

Citation

Condition or Requirement

1932(a)(1)(A)

AA Section 1932(a)(1)(A) of the Social Security Act.

The State of Kentucky enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

A recipient, who has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, will be restricted to one or more of the following:

- (1) *One (1) primary care provider who:*
 - a. *Shall be accessible to the recipient within normal time and distance standards for the community in which the recipient resides;*
 - b. *Shall provide services and manage the lock-in recipient's necessary health care services;*
 - c. *If the lock-in recipient needs a specialty service that the designated primary care provider is unable to provide, the designated primary care provider shall refer the lock-in recipient to other providers as necessary so the recipient receives all medical necessary services.*
 - d. *Shall participate in the recipient's periodic utilization review*
 - e. *If the designated primary care provider is a physician, he may also serve as the lock-in recipient's designated controlled substance prescriber; or*
- (2) *One (1) prescriber for non emergency prescriptions for controlled substances. This provider shall serve as the sole prescriber and manager of controlled substances for the lock-in recipient.*

For B.1 and B.2, place a check mark on any or all that apply.

Citation	Condition or Requirement
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)	1. The State will contract with an <ol style="list-style-type: none"><input type="checkbox"/> i. MCO<input checked="" type="checkbox"/> ii. PCCM (including capitated PCCMs that qualify as PAHPs)<input type="checkbox"/> iii. Both
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	2. The payment method to the contracting entity will be: <ol style="list-style-type: none"><input type="checkbox"/> i. fee for service;<input type="checkbox"/> ii. capitation;<input checked="" type="checkbox"/> iii. a case management fee;<input type="checkbox"/> iv. a bonus/incentive payment;<input type="checkbox"/> v. a supplemental payment, or<input type="checkbox"/> vi. other. (Please provide a description below).
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. <i>Not applicable</i> If applicable to this state plan, place a check mark to affirm the state has met all of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). <ol style="list-style-type: none"><input type="checkbox"/> i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.<input type="checkbox"/> ii. Incentives will be based upon specific activities and targets.<input type="checkbox"/> iii. Incentives will be based upon a fixed period of time.<input type="checkbox"/> iv. Incentives will not be renewed automatically.<input type="checkbox"/> v. Incentives will be made available to both public and private PCCMs.<input type="checkbox"/> vi. Incentives will not be conditioned on intergovernmental transfer agreements.

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Condition or Requirement

- X vii. Not applicable to this 1932 state plan amendment.
- CFR 438.50(b)(4) 4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*
- In order to implement this program, the State had to file an Administrative Regulation with the Legislative Research Commission. As a result, a Public Hearing was conducted allowing the public to testify in support of or in opposition of this new program.*
- The state also published Public Notices in the states three largest newspapers outlining this program.*
- In addition, letters were sent to all providers and hospitals prior to implementation. The state also sent a letter to all current Lock-In participants explaining the new program.*
- The state will continue to work with providers, legislators, advocates and recipients as this program is implemented through provider education meetings and letters.*
- 1932(a)(1)(A) 5. The state plan program will /will not X implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory X / voluntary enrollment will be implemented in the following county/area(s):
- The Lock In program will be in all counties of the state except the current 16 counties covered through Passport. Passport (PHP) does their own Lock-In Program and oversees their locked in population/members for the 16 counties in the greater Louisville area*
- Mandatory enrollment shall be initiated for a recipient if in any two (2) 180 calendar day periods within an eighteen (18) months' timeframe.*
- (a) *Received services from at least five (5) different providers;*
- (b) *Received at least ten (10) different prescription drugs; and received prescriptions from at least three (3) or more different pharmacies; or*
- (c) *Had at least four (4) hospital emergency department visits for a condition that was not an emergency medical condition; or*
- (d) *Received services from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition.*

Citation

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- i. county/counties (mandatory) _____
- ii. county/counties (voluntary) _____
- iii. area/areas (mandatory) _____
- iv. area/areas (voluntary) _____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ☐ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. ☒ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met

Exception would be freedom of choice as outlined in 42CFR 431.54.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. ☒ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)

4. ☒ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as 1905(a)(4)(C) defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)

5. ☒ The state assures that all the applicable requirements 425CFR Part 38The state as for MCOs and PCCMs will be met.

TN No.: 10-005
Supersedes
TN No.: None

Approved Date: 04-15-11

Effective Date: July 1, 2010

Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. <u> </u> The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met. Not applicable – this is not an “at risk” contract.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. <u>X</u> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 74.40	8. <u>X</u> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
D.	<u>Eligible groups</u>
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. <i>Eligible groups are as identified in Section B-5 of the pre-print as over utilizing Medicaid services. Any Medicaid recipient that is at least 19 years of age or not in the Passport service area that has been found to over utilize Medicaid services will be placed in the Lock-In program.</i>
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. <i>Not applicable – no voluntary enrollment</i>

Citation	Condition or Requirement
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ____ Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. (<i>Example: Recipients, who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.</i>)
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ____ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. ____ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ____ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ____ Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)	vi. ____ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ____ Children under the age of 19 years who are 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.

E. Identification of Mandatory Exempt Groups

Children, under the age of 19 years of age are exempt from the Lock-In Program

1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (<i>Examples: children receiving services at a specific clinic or enrolled in a particular program.</i>) <i>Children, under the age of 19 years of age are exempt from the Lock-In Program</i>
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Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	<p>2. Place a check mark to affirm if the state's definition of title V children is determined by:</p> <p><i>Not applicable because no one under the age of 19 will be enrolled into the Lock – In</i></p> <p><input type="checkbox"/> i. program participation, <input type="checkbox"/> ii. special health care needs, or <input type="checkbox"/> iii. both</p>
1932(a)(2) 42 CFR 438.50(d)	<p>3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.</p> <p><i>Not applicable because no one under the age of 19 will be enrolled into the Lock – In</i></p> <p><input type="checkbox"/> i. yes <input type="checkbox"/> ii. no</p>
1932(a)(2) 42 CFR 438.50 (d)	<p>4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: <i>(Examples: eligibility database, self- identification)</i></p> <p><i>Children, under the age of 19 years of age are exempt from the Lock-In Program. Children will be identified through age edits in the MMIS system. This response is applicable to item i. – iv. Below.</i></p> <p>i. Children under 19 years of age who are eligible for SSI under title XVI;</p> <p>ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;</p> <p>iii. Children under 19 years of age who are in foster care or other out-of-home placement;</p> <p>iv. Children under 19 years of age who are receiving foster care or adoption assistance.</p>

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	<p>5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. <i>(Example: self-identification)</i></p> <p><i>All children under 19 years of age are exempt from the Lock-In Program.</i></p>
1932(a)(2) 42 CFR 438.50(d)	<p>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: <i>(Examples: usage of aid codes in the eligibility system, self- identification)</i></p> <p>i. Recipients who are also eligible for Medicare.</p> <p><i>Medicare recipients are exempt from the Lock-In Program and will be identified through MMIS edits.</i></p> <p>ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</p> <p><i>Not applicable – Kentucky does not have Indian Tribes</i></p>
42 CFR 438.50	<p>F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</p> <p><i>Nursing facility patients that have been in the nursing home or long-term care facility for more than 30 days in a given calendar year are exempt</i></p>
42 CFR 438.50	<p>G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u></p> <p><i>Not applicable.</i></p>

Citation

Condition or Requirement

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

- i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.
- ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program.

Describe how the state's default enrollment process will preserve:

- i. the existing provider-recipient relationship (as defined in H.1.i).
If the recipient's provider has agreed to be a Lock In provider, the recipient will be allowed to continue treatment with the existing provider.
- ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).
If the recipient's provider has agreed to be a Lock In provider, the recipient will be allowed to continue treatment with the existing provider.
- iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p>3. As part of the state's discussion on the default enrollment process, include the following information:</p> <p>i. The state will <u>X</u> /will not ____ use a lock-in for managed care managed care.</p> <p>ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.</p> <p>iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. <i>(Example: state generated correspondence.)</i></p> <p><i>Lock-In recipients will receive a letter from the KY Department for Medicaid Services informing them that they are being placed in the Lock-In Program. The letter will outline the reason they are being placed in the Program, and allowing them 30 days to select their Primary Care Physician (PCP) or narcotic provider or one will be assigned for them. Medicaid recipients shall have a choice from at least two (2) participating providers in their area</i></p> <p>iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. <i>(Examples: state generated correspondence, HMO enrollment packets etc.)</i></p> <p><i>Not applicable under authority of 42 CFR 431.54</i></p> <p>v. Describe the default assignment algorithm used for auto-assignment. <i>(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</i></p> <p><i>Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program</i></p>

Citation

Condition or Requirement

- vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*
- Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program*
- 1932(a)(4)
42 CFR 438.50
- I. State assurances on the enrollment process
- Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.
- Not applicable for this program under authority of 42 CFR 431.54*
1. X The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.
2. X The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).
- Except as outlined in 42 CFR 431.54*
3. X The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.
- _____ This provision is not applicable to this 1932 State Plan Amendment.
4. _____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)
- X This provision is not applicable to this 1932 State Plan Amendment.

Citation

Condition or Requirement

1932(a)(4)
42 CFR 438.50

J. Disenrollment

5. X The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___ This provision is not applicable to this 1932 State Plan Amendment.

1. The state will X /will not ___ use lock-in for managed care.

2. The lock-in will apply for 24 months (up to 24 months).

We initially lock the member in for 24 months but at 12 months intervals, member utilization reviews are conducted. (Any subsequent lock in period is for 12 months at a time)

Per authority of 42 CFR 431.54

3. Place a check mark to affirm state compliance.

X The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

The state does not allow disenrollment without cause.

4. Describe any additional circumstances of "cause" for disenrollment (if any).

Recipient or provider may request to disenroll from the Lock In program if:

- (a) *the designated provider submits to the department a written request for a release from serving as the recipient's designated provider. The provider shall continue to serve as the recipient's designated provider until a comparable designated provider is selected;*
(b) *The recipient relocates outside of the designated provider's geographic area;*

Citation	Condition or Requirement
	(c) The recipient submits a written request to the department which: 1. Requests a designated provider change; and 2. Includes information to support cause or a necessary reason for the change, including the recipient: (d) Was denied access to a needed medical service; (e) Received poor quality of care; or (f) Does not have access to a provider qualified to treat the recipient's health care needs; (g) The designated provider withdraws or is terminated from participation in the Medicaid Program; or (h) The department determines that it is in the best interest of the lock-in recipient to change the designated provider.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Citation	Condition or Requirement
1932 (a)(1)(A)(ii)	<p>M. <u>Selective contracting under a 1932 state plan option</u></p> <p>To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.</p> <p><i>Not applicable</i></p> <ol style="list-style-type: none">1. The state will____/will not <u>X</u> intentionally limit the number of entities it contracts under a 1932 state plan option.2. ____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. <i>(Example: a limited number of providers and/or enrollees.)</i>4. <u>X</u> The selective contracting provision in not applicable to this state plan.