Table of Contents

State/Territory Name: Kentucky

State Plan Amendment (SPA) #: 18-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street S.W. Suite 4T20
Atlanta, Georgia 30303

Atlanta Regional Operations Group

June 14, 2019

Carol H. Steckel, Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001

Re: Kentucky State Plan Amendment 18-0004

Dear Ms. Steckel:

We have reviewed the proposed Kentucky state plan amendment, KY 18-0004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2018. This amendment updates the state's employer-sponsored insurance (ESI) program.

On May 20, 2019, the state agreed to amend its Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) program member handbook to include instructions for beneficiaries seeking care from an ESI provider not currently accepting Medicaid. Specifically, the state added the following narrative: "It is very important to receive services from In-Network providers that accept Medicaid. KI-HIPP is committed to working with all ESI providers to ensure that they will accept Medicaid. If you are or wish to seek care from an ESI provider that does not currently accept Medicaid, please call 1-800-635-2570."

Based on the information provided, the Medicaid State Plan Amendment KY 18-0004 was approved on June 13, 2019. The effective date of this amendment is May 1, 2019. We are enclosing the approved HCFA-179 and a copy of the state plan pages.

If you have any additional questions or need further assistance, please contact Melanie Benning at (404) 562-7414 or Melanie.Benning@cms.hhs.gov.

Sincerely,

/s/

Shantrina D. Roberts, MSN
Deputy Director
Division of Medicaid Field Operations South

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 18-004

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
May 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1906 of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 – $26,000,000 Savings
b. FFY 2019 – $45,000,000 Savings

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 2.2-A, Page 23a
Att. 2.2-A, Page 26a
Att. 4.22-C, Page 1-3
Supplement 11 to Att 2.6-A, Page 1-3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT:
The purpose of this SPA is to revise the state's current Employer Sponsored Insurance Program.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME: Carol H. Steckel

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 11/20/18

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/21/18

18. DATE APPROVED: 06/13/19

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
05/01/19

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Shantrina D. Roberts

22. TITLE: Deputy Director
Division of Medicaid Field Operations South

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Citation	Condition or Requirement

1906 of the Act — State Method on Cost Effectiveness of Employer-Based Group Health Plans

A. Cost Effectiveness

(1) The state provides both a benefits wrap and cost sharing wrap and each element is included in the cost effectiveness test.

(2) Enrollment in a group health insurance plan shall be considered cost effective when the cost of paying the premiums, coinsurance, deductibles ,other cost-sharing obligations, services provided by providers in the Medicaid network, even for benefits covered by the group health plan, and additional administrative costs is estimated to be less than the amount paid for an equivalent set of Medicaid services.

(3) When determining cost effectiveness of a group health insurance plan, the department shall consider the following information:

a. The cost of the insurance premium, cost sharing, and Medicaid managed care capitation rate, if applicable;

b. The scope of services covered under the insurance plan, including exclusions for pre-existing conditions, exclusions to enrollment, and lifetime maximum benefits imposed;

c. The cost of allowing beneficiaries to seek care from within the Medicaid network of providers, even for services that are covered by the group health plan;

d. The average anticipated Medicaid utilization:

1. By age, sex, and coverage group for persons covered under the insurance plan; and

2. Using a statewide average for the geographic component;

e. The specific health-related circumstances of the persons covered under the insurance plan; and

f. Annual administrative expenditures of an amount determined by the department per Medicaid participant covered under the group health insurance plan.

B. Cost Effectiveness Review.

(1) The department shall complete a cost effectiveness review annually at the employer's annual enrollment.

(2) The department shall perform a cost effectiveness re-determination if:

a. A predetermined premium rate, or cost sharing increases;

b. Any of the individuals covered under the group health plan lose full Medicaid eligibility; or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

c. There is a:
   1. Change in Medicaid eligibility;
   2. Loss of employment when the insurance is through an employer; or
   3. A decrease in the services covered under the policy.

(3) Changes in enrollment
   a. A health insurance premium payment program participant, who is a Medicaid enrollee, or a person on that individual's behalf, shall report all changes concerning health insurance coverage to the participant's local Department for Community Based Services (DCBS), Division of Family Support or the Medicaid KI-HIPP office within thirty (30) days of the change.
   b. Except as allowed in section (4) below, if a Medicaid enrollee who is a health insurance premium payment program participant fails to comply with paragraph (a) of this subsection, the department shall disenroll the HIPP program participating Medicaid enrollee, and any family member enrolled in the HIPP program directly through the individual if applicable, from the HIPP program.

(4) The department shall not disenroll an individual from HIPP program participation if the individual demonstrates to the department, within thirty (30) days of notice of HIPP program disenrollment, good cause for failing to comply with subsection (3) of this section.

(5) Good cause for failing to comply with subsection (3) of this section shall exist if:
   a. There was a serious illness or death of the individual, parent, guardian, or caretaker or a member of the individual's, parent's guardian's, or caretaker's family;
   b. There was a family emergency or household disaster – for example a fire, flood, tornado, or similar;
   c. The individual, parent, guardian, or caretaker offers a good cause beyond the individual's, parent's, guardian's, or caretaker's control; or
   d. There was a failure to receive the department's request for information or notification for a reason not attributable to the individual, parent, guardian, or caretaker or lack of a forwarding address shall be attributable to the individual, parent, guardian, or caretaker.

C Coverage of Non-Medicaid Family Members.

(1) If determined to be cost effective, the department shall enroll a family member who is not a Medicaid enrollee into the HIPP program if the family member has group health insurance plan coverage through which the department can obtain health insurance coverage for a Medicaid-enrollee in the family.

(2) The needs of a family member who is not a Medicaid enrollee shall not be taken into consideration when determining cost effectiveness of a group health insurance plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

(3) The department shall:
   a. Pay a HIPP program premium on behalf of a HIPP program participating family member who is not a Medicaid enrollee; and
   b. Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a HIPP program-participating family member who is not a Medicaid enrollee.

The department will not provide any services to a HIPP program-participating family member who is not a Medicaid enrollee.

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	1906 of the Act	18. Individuals required to enroll in cost-effective employer-based group health plans remain as long as their employer-based group health plans remain cost effective and maintain Medicaid eligibility
	1902(a)(10)(F) and 1902(u)(1) of the Act	19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an Individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

* Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		C. Optional Coverage of the Medically Needy(Continued)
	1906 of the Act	12. Individuals required to enroll in cost effective employer-based group health plans remain eligible as long as their employer-based group health plans remain cost effective and they maintain Medicaid eligibility. If the Medicaid beneficiary is enrolled in a managed care plan, they will be moved to the Medicaid Fee For Service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES

1902(u) of the Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

_____ The methodology as described in SMM section 3598

✓ Another cost-effective methodology as described below.

A. Cost Effectiveness

(1) Enrollment in a group health insurance plan shall be considered cost effective when the cost of paying the premiums, coinsurance, deductibles and other cost-sharing obligations, and additional administrative costs is estimated to be less than the amount paid for an equivalent set of Medicaid services.

(2) When determining cost effectiveness of a group health insurance plan, the department shall consider the following information:

a. The cost of the insurance premium, cost sharing, and Medicaid managed care capitation rate, if applicable;

b. The scope of services covered under the insurance plan, including exclusions for pre-existing conditions, exclusions to enrollment, and lifetime maximum benefits imposed;

c. The average anticipated Medicaid utilization:

1. By age, sex, and coverage group for persons covered under the insurance plan; and

2. Using a statewide average for the geographic component; and

d. Annual administrative expenditures of an amount determined by the department per Medicaid participant covered under the group health insurance plan.

B. Cost Effectiveness Review.

(1) The department shall complete a cost effectiveness review, annually at the employer's open enrollment.

(2) The department shall perform a cost effectiveness re-determination if:

a. A predetermined premium rate, or cost sharing increases;

b. Any of the individuals covered under the group health plan lose full Medicaid eligibility; or

c. There is a:
   1. Change in Medicaid eligibility;
   2. Loss of employment when the insurance is through an employer; or
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   a. A health insurance premium payment program participant, who is a Medicaid enrollee, or a person on that individual's behalf, shall report all changes concerning health insurance coverage to the participant's local Department for Community Based Services (DCBS), Division of Family Support or the Medicaid KI-HIPP office within thirty (30) days of the change.
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   c. The individual, parent, guardian, or caretaker offers a good cause beyond the individual's, parent's, guardian's, or caretaker's control; or
   d. There was a failure to receive the department's request for information or notification for a reason not attributable to the individual, parent, guardian, or caretaker or lack of a forwarding address shall be attributable to the individual, parent, guardian, or caretaker.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

(3) The department shall:

a. Pay a HIPP program premium on behalf of a HIPP program participating family member who is not a Medicaid enrollee; and

b. Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a HIPP program-participating family member who is not a Medicaid enrollee.