Kentucky HEALTH Stakeholder Advisory Forum

Note: These questions were asked during a public Stakeholder Advisory Forum in Frankfort, Kentucky on September 6, 2018

Kristi Putnam, Deputy Secretary of the Cabinet for Health and Family Services

When can we expect for Kentucky HEALTH to begin?

Unfortunately, we do not know when Kentucky HEALTH will start. The court ruling on June 29, 2018 sent the program back to the Centers for Medicare and Medicaid Services (CMS) for reconsideration. We have not made any changes to the program plan CMS originally approved. As of September 6, 2018, CMS has not requested any changes to the original Kentucky HEALTH proposal.

How many people have earned money with the My Rewards Accounts? How much money has been earned so far?

As of September 7, 2018, over 26.8 million dollars have been earned by Kentuckians for their My Rewards Accounts by accessing preventive services, taking free online courses at CitizenConnect.ky.gov, or by completing other qualifying activities.

Are Managed Care Organizations (MCOs) collecting copayments?
Please note: New information became available after the August public forum. The response below is the most recent information available as of October 3, 2018.

As of July 1, 2018, Medicaid decided to temporarily delay mandatory copay requirements. Instead, MCOs have the option to charge copayments for some services, but are not required to. Beneficiaries should contact their MCO if they have questions about the copayment policy. The MCO is required to tell beneficiaries if some services require a copayment. However, beginning January 1, 2018, all MCOs will be mandated to charge copayments for some services. Beginning on January 1, Medicaid recipients will be required to pay copayments, whether or not the Kentucky HEALTH program has been implemented.

Will emergency room (ER) copayments remain the same? Will they still be collected at the ER?

There is currently no plan to change the copayment policy. As of now, the cost of emergency room copayments will not change, and the policy of collecting copayments at the emergency room will not change.

Will employers be required to provide health care coverage for staff working less than 30 hours per week that are on Medicaid and have worked for the employer for more than a year?

Employers will not be required to change their policies for Kentucky HEALTH. Employers can choose to offer health insurance to part-time employees and/or full-time employees.

- If an employer **does not** currently offer health insurance for employees working fewer than 30 hours a week, they will not be expected to change their policy.
- If an employer **does** currently offer health insurance for employees working fewer than 30 hours a week and the employee is eligible for the coverage, the employer will continue covering the **employer portion** of the health insurance premium – just like they do now.

The Integrated Kentucky Health Insurance Premium Payment (I-KHIPP) program will become mandatory for beneficiaries if they meet all the following conditions:

1. They are eligible for Kentucky HEALTH.
2. They are eligible for health insurance offered through their employer.
3. They have been enrolled in Kentucky HEALTH for a total of 12 months.
4. They have been employed by the same employer for at least 12 continuous months.
5. The health insurance plan meets Kentucky HEALTH requirements for benefit coverage and cost-effectiveness.

Who is included in the Medically Frail eligibility group?

There is not a set list of conditions that designates a beneficiary as Medically Frail. The Commonwealth has developed a tool to determine if someone's health condition is severe enough to qualify as Medically Frail. Overall, beneficiaries who have a physical or mental condition that may prevent them from working or doing activities of daily living (like bathing, eating, or getting dressed) may be considered Medically Frail. Some of those conditions **may** include:

- Serious and complex medical condition
- Significant difficulty performing activities of daily living, like eating or getting dressed
- Disabling mental health diagnosis
- Chronic substance use disorder
- A diagnosis with HIV/AIDS
- Chronic homelessness

If beneficiaries believe they should be considered Medically Frail, they should talk to their primary care physician about filling out the Medically Frail Provider Attestation form available on the Kentucky HEALTH website here. Individuals may also contact the Department for Community Based Services (DCBS) at 1-855-306-8959 for more information.

How long is a beneficiary with a Substance Use Disorder considered Medically Frail?

All beneficiaries, including those with a Substance Use Disorder, are evaluated for Medically Frail status every 12 months. Once a beneficiary has been determined Medically Frail, he/she will be enrolled in the

Medically Frail category for 12 months. Note: no one will be enrolled in Kentucky HEALTH until the program is re-approved by CMS and implemented.

There are two Substance Use Disorder-related situations that **automatically** qualify someone as Medically Frail based on provider attestation:

- A beneficiary has had at least one inpatient or residential Substance Use Disorder (SUD) treatment episode, at least one Intensive Outpatient Program (IOP) service, **or** a partial hospitalization service for SUD treatment within the last 6 months.
- A beneficiary has had at least one drug overdose requiring medical care within the last 6 months.

How do beneficiaries end a suspension period early?

If beneficiaries do not meet their Kentucky HEALTH requirements, they may face a penalty. The penalty may be different for beneficiaries based on their individual situations. The table below shows the reasons a beneficiary may be penalized, the penalty, and how they can cure the penalty early.

<table>
<tr><th>Penalty Reason</th><th>Eligibility Group</th><th>Penalty</th><th>How to cure the penalty early</th></tr>
<tr><td rowspan="3">Did not pay premium</td><td>Medically Frail or Former Foster Youth up to age 26</td><td>• My Rewards Account suspended
• Move to No Cost Share Plan</td><td>• Pay one forward premium payment
• Complete re-entry course</td></tr>
<tr><td>Income-eligible adults or Income-eligible parents/guardians who are at or below 100% of the Federal Poverty Level (FPL)</td><td>• My Rewards Account suspended
• $25 deducted from My Rewards Account
• Move to Copay Plan</td><td rowspan="2">• Pay two missed premium payments
• Pay one forward premium payment
• Complete re-entry course</td></tr>
<tr><td>Income-eligible adults or Income-eligible parents/guardians who are above 100% of the Federal Poverty Level (FPL)</td><td>• My Rewards Account suspended
• $25 deducted from My Rewards Account
• Medical benefits suspended</td></tr>
<tr><td>Did not meet PATH Community Engagement requirement</td><td>Income-eligible adults or Income-eligible parents/guardians</td><td>• My Rewards Account suspended
• Medical benefits suspended</td><td>• Complete and report 80 hours of Community Engagement activities in 30 days OR</td></tr>
</table>

Penalty Reason	Eligibility Group	Penalty	How to cure the penalty early
			• Report a satisfactory condition or exemption **OR** • Take a re-entry course
Voluntary withdrawal from Medicaid	Income-eligible adults or Income-eligible parents/guardians	• My Rewards Account suspended, as applicable • $25 deducted from My Rewards Account, as applicable	• Reapply for coverage • Complete re-entry course • Pay initial premium • Pay any required Managed Care Organization (MCO) debt
Failed to complete recertification	Income-eligible adults or Income-eligible parents/guardians	• Medical benefits terminated	• Complete re-entry course and reapply
Failed to report changes that made beneficiary ineligible for coverage	Income-eligible adults or Income-eligible parents/guardians	• Medical benefits terminated	• Complete re-entry course and reapply