Kentucky Medicaid Program Public Notice of Kentucky HEALTH (Alternative Benefit Plan)

In accordance with 42 CFR 440.386, the Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS) announces its intention to file a state plan amendment with the Centers for Medicare and Medicaid Services (CMS) no later than April 1, 2019, modifying the Kentucky Medicaid Program's alternative benefit plan (ABP) for Kentucky HEALTH. The alternative benefit plan is the plan, which establishes the health care benefits and services that will be available to eligible individuals effective April 1, 2019.

Eligible individuals will include ALL Medicaid recipients eligible for Kentucky HEALTH; thus, the benefit plan includes services and benefits that will be available for the Adult eligibility group.

The Adult eligibility group includes individuals in what is known as the "Medicaid expansion group." This group will include adults who meet **ALL** of the following conditions:
The adult is age 19 through 64;
The adult is not pregnant;
The adult is not otherwise eligible for Medicaid benefits; **AND**
The adult has income under 138% of the federal poverty level.

The benefit plan will apply for the Adult group, beginning April 1, 2019

Until April 1, 2019, existing Medicaid recipients will continue to be eligible for services and benefits as currently established in the Kentucky Medicaid Program State Plan.

In making this public announcement, DMS is outlining its alternative benefit plan and soliciting public comment regarding the plan. Instructions on how to submit comments are stated at the bottom of this notice.

Services

No new services have been added.

For a comprehensive list of services and more details please access the DMS member Information websites listed below:

https://kentuckyhealth.ky.gov/Pages/index.aspx

https://chfs.ky.gov/agencies/dms/member/Pages/default.aspx

Coverage Changes

Limits will exist for certain services. Following are the changes to the coverage:

- Routine dental services for Kentucky HEALTH will be covered only through the My Rewards Account.

- Routine vision services for Kentucky HEALTH will be covered only through the My Rewards Account.
- Cost-sharing will be implemented. Medicaid recipients eligible for Kentucky HEALTH will have to pay cost-sharing. Kentucky HEALTH will have premiums as outlined in the Kentucky HEALTH 1115 waiver. Medicaid recipients, under 100% of the Federal Poverty Level that elect to not pay premium will be subject to the co-payments currently established in the Medicaid State Plan and Kentucky Administrative Regulations.
- Consistent with the goal of offering a commercial market experience with Kentucky HEALTH, the State has requested and received approval through the 1115 Waiver, to exclude non-emergency transportation from the Kentucky HEALTH Adult Group.
- Physical therapy will be changed from a combined 20 visit limit for rehabilitative and habilitative to 20 visits per recipient per year for rehabilitative and 20 visits per recipient per year for habilitative
- Speech therapy changed from a combined 20 visit limit for rehabilitative and habilitative to 20 visits per recipient per year for rehabilitative and 20 visits per recipient per year for habilitative
- Occupational therapy will changed from a combined 20 visit limit for rehabilitative and habilitative to 20 visits per recipient per year for rehabilitative and 20 visits per recipient per year for habilitative.

For more details regarding the Medicaid service limits please access the DMS member Information websites listed below:

https://kentuckyhealth.ky.gov/Pages/index.aspx

https://chfs.ky.gov/agencies/dms/member/Pages/default.aspx

EPSDT Assurance (42 CFR 440.345)

DMS will ensure compliance with 42 CFR 440.345 by:

- making changes to its Medicaid Management Information System (MMIS) to allow EPSDT service claims in addition to/beyond the scope of services included in the alternative benefit plan to be billed and reimbursed
- Sending written communication to all ESPDT-related provider types informing them of the coverage of services via the EPSDT option in addition to/beyond the alternative benefit plan scope of services
- Sending written communication to recipients informing them of the coverage of services via the EPSDT option in addition to/beyond the alternative benefit plan scope of services
- Posting a notice on the DMS website regarding the availability of EPSDT services in addition to/beyond the scope of services included in the alternative benefit plan
- Disseminating the above communications/notice to each Department for Community Based Services (DCBS) local office in Kentucky

Compliance with Section 5006(e) of the American Recovery and Reinvestment Act

DMS did not seek advice regarding its alternative benefit plan from an Indian Health Program or Urban Indian Organization as no Indian Health Program or Urban Indian Organization exists in Kentucky.

Exempted Individuals

In accordance with 42 CFR 440.315, individuals within one (or more) of the following groups are not required to enroll in the alternative benchmark plan, but may receive benefits as defined in the Kentucky Medicaid State Plan:

(a) An individual who is pregnant and who is required to be covered under the State plan under section 1902(a)(10)(A)(i) of the Act.

(b) An individual who qualifies for medical assistance under the State plan on the basis of being blind or
disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act

(c) An individual who is entitled to benefits under any part of Medicare

(d) An individual who is terminally ill and is receiving benefits for hospice care under title XIX

(e) An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or other medical institution, and is required, as a condition of receiving services in that institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs

(f) An individual who is medically frail or otherwise an individual with special medical needs. This individuals described in 42 CFR 438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living. The individuals described in 42 CFR 438.50(d)(3) are children under 19 years of age who are—

- **(i)** Eligible for SSI under title XVI;
- **(ii)** Eligible under section 1902(e)(3) of the Act;
- **(iii)** In foster care or other out-of-home placement;
- **(iv)** Receiving foster care or adoption assistance; or
- **(v)** Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the State in terms of either program participation or special health care needs

(g) An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act

(h) An individual who is an individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age

(i) An individual who is a parent or caretaker relative whom the State is required to cover under section 1931 of the Act

(j) An individual who is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act

(k) An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act

(l) An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act

(m) An individual who is determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs

Public Comments

Copies of this notice are available at each county's Department for Community Based Services (DCBS) office and at https://chfs.ky.gov/agencies/dms/Pages/default.aspx and https://chfs.ky.gov/agencies/dms/Pages/publicnotices.aspx. For the address of the local office, please see https://prdweb.chfs.ky.gov/Office_Phone/index.aspx. . Additional information regarding these proposed actions is available upon request at the address cited below.

A copy of this notice is available for public review at the Department for Medicaid Services at the address listed below. Comments or inquiries may be submitted in writing within thirty (30) days to:

Commissioner's Office
Department for Medicaid Services, 6W-A
275 E. Main Street
Frankfort, Kentucky 40621