



KENTUCKY HEALTH: GOVERNOR BEVIN'S 1115 MEDICAID WAIVER

WHAT IS IT?

Kentucky HEALTH is Governor Bevin's signature Medicaid program that stands for "Helping to Engage and Achieve Long Term Health." Also called an 1115 Medicaid Waiver, this program is an alternative to traditional Medicaid, meaning that the federal government has "waived" certain Medicaid rules, allowing Kentucky to make changes to the way Medicaid is administered in the Commonwealth.

Historically, the purpose of an 1115 Medicaid Waiver has been to demonstrate that a state can provide better access and better care than it is already doing. Therefore, any proposed changes should increase access to care, improve health outcomes, and make the system easier to use or less expensive to operate. In late 2017, the Centers for Medicare & Medicaid Services (CMS) changed the objectives of the waiver to discourage government dependence, instead of promoting access to affordable healthcare for low-income Americans. Kentucky HEALTH was approved on January 12th, 2018, in accordance with these new objectives.

As a result of Kentucky HEALTH, nearly 100,000 low-income Kentuckians will no longer be enrolled in Medicaid by 2022. Many more are expected to churn on and off coverage based on new requirements and penalties.

WHO WILL BE AFFECTED?

Medicaid covers low-income Kentuckians making at or below 138% of the Federal Poverty Level (FPL), about \$16,750 a year for an individual and \$34,600 for a family of four. In total, nearly 1.4 million Kentuckians are covered by Medicaid. Of these, about 1.2 million Medicaid members – covered by Aetna, Anthem, Humana CareSource, Passport, and WellCare – will be subject to some or all of the new rules of Kentucky HEALTH. That's more than 1 in 4 Kentuckians.

Medicaid members participating in Kentucky HEALTH include:

- Children
- Pregnant women
- Parents and caretakers below 55% FPL (also known as PACA)
- Parents and caretakers at or above 55% FPL (also known as Medicaid expansion)
- Former foster care youth up to age 26 (those who have "aged-out" of foster care)
- All other non-disabled adults without dependents (also known as Medicaid expansion)

The following individuals will not be subject to Kentucky HEALTH and will continue to receive traditional Medicaid:

- Over age 65
- Covered by Medicare
- Receiving SSI (Social Security Income)
- Living in a long-term care facility
- In the Medicaid buy-in program for working disabled adults
- Currently in foster care or receiving subsidized adoption
- Participating in the Breast and Cervical Cancer Treatment Program
- Enrolled in 1915c Waivers, including:
 - Home and Community Based Waiver
 - Michelle P. Waiver
 - Acquired Brain Injury (ABI) and ABI Long-term Care Waiver
 - Model Waiver II
 - Supports for Community Living

WHAT'S CHANGING?

Since 2014, Medicaid members in Kentucky have received the same level of benefits and access to care, regardless of their income, work status, or family size. Under Kentucky HEALTH, enrollees will be subject to different benefits, requirements, exemptions, and penalties based on a number of factors.

ANNUAL RE-ENROLLMENT

Every year, Medicaid members will need to submit updated information or verify that their information is still correct. This must happen within 90-days of their annual re-determination date in order to stay enrolled in coverage. **Some adults could be lock-out of coverage for six months if they do not re-enroll within the 90 day window.**

Who won't be locked-out? Children, pregnant women, and individuals deemed "medically frail" will not be subject to this lock-out period. However, they will still need to re-enroll on an annual basis or could lose coverage temporarily.

REPORTING CHANGES IN ELIGIBILITY

Medicaid members must report changes in circumstances that would impact their eligibility for Medicaid. They should not be required to report normal fluctuations, including:

- Changes in work hours that will not exceed 30 days
- A fifth or periodic paycheck
- Holidays, vacation days, or sick leave less than 30 days

If someone experiences a change in income or work hours that exceeds Medicaid eligibility limits for more than 30 days, they could be locked out of coverage. The length of time and opportunities to re-enroll may be different for each member of your household. The state may consider this Medicaid fraud, a very serious charge that is punishable by law.

EMPLOYER-SPONSORED INSURANCE

Medicaid members who work for an employer that offers health insurance will be required to enroll in their employer's plan after one year, assuming the state decides it is cost-effective. These individuals will also be encouraged to enroll their children in the same plan. The individual or family would pay the same premium required for Medicaid coverage. Medicaid would pay all out-of-pocket costs and provide "wrap-around" benefits if the employer plan does not provide every benefit offered by Medicaid. However, if the employer's plan offers fewer in-network providers or does not cover the same prescription drugs, these may not be covered by the state.

"MY REWARDS" PROGRAM

Most adults eligible for Kentucky HEALTH will have a My Rewards Account, which is intended to work like a health spending account. Medicaid members can earn virtual reward "dollars" for preventive screenings, health classes, volunteering, job training and other activities. Reward dollars can be used to "buy" services like dental and vision. In some cases, money could also be removed from your account as a penalty for using the emergency room when it is not an emergency or for missing too many medical appointments.

MCOs will continue to cover preventive vision and dental services for parents with dependent children below 55% FPL, pregnant women, children, individuals determined to be "medically frail", and former foster care youth up to age 26.

DEDUCTIBLE ACCOUNT

The Deductible Account is intended to help Medicaid members prepare for commercial coverage. The state will put \$1,000 in virtual money into the account at the beginning of the coverage year. During the year, the money in the account pays for the first \$1,000 of non-preventive medical expenses. After the account is empty, all medical services will continue to be covered by the individual's managed care plan.

Who won't use this account? Children and pregnant women will not have a deductible account.

PREMIUMS & CO-PAYS

Kentuckians with incomes above the federal poverty level (\$12,140 for an individual and \$25,100 for a family of four) will be required to pay monthly premiums of up to 4% of household income. For example, the premium payment for an individual making \$16,640 (equivalent to earning \$8/hour at 40 hours per week) will start at \$15 a month but could escalate to \$55 a month over time. **Missing two premium payments could result in a 6 month lock out from coverage.**

Who would have co-pays instead of the lock out? Adults with household incomes under 100% FPL who do not make their first premium payment will have to wait up to 60 days for coverage to start. Once enrolled, missing two or more premium payments will result in co-pays being charged for each visit. Co-pays range from \$3 - \$50 per visit and could quickly add up to a lot more than the premium payment.

Who won't have co-pays or the lock-out? Pregnant women and children will not be subject to premium payments or co-pays. People deemed "medically frail" and former foster care youth up to age 26 will not be subject to co-pays, but could lose access to their My Rewards Account if they do not pay premiums.

Premium payment schedule based on income and family size:

Federal Poverty Level	Household Income (2018)				Household Monthly Premium (up to 4% annual income)	
	Individuals		Family of 4		Minimum	Maximum
	Annual	Monthly	Annual	Monthly		
< 25%	\$3,035	\$253	\$6,275	\$523	\$1	\$10
25 - 50%	\$6,070	\$506	\$12,550	\$1,046	\$4	\$20
51 - 100%	\$12,140	\$1,012	\$25,100	\$2,092	\$8	\$40
101 - 138%	\$16,753	\$1,396	\$34,638	\$2,887	\$15	\$55

RETRO-ACTIVE COVERAGE

Medicaid usually covers medical expenses for 90 days before an individual is enrolled, assuming they were eligible during that time. This is helpful for people who experience enrollment delays, get accidentally dis-enrolled, or have a gap in coverage. Under the new plan, coverage will only begin the month the person makes their first premium payment and is fully enrolled. For example, if someone makes their first premium payment on the 5th of the month, coverage will start on the 1st day of that same month. Medicaid will not pay for medical services received before someone is fully enrolled, even if enrollment is delayed for a reason beyond that person's control.

Who won't lose this coverage? Pregnant women and children will continue to receive retroactive coverage for 90 days.

BENEFITS

Parents of dependents at or above 55% FPL and adults without dependents will no longer have access to dental and vision benefits. These individuals will only be able to access dental and vision care by earning virtual dollars through the My Rewards Account.

Who won't lose benefits? Benefits will not be reduced for parents of dependents under 55% FPL, pregnant women, children, former foster youth up to the age of 26, or individuals deemed "medically frail". Additionally, Methadone treatment has been added as a new benefit for pregnant women, children, and former foster youth up to the age of 26.

NON-EMERGENCY MEDICAL TRANSPORTATION

Most adults will no longer have access to transportation services to get to and from medical appointments. This will make it more challenging to ensure that people are able to access the right care, at the right time, at the right place.

Who won't lose transportation? Parents of dependents under 55% FPL, children, pregnant women, former foster youth up to age 26, and individuals deemed "medically frail" will still have access to transportation services.

"PATH" REQUIREMENT TO WORK, VOLUNTEER, STUDY, OR TRAIN

To be eligible for coverage, most adults will need to meet PATH (Partnering to Advance Training and Health) requirements – also referred to as “community engagement” – by completing 80 hours of approved activities each month. PATH requirements will roll out across the state from July – November 2018. Individuals may not be subject to PATH requirements right away, depending on where they live. Medicaid members should be notified by Kentucky HEALTH three months before they are required to participate. The local workforce development boards are supposed to help Medicaid members meet program requirements, gain practical skills, and obtain necessary training to navigate the program. **People who do not meet the PATH requirement will be locked out of coverage for up to six months or until they make up the hours and complete the required re-entry activities.**

What qualifies? Working, volunteering, or completing 80 hours of other approved activities each month. Individuals enrolled in SNAP (food stamps) or TANF (cash assistance), will only need to meet the work requirement once for all benefits. However, these individuals may be able to earn My Rewards dollars for completing job enhancement activities.

Who’s exempt? Pregnant women, children, and former foster care youth up to age 26 will be automatically exempt from the PATH requirement. Individuals who may be “medically frail”, primary caregivers below 55% FPL (limited to one per household), and full-time students must apply for an exemption.

MULTIPLE ACCOUNTS

Medicaid members can be enrolled in coverage as an individual or as part of a larger household.

Single adults will have two accounts:

- 1) a benefit account for enrollment, My Rewards, Deductible, and “PATH”
- 2) an account with the managed care plan to pay premiums.

Households will have three or more accounts:

- 1) the head of household will have a benefit account for enrollment
- 2) each adult household member will have a separate benefit account for My Rewards, Deductible, and “PATH”
- 3) each household will have at least one managed care plan account. If individuals living in the household are covered by different managed care plans, they will have separate accounts.

PENALTIES

There are four ways most adults can be locked-out of coverage for up to 6-months:

Lock-Out Penalties	Who’s Affected
Not re-enrolling within the 90 day window	Adults who are not pregnant or “medically frail”
Missing two or more premium payments	Adults above 100% FPL who are not pregnant, “medically frail”, or former foster youth up to age 26
Not completing at least 80 hours of work, volunteer, study, or training activities	Adults without an exemption
Not reporting a change in income or family size that makes the household ineligible	It is unclear whether this will apply to all Medicaid members or certain populations. Clarification from the Cabinet for Health & Family Services has been requested.

Note: See PATH section above and “Medically Frail” section below for details on who will be considered exempt for these requirements. Coverage can start again the first day of the month after all re-entry requirements have been completed. These requirements may be different based on the type of lock-out.

There are three additional penalties for not complying with new requirements:

Other Penalties	Who’s Affected
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Pending enrollment	Adults above 100% FPL who are not pregnant, “medically frail”, or former foster youth up to age 26
Co-pays and enrollment delay	Adults at or below 100% FPL who are not pregnant, “medically frail”, or former foster youth up to age 26
My Rewards Account suspension	Adults who are not pregnant
My Rewards Account fines	Adults

Note: See “Medically Frail” section below for details on who will be considered exempt for these requirements.

“MEDICALLY FRAIL” STATUS & “GOOD CAUSE” EXEMPTIONS

Medicaid members may be considered “medically frail” for many different reasons, including:

- Disabling mental health diagnosis
- Chronic substance use disorder
- Serious and complex medical condition
- Significant impairment in ability to perform activities of daily living
- Diagnosed with HIV/AIDs
- Eligible for Social Security Disability Insurance (SSDI)
- Chronic homelessness
- First 12 months of refugee status

Automatic Medically Frail Exemption: An individual may be granted automatic “medically frail” status for having HIV/AIDS, SSDI, or being identified as “medically frail” by their managed care plan based on existing diagnoses. Someone could also be considered “medically frail” for six months if they self-attest to being chronically homelessness or needing assistance with activities of daily living.

Pending Medically Frail Exemption: If an individual self-attests for any issue not recognized above, this will start a review process that could take up to 60 days. The managed care plan will review the person’s medical records and may ask their provider to complete an additional assessment. During this process, the individual will be subject to all applicable requirements, penalties, and reduced benefits.

Good Cause Exemption: Individuals can apply for a “good cause” exemption to avoid a penalty if they are unable to comply with program requirements due to domestic violence, eviction, homelessness, or other reasons. The exception can apply to the current month or past months, but it is not ongoing.

THIRD-PARTY PREMIUM PAYMENTS

If a Medicaid member cannot pay their monthly premium, they may be able to get help from a local hospital, clinic, church, or other community organization. Assistance options will vary from county-to-county, so individuals should ask their provider or Application Assister for more information.

WHEN WILL THESE CHANGES GO INTO EFFECT?

Kentucky HEALTH was approved by the federal government on January 12th. The waiver will be implemented in the following phases:

1. January 2018: Medicaid members can begin earning My Rewards dollars for preventive services. These dollars can later be used toward dental or vision services, over-the-counter medications, or a gym membership.
2. April 2018: The My Rewards program will be implemented, allowing Medicaid members to earn virtual dollars for certain work, education, or health-related activities. Before July, most Medicaid members will be billed by MCOs for premium payments.
3. July – Nov. 2018: the full waiver is implemented, with “PATH” requirements phased in regionally.
4. 2019: Employer-sponsored insurance will be implemented.

DEFINITIONS

1115 Medicaid Waiver: Kentucky was granted a "waiver" from the federal government, allowing the Bevin Administration to re-design our Medicaid program. Historically, the purpose of an 1115 Medicaid Waiver has been to demonstrate that a state can provide better access and better care than it is already doing. In late 2017, the Trump Administration changed the objectives of the waiver to discourage government dependence, instead of promoting access to affordable healthcare for low-income people.

Chronic Homelessness: Kentucky HEALTH will use the federal definition to determine whether someone experiencing homelessness is eligible for an exemption of certain requirements. This is defined as: someone who sleeps in a place that is not meant for humans to live (for example, on the street) OR lives in a homeless emergency shelter; AND 1) Is homeless for a year or more; OR 2) has been homeless at least four times in the last three years.

Co-pay: An amount of money people pay for each health service, office visit, or prescription medication. The amount differs depending on the services received.

Deductible: The amount people pay for covered health care services before their insurance plan starts to pay. With a \$1,000 annual deductible, for example, the person pays the first \$1,000 of covered services each year, and the insurance company pays for any expenses beyond \$1,000.

Exemption: Waiving some or all requirements and penalties for certain individuals or populations.

Federal Poverty Level (FPL): A measure of income used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage. This is based on your adjusted gross income, untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.

Lock-out: A penalty that results in an individual losing Medicaid coverage for a certain amount of time, even if they are eligible based on income.

Managed Care Plan: The company that provides your healthcare coverage on behalf of the Medicaid program. There are currently five "MCOs" in Kentucky: Aetna, Anthem, Humana CareSource, Passport, and WellCare.

Medically Frail: Kentucky Medicaid will consider individuals with certain disabling conditions to be "medically frail". This will automatically include Individuals with SSDI, diagnosed with HIV/AIDS, or a newly arrived refugee. Individuals could also be determined to be "medically frail" for six months to one year if they are chronically homeless or have a serious mental illness, chronic substance use disorder, complex medical condition, or another physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living.

Medicaid Expansion: An expansion of coverage to low-income individuals and families created by the Affordable Care Act. In 2014, Kentucky expanded Medicaid to cover adults without dependent children making 0% – 138% FPL, as well as, adults with dependent children making 55% - 138% FPL.

Premium: A fixed amount of money people have to pay each month to cover part of the cost of their health insurance.

Primary Caregiver: The primary caregiver is an adult member of a household who provides full-time care for another dependent member of the household. In general, only one adult member in the household can claim to be the primary caregiver.