	Optional 1902(e)(5)

Benefit	Description of Amount, Duration and Scope	Reference
Additional pregnancy-related and postpartum services for a 60-day period after the pregnancy ends		
Mental health services and addiction treatment		
Inpatient mental health and addiction treatment	Includes behavioral health services.	Mandatory 1905(a)(1)
Outpatient mental health and addiction treatment	Includes behavioral health services.	Mandatory 1905(a)(2), Mandatory 1905(a)(5)
Prescription drugs		
Prescribed Drugs	Covered.	Optional 1905(a)(12)
Rehabilitative and habilitative services and devices		
Physical Therapy	30 visits per calendar year limit.	Optional 1905(a)(11)
Occupational Therapy	30 visits per calendar year limit.	Optional 1905(a)(11)
Services for individuals with speech, hearing and language disorders	30 visits per calendar year limit.	Optional 1905(a)(11)
Cardiac Rehabilitation	30 visits per calendar year limit.	Optional 1905(a)(11)
Skilled Nursing Facility	Limited to 30 days per benefit period.	Mandatory 1905(a)(4)
Laboratory services		
Laboratory and X-Ray Services	Some imaging services require a prior authorization.	Mandatory 1905(a)(3)
Preventive services		
Preventive Services	“A” and “B” services recommended by the United States Preventive Services Task Force, including recommended smoking cessation services; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children, and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).	Optional 1905(a)(13)
Weight Loss programs	Limited to telephonic and online health coaching.	Optional 1905(a)(13)

Benefit	Description of Amount, Duration and Scope	Reference
Pediatric services		
EPSDT	Limited to children under 21 years of age; Prior Authorization required for orthodontia. Provided in accordance with benefits documented in the State Plan.	Mandatory 1905(a)(4)

* Prior Authorization Requirements may apply to benefits in accordance with standard industry practice.

Table 3.1.2(B): Benefits Not Provided

Benefit	Description of Amount, Duration and Scope	Reference
Private Duty Nursing	Not Covered.	Optional 1905(a)(8)
Non-Emergency Medical Transportation	Not Covered. Waiver requested.	Optional 1905(a)(29)
Hearing Exams	Not covered except for coverage provided via EPSDT benefit for those under age 21.	Optional 1905(a)(13)
Hearing Aids	Not Covered except for coverage provided via EPSDT benefit for those under age 21.	Optional 1905(a)(29)

3.1.3 My Rewards Account Benefit

Kentucky HEALTH carves out vision and dental services for the new adult group; however, this benefit change will occur three months following the initial program implementation date of the program to allow members additional time to accrue funds in their *My Rewards Account*, as these benefits are only provided through this account. Additional optional benefits, including over the counter medications and gym membership, can also be accessed via this account. The *My Rewards Account* provides a benefit incentive program for individuals that meet health and community engagement goals as discussed in *Section 4.1.2*.

Table 3.1.3: My Rewards Account Vision and Dental Carve-out and Additional Benefits

Additional services available through My Rewards Account		
Vision Services	Benefits available as a carve-out for the adult group using their <i>My Rewards Account</i> . These services will be provided in accordance with the State Plan for all other Kentucky HEALTH populations.	Optional 1905(a)(6)
Dental Services		Optional 1905(a)(10)
Over the counter medications	Benefits available for adults eligible for the waiver through their <i>My Rewards Account</i> .	Optional 1905(a)(12)
Gym memberships		1115

3.1.4 Educational Support

Educational attainment is a predictive indicator of health and economic security. However, Kentucky ranks 46th in the nation for percentage of adults 25 or older with a high school diploma

or equivalency.³⁷ In addition, GED certification attainment rates in Kentucky have declined dramatically in recent years, by more than 76%.³⁸ Recognizing that costs may be a significant barrier to GED attainment, Kentucky HEALTH will seek to cover the costs of the member's out of pocket expenses associated with completion of the GED exam for any adult Kentucky HEALTH member without a high school diploma. This benefit will be available to the expansion adult group, as well as other adults on Kentucky HEALTH receiving State Plan benefits, as described in *Table 3.1* above.

3.2 Employer Premium Assistance Program

The State currently operates a small Health Insurance Premium Payment (HIPP) program providing premium assistance to eligible individuals with access to employer-sponsored insurance (ESI). The Kentucky HEALTH employer premium assistance program builds upon this existing program, which will be modified to include all Kentucky HEALTH eligible members through the introduction of family coverage, mandatory participation for members with ESI participating in Kentucky HEALTH longer than one year, and member cost-sharing requirements aligned with Kentucky HEALTH premium contributions.

Eligible employer plans must be cost-effective for the State. The State will ensure that the employer-sponsored plan is cost-effective in accordance with the current methodology for HIPP established in the State Plan. Specifically, a plan will be determined cost-effective when the cost of paying the premiums, coinsurance, deductibles and other cost-sharing obligations, as well as additional administrative costs is estimated to be less than the amount paid for the member's participation in the standard Kentucky HEALTH program. Once determined eligible, the employer premium assistance program will subsidize the member's cost-effective employer plan by paying the member an advance premium reimbursement payment to cover the costs of the employee's share of the premium before it is deducted from the employee's paycheck in accordance with the employer's standard practice. The State will implement a system to ensure members are maintaining coverage before monthly payments are made. Like all other Kentucky HEALTH members, individuals enrolled in their employer-sponsored health plan will be required to pay a sliding scale monthly premium payment based on family income consistent with the amounts established in *Section 4.2*. The advanced reimbursement payment from the State will deduct the individual's required premium contribution.

Once enrolled, the member will have full access to their employer-sponsored health plan benefits and network providers. The Kentucky HEALTH program will act as a secondary payer to the employer plan. Therefore, members will not be subject to additional cost-sharing beyond the flat rate monthly premium required by the State. In addition, the program will wrap-around benefits applicable to their eligibility group to ensure that members have access to all Kentucky HEALTH benefits (and, if applicable, KCHIP specific benefits) not otherwise reimbursed by their employer plan. In addition, the employer premium assistance program will cover all cost-sharing, including copayments and deductibles, required by the

³⁷ Approximately 83.5% of Kentuckians 25 years of age and older have completed high school or high school equivalency. U.S. CENSUS BUREAU, *Educational Attainment, 2010-2014 American Community Survey 5 Year Estimates*, available at:

http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_S1501&src=pt

³⁸ KENTUCKY CENTER FOR ECONOMIC POLICY, *FACING CHALLENGES WITH THE NEW GED TEST IN KENTUCKY* (2015), available at <http://kypolicy.org/dash/wp-content/uploads/2015/12/2015-KY-GED-Report3.pdf>.

employer plan, such that the member will not be exposed to any cost-sharing in excess of their required monthly premium contribution.

As an additional benefit, individuals enrolled in the employer premium assistance program will also be provided a *My Rewards Account*, as described in more detail in *Section 4.1.2*. Individuals in the employer premium assistance program will have the opportunity to earn incentive dollars for the completion of community engagement or health related activities. Members may use the account to purchase enhanced benefits not otherwise covered in the base Kentucky HEALTH benefit package, and therefore will not be wrapped around their employer plan. For example, members enrolled in the employer premium assistance program may use the account to purchase over the counter medication or a membership to a gym.

3.3 Populations Exempt from Alternative Benefits Plans

3.3.1 *Medically Frail*

Individuals in the expansion population who meet the definition of medically frail will be enrolled in Kentucky HEALTH. In accordance with 42 CFR §440.315(f), a person will be determined medically frail if the individual has a disabling mental disorder (including serious mental illness), chronic SUD, serious and complex medical condition, or a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living. For example, medically frail conditions may include, but are not limited to active cancer, aplastic anemia, blood clotting disorders, chronic alcohol or substance abuse, and mental illness, including major depression or bipolar disorder. In addition, individuals otherwise eligible for Kentucky HEALTH who are either receiving hospice care, diagnosed with HIV/AIDs, or eligible for Social Security Disability Insurance (SSDI) will automatically be determined medically frail upon verification of the qualifying condition, and will not be subject to the assessment process described below.

Generally, individuals will be identified as potentially medically frail in several ways: (i) member self-identification to the MCO; (ii) provider identification and referral to MCO; and (iii) MCO identification of high-risk individuals through a standardized state approved health risk assessment and available claims data. Once identified, individuals not otherwise qualifying under one of the automatic medically frail categories will be reviewed and assessed for medically frail. While the MCO will collect the necessary information to complete the assessment, the approval process will be based on objective criteria established by the State. This process will evaluate the severity of the member's health conditions and assign a risk score based on objective criteria, such as specific underwriting guidelines. Individuals with qualifying conditions and scores would be determined medically frail. While this medically frail assessment and determination process will rely primarily on available claims data, new members or newly diagnosed individuals without significant claims history of their health condition will also have the opportunity to submit additional information for consideration. Individuals will have the ability to appeal the medically frail determination in accordance with standard grievance and appeals processes.

Medically frail individuals will receive State plan benefits, which include non-emergency transportation. In addition, medically frail individuals will be exempt from copayments under the Kentucky HEALTH waiver, as detailed in *Section 4.2.1*.

3.3.2 Pregnant Women and Low-Income Families

The following populations covered by Kentucky HEALTH are exempt from the benchmark equivalent benefit package and will be provided the standard Medicaid State Plan benefits, including non-emergency transportation (NEMT) coverage:

- Pregnant women;
- Children under age 19; and
- Parents and caretaker relatives eligible pursuant to Section 1931.

In addition, all children enrolled in Kentucky HEALTH or the employer premium assistance program will continue to be provided full EPSDT benefits.

4 Cost-Sharing

The cost-sharing structure of Kentucky HEALTH differs from the existing State Plan, which currently imposes copayments for services. In lieu of these copayments, Kentucky HEALTH requires all members (except pregnant women, children, and medically frail) to contribute to the cost of their healthcare coverage through the payment of monthly premiums, as detailed in *Section 4.2*.³⁹ While Kentucky HEALTH encourages members to make upfront monthly premium contributions to prepare for commercial market coverage policies, individuals at or below 100% FPL may elect to not make their required premium payments and, instead, continue to be charged copayments for services. The overall Kentucky HEALTH cost-sharing structure is designed to introduce members to critical commercial market features, including making timely monthly premiums, tracking deductibles, and managing a healthcare account.

4.1 Member-Managed Healthcare Accounts

Kentucky HEALTH will be structured as a consumer-driven, high deductible health plan. Members will be provided two member managed healthcare spending accounts, one to cover deductible expenses and the other (the *My Rewards Account*) to accrue savings and earned incentive dollars to purchase optional enhanced benefits. The accounts will work together, creating incentives for members to obtain preventive care, participate in disease management programs, and prudently manage their spending from both accounts. In addition, member oversight and control of the accounts will provide beneficiaries the skills and training to help prepare them to eventually manage health savings accounts or flexible spending accounts available in the private market.

Pregnant women and children enrolled in Kentucky HEALTH will not be required to make monthly premium contributions, nor will their benefit plans include a deductible. Therefore, these covered populations will not be provided a deductible account. However, pregnant women are eligible to earn incentive dollars and utilize the *My Rewards Account*.

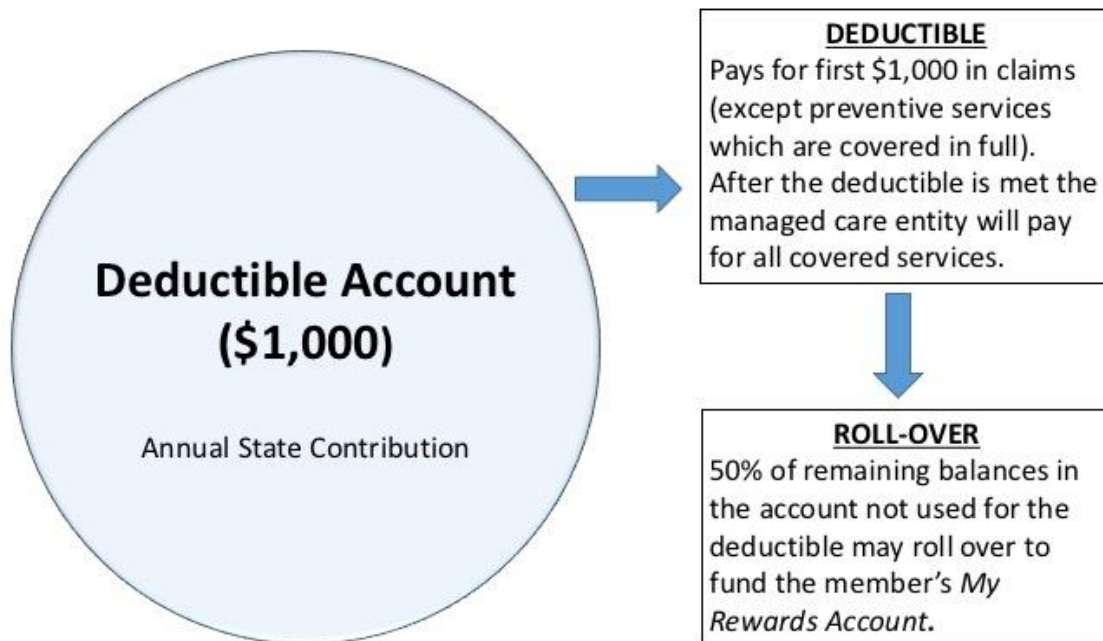
4.1.1 Deductible Account

Similar to most commercial health products and those offered in the Marketplace, Kentucky HEALTH will include a \$1,000 deductible that applies to all non-preventive healthcare services. However, each member will be provided a fully funded deductible account equal to \$1,000,

³⁹ Pregnant women and children are exempt from all cost-sharing requirements of the waiver. However, while medically frail members are not subject to cost-sharing as a condition of participation, monthly premiums will be required for medically frail members to obtain the benefits of the *My Rewards Account*.

which will be immediately available to cover the initial medical expenses for the deductible. Members will receive monthly account statements detailing the cost of each service utilized during the month and the overall account balance so the member may learn about the cost of healthcare services and begin to actively manage the account and their healthcare utilization.

To further encourage this effort, the deductible account will provide financial incentives to prudently manage the State funds in the account. At the end of the benefit period, members who have a balance remaining in their deductible account may transfer 50% of the total remaining balance to their *My Rewards Account* to purchase enhanced benefits. The deductible account exposes members to the cost of healthcare and encourages them to act as consumers of healthcare by evaluating cost and quality as they seek care.



4.1.2 *My Rewards Account*

All Kentucky HEALTH and employer premium assistance program members, with the exception of children, will be provided a *My Rewards Account*, which may be used to access benefits not covered in the base benefit plan. In addition to the balances carried over from the Kentucky HEALTH deductible account each year, the *My Rewards Account* will also contain incentive dollars that members may earn by completing specified activities. Qualifying activities are designed to improve member health (i.e. disease management class) or to increase community engagement (i.e. volunteer work, public service opportunities, or job search and training activities). In addition, adult Kentucky HEALTH members without a high school diploma will also be rewarded for improving their employability through obtaining a GED. To remove potential cost barriers for taking the exam, Kentucky HEALTH will cover the costs for the out-of-pocket expenses associated with completing the GED exam as a program benefit.

Some activities can be accomplished immediately upon enrollment to quickly bolster the *My Rewards Account*, such as completion of a new member health risk and/or an employment

assessment within the first quarter following plan enrollment. In addition, each reward activity type will be capped so a member must complete different activities in order to receive additional funds in the reward account. Also, for purposes of clarification, community engagement activities listed in the chart below will only qualify for reward activity dollars for hours completed in excess of the minimum requirements established for the community engagement and employment initiative, detailed in *Section 2.2*. For example, individuals who complete work search activities as part of their program eligibility requirements will not be eligible to receive credits to their *My Rewards Account* for the same work search activities. My Rewards Account credits will only be provided for community engagement activities in excess of the minimum amount required to maintain eligibility.

Incentive activities may include any of the activities detailed in the table below, which will be further refined prior to program implementation.⁴⁰ In addition to the general activities below, pregnant women will be able to obtain reward dollars for completion of activities important to promoting healthy babies, such as completion of prenatal care visits.

Table 4.1.2(A): My Rewards Account Earned Incentive Activities

Community Engagement Activities		Health Incentive Activities	
Activity	Earned \$*	Activity	Earned \$*
Register with Career Center and complete job needs assessment	\$150 (one-time only)	Complete health risk assessment with MCO	\$25 (1 st quarter, limit one per year)
Participate in qualifying community service activity (including caretaking services)**	\$10 per event (max \$50 per year)	Complete diabetes, cardiovascular, or other chronic disease management, or weight management course	\$50 per course
Complete job skills training or training with career coach	\$25 per course (max \$50 per year)	No inappropriate ER Visits Within 12 months	\$20 per year
Complete job search activities	\$10 per month	Sign non-smoking pledge & participate in smoking cessation activity	\$50 per course
Employment-related education or GED-prep classes	\$25 per course (max \$50 per year)	Sign drug-free pledge & participate in drug addiction counseling services	\$50 per activity
Passing the GED exam	\$50 (one-time only)	Complete well-child, preventive dental exam, or vision screening for dependent child.	\$10 per activity (max \$40 per year)

In addition to the community engagement and health incentives reward activities, the *My Rewards Account* will also incentivize appropriate healthcare utilization, including appropriate

⁴⁰ *Amounts and listed activities are for illustrative purposes only and may be adjusted.

** Qualifying caregiving services include those provided for a non-dependent relative or other person with a chronic, disabling health condition.

use of hospital emergency departments as well as keeping scheduled appointments for healthcare services.

Kentucky HEALTH encourages all members to seek care in the most appropriate setting possible, including avoiding the use of hospital emergency departments (one of the most costly settings) except in the case of a true emergency. In 2015, nearly 125,000 Medicaid managed care enrollees utilized a hospital emergency room for a non-urgent condition.⁴¹ Therefore, consistent with the plan structure, the Kentucky HEALTH emergency room utilization policy relies on complementing incentives and disincentives. To encourage appropriate emergency room utilization, members will be eligible for a \$20 financial contribution to their *My Rewards Account* for each year in which the member avoids unnecessary emergency room services and seeks appropriate alternative providers for care. In addition, Kentucky HEALTH will simultaneously discourage inappropriate emergency room utilization by deducting funds from the member's *My Rewards Account* for each inappropriate emergency room visit. The amount of the penalty will escalate in accordance with the table below for each subsequent unnecessary emergency room visit. The State will also ensure that hospitals comply with 42 CFR 447.54(d) in educating members about appropriate alternative settings.

Table 4.1.2(B): Escalated *My Reward Account* Penalty for Inappropriate ER Utilization

Inappropriate ER Visit	Account Deduction
1 st Visit	\$20
2 nd Visit	\$50
3 rd Visit or More	\$75

In addition, the State will consider developing a similar complementing incentive and disincentive feature related to excessive missed healthcare appointments, whereby members may earn reward dollars for keeping all scheduled appointments in the benefit period, or, in the alternative, lose dollars from the account for each healthcare appointment missed without adequate cancellation or good cause. The proposed *My Rewards Account* penalty amounts are not member copayments and do not utilize member out-of-pocket funds.

Members maintain the *My Rewards Account* as long as they are enrolled in the program and continue to make their required monthly premium contributions. Each year the full balance of the *My Rewards Account* will roll-over to the subsequent year to be used for the purchase of qualifying enhanced benefits. In addition, as an incentive and reward for members to obtain employment, the balance of the *My Rewards Account* will be transferable to reward members who are successful in finding a path to long-term stable employment and independence from public assistance. Specifically, former members who are able to maintain stable employment and remain commercially insured without Medicaid for at least eighteen months may apply to receive the balance remaining in their *My Rewards Account*, up to \$500.

⁴¹ Kentucky Department for Medicaid Services, CY 2015 Non-Emergent ER Visits (May 26, 2016) (on file with the State).

This reward opportunity not only provides an additional work incentive complementing Kentucky HEALTH community engagement and employment initiative requirements, it also provides members an incentive to accumulate earned incentives dollars in the account and to prudently manage those funds. Members that leave the program but transition back to Kentucky HEALTH prior to eighteen months will have their *My Rewards Account* reactivated at its ending balance and will be able to access the full balance of their account for the purchase of enhanced services.

Ultimately, the two member managed accounts coordinate incentives to drive member behavior in positive ways. The deductible account incentivizes the member to prudently manage the account by obtaining preventive care and seeking price transparency in order to maximize roll-over amounts. Similarly, the *My Rewards Account* encourages members to actively participate in healthy behaviors, such as participation in disease management courses. In addition, the member is incentivized to carefully manage the *My Rewards Account* to maximize the potential cash-out reward. Fundamentally, through these many layered incentives, Kentucky HEALTH empowers members to become active members in their healthcare.

4.2 Member Required Contributions

As a condition of eligibility, all Kentucky HEALTH members, with the exception of medically frail individuals, pregnant women, and children, will be required to make sliding scale flat rate monthly premium payments based on family income. The payment rates are affordable and established to be less than 2% of household income across each income threshold payment band. As these amounts are established based on household income, the premium payment applies towards all Kentucky HEALTH members in the household, such that premiums will not be collected on a per person basis. As long as the required monthly premiums are paid, Kentucky HEALTH will not require additional cost-sharing for services. Except for medically frail members who are exempt, copayments for healthcare services will only be charged for Kentucky HEALTH enrolled adults with income below 100% FPL who fail to pay their required premiums.

Table 4.2(A): Kentucky HEALTH Sliding Scale Premium Contribution Amounts

Federal Poverty Level	Premium Payment
Under 25% FPL	\$1.00 per month
25-50% FPL	\$4.00 per month
51-100% FPL	\$8.00 per month
101-138% FPL	\$15.00 per month

Consistent with the goal of encouraging community engagement, the State will permit third parties to pay required premium payments on behalf of a member. Non-profit organizations, provider groups, and other third parties may assist members in their monthly premium responsibilities. However, these premium payments are critical to member engagement, as studies have shown that making regular monthly premiums may actually lead to better health outcomes for members. In Indiana, where Medicaid eligible adults are required to pay monthly premiums equal to 2% of income, members making

contributions had higher satisfaction rates, higher primary and preventative care utilization, higher drug adherence, and lower emergency room use than those who did not.⁴²

In addition, Kentucky HEALTH is intended to be a temporary stepping stone for able-bodied low-income adults. It seeks to encourage employment and assist individuals as they move from dependence on public assistance to independence. To avoid “coverage cliffs” and help prepare members to transition to Marketplace coverage, individuals with income greater than 100% FPL will be subject to gradually increasing premium contributions beginning in the member’s third year of enrollment. The cost-sharing will increase incrementally by 50% of the original base premium amount each year the individual remains on Kentucky HEALTH, in accordance with the table below. The escalating payment rates continue to be affordable, and even at the maximum premium amount of \$37.50, the payment represents less than 4% of income (below Medicaid’s 5% of income maximum allowable cost-sharing amount). The increasing premium requirement will also be applied to individuals enrolled in employer premium assistance program receiving premium assistance to participate in their employer-sponsored health plan. Ultimately, the increased cost-sharing requirements bring the premium amounts more in line with the premiums required in the Marketplace, and discourages Medicaid dependency by preparing individuals for the costs associated with commercial or Marketplace coverage.

Table 4.2(B): Sliding Scale Increased Premium Amounts for Individuals Over 100% FPL

FPL	Year 1-2 Premium	Year 3 Premium	Year 4 Premium	Year 5+ Premium
101-138% FPL	\$15.00	\$22.50	\$30.00	\$37.50

4.2.1 Non-Payment Penalties

Members will be provided a 60-day grace period to make their required monthly premium payment. Similar to commercial plans, Kentucky HEALTH will impose consequences for non-compliance in order to help educate members about standard commercial market policies. Therefore, individuals who do not elect to pay a required premium payment within sixty calendar days from the due date will face a six-month non-payment penalty. The non-payment penalty varies based on whether the member has income above or below federal poverty in accordance with the table below. However, recognizing that Kentucky HEALTH is intended to educate and ease individuals into commercial market policies, members will have the opportunity to end their non-payment penalty period sooner than six months, as detailed below in *Section 4.2.2*.

Table 4.2.1: Non-Payment Penalty

Member FPL	Non-Payment Penalty	Early Re-Entry Option
Above 100% FPL	<ul style="list-style-type: none"> Disenrolled from Kentucky HEALTH Re-enrollment waiting period of six months 	<ul style="list-style-type: none"> Pay past debt; Pay premium for reinstatement month; and
At or below 100% FPL	<ul style="list-style-type: none"> State Plan copayments required for all services \$25 is deducted from the <i>My Rewards Account</i> <i>My Rewards Account</i> is suspended 	

⁴² THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0 INTERIM EVALUATION REPORT (2016), available at http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

	<ul style="list-style-type: none"> ○ Not able to use funds in account ○ Not able to accrue funds in account ● No impact to eligibility 	<ul style="list-style-type: none"> ● Participate in financial or health literacy course
Medically Frail	<ul style="list-style-type: none"> ● <i>My Rewards Account</i> is suspended <ul style="list-style-type: none"> ○ Not able to use funds in account ○ Not able to accrue funds in account ● No impact to eligibility ● No copayments required 	
Pregnant Women and Children	Not applicable. Exempt from all cost-sharing requirements.	Not applicable

Members with annual income above 100% FPL, who are not medically frail or otherwise exempt from cost-sharing, will be disenrolled from Kentucky HEALTH for non-payment following the sixty-day grace period. Further, consistent with the commercial market, members terminated from Kentucky HEALTH due to non-payment will be required to wait six months to re-enroll, unless they meet the criteria for early re-entry as detailed below in *Section 4.2.2*. This policy helps prepare individuals for Marketplace policies, which suspend claims payment after thirty-day payment delinquency, terminate coverage after ninety days, and prevent reenrollment until the next annual open enrollment period.

Individuals who are determined medically frail in accordance with *Section 3.3.1* are not subject to disenrollment due to non-payment of premium, even if income is greater than 100% FPL. In addition, medically frail individuals are exempt from the imposition of copayments following non-payment of premium, however, access to the member’s *My Rewards Account* will continue to be conditioned on payment of premiums.

Individuals below the FPL that choose not to make payments will not lose coverage. However, in lieu of disenrollment, individuals with annual income at or below 100% FPL will be subject to a six-month non-payment penalty period in which they will be subject to copayments. Required copayments during the member’s non-payment penalty period will be equal to the current copayments scheduled in the Kentucky Medicaid State Plan, which range from \$3.00 for physician office visits and up to \$50.00 for hospital inpatient services. A detailed copayment schedule is set forth in 907 Kentucky Administrative Regulations 1:604. In addition to copayments, \$25.00 will be deducted from the member’s *My Rewards Account*, and the account will be suspended for six months, thus prohibiting access to the enhanced benefits. During this period, the account is effectively “frozen” and members will not be permitted to use the account or earn additional contributions to the account. The potentially increased cost-sharing along with the reduced benefits create an incentive for members to make consistent monthly premium payments to maintain health insurance coverage, while also maintaining a safety net for individuals who are below the FPL or medically frail.

4.2.2. Early Re-Entry Opportunity

While the penalties above are created to encourage compliance, Kentucky HEALTH ensures that members have opportunities to return to full benefits at any time. All members in a non-

payment penalty period will be provided the opportunity to re-enter the standard program with full access to their plan and the *My Rewards Account* benefits prior to the expiration of the six-month non-payment penalty period. Early re-entry requires the individual to pay outstanding premium payments and complete a financial or health literacy course. Specifically, the individual would be required to pay a one-time payment equal to three months of premium contributions. This re-entry premium amount would effectively cover the two months of debt in which the member received healthcare coverage during the 60-day grace period prior to the effective date of the non-payment penalty, as well as the advance premium payment required to restart coverage.

In addition to the re-entry payment, individuals seeking early re-entry will be required to attend a financial or health literacy course. The financial literacy course will educate members on the basics of money management to assist individuals in increasing income, paying debt, and achieving financial stability, while the health literacy course will educate members on enrollment policies, managing healthcare expenditures, and appropriate use of healthcare services. Completion of a course is voluntary but will allow members to regain eligibility prior to the end of the six-month non-payment penalty period.

4.3 Cost-Sharing Exemption

Pregnant women and children will be exempt from all cost-sharing required under the waiver. In addition, medically frail members will not be required to pay premiums as a condition of participation in Kentucky HEALTH. However, premium payment will be a condition to access the member’s *My Reward Account*. In the event of non-payment, all medically frail members will be exempt from the imposition of copayments. In addition, Kentucky HEALTH covers several other populations exempt from alternative benefit plan (ABP) enrollment, and these populations will be subject to modified cost-sharing as detailed in the table below.

Table 4.3: Cost-Sharing for Exempt Populations

Applicable Policies	Children	Pregnant Women	Section 1931 Parents	Medically Frail
Premiums	No premiums	No premiums	Yes	Optional
Copayments	Consistent with current State Plan	No copayments	Copayments only if fail to pay premium	No copayments
Deductible Account	No	No	Yes	Yes
My Rewards Account	No	Yes	Yes	Yes
Non-Payment Penalty	Not applicable	Not applicable	Copayments and Suspension of <i>My Rewards Account</i>	Suspension of <i>My Rewards Account</i>

5 Delivery System and Payment Rates for Services

Consistent with the current Medicaid expansion program, Kentucky HEALTH will continue to be operated through a managed care delivery system. In addition to the new requirements for members, Kentucky HEALTH will also increase accountability of the healthcare system by adding new payment

incentives aimed at furthering the “Triple Aim” of improving the patient experience, improving population health, and lowering costs.

5.1 Delivery System Reforms

The creation of the Kentucky HEALTH program is just one part of an overall Medicaid transformation initiative being undertaken by the State to improve quality, access, efficiency and value in healthcare. Through this demonstration project, Kentucky will make significant delivery system reforms to improve quality and outcomes, including efforts related to substance use disorders, chronic disease management, and general managed care reforms. Further, to support each of these delivery system initiatives, the State will continue to strengthen its data collection efforts. The State will implement an initiative to improve data collection, including appropriate interoperability of data, and ensure that data driven decisions are aligned with overall goals to further improve quality and outcomes across the delivery system.

5.1.1 Substance Use Disorder Delivery System Reform Pilot Program

A report from the Substance Abuse and Mental Health Services Association (SAMHSA) estimated the prevalence of SUD among Medicaid eligible adults at 21%.⁴³ Applied to Kentucky’s expansion population, it is estimated that nearly 90,000 newly enrolled Kentuckians may have a SUD requiring treatment. In 2014 with the expansion of Medicaid, Kentucky greatly expanded coverage to mental health and SUD treatment options, allowing Medicaid recipients to receive coverage for the full spectrum of inpatient and outpatient SUD services. However, coverage of benefits means little without access to providers.

Federal law generally prohibits federal financial participation for medically necessary Medicaid services provided to adults aged 21 through 64 in certain facilities that meet the federal definition of an institution for mental disease (IMD), specifically, free-standing psychiatric hospitals with more than 16 beds. In Kentucky, there are 26 qualified mental health facilities capable of providing covered mental health and SUD services to Medicaid recipients with SUD, however, they are prohibited from doing so due to the IMD exclusion. Instead, individuals in need of mental health or SUD inpatient services must either travel long distances out of their communities to access services and/or experience long wait times for a bed to open, putting the individual at risk of experiencing a crisis and ending up in either the criminal justice system or high-cost hospital emergency departments.

Kentucky currently faces a drug abuse epidemic, and access to the Medicaid program’s comprehensive mental health and SUD benefits is critical. In July 2015, CMS issued a letter indicating a willingness to offer states a waiver of the IMD exclusion, provided the State also develops broad based reforms regarding the provision of SUD services to Medicaid recipients. The State will explore this opportunity through pilot programs in ten to twenty select high-risk counties. Counties will be identified based on the recent CDC HIV/hepatitis C outbreak study

⁴³ SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, BEHAVIORAL HEALTH TREATMENT NEEDS ASSESSMENT TOOLKIT FOR STATES, PUB. NO. SMA13-4757 (2013), *available at* <https://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf>.

described in *Section 1*, the State's existing Shaping Our Appalachian Region (SOAR) initiative,⁴⁴ and public input received during the demonstration waiver public notice and comment period.

The pilot program will seek to increase access to mental health and SUD services through a waiver of the IMD exclusion to allow federal financial participation for covered services provided to Medicaid eligible adults ages 21 through 64 residing in an IMD for short-term residential stays of up to thirty days. The pilot programs are intended to evaluate the impact of increased access to treatment in IMD's. The State will work with CMS in the design of the pilot project, examining the current mental health and SUD delivery system for best practice improvements related to standards of care, inclusion of recommended SUD as well as HIV quality indicators, care coordination between levels and settings of care, and strategies to address prescription drug abuse and opioid use disorder.

In addition, Kentucky intends to align standards of care for SUD treatment with the national best practice criteria set forth by the American Society of Addiction Medicine in the pilot counties. To further improve the quality and consistent delivery of these services, the State will also require certain SUD treatment providers to become accredited.

5.1.2 Chronic Disease Management

Several Kentucky HEALTH program components have been designed to support existing statewide efforts to improve chronic disease prevention and management. For example, the Kentucky HEALTH *My Rewards Account*, described in *Section 4.1.2*, will incentivize members to participate in a variety of health activities including health risk assessments, chronic disease or weight management courses, and smoking cessation programs, many of which are already offered through State and local health departments across Kentucky.

The State will also explore encouraging, through its contracts, MCO participation in existing initiatives designed to drive public health outcomes and focused on Kentucky Department for Public Health (DPH) key priorities, which currently include, but are not limited to, diabetes, obesity, cardiovascular disease, lung cancer, and substance use disorder. State-based programs include, but are not limited to, the Kentucky Diabetes Prevention and Control Program and the Kentucky Tobacco Prevention and Cessation Program.

In addition, the State will continue participation in existing federal programs, such as the National Diabetes Prevention Program (DPP), a Centers for Disease Control and Prevention (CDC)-supported program aimed at preventing or delaying type two diabetes for at-risk individuals. The DPP consists of a series of group counseling sessions focused on nutrition and physical activity targeted to individuals that meet specific at-risk diagnostic criteria, including body mass index greater than 24 and elevated blood sugar levels within pre-diabetic range. The DPP has been evaluated and shown effective at preventing the development of type 2 diabetes by the National Institutes of Health and the CDC.

5.1.3 Managed Care Reforms

All of the populations that will transition to Kentucky HEALTH currently receive medical benefits through an MCO. Kentucky HEALTH will continue to provide services through the current MCOs.

⁴⁴ The SOAR initiative seeks to expand job creation, enhance regional opportunity, innovation, and identity, improve the quality of life, and support all those working to achieve these goals in Appalachian Kentucky.

However, in order to implement the programmatic changes resulting from this Section 1115 demonstration project, the State will update existing managed care contracts. While the State has already taken a critical look at its managed care rates, it will continue to make several additional contract reforms to reduce the inflated managed care profits which are nearly five times the national average.⁴⁵ The contracts will be further revised to control the rate of growth and trends, ensure that the MCOs are spending more of their capitation on medical benefits, and incorporate other contract efficiencies to ensure value. In addition, MCOs will no longer be able to waive copayments.

In addition, the Kentucky HEALTH contract revisions will seek to further the “Triple Aim” of improving the patient experience, population health goals, and lowering costs. First, this waiver will add initiatives to the managed care program consistent with industry standards and aligned with CMS quality payment guidelines. The MCOs will be contractually required to develop innovative provider contracting strategies aimed at transitioning from a reimbursement model that rewards providers solely based on volume, to a model that aligns payment incentives with quality performance and outcomes. Through this initiative each MCO will be required to ensure a meaningful portion of its total Medicaid population is participating in a purchasing arrangement that aims to achieve improvements in population health outcomes and decrease total costs of care for the participating population.

In addition, the State will introduce new MCO payment incentives for quality performance and outcomes for both the MCOs and providers participating in Kentucky HEALTH. The MCOs operating Kentucky HEALTH will be subject to a quality withhold, in which a portion of the capitation payment is withheld and eligible to be paid to the MCO following achievement of specified quality health outcomes. The outcome measures will be designed to align with the overall Kentucky HEALTH program goals, such as increasing the number of members who receive preventive services, reduced smoking rates, and demonstrated improvement in health of members participating in disease management programs (e.g., diabetes programs).

MCOs will also be required to implement a provider bonus program, in which providers may earn a quality bonus from the MCO. The bonus will be aligned to encourage provider participation and support of the same member health activities incentivized by the *My Rewards Account*. By ensuring that the MCO, provider, and member incentives are aligned, Kentucky HEALTH seeks to make a measurable impact on member health over the course of the five-year demonstration period. Further, the State will pursue several additional managed care system reform measures aimed at improving the efficiency and responsiveness of the current managed care delivery system. For example, on the enrollee level, the State will look to implement strategies to improve MCO call center performance. For providers, the State will include MCO contract provisions aimed at aligning processes and establishing consistencies in administrative

⁴⁵ The average underwriting ratio (profit margin) for Kentucky’s five Medicaid MCOs was reported at 11.3%, significantly above the national average of 2.6% (3.3% for expansion states). JEREMY D. PALMER & CHRISTOPHER T. PETTIT, MILLIMAN, MEDICAID RISK-BASED MANAGED CARE: ANALYSIS OF FINANCIAL RESULTS FOR 2015 (2016), available at <http://www.milliman.com/uploadedFiles/insight/2016/medicaid-risk-based-managed-care-analysis-2015.pdf>.

requirements across the contracted MCOs, such as formulary alignment efforts and uniform credentialing processes.

5.2 Managed Care Delivery System

Kentucky HEALTH will utilize a statewide mandatory managed care delivery system for all populations covered under this demonstration waiver. Only eligible members participating in the employer premium assistance program will be exempted from mandatory managed care enrollment under this demonstration.

Table 5.2: Managed Care Enrollment Table

Eligibility Group	Managed Care Enrollment	Note
New adult population	Mandatory	Freedom of Choice Waiver Requested
Parents and other caretaker relatives		
Transitional medical assistance		
Pregnant women		
Newborn Children		
Infants and Children Under Age 19		
Title XXI Separate CHIP Program		

The State currently contracts with MCOs previously selected through a competitive procurement process. The State intends to renegotiate and amend the existing contracts to implement Kentucky HEALTH. Therefore, since Kentucky HEALTH will be built off of the State’s well-established statewide managed care program, the Kentucky HEALTH managed care implementation will not be phased in, but will rather roll-out on a statewide basis. The MCOs operating in the State are compliant with provider network adequacy standards. However, prior to the implementation of Kentucky HEALTH, the State will conduct readiness review to ensure operational readiness for Kentucky HEALTH.

5.3 Health Plan Choice

Consistent with current processes, Kentucky HEALTH applicants will be able to select one of the MCOs operating statewide at the time they apply. If a member does not actively choose an MCO, the individual will be auto-assigned to a health plan. The member will be provided the opportunity to select a new MCO until such time that the individual makes their first premium contribution. However, once the individual is fully enrolled and begins coverage under Kentucky HEALTH, the member must remain with the selected MCO for the duration of the member’s twelve-month benefit period. The State will seek a waiver of the ninety-day managed care choice period in order to mirror commercial market policies, which do not permit health plan selection changes outside of annual open enrollment periods. Notwithstanding the foregoing, Kentucky HEALTH members will be permitted to change MCOs at any time during the benefit period due to one of the “for cause” reasons described in 42 CFR 438.56(d)(2), such as poor quality of care.

5.4 Excluded services

All Kentucky HEALTH covered services will be provided through a managed care delivery system, except for long-term care services. Consistent with the current processes, the MCO will not be responsible for a member’s nursing facility costs during the first thirty days; however, if a member is admitted to a nursing facility, the MCO will be required to cover the costs of any health services provided to the member while the member resides in the nursing facility, for up to thirty days, until the individual is

disenrolled from the MCO. In addition, all covered benefits that will be wrapped around an employer premium assistance program member's employer-sponsored health plan will be excluded from managed care, and will be reimbursed on a fee-for-service basis.

5.6 Fee-for-service

The only covered services that will be provided under fee for services are benefits that are wrapped around employer-sponsored health insurance for individuals enrolled in the employer premium assistance program. Member premiums for such individuals will be paid to the employer, and services not covered by the employer plan will be paid on a fee for service basis to the rendering provider. Such payments will not deviate from State Plan provider payment rates. In addition, the State may carve out the services provided through the *My Rewards Account* from managed care, and reimburse on a fee-for-service basis.

5.7 Capitated payments

As the State updates the contracts with the existing MCOs, the State will also adjust the capitation rates to reflect program changes resulting from this demonstration program. All risk-based capitation rates will be developed based on federal regulations and actuarial standards of practice, as well as reflect the historical experience of all populations with eligibility under this program. The capitation rate development process will not deviate from the payments and contracting requirements under 42 CFR 428.

5.8 Quality

All quality initiatives and quality related payments will be detailed in the Scope of Work with the MCOs, as well as the State's quality strategy. Quality related withhold incentives will be included in the updated MCO contracts, as described in *Section 5.1.2* of this demonstration application. In addition, all MCOs will continue to be required to submit Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. Further, MCOs will be required to report on additional quality measures and data targeted by the State and required for the evaluation of the Kentucky HEALTH waiver.

6 Implementation of Demonstration

The State will implement the Kentucky HEALTH program on a statewide basis on or about six months post-approval, however, this date may vary depending on the approval date from CMS. Notwithstanding the foregoing, the Kentucky HEALTH community engagement and employment initiative may be phased in on a county basis. Prior to implementation and enforcement of the initiative, each county will be assessed to ensure adequate resources are available to members residing in the county seeking to fulfill the community engagement, job training, and employment hour requirements. Further, staggered implementation of this new demonstration initiative will allow for measured review of the policy impact. In addition, the changes to the current vision and dental coverage will be implemented three months after the Kentucky HEALTH waiver is implemented. This three month delay will provide members the opportunity to maintain existing vision and dental coverage while accumulating available funds in their *My Rewards Account*. During this time, the State will work with various provider and stakeholder groups as well as the MCOs to aggressively communicate and educate members about the *My Rewards Account* and changes to the benefits.

Implementation of Kentucky HEALTH will require the State to amend existing managed care contracts, modify systems and other operational procedures, and conduct readiness review with the various State

vendors. In addition to these tasks, the State will also have to amend the State Plan, amend the ABP, develop State, MCO and member education materials, and prepare to transition existing members.

6.1 Enrollment

Due to the significant enrollment in the State's Medicaid program following the implementation of Medicaid expansion, the State anticipates that most eligible individuals already have Medicaid coverage, and will transition to Kentucky HEALTH from their existing Medicaid coverage. However, the State will initiate an effort to educate members about changes and will partner with stakeholder groups throughout the implementation process to ensure all potential members are notified of upcoming program changes.

The State will begin targeting formal communication and education activities to enrollees and stakeholders beginning at least ninety days prior to the anticipated implementation date. All current Medicaid populations transitioning to Kentucky HEALTH will be notified in writing at least sixty days prior to the implementation of changes to their benefits. At this time, members will also be notified of their new required monthly premium amount. Upon the implementation date, all covered populations will transition to coverage under Kentucky HEALTH, and will be provided their initial premium invoice, which will be due no later than sixty days from the date of implementation. The State and MCOs will be trained and prepared to assist members with questions regarding program changes, premium requirements, and methods of making payments. Efforts will be made to allow for use of a variety of payment methods, including money order, personal check, credit card, bank debit card, prepaid debit card, and cash. During the initial transition, the MCOs will make outbound calls to all transitioning members who are at risk of missing the initial payment date to encourage and assist them in making a contribution.

6.2 Managed Care

Kentucky HEALTH will utilize existing MCOs to provide benefits to Kentucky HEALTH enrollees. The State will not conduct procurement action prior to implementation, but will rather amend current contracts and conduct readiness review with the MCOs prior to final implementation of Kentucky HEALTH. However, current managed care contracts will expire during the course of the five-year demonstration and the State will conduct re-procurement activities as necessary.

7 Demonstration Financing and Budget Neutrality

A detailed financing and budget neutrality narrative is attached as **Attachment II** to this demonstration waiver application, and the detailed budget neutrality worksheet template prepared by Milliman Inc. is attached as **Attachment III**.

8 List of Proposed Waivers and Expenditure Authorities

8.1 Title XIX Waivers

Below is a list of proposed waivers necessary to implement Kentucky HEALTH:

1. Eligibility: Section 1902(a)(10)(A)

- To the extent necessary to enable Kentucky to not provide medical coverage until the first day of the month in which the Kentucky HEALTH member pays their first premium payment,

or for members below 100% FPL who fail to make an initial premium payment, the first day of the month following the expiration of the sixty-day payment period.

- To the extent necessary to enable Kentucky to require Kentucky HEALTH members, as a condition of eligibility, to complete specified community engagement hours.

2. Retroactive Eligibility: Section 1902(a)(34)

- To the extent necessary to enable Kentucky to not provide medical coverage for any month prior to the month in which the member finalized enrollment in Kentucky HEALTH.

3. Cost-Sharing: Section 1902(a)(14) insofar as it incorporates 1916 and 1916A

- To the extent necessary to enable Kentucky to require monthly premium payments not to exceed 5% of income, but no less than \$1.00 per month, for all Kentucky HEALTH members.

4. Amount, Duration, and Scope: Section 1902(a)(10)(B)

- To the extent necessary to enable Kentucky to vary cost-sharing requirements, such that premium contribution amounts increase each year for members with income above 100% FPL who remain on Kentucky HEALTH, not to exceed 5% of income, and to charge copayments in lieu of premiums for individuals at or below 100% FPL who fail to make their premium payment within the sixty-day payment period.
- To the extent necessary to allow Kentucky HEALTH members who continue to pay premium contributions to use their *My Rewards Account* to purchase specified enhanced benefits not otherwise available in the base Kentucky HEALTH benefit package.
- To the extent necessary to enable Kentucky to allow individuals to receive the benefits provided through their employer-sponsored plan.

5. Reasonable Promptness: Section 1902(a)(3)/Section 1902(a)(8)

- To the extent necessary to enable Kentucky to delay benefits, such that benefits do not begin until a member makes a premium contribution, or until the expiration of a sixty-day payment period for members below 100% FPL who fail to make a premium contribution.
- To the extent necessary to enable Kentucky to prohibit re-enrollment for up to six months for Kentucky HEALTH members above 100% FPL who are disenrolled for failure to make their required premium contributions within sixty days of the due date.
- To the extent necessary to enable Kentucky to implement an open enrollment period for Kentucky HEALTH, such that members who are disenrolled for failure to complete the redetermination process will be required to wait until their next open enrollment period to re-enroll (up to six months).

6. Freedom of Choice: Section 1902(a)(23)

- To the extent necessary to enable Kentucky to restrict the freedom of choice of providers for demonstration eligibility groups.

7. Non-Emergency Transportation: Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53

- To the extent necessary to relieve Kentucky of the requirement to assure non-emergency medical transportation to and from medical providers for Kentucky HEALTH members.

8.2 Costs Not Otherwise Matchable

The State requests that expenditures related to providing services in an IMD, in participating pilot project counties, as well as costs associated with providing GED testing fees as a covered benefit for

Kentucky HEALTH enrolled adults without a high school diploma, be regarded as expenditures under the State's Medicaid Title XIX State Plan.

9 Public Notice & Public Comment

Kentucky Department for Medicaid Services provided the public the opportunity to review and provide input on this §1115 demonstration waiver in accordance with the requirements set forth at 42 CFR §431.408. Governor Bevin publically announced the Kentucky HEALTH waiver application on June 22, 2016. Public notice was also provided the same day to formally open the 30-day public comment period, which ended at 5:00 p.m. on July 22, 2016. However, in response to the volume of comments that were submitted on the final day of the comment period, including after the 5:00 p.m. deadline, the State extended the comment period through 11:59 p.m. on August 14, 2016. The extension allowed for the numerous comments that came in after the official deadline to be incorporated, as well as allowed any individual who was unable to comment previously the opportunity to do so.

A copy of the full public notice that announced the three public hearings is included in **Attachment IV** of this waiver application. The notice was posted on the Cabinet for Health and Family Services website at the web address of the Section 1115 waiver program's homepage: <http://chfs.ky.gov/kentuckyhealth>. In addition, the formal public notice was also published in newspapers in the Commonwealth which serve a population of at least 50,000 (which included more areas than the minimum threshold required under the federal regulation). Electronic copies of all documents related to the Kentucky HEALTH waiver application were also available on the above listed waiver website throughout the comment period.

Although federal regulations only require two public hearings, the Commonwealth held three formal public hearings in geographically distinct areas of the state during the public comment period. In accordance with the notice, three public hearings were held on the following dates and locations as scheduled and publicized: (1) June 28, 2016 in Bowling Green, Kentucky; (2) June 29, 2016 at the Advisory Council for Medical Assistance (MAC) Special Meeting in Frankfort, Kentucky; and (3) July 6, 2016 in Hazard, Kentucky. In addition, although federal regulations do not require telephonic and/or web conference capabilities be made available if at least two public hearings were held in geographically distinct areas of the state, a toll-free conference call line was made available for the June 28th hearing, and live internet streaming was available for both the June 28th and July 6th hearing dates. All of the public hearings followed the same format, beginning with an overview of the Kentucky HEALTH waiver proposal, a brief question and answer session, followed by the collection of formal public comments. A court reporter transcribed and entered into the public record all verbal comments presented during each of the public hearings.

On June 29, 2016, a special Medicaid Advisory Committee (MAC) meeting was held to provide an overview of the waiver to the committee members and receive comments from the public. Prior to taking public comment at this meeting, committee members were provided the opportunity to raise questions or concerns about the waiver. The questions raised spanned a variety of topics and were primarily technical in nature. For example, committee members sought clarification on how CHIP children will be impacted, what requirements are in place for the community engagement program, how the *My Rewards Account* will function, medically frail premium requirements, MCO contract term questions and how many individuals will be impacted by the waiver. They also posed questions about the benefit package and how the SUD program will operate. Representatives from the State provided clarification to the questions.

In addition to the MAC meeting, the Kentucky HEALTH waiver was also presented to several public legislative committee hearings throughout the course of the public comment period. Specifically, the waiver was presented to the Interim Joint Committee on Health and Welfare on July 20, the Interim Joint Committee on Appropriations and Revenue on July 23, and the Budget Review Subcommittee on Human Resources on August 1. Each of these legislative hearings was open to the public, and members of the legislative committees were able to ask questions and comment on the waiver.

Following both the initial public comment period as well as the extension thereof, all comments were cataloged, summarized, and organized. In total, the State received 1,428 public comments during the entire public comment period, including 1,342 unduplicated written comments, and 86 verbal testimonies at the three public hearings. In addition to these, several organizations gathered input and statements from their constituencies which were synthesized within the organization's overall submission. The below summary combines the testimony offered at the public hearings as well as the formal comments received by the State via mail and email.

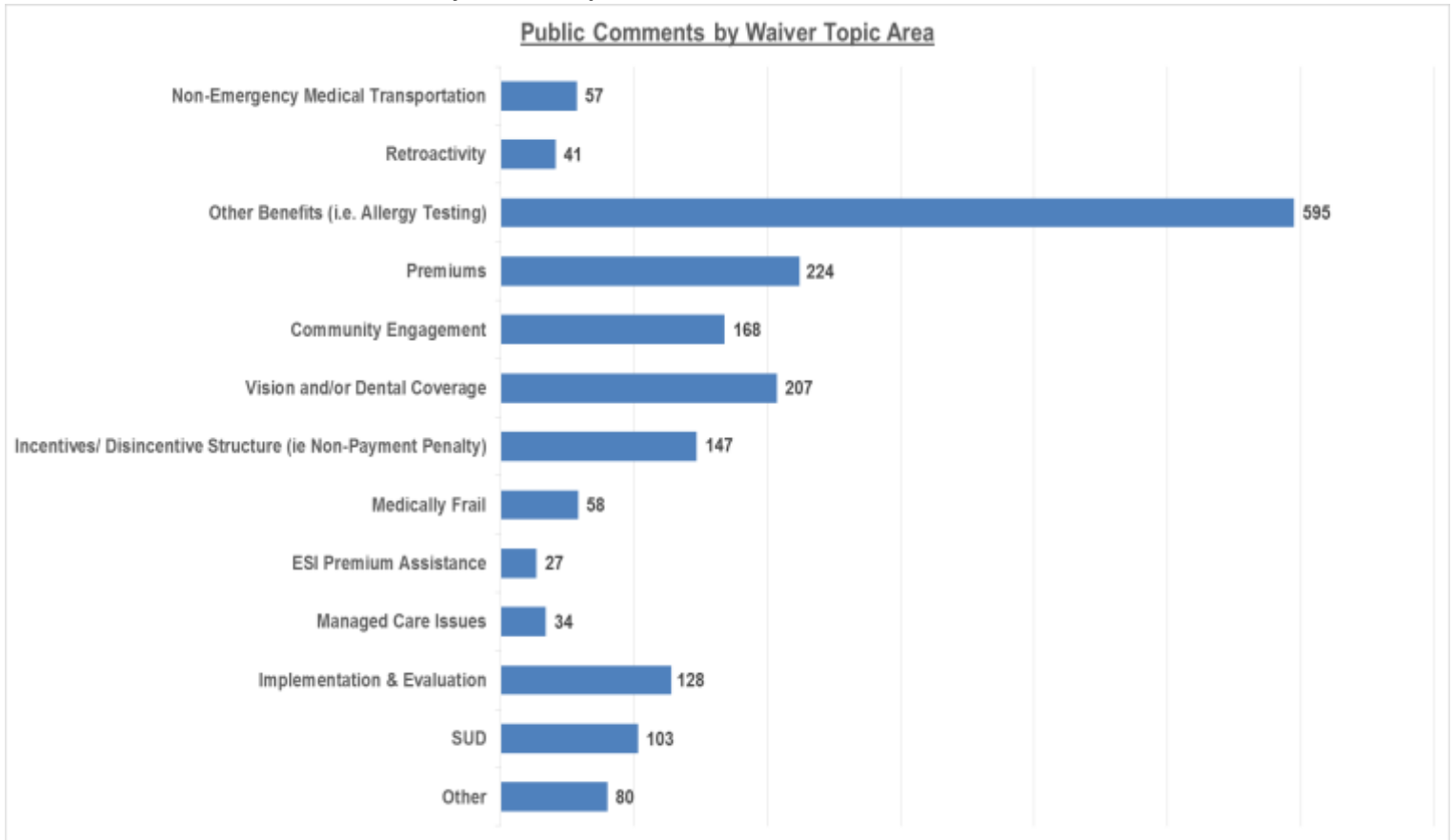
9.1 Summary of Public Comments and State Response

A significant portion of the public comments targeted the waiver proposal as a whole. These comments shared either general support of the waiver initiative or general opposition to any changes to the existing Medicaid expansion program, without offering substantive comments on any particular aspect of the proposal. However, the majority of comments received were robust and touched on a broad range of topics that generally fell into the following categories:

- Changes to benefits;
- Premiums and cost sharing;
- Community engagement and employment initiative;
- *My Rewards Account* and the proposed changes to vision and dental coverage;
- Incentive and disincentive structure of Kentucky HEALTH (i.e. non-payment penalties);
- Medically frail;
- Employer-sponsored insurance (ESI) premium assistance program;
- Managed care and implementation of the waiver program; and
- Substance use disorder (SUD) waiver pilot project.

The frequency with which each of these topics were raised within the comments is listed below in [*Table 9.1*](#). Further, each topic area theme is summarized and discussed in more detail below.

Table 9.1 Public Comment by Waiver Topic Area



1. Changes to Covered Benefits

- a. **Summary of Comments:** Over 40% of the total comments received during the public comment period (or roughly 595 comments) were specific to the proposed state plan amendment, primarily the elimination of allergy testing. Generally, commenters encouraged continued coverage of allergy testing, and shared personal anecdotes of how they had personally benefitted from the service. Other commenters noted that allergy testing is a critical component of diagnosis, establishing appropriate treatment plans, and educating patients about potential triggers to avoid. Several of the allergy and asthma providers and interest groups cited high rates of allergies and asthma in the Commonwealth, and provided detailed evidence that allergy testing and treatment is a highly effective and cost efficient benefit for the Medicaid program. Further, several commenters suggested that appropriate allergy testing and treatment can increase productivity and reduce missed days of school and work, therefore, supporting the overall goals of the Kentucky HEALTH waiver.

A relatively few number of comments were received related to proposed changes to non-emergency medical transportation and retroactivity, which received 57 comments (4% of total comments) and 41 comments (3% of total comments) respectively. Half of the comments received on these topics were from impacted providers and advocacy groups, many of which expressed concern with the potential negative economic impact these

changes would have on providers through missed appointments and uncompensated care. In addition, many commenters expressed concern about the potential impact that lack of NEMT services would have on access to care, particularly on the State's more vulnerable clients living in rural areas.

Ultimately, the overwhelming majority of comments received during the public comment period were related to proposed changes in allergy testing services. Most of the benefit related comments were submitted by impacted provider groups and their patients. Several commenters supported efforts to make Kentucky HEALTH benefits equal to the Kentucky State Employees' Health Plan, as well as efforts to maintain the current robust Medicaid mental health and substance use disorder benefits.

- b. **State Response:** Based on the overwhelming public response and significant evidence provided related to the cost effectiveness of the allergy testing benefit, the State will not pursue a state plan amendment to remove the additional benefits added in 2014, including allergy testing and private duty nursing.

In regards to comments related to non-emergency medical transportation, the Division of Medicaid Services data indicates that utilization for this benefit among expansion adults has been extremely low. From June 2014 through June 2015, the expansion adult population of more than 400,000 individuals utilized less than 140,000 non-emergency trips.⁴⁶ In addition, data from Iowa and Indiana, two states currently operating Medicaid expansion programs without NEMT benefits, indicates that members have not experienced any meaningful obstruction of member access to care. In fact, two independent evaluation surveys of Indiana members found that those without NEMT benefits missed fewer appointments than members with NEMT benefits (whether those benefits were provided by the State or as an enhancement through MCOs).⁴⁷ Due to this research as well as the under-utilization of this benefit among the expansion population in Kentucky, no changes were made to the waiver resulting from these comments, and the State will continue to seek a waiver of the NEMT benefit for the adult expansion group only. However, for purposes of clarification, NEMT will remain a covered service for the more vulnerable populations participating in Kentucky HEALTH, including children, pregnant women, medically frail individuals, and any individuals eligible for Medicaid prior to the passage of the Affordable Care Act.

In addition, the State has opted not to modify the waiver related to retroactive coverage. One of the main goals of Kentucky HEALTH is to "encourage individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance." A waiver of retroactive eligibility is consistent with this goal, as commercial market coverage begins after payment of a premium. In addition, Medicaid expansion has been in effect since 2014, therefore, most individuals are already covered, eliminating the

⁴⁶ Kentucky Department for Medicaid Services, Non-Emergency Medical Transportation Utilization of Adult Expansion Population from June 2014 through May 2015 (May 23, 2016) (on file with the State).

⁴⁷ Indiana NEMT Waiver Amendment Request to the Healthy Indiana Plan (HIP) 2.0 Medicaid Section 1115 Demonstration Waiver (2016) available at: <http://in.gov/fssa/hip/files/Indiana%20HIP%202.0%20NEMT%20Waiver%20Amendment%20Request%20-%202008%2001%202016.pdf>

need for retroactive coverage—as demonstrated by the relatively few comments on this policy (approximately 2%). Further, retroactivity has been widely waived by CMS in other states. However, in recognition of the concerns in the provider community, the Kentucky HEALTH waiver proposed to expand the presumptive eligibility program to allow more providers the opportunity to facilitate expedited enrollment for their uninsured patients in a time of need. This policy should address the few concerns related to increased uncompensated care.

2. Premiums and Other Cost Sharing

- a. **Summary of Comments:** Approximately 16% of all comments received (or 224 comments) addressed member cost-sharing components of the waiver. The State received several supportive comments, with even one Medicaid recipient indicating they would be willing to pay more for coverage. Several individuals indicated that the collection of even one dollar helps members engage in their own care as well as appropriately manage utilization and cost. In contrast, many commenters expressed general concern related to the affordability of the cost-sharing provisions for this population. Several commenters suggested there was no evidence that charging premiums would increase patient engagement. In addition, several stakeholder groups cited various studies indicating that any form of cost-sharing would negatively impact access to care and reduce coverage. In addition, several commenters opposed increasing premiums for individuals with income greater than the poverty level.

Other commenters focused on potential logistical difficulties that many low income individuals would face in making regular premium payments, particularly those individuals with mental disorders and those without a checking account or stable address. These concerns were most pronounced in regards to individuals determined medically frail. Many advocates and other stakeholders expressed concern with applying any form of cost-sharing (premiums or copayments) to the medically frail population. While many supported exempting these individuals from disenrollment for failing to pay premiums, many commenters requested the policy go further and simply exempt individuals determined medically frail from all cost-sharing obligations. These commenters noted that individuals who miss premiums will instead be subject to copayments which may be very expensive for medically frail individuals with extensive health care needs, which could lead to pharmaceutical noncompliance and other reductions in utilization.

State Response: In regards to concerns about copayments, all Medicaid copayments are subject to the federal maximum cost-sharing limit equal to 5% of income. CMS regulations allow states to charge copayments up to this limit without a waiver. However, stakeholder feedback expressed support for predictable, lower premiums as an alternative to standard Medicaid copayments up to 5% of income, as low-income working families are better able to budget for the expense. CMS has recently approved several similar 1115 waivers that implemented premium requirements equal to 2% of income. The flat rate premium amounts proposed in this waiver are all equal to or less than 2% of income, while the increasing premium amounts for individuals with income over 100% FPL never exceed the CMS threshold of 5% of income. Therefore, the cost-sharing provisions in the waiver are consistent with federal regulations and current CMS policy.

In addition, the studies cited by a few commenters were not specific to the new adult group category. Recent data from Indiana's Healthy Indiana Plan (HIP), also a Section 1115 waiver, indicated that premiums equal to 2% of income are affordable.⁴⁸ Approximately 87% of HIP members reported they would pay more than 2% of income premiums to remain enrolled in the program and that affordability was not an issue for people that left the program.⁴⁹ Only 5% of people surveyed who left the program indicated they did so for affordability reasons.⁵⁰ In addition, individuals who made regular payments had better outcomes, higher satisfaction, higher primary and preventive care, higher drug adherence, and lower ER use.⁵¹ The State will not seek changes to the premium amounts set forth in the original waiver draft.

While there were a relatively small number of comments (approximately 16%) related to cost-sharing and premiums, the State has adjusted the plan based on a few recommendations. A couple of commenters suggested that the State implement family caps on premium requirements, such that the monthly premium equal to 2% of household income was not charged individually to all adults in the household. Based on this feedback, the Kentucky HEALTH waiver has been updated to clarify that premiums will be charged on a household basis rather than an individual basis. For example, for a married couple with household income equal to 75% FPL, the couple would be required to pay only \$8.00 per month (rather than \$16.00 per month).

In regards to the collection of premium payments, the State will ensure a variety of payment collection methods are available, including cash, money order, personal checks, credit card or debit card (including prepaid Visa debit cards). The Kentucky HEALTH program will seek to provide ample opportunity for members to make a premium payment in a method most convenient to their situation.

Finally, based on the comments received, the waiver has been updated to exempt medically frail individuals from the imposition of both premiums and copayments. The waiver was updated to allow medically frail members to choose to make premiums in order to maintain access to the My Rewards Account, however, in the event of non-payment of premium, such individuals will not be disenrolled and will not be subject to copayments for services.

3. Community Engagement & Employment Initiative

- a. **Summary of Comments:** Relatively few comments (168, or approximately 12% of the total comments) addressed the community engagement and employment initiative. Several commenters supported the idea of requiring individuals who are able to work or volunteer for their tax funded benefit, noting that the majority of Americans also have to work to obtain employer sponsored health coverage. Of the individuals opposed to the imposition of the community engagement and employment initiative, many had questions about who would be subject to the requirements, as well as what types of activities would satisfy the

⁴⁸ The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

requirements. Specifically, several individuals expressed concern that Kentucky HEALTH would increase burdens on low-income working families that are already struggling and would have little time for extra-curricular activities, such as community service. Further, several advocacy groups, including the AARP, requested that the exemption for caretakers of a dependent child be expanded to include other forms of caretaking activities. In addition, several organizations posed very detailed operational questions related to the implementation of this initiative.

- b. **State Response:** With respect to comments concerned about the increased burden on low-income working families, the proposed waiver as originally drafted indicated that employment satisfies the requirement. However, the waiver has been updated to provide further emphasis that the community engagement and employment initiative would not impact working families. Specifically, individuals who are already working more than 20 hours per week will meet the requirement of the initiative, and will not be required to perform community service or other job training activities as a condition of continued enrollment. This point is clarified in *Section 2.3* of the waiver.

In regards to caretakers, the State recognizes the value and critical role of the countless Kentuckians who serve as caretakers for aging or disabled individuals. Therefore, in response, the waiver will be amended in two ways. First, the community engagement and employment exemption will be expanded to exempt not only primary caregivers of a dependent minor child, but also primary caregivers of a disabled adult dependent. Secondly, caregiving activities for non-dependents, such as caregiving services provided to elderly parents, will be counted as a qualifying activity for the community engagement and employment initiative.

4. **My Rewards Account and Changes to Vision and Dental Coverage**

- a. **Summary of Comments:** Slightly over 200 comments (approximately 14%) were submitted in regards to the proposed changes to vision and dental coverage. Many commenters expressed concern over the elimination of dental and vision services, as well as concern that the *My Rewards Account* limits access to care through the requirement to complete reward activities in order to purchase benefits. In addition, some raised concerns over the perception that vision and dental benefits were classified in the same category as a gym membership. However, several commenters wrote in support of the *My Rewards Account* structure and related benefit change, indicating that asking a person to participate in beneficial activities in exchange for vision and dental services promotes ownership and teaches responsibility.

A significant portion of comments related to vision and dental coverage were from impacted providers and their professional organizations. Dentists and other oral health professionals expressed concern that reduction in access to dental services would lead to increased emergency room visits and increased opioid use due to tooth pain. Similarly, many optometrists opposed removing vision screenings from the base benefit package, since these preventive visits often lead to early detection of other chronic diseases. Overall, the provider communities advocated for inclusion of vision and dental in the base benefit package, as cost effective methods of addressing the overall health of the member.

Further, several commenters indicated concern that the change in dental and vision coverage for adults could negatively impact utilization of these services for children resulting from potential misunderstanding that the parents and children have different covered benefits. In addition, a few commenters indicated that, as currently structured, it would be impossible for a person to accumulate enough funds to pay for basic dental and vision services. These individuals urged inclusion of additional and more inclusive opportunities to earn rewards. In addition, several individuals recommended that coverage for eyeglasses and contacts be added to the *My Rewards Account*.

- b. **State Response:** Many of the comments indicated a misunderstanding of the waiver and additional clarifying language has been added. The Kentucky HEALTH program will continue to cover all of the vision and dental services currently covered in Medicaid. It does not propose to “eliminate” or add new coverage, but rather transition existing vision and dental services (both considered optional Medicaid services under federal law) to the *My Rewards Account*. Vision and dental benefits will be maintained in the standard benefits for children, pregnant women, medically frail individuals, and any individuals eligible for Medicaid prior to the passage of the Affordable Care Act.

The *My Rewards Account* is structured to give participants flexibility and ownership of their own benefits and healthcare spending. The State recognizes that some members may only need one dental cleaning and vision screening in a year. Rather than a one-size-fits-all approach, the *My Rewards Account* creates flexibility and tailors benefits to the individual, allowing the participant to make choices about how to spend additional funds, which may be on a gym membership or additional dental work. It is up to the individual to decide what benefit they value most and use of the account is flexible based on individual needs.

In responding to the comments, the State will delay the implementation of this benefit change by three months, to allow current members additional time to accumulate dollars in their *My Rewards Account*. In addition, the State is committed to ensuring that the structure of the account provides meaningful access to covered vision and dental benefits. The table of qualifying activities provided in the waiver is illustrative, but not definitive, and several additional opportunities will be made available for achievement of rewards. For example, parents will also be able to earn dollars in their *My Rewards Account* for obtaining prenatal and/or preventive care for their children, including recommended well-child visits, dental cleanings, and vision screenings. This will serve to educate and encourage parents to utilize the full array of children’s preventive services.

In addition, Kentucky HEALTH will also seek to encourage members to complete their GED not only by rewarding members who pass the exam with a *My Rewards Account* incentive, but also by helping to pay for the out of pocket costs associated with taking the exam. The State will seek a waiver to pay for this service as part of the Medicaid package in order to further promote independence. *Section 4.1.2* of the waiver has been updated to reflect these additions.

5. Incentive & Disincentive Program Structure

- a. **Summary of Comments:** Another set of commenters (approximately 10%) discussed various aspects of the incentive and disincentive structure of the Kentucky HEALTH waiver proposal. Several comments were received praising the use of incentives to drive healthy behaviors, as well as rewarding members for taking educational classes, health assessments, and engaging in their community. In addition, numerous commenters expressed concern about the non-payment penalty provisions of the waiver, particularly the impact of the six month disenrollment period for individuals with income greater than 100% FPL. Specifically, commenters are concerned that this policy will increase emergency room utilization and uncompensated care during coverage gaps. In addition, several providers, particularly substance use disorder (SUD) providers, stated that a disenrollment penalty would disrupt continuity of care, which is particularly important for individuals in active mental health and SUD treatment programs. In addition, a few commenters opposed the emergency room penalty, and noted that the non-emergency use of a hospital emergency department penalty is much higher than the \$8.00 federally allowable copayment amount.
- b. **State Response:** The intent of the penalties is not punitive in nature, but rather is intended to familiarize members with the requirements of private insurance to help make their eventual transition easier. Further, the disenrollment non-payment penalty does not apply to individuals with income below the poverty line or individuals determined medically frail, which would include those individuals actively participating in SUD treatment programs. Further, Indiana's Healthy Indiana Plan waiver also includes a similar six month non-payment disenrollment period for individuals with income greater than 100% FPL. According to program data, less than 6% of the individuals (2,677) were disenrolled for non-payment, and the majority (56%) were able to obtain health insurance during this six month period.⁵² While the Kentucky waiver contains similar disincentives to encourage key behaviors, it is also designed to create a way for individuals to minimize or eliminate the penalty. As drafted, the waiver provides disenrolled members the opportunity to take a financial or health literacy class, as well as pay owed premiums for the months they received coverage but did not pay, in order to regain coverage prior to the expiration of the six month disenrollment period.

In regards to the non-emergency use of hospitals emergency department penalty, the penalty is not an actual member copayment and does not use member out-of-pocket funds. Instead, it reduces reward dollars from the *My Rewards Account* that were gained through positive behavior, which may also include reward contributions for avoiding inappropriate emergency room use. In addition, the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations at 42 CFR §489.24, which sets special responsibilities for hospitals in emergency cases, including definitions of emergency conditions, will apply and members may not be refused treatment.

⁵² The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf

6. Medically Frail

- a. **Summary of Comments:** Approximately 4% of comments (or 58 comments) were received specific to medically frail. Many of the commenters sought additional detail regarding the state-specific definition of “medically frail.” Several commenters asked that certain populations be explicitly identified and included in the definition, including those receiving Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). In addition, the American Academy of HIV medicine specifically recommended that individuals with HIV be automatically considered medically frail due to the critical importance of medication adherence and continuity of care. Further, several commenters also requested additional information regarding the medically frail determination process.
- b. **State Response:** The State concurs with the commenters that providing a clear, concise, and objective definition of medically frail will be critical to ensuring that the most vulnerable members participating in Kentucky HEALTH are quickly and appropriately identified. In response to several comments received about the urgency in quickly identifying specific segments of the medically frail population, the State will modify the waiver to create specific populations that automatically will be considered medically frail, including (1) individuals in hospice care, (2) individuals living with HIV/ AIDS, and (3) individuals receiving SSDI.

The waiver also has been updated to provide additional clarification that individuals with SSI are not included under the Kentucky HEALTH waiver and will retain traditional disability Medicaid benefits. By contrast, individuals otherwise eligible for Kentucky HEALTH who also receive SSDI will be automatically determined medically frail under this waiver program. Further, in response to the requests that additional detail be provided regarding the medically frail determination process, *Section 3.2* of the waiver was modified to provide additional detail about the process, as well as the role of the MCOs in providing information to the State for medically frail determinations.

7. ESI Premium Assistance

- a. **Summary of Comments:** Only 27 comments (approximately 2% of the total received) expressed concerns that employer sponsored insurance (ESI) is too expensive and individuals will not qualify for the employer premium assistance program due to their part-time employment status. Two comments were received requesting input from stakeholders, including MCOs, in the design and operationalization of the program.
- b. **State Response:** As stated in *Section 3.2* of the original waiver proposal, individuals eligible for the employer premium assistance program will not be subject to out-of-pocket expenses in excess of the Kentucky HEALTH required premiums. Additionally, enrollment in ESI will only be required to the extent an individual qualifies and the employer plan is cost-effective to the State. Therefore, no changes were made to the waiver in response to comments received, as the concerns raised were due to a misinterpretation of the program requirements.

8. Managed Care and Implementation Concerns

- a. **Summary of Comments:** Many commenters discussed the implementation of Kentucky HEALTH, including comments about changes to managed care (34 comments or 2%) and the administration of the plan more generally (128 comments or approximately 9% of the total comments). Several commenters indicated that they appreciated the proposed MCO reforms contained within Kentucky HEALTH and indicated they have struggled with the administrative burden of working with multiple MCOs. These commenters encouraged reducing the number of MCOs in future contracting. In addition, many commenters also explicitly supported efforts to implement a single formulary, consistent prior authorization processes and standardized forms, as well as uniform credentialing. More generally, a number of comments were received that expressed various concerns with perceived administrative complexities built into the program that will impact the Commonwealth, the MCOs and their members, as well as increase overall program costs. In addition, a few commenters were concerned that the program would be too difficult for members to understand and navigate.
- b. **State Response:** No additional revisions to the waiver were made resulting from these comments, except that the State removed specific references to “five” MCOs, as the state is making a number of reforms to its contracting and cannot affirmatively state that the program will continue to be administered by five MCOs for the duration of the waiver. The State intends to build on existing infrastructure within the SNAP program to operationalize the community engagement initiative and will explore existing technology solutions to track engagement. Ultimately, the investment in developing the workforce in the Commonwealth is important for not only to reduce unemployment, but also to improve health outcomes. As detailed in the waiver, there is a known link between health and employment, and CMS states it is “essential to individual's economic self-sufficiency, self-esteem and well-being.”⁵³ Kentucky HEALTH aims to work across the various Cabinets in the Commonwealth to leverage existing health and employment-related programs and focus efforts on assisting Kentucky HEALTH members achieve improved health and self-sufficiency. The State intends to partner with stakeholder groups and initiate a strong communications effort to educate members about changes to the program throughout the implementation process to ensure all members and potential members are notified of upcoming program changes.

9. SUD Pilot Project

- a. **Summary of Comments:** Nearly all of the 103 comments received related to the proposed SUD pilot project were supportive. Commenters described the devastating impact of addiction and commended the State for addressing this issue and increasing access to critical services through the proposed pilot project. Many commenters took the opportunity to ask questions related to the specific details of the program, and provided detailed suggestions for the design of the pilot project. Suggestions included specific quality measures to study, provider qualifications for telehealth and partial hospitalization

⁵³ Medicaid Employment Initiatives, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (last visited June 7, 2016).

programs and expansion of the IMD waiver on a statewide basis. Commenters also requested specific counties be included in the pilot project and provided suggested criteria for determining which counties to include.

- b. **State Response:** The State will utilize the comments received in the development of the operational components of the SUD pilot project. Additionally, regarding expansion of the IMD exclusion, the State intends to permit MCOs to utilize IMDs for up to fifteen (15) days as an in-lieu of service, as available under 42 CFR §438.6(e). In accordance with these new federal regulations, this will be accomplished through the MCO contracting and rate setting process and does not require a modification to the waiver proposal. Further information on this change will be provided at a later time. By contrast to the 15 day IMD stay permitted under the new managed care rule, the IMD waiver sought for the SUD pilot project would allow Medicaid to reimburse for IMD stays up to 30 days in length.

10. Questions and Misconceptions

- a. **Summary of Comments:** During the public comment process, many individuals took the opportunity to ask specific questions related to the program generally, including how it will impact specific individuals, details regarding how it will be operationalized and which vendors will be utilized. Also, several comments were based on misunderstandings of various aspects of the waiver. For example, several comments were received related to perceived reductions in the coverage of smoking cessation benefits or perceived elimination of hearing aid coverage. In addition, others were concerned about estimated reductions in enrollment of children over the 5 year demonstration period.
- b. **State Response:** To clarify, in regards to the smoking cessation benefit, there are no changes to benefits related to the coverage of smoking cessation counseling and medication. The State will continue to cover all services (including smoking cessation services) given an "A" or "B" from the United States Preventive Services Task Force (USPSTF), at no cost to the recipient. All preventive services are covered by the managed care organization outside of the member's deductible account.

Many of the questions asked specific operational questions that will be helpful in the future as the State works to operationalize and further refine the program. In addition, the State plans to use the comments to develop member and stakeholder communication material prior to implementation. However, as these types of questions did not provide specific feedback on the waiver, no modifications were made to the waiver as a result.

In addition, the enrollment figures for children contained in the initial waiver draft were mistakenly transposed with the enrollment numbers for expansion adults in the table on Page 18 of the waiver. The correct enrollment figures were available on Page 3 of Attachment III. To clarify, the State does not anticipate that enrollment for children will decrease, rather it may actually increase under the waiver.

9.2 Summary of Waiver Changes Following Public Comment

The State appreciates the massive public response to its 30-day request for public comments. Due to the robust and thoughtful input, the State took additional time to thoroughly review and give due consideration to each comment. While the broad themes are summarized and discussed above, each

comment received during the public comment period helps inform not only the development of the waiver, but also future discussions with CMS, the design of the program evaluation, member communication strategies, and other operational considerations. In addition, the State has chosen to directly respond to a number of significant concerns and specific recommendations suggested during this process, and has made changes and modifications to the waiver as a direct result of public input. These changes were discussed above and are also summarized in the below table:

Section	Description of Change	Page #
Kentucky Health Overview (Section 1.2.2)	<p>Several updates and clarifications were added to the program overview section, including:</p> <ul style="list-style-type: none"> • Clarified that benefits will not change for children, pregnant women, medically frail, and adults eligible for Medicaid before expansion. • Listed eligibility groups excluded from waiver. • Added language that premiums will only be applied on a family basis. • Clarified that members may choose how to use the <i>My Rewards Account</i> benefits. • Added language about Medicaid policy goals in support of services to support independence. • Added caretaking as community engagement & employment activity, and clarified list of exempt individuals. 	Pages 9, 10, 12, & 13
Demonstration Area and Timeframe (Section 1.5)	The implementation of changes to the dental and vision benefit will be delayed by three months to allow members time to accrue funds in the <i>My Rewards Account</i> .	Page 14
Impact to Medicaid and Chip (Section 1.6)	Clarification was added to explain that this waiver primarily only impacts “non-disabled” individuals in traditional Medicaid populations.	Page 14
Eligibility (Sections 2 and 2.1)	<ul style="list-style-type: none"> • Added description and chart describing groups excluded from the waiver: <ul style="list-style-type: none"> ○ Former foster children up to age 26; ○ Individuals on a 1915(c) waiver; ○ Individuals in an institution; and ○ Individuals eligible for Medicaid on the bases of age, blindness, or disability, including individuals eligible for social security income (SSI). • Made technical correction to listed income levels for Section 1931 parents and caretakers in <i>Table 2.1(A)</i> 	Pages 15-16
Community Employment & Engagement (Section 2.2)	<p>Several revisions and clarifications were made to this section, including:</p> <ul style="list-style-type: none"> • Added language about Medicaid policy goals in support of services to support independence. • Extended community engagement & employment exemption for primary caretakers of minor children as well as disabled adult dependents. 	Pages 16-18

	<ul style="list-style-type: none"> Clarified that students or individuals employed more than 20 hours a week meet the requirements of this section, and no additional community engagement activities are required to maintain benefits. Added “caregiving services for a family member or other person with a chronic, disabling health condition” as a qualifying activity. Added clarification around education component of the initiative, and added GED benefit. 	
Projected Enrollment (Section 2.3)	Made a technical correction to the enrollment chart.	Page 19
Kentucky HEALTH Benefits (Sections 3 & 3.1.2)	<p>Made changes to proposed benefit changes as follows:</p> <ul style="list-style-type: none"> <u>Allergy Testing</u>: Removed proposed amendment to the Medicaid State Plan, as allergy testing and private duty nursing will continue to be covered services. <u>Smoking Cessation</u>: Clarified that current smoking cessation benefits will continue to be covered as an “A” and “B” service recommended by the United States Preventive Services Task Force. 	Pages 21 & 23
<i>My Rewards Account</i> Benefit (Section 3.1.3)	The dental and vision benefit change will be delayed by three months to allow members time to accrue funds in the <i>My Rewards Account</i> .	Page 24
Educational Support (Section 3.1.4)	Added GED testing costs as an additional covered benefit for Kentucky HEALTH members.	Pages 24 & 25
Medically Frail (Section 3.3.1)	<p>Clarified the definition and process</p> <ul style="list-style-type: none"> Certain populations will be determined automatically medically frail, including individuals receiving hospice care, persons with HIV/AIDS, and individuals receiving SSDI. Added additional detail regarding the medically frail identification, determination and appeal process. Medically frail individuals will be exempt from copayments. 	Page 26
<i>My Rewards Account</i> (Section 4.1.2)	<p>Clarified and added the following:</p> <ul style="list-style-type: none"> Added description of educational support benefit Community engagement related activities will only qualify for a reward deposit if in excess of hours required to maintain coverage as set forth in <i>Section 2.2</i>. Expanded the reward activity chart to include caretaking responsibilities, passing the GED, and completion of child preventive services. Clarified that the inappropriate emergency room penalty is not a member copayment. Added an incentive and disincentive option for excessive missed healthcare appointments 	Pages 28-30
Member Required Contributions (Section 4.2)	<p>Clarified and added the following:</p> <ul style="list-style-type: none"> Added an explanation that premiums will be paid on a household basis rather than per person. 	Pages 31-33

	<ul style="list-style-type: none"> Added an exemption for medically frail from the imposition of premiums and copayments. Included study results supporting positive impact premium payment has on member health outcomes. 	
Cost-Sharing Exemption (Section 4.3)	Clarified that medically frail members will be exempt from the imposition of premiums and copayments. However, premiums are still required to maintain the member's <i>My Rewards Account</i> .	Page 34
SUD Pilot Program (Section 5.1.1)	Added that the pilot project will include measurement of specific recommended SUD and HIV quality indicators.	Page 35
Managed Care Reforms (Section 5.1.3)	Removed references to 5 MCOS, as the State is not committed to maintaining this number of MCOs in the future.	Page 38
Fee for Service (Section 5.6)	Clarified that the State may carve out the services provided through the <i>My Rewards Account</i> from managed care.	Page 38
Implementation (Section 6)	The implementation of changes to the dental and vision benefit will be delayed by three months to allow members time to accrue funds in the <i>My Rewards Account</i> .	Page 39
Costs Not Otherwise Matchable (Section 8.2)	Added a request that GED testing fees be regarded as a Medicaid expenditure.	Page 41
Evaluation Plan (Attachment I)	Added a new evaluation metric related to measuring GED participation rates.	Page 61
Financing & Budget Neutrality Summary (Attachment II)	<ul style="list-style-type: none"> Eliminated reference to removal of private duty nursing. Added GED certification fees for expansion and non-expansion adults as a covered benefit. Clarified premiums will be collected on a household basis. Made allowance for a three month delay in changes to the vision and dental benefit in the first year of the waiver. 	Pages 67 & 68

Other than the changes noted above, the content of this application is identical to the copy of the application initially posted on the Cabinet for Health and Family Services website on June 22, 2016.

10 Demonstration Administration

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ATTACHMENT I: Evaluation plan

The table below presents an overview of a preliminary plan for how the State may evaluate the Kentucky HEALTH program. This evaluation plan is subject to change and will be further defined to reflect operational details as the program is implemented.

#	Hypothesis	Methodology	Data Sources and Metrics
Goal 1: Improve member’s health and help them be responsible for their health			
1.1	Kentucky HEALTH policies will promote member use of preventive and primary care.	Track and compare health service utilization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.	Claims data: <ul style="list-style-type: none"> • Primary care encounters; • Specialist care encounters; • ED visits; and • Preventive care codes.
		Track preventive care utilization rates and trends among different age and gender groups.	Claims data: <ul style="list-style-type: none"> • Number, type, and frequency of preventive care services used; and • Gender- and age-specific rates of pre-determined preventive service utilization.
1.2	Kentucky HEALTH policies will promote member compliance with chronic disease management.	Track and compare chronic disease management compliance rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.	Claims data: <ul style="list-style-type: none"> • Chronic disease management codes; and • Participation in disease management program.
1.3	Kentucky HEALTH policies will reduce member hospitalization of ambulatory care sensitive conditions (ACSCs).	Track and compare ACSCs hospitalization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.	Claims data: <ul style="list-style-type: none"> • Ambulatory care sensitive conditions (ACSCs) codes.
1.4	Kentucky HEALTH will increase access to substance use disorder (SUD) services with special focus on Institutions for Mental Diseases (IMD).	Track and compare inpatient specialty care/SUD utilization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.	Claims data: <ul style="list-style-type: none"> • Specialist care encounters. Administrative data and MCO reported data: <ul style="list-style-type: none"> • Network adequacy; • Number of certified providers; • Change in ED utilization and costs; and

			<ul style="list-style-type: none"> Change in inpatient utilization and costs. <p>Member survey:</p> <ul style="list-style-type: none"> Percentage of members who report the wait times for SUD services.
Goal 2: Encourage individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance			
2.1	Kentucky HEALTH policies will provide incentives to monitor and manage the two member managed account funds.	Track and compare remaining balances in member deductible accounts at the end of each benefit period.	Administrative data: <ul style="list-style-type: none"> Percentage of deductible accounts that have a balance at the end of a benefit period.
		Track and compare balances in member <i>My Rewards</i> accounts at the end of each benefit period.	Administrative data: <ul style="list-style-type: none"> Percentage of <i>My Rewards Accounts</i> that have a balance at the end of the benefit period.
		Track account balances transferred from the deductible account to the <i>My Rewards Account</i> at the end of each benefit period. <ul style="list-style-type: none"> Number of members with unused deductible account balances at the end of each benefit period; and Average amount transferred to <i>My Rewards Account</i> at the end of each benefit period. 	Administrative data: <ul style="list-style-type: none"> Average deductible account balance amount at the end of each benefit period; and Average <i>My Rewards Account</i> balance at the end of each benefit period.
		Track number of people checking their account balances: <ul style="list-style-type: none"> Weekly; Monthly; Semi-Annually; Annually. 	MCO administrative data.
2.2	Kentucky HEALTH policies will encourage healthy behaviors and increase member access to enhanced health services (such	Track and compare <i>My Reward Account</i> expenditures on enhanced health services.	Administrative data: <ul style="list-style-type: none"> Percentage of <i>My Reward Accounts</i> that have expenditures for

	as dental, vision, gym memberships and over-the-counter medications).		<p>enhanced health services at the end of each benefit period;</p> <ul style="list-style-type: none"> • Average <i>My Reward Account</i> expenditures for enhanced health services at the end of each benefit period; and • Percent of <i>My Reward Account</i> expenditures for enhanced health services at the end of each benefit period.
		Track and compare member achievement of healthy incentives contributions to the <i>My Rewards Account</i> .	<p>Administrative data:</p> <ul style="list-style-type: none"> • Members receiving any healthy incentive contributions; • Type/source of healthy incentive contribution (e.g., avoidance of inappropriate ER visits, completed job search, GED, etc.); • Average number of healthy incentive contributions earned; • Total dollar amount of healthy incentive contributions received; and • Average dollar amount of healthy incentive contributions received.
		Track and compare type of enhanced health services used by member <i>MY Rewards</i> accounts.	<ul style="list-style-type: none"> • Enhanced services used, by percent of total enhanced services offered (e.g., 40% of all enhanced services used for gym memberships; 30% of all enhanced services used for OTC medications, etc.); • Enhanced services used, by number of services (e.g., 4,000 total gym memberships received; 3,000 total OTC

			<p>medications received, etc.);</p> <ul style="list-style-type: none"> • Total dollar amount spent on enhanced services; and • Average amount spent on enhanced services.
2.3	Kentucky HEALTH policies will promote member compliance with making premium payments.	<p>Track premium initial and ongoing premium payments.</p> <ul style="list-style-type: none"> • Overall; • Above 100% FPL; • At or below 100% FPL; and • Medically Frail Status. 	<p>Health plan contribution and enrollment data:</p> <ul style="list-style-type: none"> • Number and percentage making premium payments within allowed time; • Number and percentage disenrolled from Kentucky HEALTH due to non-payment of premium (above 100% FPL); • Number and percentage suspended with copayments applied (below 100% FPL) due to non-payment of premium; • Number and percentage reinstated early (before 6 months) into Kentucky HEALTH after disenrollment (above 100% FPL) or suspension (at or below 100%) due to non-payment of premium; and • Number and percentage reinstated on-time (after 6 months) into Kentucky HEALTH following non-payment of premium.
2.4	Kentucky HEALTH open enrollment policy will increase member compliance with redetermination process.	<p>Track member compliance with redetermination.</p> <ul style="list-style-type: none"> • Overall; • Above 100% FPL; • At or below 100% FPL; and • Medically Frail Status 	<ul style="list-style-type: none"> • Number and percentage disenrolled from Kentucky HEALTH due to failure to comply with redetermination process; • Number and percentage reinstated prior to next open enrollment period; and

			<ul style="list-style-type: none"> Number and percentage reinstated at next open enrollment period (after six months).
2.5	Kentucky HEALTH’s incentive and disincentive policies related to non-emergency use of hospital emergency room will reduce inappropriate utilization among Kentucky HEALTH members.	Compare annual rates of inappropriate emergency department utilization between Kentucky Medicaid populations for the years <i>before waiver</i> (prior to 2017) and <i>after waiver</i> (2017 and beyond).	Claims data: <ul style="list-style-type: none"> Annual overall emergency department utilization rates (percent of members and visits/100,000 members); and Annual non-emergency emergency department utilization rates (percent of members and visits/100,000 members).
		Survey Kentucky HEALTH members on whether the incentives and disincentives related to the <i>My Rewards Account</i> for appropriate emergency room utilization caused them to seek services with their primary care physician or in an alternative urgent care setting.	Member survey: <ul style="list-style-type: none"> Percentage of members who report the disincentive caused them to seek services with their primary care physician or in an alternative urgent care setting in lieu of the emergency department. Percentage of members who report the incentive caused them to seek services with their primary care physician or in an alternative urgent care setting in lieu of the emergency department.
		Compare annual rates of members subject to the escalating <i>My Rewards Account</i> disincentive based on repeated inappropriate hospital emergency department utilization.	MCO reported data: <ul style="list-style-type: none"> Number of members that utilized inappropriate emergency services: <ul style="list-style-type: none"> Only once; Two times; Three times; and More than three times.

Goal 3: Empower people to seek employment and transition to commercial health insurance coverage			
3.1	Kentucky HEALTH policies will encourage members to increase community engagement.	Track and compare member achievement of community engagement and employment contributions to the <i>My Rewards Account</i> .	Administrative data: <ul style="list-style-type: none"> • Members receiving any community engagement and employment related contributions to their <i>My Rewards Account</i>; and • Average number of such contributions earned.
3.2	Kentucky HEALTH policies will encourage members to obtain their GED certification.	Track members preparing for, taking and passing the GED exam.	Administrative data: <ul style="list-style-type: none"> • Members receiving contributions to their <i>My Rewards Account</i> for GED related activities • Members reporting GED related activities for their required community engagement hour requirements • Members who utilize the GED exam fee benefit
3.3	Kentucky HEALTH policies will encourage members to seek employment.	Track members participating in job search activities.	Administrative data: <ul style="list-style-type: none"> • Number and percent of members who register with Career Center and complete job needs assessment; • Number and percent of members who participate in qualifying community service activity; • Number and percent of members who complete job skills training (i.e. vocational education, training); and • Number and percent of members who complete job search activities.

3.4	Kentucky HEALTH policies will encourage members to earn employment and ultimately transition to commercial health insurance coverage.	Track number of former Medicaid members successfully transitioning to commercial health insurance coverage and accessing the <i>My Rewards Account</i> bonus after eighteen months.	Administrative data: <ul style="list-style-type: none"> • Number of former members able to receive a cash reward after transitioning to commercial health insurance coverage; • Average <i>My Rewards Account</i> balance payoff; and • Number of individuals that reenter program prior to achieving a full eighteen months of commercial health insurance coverage.
		Track number of individuals employed over twenty hours per week.	Administrative data: <ul style="list-style-type: none"> • Number of members who move from part-time employment to full-time employment; • Number of members who move from unemployment to part-time employment; and • Number of members who move from unemployment to full-time employment.
		Track earnings of members who earn employment.	Administrative data: <ul style="list-style-type: none"> • % FPL of individual income; and • % FPL of household income.
3.5	The employer premium assistance program will increase the proportion of Kentucky residents under 138% FPL covered by employer-sponsored insurance (ESI).	Track the number of Kentucky residents with income under 138% FPL covered by ESI over the demonstration period.	Current Population Survey & American Community Survey: <ul style="list-style-type: none"> • ESI coverage rate estimates, all ages.
		Track employer premium assistance program member enrollment.	Kentucky HEALTH enrollment and premium assistance records: <ul style="list-style-type: none"> • Number of Kentucky HEALTH members who are eligible for the

			<p>employer premium assistance program;</p> <ul style="list-style-type: none"> • Number of Kentucky HEALTH members who enroll into the employer premium assistance program. • Percentage of total demonstration enrollees participating in the employer premium assistance program—monthly and annually; and • Number of employer premium assistance program enrollees who receive premium assistance to purchase ESI—monthly and annually.
		Track employer premium assistance program employer enrollment.	<p>Employer premium assistance program administrative data:</p> <ul style="list-style-type: none"> • Number of employers who enroll in the employer premium assistance program, by employer size (e.g., small, medium, large).
		Track employer premium assistance program wrap-around coverage expenditures.	<p>Claims data:</p> <ul style="list-style-type: none"> • Number, type, and frequency of wrap-around service used; • Average cost of wrap-around service used; and • Total cost of wrap-around service used.
3.6	Kentucky HEALTH’s sliding scale increased premium payment amounts will discourage dependency on public assistance and encourage members to transition to commercial health insurance coverage.	Compare annual rates of Medicaid enrollment between Kentucky Medicaid populations for the years <i>before waiver</i> (prior to 2017) and <i>after waiver</i> (2017 and beyond).	<p>Administrative data:</p> <ul style="list-style-type: none"> • Monthly Medicaid enrollment; and • Annual Medicaid enrollment.
		Survey Kentucky HEALTH members on whether the	Member survey:

		sliding scale increased premium payment amount caused them to seek employment and/or other forms of health insurance coverage.	<ul style="list-style-type: none"> Percentage of members who report the sliding scale increased premium payment amount caused them to seek employment and/or other forms of health insurance coverage.
		Compare annual rates of members paying increased premium amounts based on continued annual enrollment in Kentucky HEALTH.	MCO reported data: <ul style="list-style-type: none"> Premium payment amounts, by year of coverage.
Goal 4: Implement delivery system reforms to improve quality and outcomes			
4.1	Kentucky HEALTH policies will promote high quality healthcare delivered by providers.	Track MCO ability to meet quality and outcome benchmarks within their service contracts.	Claims data: <ul style="list-style-type: none"> Kentucky HEALTH outcomes compared to MCO benchmark requirements: <ul style="list-style-type: none"> Primary care; Preventive care; Specialist care; Emergency care; and Ambulatory care sensitive conditions.
		Track Kentucky providers receiving bonus payments from MCOs for meeting quality and outcomes standards.	MCO reported data: <ul style="list-style-type: none"> Bonus payments paid to provider.
Goal 5: Ensure fiscal sustainability			
5.1	Kentucky HEALTH will remain budget-neutral for both the federal and State governments.	Conduct a budget neutrality analysis and document adherence to waiver margin.	<ul style="list-style-type: none"> Calculation of the waiver margin (annual and cumulative); Documentation of all State and federal costs; and Demonstration of budget neutrality.

ATTACHMENT II: Financing and Budget Neutrality Summary

Milliman, Inc. (Milliman) was engaged to develop the response to the Budget Neutrality Form section for the Section 1115 Medicaid Demonstration Waiver Application (1115 Waiver). The Centers for Medicare and Medicaid Services (CMS) requires all 1115 Waivers to demonstrate budget neutrality. Budget neutrality is a comparison of without waiver expenditures (WoW) to with waiver expenditures (WW). CMS recommends two potential methodologies of demonstrating budget neutrality:

1. Per Capita Method: Assessment of the per member per month (PMPM) cost of the Demonstration
2. Aggregate Method: Assessment of both the number of members and PMPM cost of the Demonstration

Budget neutrality for the Kentucky HEALTH 1115 Waiver will be demonstrated through the use of the aggregate method. The budget neutrality projections were developed using CMS budget neutrality requirements. A detailed budget neutrality worksheet is attached as **Attachment III**.

Milliman has relied upon certain data and information provided by the Kentucky Department for Medicaid Services in the development of the estimates contained in the Budget Neutrality Worksheet. Milliman has relied upon the Kentucky Department for Medicaid Services for the accuracy of the data and accepted it without audit. Additionally, Milliman relied on data and other information from the Current Population Survey and Medical Expenditure Panel Survey. To the extent that the data provided is not accurate, the results of this analysis may need to be modified to reflect revised information.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. It should be emphasized that the values in the Budget Neutrality Form are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this analysis.

Appendix III illustrates the 1115 Waiver Budget Neutrality spreadsheet. The rest of this section documents the supporting data included in the spreadsheet using guidance provided by CMS in the Budget Neutrality Form.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual Data

We have provided actual historical data separately for three Medicaid populations contained in the waiver: Children (Age 18 and Under), Adults: Non-Expansion, and Adults: Expansion.

For both the Children and Adult Non-Expansion populations, we have provided historical data for calendar years 2011 through 2015. For the Adult Expansion population, we have provided historical data for the program's first two years, calendar year (CY) 2014 through 2015. For each eligibility group, the historical data includes capitation payments and fee-for-service experience for members who were enrolled in program that will be eligible for Kentucky HEALTH.

B. Bridge Period

The bridge period is January 1, 2016 to December 31, 2016 (12 months).

C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification

For the Children and Adult Non-Expansion populations, we developed annual trend rates for member months based on CY 2011 to CY 2015 eligible member months. For PMPM cost trend, we used observed 5-year average trends developed based on the CY 2011 through CY 2015 historic data.

We were unable to observe reasonable enrollment and PMPM cost trends for the Expansion eligibility group due to the infancy of the program. Therefore, we used eligible member months and PMPM cost trend rates equal to the observed 5-year average trend rate for the Adult Non-Expansion eligibility group.

D. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

To project with-waiver PMPM cost and member months, we estimated the impact of key features of Kentucky HEALTH for each eligibility group. PMPM cost and enrollment changes were estimated through the use of data and information provided by the Kentucky Department for Medicaid Services. Additionally, we relied on data and other information from the Current Population Survey and Medical Expenditure Panel Survey. We also relied on data and other information from similar Medicaid programs to develop with-waiver projection estimates as appropriate.

Key features of Kentucky HEALTH reflected in the with-waiver projections include the following:

Benefit Package Changes. Specific benefit changes reflected in the with-waiver projections for the Expansion eligibility group include:

- Removal of non-emergency medical transportation (NEMT) for non-medically frail expansion eligibility group;
- Modification of service limits for PT/OT/ST; and,
- Addition of GED certification fees for Expansion and non-Expansion adults.

We relied on data and other information provided by consultants to the Kentucky Department for Medicaid Services in developing estimated impacts for these benefit package changes. Please note that no benefit package changes were assumed for the Children and Adult Non-Expansion eligibility groups.

Coverage Effective Date & Retroactive Coverage. For non-exempted eligibility groups, we assumed that retroactive eligibility will no longer apply. We anticipate that presumptive eligibility will be introduced at additional providers corresponding with this program change. The removal of retroactive eligibility is expected to have an impact to both enrollment and per capita claims. With no retroactive eligibility, we expect to see anywhere from zero to three months of enrollment removed for newly eligible beneficiaries. We assumed a different level of cost on a PMPM basis for these retroactive months, relative to non-retroactive eligibility months, as the members are not fully acclimated to Medicaid and may not fully utilize Medicaid covered services. Aggregate expenditures are estimated to be reduced due to the removal of retroactive eligibility months.

To estimate the impact of this change, we compared base medical member months and PMPMs with and without retroactive months for a similar Medicaid population. We reviewed the changes in enrollment and cost between the two scenarios by eligibility group segment to estimate the impact of removing retroactive eligibility. In developing these estimates, we considered the impact of presumptive eligibility at additional providers, a provision which will partially offset the removal of retroactive eligibility.

Employer Premium Assistance Program. We estimated the impact associated with the premium assistance program through the use of Medical Expenditure Panel Survey data from the Agency for Healthcare Research and Quality (AHRQ), along with the 2014 Current Population Survey. We expect membership levels to increase under the premium assistance program as members with existing Employer Sponsored Insurance (ESI) coverage apply for Medicaid ESI assistance. We developed enrollment projections through the use of take up rates which varied by eligibility and age group.

Additionally, we estimated that the PMPM cost for the eligibility groups will decrease as the average cost of ESI premium and cost sharing assistance is estimated to be lower than that of a traditional Medicaid beneficiary. We estimated the impact of this by reviewing the employee premium and cost sharing amounts for an ESI member as compared to Medicaid capitation rates and wrap around coverage, stratified by quartile and eligibility group.

Premium Contributions and My Rewards Account Benefit. To estimate the impact of the introduction of premiums on a household basis, we valued required premium contributions by income band and assumed varying payment rates by eligibility group. Premium amounts were compared to existing copayment requirements to estimate the net impact of member premium contributions.

To estimate the impact of the *My Rewards Account*, we modeled the PMPM cost or savings of each program component by eligibility group. We estimated the impact of the eligible benefits (dental, vision, and OTC drugs) based on PMPM cost estimates for these services, with allowances made for the delayed implementation of vision and dental benefits in the first year of the waiver. We valued the impact of deductible rollover by modeling the distribution of remaining year-end deductible levels based on data and other information from a similar Medicaid program. We estimated the penalty assessed for non-emergent emergency room use and the incentive for proper emergency room use by reviewing the distribution of non-emergent and emergent emergency room utilization based on data provided by the Kentucky Department for Medicaid Services.

Managed Care Reforms. We estimated that requiring the managed care organizations to align payment incentives with quality performance and outcomes has the potential to reduce annualized trends by 0.5% on a PMPM basis.

Community Engagement and Employment. Kentucky HEALTH is structured to encourage employment and community engagement by requiring a graduated weekly commitment from all able bodied adults. We utilized data from the 2014 Current Population Survey to model employment rates in Kentucky while adjusting for children, pregnant women, medically frail, and adults with primary caretaking responsibility for a dependent, which are exempt from the community engagement and employment initiative. We modeled enrollment changes and the corresponding morbidity effects based on a 2 year program phase in for community engagement requirements.

E. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

The impact of each feature of Kentucky HEALTH is fully reflected in the trend rates displayed in **Appendix III**. The development and justification for these rates is described in *Section D* above.

II. Cost Projections for New Populations

Not applicable

III. Disproportionate Share Hospital Expenditure Offset

Not applicable

IV. Summary of Budget Neutrality

Appendix III illustrates the 1115 Waiver Budget Neutrality spreadsheet, which includes the following applicable tabs:

- i. Historic Data
- ii. WOW (Without-Waiver)
- iii. WW (With-Waiver)
- iv. Summary (of Budget Neutrality)

V. Additional Information to Demonstrate Budget Neutrality

We do not believe there is any other information necessary for CMS to complete its analysis of the budget neutrality submission.

ATTACHMENT III: Budget Neutrality Worksheets

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

<u>Children (Age 18 and Under)</u>	2011	2012	2013	2014	2015	5-YEARS
TOTAL EXPENDITURES	\$ 1,278,702,725	\$ 1,310,253,249	\$ 1,376,613,845	\$ 1,477,821,840	\$ 1,618,128,571	\$ 7,061,520,230
ELIGIBLE MEMBER MONTHS	5,265,504	5,273,555	5,271,564	5,623,907	5,986,896	
PMPM COST	\$ 242.85	\$ 248.46	\$ 261.14	\$ 262.77	\$ 270.28	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE		2.47%	5.06%	7.35%	9.49%	6.06%
ELIGIBLE MEMBER MONTHS		0.15%	-0.04%	6.68%	6.45%	3.26%
PMPM COST		2.31%	5.10%	0.63%	2.86%	2.71%

<u>Adults: Non-Expansion</u>	2011	2012	2013	2014	2015	5-YEARS
TOTAL EXPENDITURES	\$ 667,466,616	\$ 717,268,238	\$ 749,662,818	\$ 808,989,927	\$ 892,510,877	\$ 3,835,898,476
ELIGIBLE MEMBER MONTHS	1,592,467	1,585,041	1,612,831	1,554,892	1,626,900	
PMPM COST	\$ 419.14	\$ 452.52	\$ 464.81	\$ 520.29	\$ 548.60	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE		7.46%	4.52%	7.91%	10.32%	7.53%
ELIGIBLE MEMBER MONTHS		-0.47%	1.75%	-3.59%	4.63%	0.54%
PMPM COST		7.96%	2.72%	11.93%	5.44%	6.96%

<u>Adults: Expansion</u>	2011	2012	2013	2014	2015	5-YEARS
TOTAL EXPENDITURES	\$ -	\$ -	\$ -	\$ 2,316,349,837	\$ 3,118,683,205	\$ 5,435,033,042
ELIGIBLE MEMBER MONTHS	-	-	-	4,422,028	5,977,024	
PMPM COST	\$ -	\$ -	\$ -	\$ 523.82	\$ 521.78	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE		0.00%	0.00%	0.00%	34.64%	34.64%
ELIGIBLE MEMBER MONTHS		0.00%	0.00%	0.00%	35.16%	35.16%
PMPM COST		0.00%	0.00%	0.00%	-0.39%	-0.39%

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					DY 01	DY 02	DY 03	DY 04	DY 05	
Children (Age 18 and Under)										
Pop Type: Medicaid										
Eligible Member Months	3.3%	12	6,182,069	3.3%	6,383,604	6,591,709	6,806,599	7,028,494	7,257,623	
PMPM Cost	2.7%	12	\$ 277.60	2.7%	\$ 285.12	\$ 292.85	\$ 300.79	\$ 308.94	\$ 317.31	
Total Expenditure					\$ 1,820,093,153	\$ 1,930,382,104	\$ 2,047,356,958	\$ 2,171,383,023	\$ 2,302,916,416	\$ 10,272,131,654
Adults: Non-Expansion										
Pop Type: Medicaid										
Eligible Member Months	0.5%	12	1,635,685	0.5%	1,644,518	1,653,398	1,662,326	1,671,303	1,680,328	
PMPM Cost	7.0%	12	\$ 586.78	7.0%	\$ 627.62	\$ 671.30	\$ 718.02	\$ 767.99	\$ 821.44	
Total Expenditure					\$ 1,032,132,205	\$ 1,109,926,148	\$ 1,193,583,641	\$ 1,283,544,004	\$ 1,380,288,676	\$ 5,999,474,674
Adults: Expansion										
Pop Type: Medicaid										
Eligible Member Months	0.5%	12	6,009,300	0.5%	6,041,750	6,074,376	6,107,177	6,140,156	6,173,313	
PMPM Cost	7.0%	12	\$ 558.09	7.0%	\$ 596.93	\$ 638.48	\$ 682.92	\$ 730.45	\$ 781.29	
Total Expenditure					\$ 3,606,502,037	\$ 3,878,367,462	\$ 4,170,713,612	\$ 4,485,077,089	\$ 4,823,147,740	\$ 20,963,807,940

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01	DY 02	DY 03	DY 04	DY 05	
Children (Age 18 and Under)								
Pop Type:	Medicaid							
Eligible Member Months	6,182,069	3.3%	6,387,155	6,599,045	6,817,965	7,044,147	7,277,833	
PMPM Cost	\$ 277.60	2.2%	\$ 283.62	\$ 289.77	\$ 296.05	\$ 302.47	\$ 309.02	
Total Expenditure			\$ 1,811,524,938	\$ 1,912,205,384	\$ 2,018,458,538	\$ 2,130,643,184	\$ 2,248,995,873	\$ 10,121,827,918
Adults: Non-Expansion								
Pop Type:	Medicaid							
Eligible Member Months	1,635,685	-2.2%	1,600,019	1,565,130	1,531,003	1,497,619	1,464,964	
PMPM Cost	\$ 586.78	6.9%	\$ 627.17	\$ 670.35	\$ 716.50	\$ 765.82	\$ 818.54	
Total Expenditure			\$ 1,003,483,850	\$ 1,049,185,216	\$ 1,096,963,509	\$ 1,146,906,800	\$ 1,199,131,380	\$ 5,495,670,754
Adults: Expansion								
Pop Type:	Medicaid							
Eligible Member Months	6,009,300	-2.3%	5,868,387	5,730,779	5,596,397	5,465,167	5,337,013	
PMPM Cost	\$ 558.09	7.4%	\$ 599.55	\$ 644.09	\$ 691.94	\$ 743.34	\$ 798.56	
Total Expenditure			\$ 3,518,391,637	\$ 3,691,137,353	\$ 3,872,371,048	\$ 4,062,476,931	\$ 4,261,925,309	\$ 19,406,302,278

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Children (Age 18 and Under)	\$ 1,820,093,153	\$ 1,930,382,104	\$ 2,047,356,958	\$ 2,171,383,023	\$ 2,302,916,416	\$ 10,272,131,654
Adults: Non-Expansion	\$ 1,032,132,205	\$ 1,109,926,148	\$ 1,193,583,641	\$ 1,283,544,004	\$ 1,380,288,676	\$ 5,999,474,674
Adults: Expansion	\$ 3,606,502,037	\$ 3,878,367,462	\$ 4,170,713,612	\$ 4,485,077,089	\$ 4,823,147,740	\$ 20,963,807,940
TOTAL	\$ 6,458,727,395	\$ 6,918,675,714	\$ 7,411,654,210	\$ 7,940,004,116	\$ 8,506,352,832	\$ 37,235,414,268

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Children (Age 18 and Under)	\$ 1,811,524,938	\$ 1,912,205,384	\$ 2,018,458,538	\$ 2,130,643,184	\$ 2,248,995,873	\$ 10,121,827,918
Adults: Non-Expansion	\$ 1,003,483,850	\$ 1,049,185,216	\$ 1,096,963,509	\$ 1,146,906,800	\$ 1,199,131,380	\$ 5,495,670,754
Adults: Expansion	\$ 3,518,391,637	\$ 3,691,137,353	\$ 3,872,371,048	\$ 4,062,476,931	\$ 4,261,925,309	\$ 19,406,302,278
TOTAL	\$ 6,333,400,425	\$ 6,652,527,953	\$ 6,987,793,094	\$ 7,340,026,915	\$ 7,710,052,562	\$ 35,023,800,949

VARIANCE	\$ 125,326,970	\$ 266,147,762	\$ 423,861,116	\$ 599,977,201	\$ 796,300,270	\$ 2,211,613,318
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ATTACHMENT IV: Public Notice

**NOTICE OF KENTUCKY DEPARTMENT FOR MEDICAID SERVICES
PUBLIC HEARINGS AND COMMENT PERIOD FOR
§1115 DEMONSTRATION WAIVER**

Pursuant to 42 CFR 431.408, notice is hereby given that the Kentucky Department for Medicaid Services will provide the public the opportunity to review and provide input on a §1115 demonstration waiver that will be submitted to the Centers for Medicare and Medicaid Services (CMS) to implement Kentucky HEALTH. This notice provides details about the waiver submission and serves to open the 30-day public comment period, which closes on Friday, July 22, 2016 at 5:00 p.m.

In addition to the 30-day public comment period in which the public will be able to provide written comments to the agency via the US postal service or electronic mail, the Commonwealth will also host two public hearings in which the public may provide verbal comments directly to the Agency. The public hearings will be held on the following dates and times at the following geographically distinct locations:

Tuesday, June 28, 2016, 10:00 AM – 12:00 PM (CST)

Western Kentucky University
Knicey Conference Center Auditorium
2355 Nashville Road
Bowling Green, KY 42101

Wednesday, June 29, 2016, 1:00 PM – 2:00 PM (EST)

Advisory Council for Medical Assistance (MAC) Special Meeting
Kentucky Capitol Annex
702 Capital Avenue
Frankfort, KY 40601

Wednesday, July 6, 2016, 11:00 AM – 1:00 PM (EST)

Hazard Community and Technical College Campus
Room 208, Jolly Classroom Center
1 Community College Drive
Hazard, KY 41701

Prior to finalizing the proposed waiver, the Commonwealth will consider all of the public comments received during the public comment period, both written and verbal. The comments will be summarized and addressed in the final draft of the waiver to be submitted to CMS.

WAIVER PROPOSAL SUMMARY

The §1115 demonstration waiver seeks to secure the long-term viability of Medicaid expansion in Kentucky, and introduce reforms intended to tailor the program to a non-disabled working-age adult population. The §1115 demonstration waiver creates an innovative, transformative healthcare program designed to not only improve health outcomes for members, but also improve their overall quality of life by addressing some of the underlying social determinants of health and helping to break the cycle of poverty. The §1115 demonstration waiver includes the

creation of the Kentucky HEALTH program and introduces comprehensive delivery system reforms targeting substance use disorder (SUD), chronic disease management, and managed care to improve quality and outcomes.

Kentucky HEALTH offers eligible individuals two pathways to coverage: (i) an employer premium assistance program, which assists individuals in purchasing their employer-sponsored health insurance plan; and (ii) a consumer-driven health plan option, which offers members a high-deductible health plan with commercial market benefits.

1. Employer Premium Assistance Program: Members who currently have access to health insurance through their employer will have the option to enroll their family into their employer-sponsored health insurance plan. Participation in the premium assistance program in lieu of the standard Kentucky HEALTH consumer driven health plan is optional during their first year of enrollment, but mandatory after the member's second year of eligibility, provided the member has been employed with their employer at least one year. The employer premium assistance program will subsidize the member's employer-sponsored health insurance plan.
2. Consumer-Driven Health Plan: This innovative, transformative healthcare program introduces commercial market health insurance features and encourages members to become active consumers of healthcare. Kentucky HEALTH will be managed through a managed care delivery system and will offer a new benefit package modeled after the Kentucky State Employees' Health Plan, while maintaining current mental health and substance use disorder benefits. In addition, Kentucky HEALTH provides a consumer-driven, high-deductible health plan paired with two member controlled healthcare spending accounts: (i) the deductible account, to cover deductible expenses; and (ii) the *My Rewards Account*, to accrue savings and earned incentive dollars that can be used to purchase enhanced benefits not covered in the base benefit package.

Kentucky HEALTH is designed to improve member health, prepare them for employment, and provide them with the tools to successfully transition to commercial market insurance coverage. First, the program focuses on engaging people to improve their overall health and wellbeing by creating incentives for preventive care, participation in disease management programs, and healthy lifestyles. Second, the program embraces commercial market policies and principles to familiarize participants with commercial market coverage by requiring member premiums and establishing an open enrollment period. Finally, the program actively assists members in transitioning to commercial market insurance coverage by requiring participation in minimum community engagement activities, incentivizing employment, and rewarding members who are successfully able to obtain employment and commercial health insurance for at least eighteen months.

GOALS & OBJECTIVES

The Kentucky HEALTH seeks to comprehensively transform Medicaid and accomplish the following goals:

1. Improve participants' health and help them be responsible for their health;

2. Encourage individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance;
3. Empower people to seek employment and transition to commercial health insurance coverage;
4. Implement delivery system reforms to improve quality and outcomes; and
5. Ensure fiscal sustainability.

ELIGIBILITY

Kentucky HEALTH is designed specifically for able-bodied working age adults and their families. Currently, the Commonwealth has expanded Medicaid to cover this new adult group up to 138% of the federal poverty level (FPL). This expansion will be maintained through Kentucky HEALTH. In addition, the Commonwealth will seek to transition all other non-disabled adult Medicaid recipients to Kentucky HEALTH. Finally, Kentucky HEALTH will seek to provide seamless coverage for families by including children covered under the KCHIP program.

Kentucky HEALTH will include the following eligibility categories:

- Individuals eligible in the new adult group pursuant to Section 1902(a)(10)(i)(VIII) of the Social Security Act (the Act);
- Low-income parents and caretaker relatives pursuant to Section 1931 of the Act;
- Individuals eligible for transitional medical assistance pursuant to Section 1925 of the Act;
- Women eligible in the pregnant women category;
- Newborn children;
- Medicaid eligible infants and children under age 19; and
- Children eligible under Title XXI CHIP Program.

Kentucky HEALTH may also affect member eligibility due to the introduction of several commercial market policies as well as the community engagement and employment initiative.

- Commercial Market Policies: Similar to the commercial health insurance market, individuals determined eligible for Kentucky HEALTH (excluding children and pregnant women) will be required to make their first month's required premium payment (as described in the Cost Sharing section below) prior to the start of benefits. Notwithstanding the foregoing, individuals with income at or below 100% FPL who do not make an initial premium payment within sixty calendar days from the date of the invoice, will begin benefits but subject to the non-payment penalty described below in the "Member Cost Sharing" section of this notice. In addition, Kentucky HEALTH will establish a client-specific open enrollment period. That is, if an individual is disenrolled from the program in accordance with current practice for failing to comply with annual eligibility redetermination requirements, the individual will be required to wait six months for a new open enrollment period. This policy will educate members of the importance of meeting commercial health insurance market open enrollment deadlines. Members may rejoin the program at any time prior to the six-month date by completing a financial or health literacy course.
- Community Engagement & Employment Initiative: To further the goal of helping members transition to commercial health insurance coverage, Kentucky HEALTH will implement a

community engagement and employment initiative. After three months of program eligibility, all able-bodied working age adult Kentucky HEALTH members will be required to participate in a community engagement activity, such as volunteer work, employment or job training, and job search activities. To help transition members into this requirement, the hour requirement will gradually increase to require at least twenty hours of community engagement activities each week after the first year. Children, pregnant women, individuals determined medically frail, and individuals who are the primary caregiver of a dependent will be exempt from this requirement.

Escalated Community Engagement & Employment Hours

Eligibility Period	Required Engagement Hours
1-3 months	0 hours per week
4-6 months	5 hours per week
6-9 months	10 hours per week
9-12 months	15 hours per week
12+ months	20 hours per week

ENROLLMENT & FISCAL PROJECTIONS

It is anticipated that enrollment in Kentucky HEALTH will fluctuate for a variety of reasons, including program non-compliance. Members may have health coverage temporarily suspended for not meeting the community engagement and employment initiative requirements or for failing to pay required monthly premiums. However, all individuals will have the opportunity to regain coverage at any time through compliance with the community engagement requirements, or by completing a health or financial literacy class and paying premiums. In addition, initial enrollment may fluctuate as individuals with little to no claims activity choose to leave the program rather than pay premiums, however, over time this will settle as individuals become familiar with the advantages of the program. Finally, in later demonstration years, more participants are expected to transition to commercial coverage.

The following table illustrates the State’s enrollment projections by total member months.

Estimated Enrollment Projections

Year	Without Waiver	KENTUCKY HEALTH	Difference
1 (2017)	14,070,000	13,856,000	(214,000)
2 (2018)	14,319,000	13,895,000	(424,000)
3 (2019)	14,576,000	13,945,000	(631,000)
4 (2020)	14,840,000	14,007,000	(833,000)
5 (2021)	15,111,000	14,080,000	(1,031,000)

Note: Values shown have been rounded and represent member months.

Over the five-year demonstration period, Kentucky HEALTH will save a total of approximately \$2.2 billion. The table below provides the estimated State and federal costs divided by year.

Estimated Fiscal Projections

Demonstration Year	Expenditures			State Share of Expenditure Difference
	Without Waiver	Kentucky HEALTH	Difference	
1 (2017)	\$ 6,458,700,000	\$ 6,332,300,000	\$ (126,500,000)	\$ (15,500,000)
2 (2018)	\$ 6,918,700,000	\$ 6,650,100,000	\$ (268,600,000)	\$ (34,900,000)
3 (2019)	\$ 7,411,700,000	\$ 6,983,900,000	\$ (427,700,000)	\$ (58,500,000)
4 (2020)	\$ 7,940,000,000	\$ 7,334,700,000	\$ (605,300,000)	\$ (95,600,000)
5 (2021)	\$ 8,506,400,000	\$ 7,703,000,000	\$ (803,300,000)	\$ (126,800,000)

Note: Values have been rounded.

BENEFITS

Kentucky HEALTH seeks to provide its members with a commercial health insurance experience in order to better prepare members to transition to commercial insurance. The Kentucky HEALTH benefit plan for the expansion population will align with the Kentucky State Employees' Health Plan, which provides a comprehensive commercial health insurance benefit package. Kentucky HEALTH will preserve all current mental health and SUD services. Further, additional benefits including dental services, vision services, over the counter medications, and gym membership reimbursement will be available through the member's *My Rewards Account*. Further, consistent with the goal of offering a commercial health insurance market experience, the Commonwealth will not provide coverage for non-emergency medical transportation (NEMT) to the newly eligible adult group, and will seek a waiver of this non-commercial health insurance benefit.

Children, pregnant women, medically frail individuals, and individuals eligible for Medicaid prior to the passage of the Affordable Care Act will be eligible to receive standard Medicaid State Plan benefits, including NEMT, vision services, and dental services. In addition, all children receiving services through the waiver will continue to receive all early and periodic screening, diagnostic, and treatment (EPSDT) services. The Commonwealth will make several minor modifications to the current State Plan covered services via State Plan Amendment to remove certain non-traditional Medicaid benefits that were added in 2014 with expansion, such as private duty nursing and allergy testing.

In addition, this §1115 demonstration waiver seeks to implement a new employer premium assistance program, which will allow eligible members to purchase their employer-sponsored health insurance plan in lieu of participating in Kentucky HEALTH. Members participating in the employer premium assistance option will have full access to the benefits and network of the employer plan; however, the Commonwealth will provide wrap-around benefits to ensure that members have access to all Kentucky HEALTH benefits not otherwise covered by the employer-sponsored health insurance plan.

MEMBER COST SHARING

All Kentucky HEALTH members, with the exception of pregnant women and children, will be required to pay a monthly premium amount, increasing on a sliding scale based on family income, ranging from \$1.00 per month up to a maximum of \$15.00 per month.

Kentucky HEALTH Sliding Scale Premium Contribution Amounts

Federal Poverty Level	Premium Payment
Under 25% FPL	\$1.00 per month
25-50% FPL	\$4.00 per month
51-100% FPL	\$8.00 per month
101-138% FPL	\$15.00 per month

To discourage long-term program dependency and to prepare higher income members for Marketplace coverage, premium requirements will gradually increase for individuals with income greater than 100% FPL each year the member remains Kentucky HEALTH, in accordance with the table below.

Increased Premium Amounts for Individuals Over 100% FPL

FPL	Year 1-2 Premium	Year 3 Premium	Year 4 Premium	Year 5+ Premium
101-138%	\$15.00	\$22.50	\$30.00	\$37.50

In addition to monthly premiums, Kentucky HEALTH will include a deductible (equal to \$1,000), and each member (except pregnant women and children who are exempt from all cost sharing) will be provided a fully funded deductible account to pay for the deductible. Preventive services, such as annual examinations, are covered without charge to the member and are not included in the plan deductible amount. After the \$1,000 deductible is met through the utilization of the member’s deductible account, the managed care plan will pay for all covered services in full.

Members who consistently make their required premium contributions will have access to the *My Rewards Account*. The *My Rewards Account* will contain incentive dollars which members may earn by completing specified activities designed to improve member health (i.e. participation in disease management course) and increase community engagement (i.e. volunteer work, participation in job search or training, etc.). In addition, members may transfer up to 50% of any unused balance in their deductible account to the *My Rewards Account* at the end of the benefit period. As funds accumulate in the *My Rewards Account*, the member may purchase additional benefits (as described in the Benefits section above).

Members will have a sixty-day grace period to make their required monthly premium payment contribution to the deductible account. Similar to commercial plans, Kentucky HEALTH will impose consequences for non-compliance in order to help educate members about standard commercial health insurance market policies. Therefore, individuals that do not pay a required premium payment within sixty calendar days from the due date will face a six-month non-payment penalty, as detailed in the table below. However, all individuals will have the ability to end their non-payment penalty period by completing one of the early re-entry options outlined in the table below.

Non-Payment Penalty

Member FPL	Non-Payment Penalty	Early Re-Entry Option
Above 100% FPL	<ul style="list-style-type: none"> Disenrolled from Kentucky HEALTH Re-enrollment waiting period of six months 	<ul style="list-style-type: none"> Pay past debt; Pay premium for reinstatement month; and Participate in financial or health literacy course
At or below 100% FPL & Medically Frail	<ul style="list-style-type: none"> State Plan copayments required for all services \$25 is deducted from the <i>My Rewards Account</i> <i>My Rewards Account</i> is suspended <ul style="list-style-type: none"> Not able to use funds in account Not able to accrue funds in account 	
Pregnant Women and Children	Not applicable. Exempt from all cost-sharing requirements.	Not applicable

As long as the member is consistently paying their monthly premium, Kentucky HEALTH will not require additional copayments for services. Kentucky HEALTH will only apply copayments to services for individuals with income at or below 100% FPL or for those determined medically frail. Required copayments during the member's non-payment penalty period will be equal to the current copayments scheduled in the Kentucky Medicaid State Plan, which range from \$3.00 for a physician office visit and up to \$50.00 for hospital inpatient services.

In addition, to incentivize appropriate hospital emergency department utilization, Kentucky HEALTH will implement incentives and disincentive related to the members *My Rewards Account*. Members will be eligible for a \$20 financial contribution to the *My Rewards Account* for each year in which the member avoids unnecessary emergency room services and seeks appropriate alternative providers for care, and be subject to escalating deductions from the *My Rewards Account* for each inappropriate emergency room visit.

Inappropriate Emergency Room Utilization *My Rewards Account* Penalty

Inappropriate ER Visit	Account Deduction
1 st Visit	\$20
2 nd Visit	\$50
3 rd Visit or More	\$75

HEALTH CARE DELIVERY SYSTEM

Kentucky HEALTH will rely on the Commonwealth's existing managed care delivery system. In addition to the creation of the Kentucky HEALTH program, the §1115 demonstration waiver will also introduce comprehensive delivery system reforms targeting substance use disorder (SUD), chronic disease management, and managed care to improve quality and outcomes.

- Substance Use Disorder: Kentucky HEALTH will maintain all current mental health and substance use disorder (SUD) benefits. However, this §1115 demonstration waiver will also implement a pilot program in ten to twenty select counties to improve access to

mental health and SUD services. Counties will be identified based on a recent CDC HIV/hepatitis C outbreak study, the State's existing Shaping Our Appalachian Region (SOAR) initiative, and public input received during the demonstration waiver public notice and comment period. Specifically, the Commonwealth will request a waiver of the Institutions for Mental Disease (IMD) exclusion to allow Medicaid reimbursement for short-term residential stays of up to thirty days in an IMD. The pilot program will also examine best practice improvements related to standards of care, care coordination between levels and settings of care, and strategies to address prescription drug abuse and opioid use disorder.

- Chronic Disease Management: The waiver will align various Kentucky HEALTH program components to support the Commonwealth's existing public health infrastructure and current efforts to improve chronic disease prevention and management. In addition, the Commonwealth will work with Kentucky's Medicaid managed care organizations to continue implementing best practices from nationally recognized disease management programs, such as the National Diabetes Prevention Program.
- Managed Care Reforms: Prior to implementing Kentucky HEALTH, the Commonwealth will align incentives across the delivery system by introducing mechanisms to control spending, as well as payment incentives for providers and the managed care organizations to improve quality and align with member incentives. In addition, the Kentucky Department for Medicaid Services will continue to seek improvements and administrative efficiencies in the existing Medicaid managed care program, such as uniform credentialing and formulary alignment.

IMPLEMENTATION

The Commonwealth will implement the Kentucky HEALTH program on a statewide basis on or about six months post-§1115 demonstration waiver approval; however, this date may vary depending on the approval date from CMS. The Kentucky HEALTH community engagement and employment initiative will be phased in on a county-by-county basis and may take longer. Implementation of this 1115 demonstration waiver will require the Commonwealth to amend the existing managed care contracts, modify systems and other operational procedures, and conduct a readiness review of various vendors. In addition to these tasks, the Commonwealth will also have to amend the Medicaid State Plan, amend the Alternative Benefit Plan, develop education materials, and prepare to transition existing members.

HYPOTHESES & EVALUATION

This Section 1115 demonstration waiver will investigate the following research hypotheses related to each program goal:

Goal 1: Improve participant's health and help them be responsible for their health

- Hypothesis: Kentucky HEALTH policies will promote member use of preventive and primary care.
 - Track and compare health service utilization rates between current Kentucky HEALTH members and their previous Medicaid enrollment category.

- Track preventive care utilization rates and trends among different age and gender groups.
- Hypothesis: Kentucky HEALTH policies will promote member compliance with chronic disease management.
 - Track and compare chronic disease management compliance rates between current Kentucky HEALTH members and their previous Medicaid enrollment category.
- Hypothesis: Kentucky HEALTH policies will reduce member hospitalization of ambulatory care sensitive conditions (ACSCs).
 - Track and compare ACSCs hospitalization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.
- Hypothesis: Kentucky HEALTH policies will increase access to substance use disorder (SUD) services with special focus on Institutions for Mental Diseases (IMD).
 - Track and compare inpatient specialty care/SUD utilization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.

Goal 2: Transform individuals from passive beneficiaries to active participants and consumers of healthcare who are prepared to use commercial health insurance

- Hypothesis: Kentucky HEALTH policies will provide incentives to monitor and managed the two member managed account funds.
 - Track and compare remaining balances in member deductible accounts at the end of each benefit period.
 - Track and compare balance in member *My Rewards Accounts* at the end of each benefit period.
 - Track account balances transferred from the deductible account to the *My Rewards Account* at the end of each benefit period, including number of members with unused deductible account balances at the end of each benefit period and the average amount transferred to the *My Rewards Account* at the end of each benefit period.
 - Track number of people checking their account balances, as well as how often they are checked (i.e. weekly, monthly, semi-annually, and annually).
- Hypothesis: Kentucky HEALTH policies will encourage healthy behaviors and increase member access to enhanced health services (such as gym memberships and over-the-counter medications).
 - Track and compare *My Reward Account* expenditures on enhanced health services.
 - Track and compare member achievement of healthy incentives contributions to the *My Rewards Account*.
 - Track and compare type of enhanced health services used by member *MY Rewards* accounts.
- Hypothesis: Kentucky HEALTH policies will promote member compliance with making premium payments.
 - Track premium initial and ongoing premium payments.
- Hypothesis: Kentucky HEALTH open enrollment policy will increase member compliance with redetermination process.

- Track member compliance with redetermination.
- Hypothesis: Kentucky HEALTH's incentive and disincentive policies related to non-emergency use of hospital emergency room will reduce inappropriate utilization among Kentucky HEALTH members.
 - Compare annual rates of inappropriate emergency department utilization between Kentucky Medicaid populations for the years *before waiver* (prior to 2017) and *after waiver* (2017 and beyond).
 - Survey Kentucky HEALTH members on whether the incentives and disincentives related to the *My Rewards Account* for appropriate emergency room utilization caused them to seek services with their primary care physician or in an alternative urgent care setting.
 - Compare annual rates of members subject to the escalating *My Rewards Account* disincentive based on repeated inappropriate hospital emergency department utilization.

Goal 3: Empower people to seek employment and transition to commercial health insurance coverage

- Hypothesis: Kentucky HEALTH policies will encourage members to increase community engagement.
 - Track and compare member achievement of community engagement and employment contributions to the *My Rewards Account*.
- Hypothesis: Kentucky HEALTH policies will encourage members to seek employment.
 - Track members participating in job search activities.
- Hypothesis: Kentucky HEALTH policies will encourage members to earn employment and ultimately transition to commercial health insurance coverage.
 - Track number of individuals successfully transitioning to commercial health insurance coverage and accessing the *My Rewards Account* bonus after eighteen months.
 - Track number of individuals employed over twenty hours per week.
 - Track earnings of members who earn employment.
- Hypothesis: The employer premium assistance program will increase the proportion of Kentucky residents under 138% FPL covered by employer sponsored insurance.
 - Track the number of Kentucky residents with income under 138% FPL covered by ESI over the demonstration.
 - Track employer premium assistance program member enrollment.
 - Track employer premium assistance program employer enrollment.
 - Track employer premium assistance program wrap-around coverage expenditures.
- Hypothesis: Kentucky HEALTH's sliding scale increase premium payment amounts will discourage dependency on public assistance and encourage members to transition to commercial health insurance coverage.
 - Compare annual rates of Medicaid enrollment between Kentucky Medicaid populations for the years *before waiver* (prior to 2017) and *after waiver* (2017 and beyond).

- Survey Kentucky HEALTH members on whether the sliding scale increased premium payment amount caused them to seek employment and/or other forms of health insurance coverage.
- Compare annual rates of members paying increased premium amounts based on continued annual enrollment in Kentucky HEALTH.

Goal 4: Implement Delivery System Reform to Improve Quality and Outcomes

- Hypothesis: Kentucky HEALTH policies will promote high quality healthcare delivered by providers.
 - Track managed care organizations ability to meet quality and outcome benchmarks within their service contracts.
 - Track Kentucky providers receiving bonus payments from the managed care organizations for meeting quality and outcomes standards.

Goal 5: Ensure fiscal sustainability

- Hypothesis: Kentucky HEALTH will remain budget-neutral for both the federal and State governments.
 - Conduct a budget neutrality analysis and document adherence to waiver margin.

WAIVER & EXPENDITURE AUTHORITIES

Below is a list of proposed waivers the Commonwealth will seek from CMS to implement Kentucky HEALTH:

1. **Eligibility: Section 1902(a)(10)(A)**
 - To the extent necessary to enable Kentucky to not provide medical coverage until the first day of the month in which the Kentucky HEALTH member pays their first premium payment, or for members below 100% FPL who fail to make an initial premium payment, the first day of the month following the expiration of the 60-day payment period.
 - To the extent necessary to enable Kentucky to require Kentucky HEALTH members, as a condition of eligibility, to complete specified community engagement hours.
2. **Retroactive Eligibility: Section 1902(a)(34)**
 - To the extent necessary to enable Kentucky to not provide medical coverage for any month prior to the month in which the member finalized enrollment in Kentucky HEALTH.
3. **Cost-Sharing: Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**
 - To the extent necessary to enable Kentucky to require monthly premium payments not to exceed 5% of income, but no less than \$1.00 per month, for all Kentucky HEALTH members.
4. **Amount, Duration, and Scope: Section 1902(a)(10)(B)**
 - To the extent necessary to enable Kentucky to vary cost-sharing requirements, such that premium contribution amounts increase each year members with income above 100% FPL remain on Kentucky HEALTH, not to exceed 5% of income, and to charge copayments in lieu of premiums for individuals at or below 100% FPL who fail to make their premium payment within the sixty-day payment period.

- To the extent necessary to allow Kentucky HEALTH members who continue to pay premium contributions to use their *My Rewards Account* to purchase specified enhanced benefits not otherwise available in the base Kentucky HEALTH benefit package.
 - To the extent necessary to enable Kentucky to allow individuals to receive the benefits provided through their employer-sponsored plan.
- 5. Reasonable Promptness: Section 1902(a)(3)/Section 1902(a)(8)**
- To the extent necessary to enable Kentucky to delay benefits, such that benefits do not begin until a member makes a premium contribution, or until the expiration of a 60-day payment period for members below 100% FPL who fail to make a premium contribution.
 - To the extent necessary to enable Kentucky to prohibit re-enrollment for up to six months for Kentucky HEALTH members above 100% FPL who are disenrolled for failure to make their required premium contributions within 60 days of the due date.
 - To the extent necessary to enable Kentucky to implement an open enrollment period for Kentucky HEALTH, such that members who are disenrolled for failure to complete redetermination process will be required to wait until their next open enrollment period to re-enroll (up to six months).
- 6. Freedom of Choice: Section 1902(a)(23)**
- To the extent necessary to enable Kentucky to restrict the freedom of choice of providers for demonstration eligibility groups.
- 7. Non-Emergency Transportation: Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**
- To the extent necessary to relieve Kentucky of the requirement to assure non-emergency medical transportation to and from medical providers for Kentucky HEALTH members.

In addition, the Commonwealth requests that expenditures related to providing services in an Institution for Mental Disease (IMD), in participating pilot project counties, be regarded as expenditures under the Commonwealth's Medicaid Title XIX State Plan.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

All information regarding the Kentucky HEALTH §1115 demonstration waiver, including this public notice, the waiver application, and other documentation regarding the proposal are available at: <http://chfs.ky.gov/kentuckyhealth>. In addition, the Kentucky HEALTH §1115 demonstration waiver application is available for in-person public review at Cabinet for Health and Family Services, Office of the Secretary, 275 E. Main St., Frankfort, KY 40621.

Written comments regarding the Kentucky HEALTH waiver application may be mailed to Commissioner Stephen Miller, Department for Medicaid Services, 275 E. Main Street, Frankfort, KY 40621. Comments may also be sent via electronic mail to kyhealth@ky.gov. All comments must be received by Friday, July 22, 2016 at 5:00 p.m.

NOTICE OF KENTUCKY DEPARTMENT FOR MEDICAID SERVICES PUBLIC COMMENT PERIOD FOR §1115 DEMONSTRATION WAIVER

Notice is hereby given that the Kentucky Department for Medicaid Services (DMS) will extend the public comment period on the §1115 demonstration waiver that will be submitted to the Centers for Medicare and Medicaid Services (CMS) to implement Kentucky HEALTH. This notice provides details about the waiver submission and serves as formal notice of the public comment period extension through Friday, August 12, 2016 at 5:00 p.m.

DMS previously held open a 30-day public comment period on the same Kentucky HEALTH waiver from June 22, 2016 through July 22, 2016. In response to the volume of comments that were submitted on the final day of the comment period, including after the 5:00 p.m. deadline, DMS is extending the comment period through 5:00 p.m. on August 12, 2016. This will allow for the numerous comments that came in after the official deadline to be incorporated, as well as allow any individual who was unable to comment previously the opportunity to do so.

Prior to finalizing the proposed waiver, the Commonwealth will consider all comments received on the Kentucky HEALTH waiver, including the original 30-day public comment period as well as this extended public comment period. All comments will be summarized and addressed in the final waiver to be submitted to CMS.

WAIVER PROPOSAL SUMMARY

The §1115 demonstration waiver seeks to secure the long-term viability of Medicaid expansion in Kentucky, and introduce reforms intended to tailor the program to a non-disabled working-age adult population. The §1115 demonstration waiver creates an innovative, transformative healthcare program designed to not only improve health outcomes for members, but also improve their overall quality of life by addressing some of the underlying social determinants of health and helping to break the cycle of poverty. The §1115 demonstration waiver includes the creation of the Kentucky HEALTH program and introduces comprehensive delivery system reforms targeting substance use disorder (SUD), chronic disease management, and managed care to improve quality and outcomes.

Kentucky HEALTH offers eligible individuals two pathways to coverage: (i) an employer premium assistance program, which assists individuals in purchasing their employer-sponsored health insurance plan; and (ii) a consumer-driven health plan option, which offers members a high-deductible health plan with commercial market benefits.

1. Employer Premium Assistance Program: Members who currently have access to health insurance through their employer will have the option to enroll their family into their employer-sponsored health insurance plan. Participation in the premium assistance program in lieu of the standard Kentucky HEALTH consumer driven health plan is optional during their first year of enrollment, but mandatory after the member's second year of eligibility, provided the member has been employed with their employer at least one year. The employer premium assistance program will subsidize the member's employer-sponsored health insurance plan.

2. Consumer-Driven Health Plan: This innovative, transformative healthcare program introduces commercial market health insurance features and encourages members to become active consumers of healthcare. Kentucky HEALTH will be managed through a managed care delivery system and will offer a new benefit package modeled after the Kentucky State Employees' Health Plan, while maintaining current mental health and substance use disorder benefits. In addition, Kentucky HEALTH provides a consumer-driven, high-deductible health plan paired with two member controlled healthcare spending accounts: (i) the deductible account, to cover deductible expenses; and (ii) the *My Rewards Account*, to accrue savings and earned incentive dollars that can be used to purchase enhanced benefits not covered in the base benefit package.

Kentucky HEALTH is designed to improve member health, prepare them for employment, and provide them with the tools to successfully transition to commercial market insurance coverage. First, the program focuses on engaging people to improve their overall health and wellbeing by creating incentives for preventive care, participation in disease management programs, and healthy lifestyles. Second, the program embraces commercial market policies and principles to familiarize participants with commercial market coverage by requiring member premiums and establishing an open enrollment period. Finally, the program actively assists members in transitioning to commercial market insurance coverage by requiring participation in minimum community engagement activities, incentivizing employment, and rewarding members who are successfully able to obtain employment and commercial health insurance for at least eighteen months.

GOALS & OBJECTIVES

The Kentucky HEALTH seeks to comprehensively transform Medicaid and accomplish the following goals:

1. Improve participants' health and help them be responsible for their health;
2. Encourage individuals to become active participants and consumers of healthcare who are prepared to use commercial health insurance;
3. Empower people to seek employment and transition to commercial health insurance coverage;
4. Implement delivery system reforms to improve quality and outcomes; and
5. Ensure fiscal sustainability.

ELIGIBILITY

Kentucky HEALTH is designed specifically for able-bodied working age adults and their families. Currently, the Commonwealth has expanded Medicaid to cover this new adult group up to 138% of the federal poverty level (FPL). This expansion will be maintained through Kentucky HEALTH. In addition, the Commonwealth will seek to transition all other non-disabled adult Medicaid recipients to Kentucky HEALTH. Finally, Kentucky HEALTH will seek to provide seamless coverage for families by including children covered under the KCHIP program.

Kentucky HEALTH will include the following eligibility categories:

- Individuals eligible in the new adult group pursuant to Section 1902(a)(10)(i)(VIII) of the Social Security Act (the Act);
- Low-income parents and caretaker relatives pursuant to Section 1931 of the Act;
- Individuals eligible for transitional medical assistance pursuant to Section 1925 of the Act;
- Women eligible in the pregnant women category;
- Newborn children;
- Medicaid eligible infants and children under age 19; and
- Children eligible under Title XXI CHIP Program.

Kentucky HEALTH may also affect member eligibility due to the introduction of several commercial market policies as well as the community engagement and employment initiative.

- Commercial Market Policies: Similar to the commercial health insurance market, individuals determined eligible for Kentucky HEALTH (excluding children and pregnant women) will be required to make their first month’s required premium payment (as described in the Cost Sharing section below) prior to the start of benefits. Notwithstanding the foregoing, individuals with income at or below 100% FPL who do not make an initial premium payment within sixty calendar days from the date of the invoice, will begin benefits but subject to the non-payment penalty described below in the “Member Cost Sharing” section of this notice. In addition, Kentucky HEALTH will establish a client-specific open enrollment period. That is, if an individual is disenrolled from the program in accordance with current practice for failing to comply with annual eligibility redetermination requirements, the individual will be required to wait six months for a new open enrollment period. This policy will educate members of the importance of meeting commercial health insurance market open enrollment deadlines. Members may rejoin the program at any time prior to the six-month date by completing a financial or health literacy course.
- Community Engagement & Employment Initiative: To further the goal of helping members transition to commercial health insurance coverage, Kentucky HEALTH will implement a community engagement and employment initiative. After three months of program eligibility, all able-bodied working age adult Kentucky HEALTH members will be required to participate in a community engagement activity, such as volunteer work, employment or job training, and job search activities. To help transition members into this requirement, the hour requirement will gradually increase to require at least twenty hours of community engagement activities each week after the first year. Children, pregnant women, individuals determined medically frail, and individuals who are the primary caregiver of a dependent will be exempt from this requirement.

Escalated Community Engagement & Employment Hours

Eligibility Period	Required Engagement Hours
1-3 months	0 hours per week
4-6 months	5 hours per week
6-9 months	10 hours per week
9-12 months	15 hours per week
12+ months	20 hours per week

ENROLLMENT & FISCAL PROJECTIONS

It is anticipated that enrollment in Kentucky HEALTH will fluctuate for a variety of reasons, including program non-compliance. Members may have health coverage temporarily suspended for not meeting the community engagement and employment initiative requirements or for failing to pay required monthly premiums. However, all individuals will have the opportunity to regain coverage at any time through compliance with the community engagement requirements, or by completing a health or financial literacy class and paying premiums. In addition, initial enrollment may fluctuate as individuals with little to no claims activity choose to leave the program rather than pay premiums, however, over time this will settle as individuals become familiar with the advantages of the program. Finally, in later demonstration years, more participants are expected to transition to commercial coverage.

The following table illustrates the State’s enrollment projections by total member months.

Estimated Enrollment Projections

Year	Without Waiver	KENTUCKY HEALTH	Difference
1 (2017)	14,070,000	13,856,000	(214,000)
2 (2018)	14,319,000	13,895,000	(424,000)
3 (2019)	14,576,000	13,945,000	(631,000)
4 (2020)	14,840,000	14,007,000	(833,000)
5 (2021)	15,111,000	14,080,000	(1,031,000)

Note: Values shown have been rounded and represent member months.

Over the five-year demonstration period, Kentucky HEALTH will save a total of approximately \$2.2 billion. The table below provides the estimated State and federal costs divided by year.

Estimated Fiscal Projections

Demonstration Year	Expenditures			State Share of Expenditure Difference
	Without Waiver	Kentucky HEALTH	Difference	
1 (2017)	\$ 6,458,700,000	\$ 6,332,300,000	\$ (126,500,000)	\$ (15,500,000)
2 (2018)	\$ 6,918,700,000	\$ 6,650,100,000	\$ (268,600,000)	\$ (34,900,000)
3 (2019)	\$ 7,411,700,000	\$ 6,983,900,000	\$ (427,700,000)	\$ (58,500,000)
4 (2020)	\$ 7,940,000,000	\$ 7,334,700,000	\$ (605,300,000)	\$ (95,600,000)
5 (2021)	\$ 8,506,400,000	\$ 7,703,000,000	\$ (803,300,000)	\$ (126,800,000)

Note: Values have been rounded.

BENEFITS

Kentucky HEALTH seeks to provide its members with a commercial health insurance experience in order to better prepare members to transition to commercial insurance. The Kentucky HEALTH benefit plan for the expansion population will align with the Kentucky State Employees’ Health Plan, which provides a comprehensive commercial health insurance benefit package. Kentucky HEALTH will preserve all current mental health and SUD services. Further, additional benefits including dental services, vision services, over the counter medications, and gym membership reimbursement will be available through the member’s *My Rewards Account*.

Further, consistent with the goal of offering a commercial health insurance market experience, the Commonwealth will not provide coverage for non-emergency medical transportation (NEMT) to the newly eligible adult group, and will seek a waiver of this non-commercial health insurance benefit.

Children, pregnant women, medically frail individuals, and individuals eligible for Medicaid prior to the passage of the Affordable Care Act will be eligible to receive standard Medicaid State Plan benefits, including NEMT, vision services, and dental services. In addition, all children receiving services through the waiver will continue to receive all early and periodic screening, diagnostic, and treatment (EPSDT) services. The Commonwealth will make several minor modifications to the current State Plan covered services via State Plan Amendment to remove certain non-traditional Medicaid benefits that were added in 2014 with expansion, such as private duty nursing and allergy testing.

In addition, this §1115 demonstration waiver seeks to implement a new employer premium assistance program, which will allow eligible members to purchase their employer-sponsored health insurance plan in lieu of participating in Kentucky HEALTH. Members participating in the employer premium assistance option will have full access to the benefits and network of the employer plan; however, the Commonwealth will provide wrap-around benefits to ensure that members have access to all Kentucky HEALTH benefits not otherwise covered by the employer-sponsored health insurance plan.

MEMBER COST SHARING

All Kentucky HEALTH members, with the exception of pregnant women and children, will be required to pay a monthly premium amount, increasing on a sliding scale based on family income, ranging from \$1.00 per month up to a maximum of \$15.00 per month.

Kentucky HEALTH Sliding Scale Premium Contribution Amounts

Federal Poverty Level	Premium Payment
Under 25% FPL	\$1.00 per month
25-50% FPL	\$4.00 per month
51-100% FPL	\$8.00 per month
101-138% FPL	\$15.00 per month

To discourage long-term program dependency and to prepare higher income members for Marketplace coverage, premium requirements will gradually increase for individuals with income greater than 100% FPL each year the member remains Kentucky HEALTH, in accordance with the table below.

Increased Premium Amounts for Individuals Over 100% FPL

FPL	Year 1-2 Premium	Year 3 Premium	Year 4 Premium	Year 5+ Premium
101-138%	\$15.00	\$22.50	\$30.00	\$37.50

In addition to monthly premiums, Kentucky HEALTH will include a deductible (equal to \$1,000), and each member (except pregnant women and children who are exempt from all cost

sharing) will be provided a fully funded deductible account to pay for the deductible. Preventive services, such as annual examinations, are covered without charge to the member and are not included in the plan deductible amount. After the \$1,000 deductible is met through the utilization of the member’s deductible account, the managed care plan will pay for all covered services in full.

Members who consistently make their required premium contributions will have access to the *My Rewards Account*. The *My Rewards Account* will contain incentive dollars which members may earn by completing specified activities designed to improve member health (i.e. participation in disease management course) and increase community engagement (i.e. volunteer work, participation in job search or training, etc.). In addition, members may transfer up to 50% of any unused balance in their deductible account to the *My Rewards Account* at the end of the benefit period. As funds accumulate in the *My Rewards Account*, the member may purchase additional benefits (as described in the Benefits section above).

Members will have a sixty-day grace period to make their required monthly premium payment contribution to the deductible account. Similar to commercial plans, Kentucky HEALTH will impose consequences for non-compliance in order to help educate members about standard commercial health insurance market policies. Therefore, individuals that do not pay a required premium payment within sixty calendar days from the due date will face a six-month non-payment penalty, as detailed in the table below. However, all individuals will have the ability to end their non-payment penalty period by completing one of the early re-entry options outlined in the table below.

Non-Payment Penalty

Member FPL	Non-Payment Penalty	Early Re-Entry Option
Above 100% FPL	<ul style="list-style-type: none"> • Disenrolled from Kentucky HEALTH • Re-enrollment waiting period of six months 	<ul style="list-style-type: none"> • Pay past debt; • Pay premium for reinstatement month; and • Participate in financial or health literacy course
At or below 100% FPL & Medically Frail	<ul style="list-style-type: none"> • State Plan copayments required for all services • \$25 is deducted from the <i>My Rewards Account</i> • <i>My Rewards Account</i> is suspended <ul style="list-style-type: none"> ○ Not able to use funds in account ○ Not able to accrue funds in account 	
Pregnant Women and Children	Not applicable. Exempt from all cost-sharing requirements.	Not applicable

As long as the member is consistently paying their monthly premium, Kentucky HEALTH will not require additional copayments for services. Kentucky HEALTH will only apply copayments to services for individuals with income at or below 100% FPL or for those determined medically frail. Required copayments during the member’s non-payment penalty period will be equal to the

current copayments scheduled in the Kentucky Medicaid State Plan, which range from \$3.00 for a physician office visit and up to \$50.00 for hospital inpatient services.

In addition, to incentivize appropriate hospital emergency department utilization, Kentucky HEALTH will implement incentives and disincentive related to the members *My Rewards Account*. Members will be eligible for a \$20 financial contribution to the *My Rewards Account* for each year in which the member avoids unnecessary emergency room services and seeks appropriate alternative providers for care, and be subject to escalating deductions from the *My Rewards Account* for each inappropriate emergency room visit.

Inappropriate Emergency Room Utilization *My Rewards Account* Penalty

Inappropriate ER Visit	Account Deduction
1 st Visit	\$20
2 nd Visit	\$50
3rd Visit or More	\$75

HEALTH CARE DELIVERY SYSTEM

Kentucky HEALTH will rely on the Commonwealth’s existing managed care delivery system. In addition to the creation of the Kentucky HEALTH program, the §1115 demonstration waiver will also introduce comprehensive delivery system reforms targeting substance use disorder (SUD), chronic disease management, and managed care to improve quality and outcomes.

- **Substance Use Disorder:** Kentucky HEALTH will maintain all current mental health and substance use disorder (SUD) benefits. However, this §1115 demonstration waiver will also implement a pilot program in ten to twenty select counties to improve access to mental health and SUD services. Counties will be identified based on a recent CDC HIV/hepatitis C outbreak study, the State’s existing Shaping Our Appalachian Region (SOAR) initiative, and public input received during the demonstration waiver public notice and comment period. Specifically, the Commonwealth will request a waiver of the Institutions for Mental Disease (IMD) exclusion to allow Medicaid reimbursement for short-term residential stays of up to thirty days in an IMD. The pilot program will also examine best practice improvements related to standards of care, care coordination between levels and settings of care, and strategies to address prescription drug abuse and opioid use disorder.
- **Chronic Disease Management:** The waiver will align various Kentucky HEALTH program components to support the Commonwealth’s existing public health infrastructure and current efforts to improve chronic disease prevention and management. In addition, the Commonwealth will work with Kentucky’s Medicaid managed care organizations to continue implementing best practices from nationally recognized disease management programs, such as the National Diabetes Prevention Program.
- **Managed Care Reforms:** Prior to implementing Kentucky HEALTH, the Commonwealth will align incentives across the delivery system by introducing mechanisms to control spending, as well as payment incentives for providers and the managed care organizations to improve quality and align with member incentives. In addition, the

Kentucky Department for Medicaid Services will continue to seek improvements and administrative efficiencies in the existing Medicaid managed care program, such as uniform credentialing and formulary alignment.

IMPLEMENTATION

The Commonwealth will implement the Kentucky HEALTH program on a statewide basis on or about six months post-§1115 demonstration waiver approval; however, this date may vary depending on the approval date from CMS. The Kentucky HEALTH community engagement and employment initiative will be phased in on a county-by-county basis and may take longer. Implementation of this 1115 demonstration waiver will require the Commonwealth to amend the existing managed care contracts, modify systems and other operational procedures, and conduct a readiness review of various vendors. In addition to these tasks, the Commonwealth will also have to amend the Medicaid State Plan, amend the Alternative Benefit Plan, develop education materials, and prepare to transition existing members.

HYPOTHESES & EVALUATION

This Section 1115 demonstration waiver will investigate the following research hypotheses related to each program goal:

Goal 1: Improve participant's health and help them be responsible for their health

- Hypothesis: Kentucky HEALTH policies will promote member use of preventive and primary care.
 - Track and compare health service utilization rates between current Kentucky HEALTH members and their previous Medicaid enrollment category.
 - Track preventive care utilization rates and trends among different age and gender groups.
- Hypothesis: Kentucky HEALTH policies will promote member compliance with chronic disease management.
 - Track and compare chronic disease management compliance rates between current Kentucky HEALTH members and their previous Medicaid enrollment category.
- Hypothesis: Kentucky HEALTH policies will reduce member hospitalization of ambulatory care sensitive conditions (ACSCs).
 - Track and compare ACSCs hospitalization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.
- Hypothesis: Kentucky HEALTH policies will increase access to substance use disorder (SUD) services with special focus on Institutions for Mental Diseases (IMD).
 - Track and compare inpatient specialty care/SUD utilization rates between current Kentucky HEALTH members, and their previous Medicaid enrollment category.

Goal 2: Transform individuals from passive beneficiaries to active participants and consumers of healthcare who are prepared to use commercial health insurance

- Hypothesis: Kentucky HEALTH policies will provide incentives to monitor and managed the two member managed account funds.

- Track and compare remaining balances in member deductible accounts at the end of each benefit period.
- Track and compare balance in member *My Rewards Accounts* at the end of each benefit period.
- Track account balances transferred from the deductible account to the *My Rewards Account* at the end of each benefit period, including number of members with unused deductible account balances at the end of each benefit period and the average amount transferred to the *My Rewards Account* at the end of each benefit period.
- Track number of people checking their account balances, as well as how often they are checked (i.e. weekly, monthly, semi-annually, and annually).
- Hypothesis: Kentucky HEALTH policies will encourage healthy behaviors and increase member access to enhanced health services (such as gym memberships and over-the-counter medications).
 - Track and compare *My Reward Account* expenditures on enhanced health services.
 - Track and compare member achievement of healthy incentives contributions to the *My Rewards Account*.
 - Track and compare type of enhanced health services used by member *MY Rewards* accounts.
- Hypothesis: Kentucky HEALTH policies will promote member compliance with making premium payments.
 - Track premium initial and ongoing premium payments.
- Hypothesis: Kentucky HEALTH open enrollment policy will increase member compliance with redetermination process.
 - Track member compliance with redetermination.
- Hypothesis: Kentucky HEALTH's incentive and disincentive policies related to non-emergency use of hospital emergency room will reduce inappropriate utilization among Kentucky HEALTH members.
 - Compare annual rates of inappropriate emergency department utilization between Kentucky Medicaid populations for the years *before waiver* (prior to 2017) and *after waiver* (2017 and beyond).
 - Survey Kentucky HEALTH members on whether the incentives and disincentives related to the *My Rewards Account* for appropriate emergency room utilization caused them to seek services with their primary care physician or in an alternative urgent care setting.
 - Compare annual rates of members subject to the escalating *My Rewards Account* disincentive based on repeated inappropriate hospital emergency department utilization.

Goal 3: Empower people to seek employment and transition to commercial health insurance coverage

- Hypothesis: Kentucky HEALTH policies will encourage members to increase community engagement.
 - Track and compare member achievement of community engagement and employment contributions to the *My Rewards Account*.

- Hypothesis: Kentucky HEALTH policies will encourage members to seek employment.
 - Track members participating in job search activities.
- Hypothesis: Kentucky HEALTH policies will encourage members to earn employment and ultimately transition to commercial health insurance coverage.
 - Track number of individuals successfully transitioning to commercial health insurance coverage and accessing the *My Rewards Account* bonus after eighteen months.
 - Track number of individuals employed over twenty hours per week.
 - Track earnings of members who earn employment.
- Hypothesis: The employer premium assistance program will increase the proportion of Kentucky residents under 138% FPL covered by employer sponsored insurance.
 - Track the number of Kentucky residents with income under 138% FPL covered by ESI over the demonstration.
 - Track employer premium assistance program member enrollment.
 - Track employer premium assistance program employer enrollment.
 - Track employer premium assistance program wrap-around coverage expenditures.
- Hypothesis: Kentucky HEALTH's sliding scale increase premium payment amounts will discourage dependency on public assistance and encourage members to transition to commercial health insurance coverage.
 - Compare annual rates of Medicaid enrollment between Kentucky Medicaid populations for the years *before waiver* (prior to 2017) and *after waiver* (2017 and beyond).
 - Survey Kentucky HEALTH members on whether the sliding scale increased premium payment amount caused them to seek employment and/or other forms of health insurance coverage.
 - Compare annual rates of members paying increased premium amounts based on continued annual enrollment in Kentucky HEALTH.

Goal 4: Implement Delivery System Reform to Improve Quality and Outcomes

- Hypothesis: Kentucky HEALTH policies will promote high quality healthcare delivered by providers.
 - Track managed care organizations ability to meet quality and outcome benchmarks within their service contracts.
 - Track Kentucky providers receiving bonus payments from the managed care organizations for meeting quality and outcomes standards.

Goal 5: Ensure fiscal sustainability

- Hypothesis: Kentucky HEALTH will remain budget-neutral for both the federal and State governments.
 - Conduct a budget neutrality analysis and document adherence to waiver margin.

WAIVER & EXPENDITURE AUTHORITIES

Below is a list of proposed waivers the Commonwealth will seek from CMS to implement Kentucky HEALTH:

1. Eligibility: Section 1902(a)(10)(A)

- To the extent necessary to enable Kentucky to not provide medical coverage until the first day of the month in which the Kentucky HEALTH member pays their first premium payment, or for members below 100% FPL who fail to make an initial premium payment, the first day of the month following the expiration of the 60-day payment period.
- To the extent necessary to enable Kentucky to require Kentucky HEALTH members, as a condition of eligibility, to complete specified community engagement hours.

2. Retroactive Eligibility: Section 1902(a)(34)

- To the extent necessary to enable Kentucky to not provide medical coverage for any month prior to the month in which the member finalized enrollment in Kentucky HEALTH.

3. Cost-Sharing: Section 1902(a)(14) insofar as it incorporates 1916 and 1916A

- To the extent necessary to enable Kentucky to require monthly premium payments not to exceed 5% of income, but no less than \$1.00 per month, for all Kentucky HEALTH members.

4. Amount, Duration, and Scope: Section 1902(a)(10)(B)

- To the extent necessary to enable Kentucky to vary cost-sharing requirements, such that premium contribution amounts increase each year members with income above 100% FPL remain on Kentucky HEALTH, not to exceed 5% of income, and to charge copayments in lieu of premiums for individuals at or below 100% FPL who fail to make their premium payment within the sixty-day payment period.
- To the extent necessary to allow Kentucky HEALTH members who continue to pay premium contributions to use their *My Rewards Account* to purchase specified enhanced benefits not otherwise available in the base Kentucky HEALTH benefit package.
- To the extent necessary to enable Kentucky to allow individuals to receive the benefits provided through their employer-sponsored plan.

5. Reasonable Promptness: Section 1902(a)(3)/Section 1902(a)(8)

- To the extent necessary to enable Kentucky to delay benefits, such that benefits do not begin until a member makes a premium contribution, or until the expiration of a 60-day payment period for members below 100% FPL who fail to make a premium contribution.
- To the extent necessary to enable Kentucky to prohibit re-enrollment for up to six months for Kentucky HEALTH members above 100% FPL who are disenrolled for failure to make their required premium contributions within 60 days of the due date.
- To the extent necessary to enable Kentucky to implement an open enrollment period for Kentucky HEALTH, such that members who are disenrolled for failure to complete redetermination process will be required to wait until their next open enrollment period to re-enroll (up to six months).

6. Freedom of Choice: Section 1902(a)(23)

- To the extent necessary to enable Kentucky to restrict the freedom of choice of providers for demonstration eligibility groups.

7. Non-Emergency Transportation: Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53

- To the extent necessary to relieve Kentucky of the requirement to assure non-emergency medical transportation to and from medical providers for Kentucky HEALTH members.

In addition, the Commonwealth requests that expenditures related to providing services in an Institution for Mental Disease (IMD), in participating pilot project counties, be regarded as expenditures under the Commonwealth's Medicaid Title XIX State Plan.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

All information regarding the Kentucky HEALTH §1115 demonstration waiver, including this public notice, the waiver application, and other documentation regarding the proposal are available at: <http://chfs.ky.gov/kentuckyhealth>. In addition, the Kentucky HEALTH §1115 demonstration waiver application is available for in-person public review at Cabinet for Health and Family Services, Office of the Secretary, 275 E. Main St., Frankfort, KY 40621.

Written comments regarding the Kentucky HEALTH waiver application may be mailed to Commissioner Stephen Miller, Department for Medicaid Services, 275 E. Main Street, Frankfort, KY 40621. Comments may also be sent via electronic mail to kyhealth@ky.gov.

All comments must be received by **Friday, August 12, 2016 at 5:00 p.m.**