Kentucky Waiver: Kentucky Helping to Engage and Achieve Long Term Health

Overview

On January 12, 2018, Kentucky received federal approval to implement a five-year Section 1115 demonstration waiver effective through September 30, 2023. The waiver, Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH), contains several initiatives affecting a broad range of Medicaid beneficiaries, including a program called Kentucky HEALTH. Kentucky HEALTH targeted adults eligible for Medicaid not on the basis of disability, and included provisions similar to those implemented in other waivers, such as enrollee contribution requirements and healthy behavior incentives, as well as some not previously approved, such as disenrollment and lockout for failure to submit necessary information for eligibility redetermination. Due to legal challenges and the election of a new governor, Kentucky HEALTH was never implemented, although the other portions of the state's demonstration waiver (KY HEALTH) will continue, including the state's substance use disorder demonstration program.

Kentucky received initial approval for a demonstration of work and community engagement requirements in January 2018, which had been scheduled to take effect on July 1, 2018. A June 2018 ruling in *Stewart v. Azar* vacated the approval, remanding it to the Centers for Medicare & Medicaid Services (CMS) for further review. CMS issued a reapproval for Kentucky's demonstration program on November 20, 2018, which was again vacated in March 2019 (CMS 2018e).[1] Although Kentucky initially appealed this ruling, it later chose to terminate the Kentucky HEALTH program (CHFS 2019).[2]

This brief discusses Kentucky's waiver as it was approved for the second time in November 2018. For more on the details of section 1115 demonstration waivers used to test new approaches to coverage, please see *Testing New Program Features through Section 1115 Waivers*.

Demonstration Goals

The state seeks to accomplish the following goals with the Kentucky HEALTH program:

- strengthen beneficiaries' engagement in their personal health care through incentives for responsible decision making;
- motivate beneficiaries to use health services more efficiently by requiring them to pay monthly premiums;
- achieve better health outcomes, lower overall health care costs, and improved socioeconomic conditions for beneficiaries through incentives for healthy behavior; and
- help beneficiaries obtain employment, transition to commercial health insurance, and achieve improved health outcomes through community engagement requirements.[3]

Populations Included

Kentucky HEALTH includes expansion adults with incomes up to 138 percent of the federal poverty level (FPL), as well as non-disabled adults covered under traditional Medicaid, including parents, pregnant women, former foster care youth, and transitional medical assistance (TMA) beneficiaries.

Eligibility and Enrollment

Kentucky HEALTH contains several policies related to eligibility and enrollment that alter the effective date of coverage, and beneficiary reporting requirements for annual redeterminations and changes in circumstances. The program also implements a new work and community engagement requirement as a condition of eligibility.

Effective date of coverage

Kentucky's demonstration includes a waiver of the Medicaid requirement for three months of retroactive coverage, except for pregnant women and former foster care youth, who continue to be covered retroactively. Individuals who are medically frail will have coverage effective the first day of the month in which they applied for coverage.

Coverage for individuals subject to premiums (i.e., new adult enrollees, parents and caretakers, and TMA enrollees, but not people who are medically frail) begins on the first day of the month in which the first premium payment is made. Individuals with incomes above 100 percent FPL who do not make an initial payment within 60 days will not be enrolled in Medicaid. Coverage for individuals with incomes below 100 percent FPL who do not make an initial payment begins after the 60-day payment period expires.[4] Individuals can also make an initial pre-payment to expedite coverage to the first day of the month in which the payment was made.

Beneficiary reporting requirements

Beneficiaries who fail to provide information to complete the annual redetermination process are disenrolled, and those who do not submit the required information within a 90-day reconsideration period are locked out of coverage for up to 6 months. Additionally, beneficiaries who fail to report changes in circumstances affecting their eligibility within 10 days are prevented from reenrolling for up to six months.[5] These provisions do not apply to pregnant women, former foster care youth, and enrollees who are medically frail.[6] Individuals who are disenrolled and locked out of coverage for failure to comply with these provisions can re-enroll prior to the end of the lockout period with full benefits once every 12 month benefit period by paying a new initial premium contribution and attending a state-certified course on health or financial literacy. Kentucky is required to provide beneficiaries with notice, education, and outreach about these policies; the state must also maintain the use of ex parte renewals (i.e., confirming continued Medicaid eligibility through third party data sources without requesting more information from the beneficiary), and prepopulated renewal forms.

Work and community engagement requirement

Kentucky HEALTH will implement a work and community engagement requirement as a condition of Medicaid eligibility for adult waiver beneficiaries who are not exempt (Table 1). Non-exempt beneficiaries who either work at least 120 hours per month or meet certain conditions will be deemed to satisfy the work requirement automatically, while others must participate in qualifying activities for at least 80 hours per calendar month and document their participation on at least a monthly basis.[7] Individuals who are newly subject to the work requirement (or have not been subject to it in the previous five years) will be given a three-month grace period before they have to meet it. Details regarding documentation and verification of beneficiary exemptions or compliance with the requirement are not included in the special terms and conditions of the waiver.

TABLE 1. Work and Community Engagement Requirement Exemptions and Qualifying Activities

Exempt	Non-exempt	
	Beneficiaries deemed to satisfy work requirement	**Qualifying activities (80 hours must be completed and documented monthly)**
• former foster care youth • pregnant women • primary caregivers of a dependent minor child or disabled adult (limited to one caregiver per household) • beneficiaries identified as medically frail • beneficiaries diagnosed with an acute medical condition that would prevent them from complying with the requirements • full-time students as determined by the state • beneficiaries under age 19 or over 64	• employed at least 120 hours per calendar month • meet the requirements of or are exempt from SNAP or TANF work requirements • enrolled in the state's Medicaid-funded employer-sponsored insurance premium assistance program and their spouses or dependents	• job skills training • job search activities • education related to employment (e.g., management training) • general education (e.g., high school, general equivalency diploma, college or graduate education, English as a second language) if not a full-time student • vocational education and training • self-employment (if less than 120 hours per month) • subsidized or unsubsidized employment (if less than 120 hours per month) • community work experience • community or public service • caregiving services for a non-dependent relative or other person with a disabling medical condition • participation in substance use disorder treatment

Note: SNAP is the supplemental nutrition assistance program. TANF is temporary assistance for needy families. Individuals who are deemed to have satisfied satisfy the work requirement do not have to actively document their participation in qualifying activities, but the state will verify their compliance (details regarding how the state will verify compliance are not specified in the special terms and conditions of the waiver).

Source: CMS 2018a.

Penalties for non-compliance. For beneficiaries who fail to meet the work and community engagement requirement for one month, Medicaid eligibility will be suspended unless they apply for and receive a good-cause exemption.[8] In the month after failing to meet the requirement, beneficiaries can avoid suspension by completing all required hours for that month, and either make up missed hours or complete a state-approved health or financial literacy course. Otherwise, eligibility is suspended effective the first day of the following month (i.e., two months after their initial failure to meet requirements). Eligibility remains suspended until the first day of the month after the beneficiary completes 80 hours of qualifying activities in a 30-day period or a state-approved health or financial literacy course. If a beneficiary's eligibility is suspended on the date of his or her annual redetermination, eligibility will be terminated.[9]

State assurances. Kentucky must make a number of assurances, including maintaining system capability to implement suspension of eligibility and lifting those suspensions (including suspending and reactivating capitation payments to managed care organizations), setting up systems to allow beneficiaries to report hours and seek data from other sources such as the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families, and ensuring timely and adequate beneficiary notices and outreach. Kentucky also is required to provide appeal and due process mechanisms, make good faith efforts to connect beneficiaries to existing community supports (e.g., non-Medicaid transportation assistance, child care, and language services), assess areas within the state that have limited employment or educational opportunities to determine if further exemptions are warranted, and provide reasonable modifications for individuals with disabilities.[10]

Additionally, Kentucky must submit an implementation plan to CMS within 90 calendar days of the waiver approval (February 2019). Kentucky must submit a monitoring protocol within 150 calendar days of approval (April 2019) that describes both the required quantitative metrics and the operational updates that will be reported. The monitoring reports must include data on compliance with the requirements, the effect of the demonstration in providing insurance coverage to beneficiaries and the uninsured, health care outcomes, quality and cost of care, and access to care. If monitoring reports indicate that demonstration features are not likely to assist in promoting the objectives of the Medicaid program, CMS can require the state to submit a corrective action plan to CMS as an interim step to withdrawing waiver authorities.

Benefits

Waiver beneficiaries in the new adult group will receive benefits through an alternative benefit plan, while pregnant women, former foster care youth, medically frail individuals, and other adults will continue to receive the Medicaid state plan benefit package. All beneficiaries under age 21 will continue to receive early and periodic screening, diagnostic, and treatment (EPSDT) services. The state is not required to provide non-emergency medical transportation (NEMT) to the new adult group for any services but will continue providing NEMT to other populations for most services, except for methadone treatment.[11]

Beneficiaries can use money accrued in their My Rewards accounts to purchase additional services, including vision and dental services.

Beneficiary-Managed Accounts

Kentucky HEALTH beneficiaries will be provided with two member-managed health accounts—a deductible account, intended to cover the first $1,000 of claims, and a My Rewards account, which can be used to purchase additional services.

Deductible account

The state will provide waiver beneficiaries—except for pregnant women and beneficiaries receiving employer-sponsored coverage through premium assistance—with a deductible account funded at $1,000 at the beginning of the benefit year, which will cover claims associated with non-preventive services. This account is intended to educate beneficiaries about the cost of health services but exhausting the account within a benefit period does not affect beneficiaries' ability to access services. Up to 50 percent of any funds remaining at the end of the benefit period can be transferred to the rewards account.

My Rewards account

The state will provide all adult waiver beneficiaries with a My Rewards account that they can use to purchase additional benefits and approved items (e.g., vision and dental services, over-the-counter medications, limited fitness-related services).[12]

Beneficiaries can add to their balances by completing healthy behavior activities and participating in community engagement activities that exceed the 80-hour participation requirement, and avoiding non-emergency use of the emergency department, as long as the account is active (i.e., an enrollee is not suspended) and they make their required premium payments. The state can reduce account balances for non-payment of premiums, non-emergency use of the emergency department, and missed appointments without good cause. The account balance can drop below zero but beneficiaries cannot be charged.

Premiums

All waiver beneficiaries will be required to make monthly premium contributions, except for medically frail individuals, pregnant women, and former foster care youth.

Premium amounts. The waiver allows the state to determine premium amounts but specifies that these amounts will be at least $1 per month and no more than four percent of monthly income. If beneficiaries reach the 5 percent of income cap on out-of-pocket spending for a calendar quarter, their contributions will be reduced to the $1 minimum premium for the remainder of the calendar quarter. The state must recalculate the required premium annually or whenever a member's circumstances change.[13]

Premium collection. Plans are responsible for billing and collecting premiums. Monthly invoices must include information about how to report changes in income, how income is calculated, and the consequences for non-payment and failure to report changes in circumstances. Beneficiaries are required to make their required premium payments within 60 days of the invoice to avoid non-payment penalties. Third parties are also permitted to make premiums on behalf of beneficiaries.

Penalties for nonpayment. Members with incomes below 100 percent FPL, as well as medically frail individuals and former foster care youth, will be subject to copayments and suspension of their rewards accounts if they do not make premium payments for 60 days.[14] Individuals with income above 100 percent FPL can be disenrolled and subject to a lockout period of up to six months.[15] Members who re-enroll following the full lockout period are not required to pay past premium debt, although funds will be deducted from their My Rewards accounts.

All members may end their respective penalties early by meeting a good-cause exemption or completing the following steps:

- pay the premium required for the first month of coverage to restart benefits,
- make a one-time payment equal to premiums owed during their 60-day payment period, and
- attend an early re-enrollment educational course certified by the state on health or financial literacy.

Plans cannot report unpaid premiums to credit agencies, refer cases to debt collectors, or seek liens on members' homes or their earnings.

State assurances. Prior to implementation, the state is required to make assurances, including providing beneficiaries with timely and adequate notice of policies related to premiums or actions that affect their eligibility; providing good cause exemptions from penalties; setting up processes to refund members for premium payments made for any months in which they were ineligible; and ensuring that reasonable modifications are made for individuals with disabilities protected by federal statute. In addition, the state must review the enrollees' eligibility for all other categories prior to disenrollment.[16]

Premium Assistance

The waiver continues the state's existing employer-sponsored insurance (ESI) premium assistance program. Individuals enrolled in premium assistance will have their Medicaid eligibility re-determinations aligned with the ESI open enrollment period.

Delivery System

Kentucky will continue to use statewide mandatory managed care, except for individuals receiving coverage through the Medicaid-funded employer-sponsored insurance premium assistance program. Once individuals make their initial premium payment, beneficiaries may not change plans without cause until their annual reenrollment period.

Endnotes

[1] *Stewart v. Azar* 313 F. Supp. 3d 237 (D.D.C. 2018).

[2] The decision to terminate the Kentucky HEALTH program was made following a change in state administration: Governor Andy Beshear announced this action soon after taking office in December 2019 (CHFS 2019).

[3] Demonstration goals also include those related to increasing access to substance use disorder (SUD) services, but they are beyond the scope of this fact sheet. Demonstration goals will inform the hypotheses in the state's evaluation design plan.

[4] Individuals who are found eligible through presumptive eligibility transition to being fully eligible on the first day of the month of the state's eligibility determination. Individuals known to be medically frail at the time of application are enrolled effective the first day of the month of application. Pregnant women and former foster care youth are enrolled with effective dates consistent with Medicaid regulations (i.e., three months of retroactive eligibility).

[5] The 10-day reporting window is not specified in the special terms and conditions, but is specified in the approval letter.

[6] These provisions also do not apply if the individual needed and was not provided with reasonable modifications, or for individuals provided with a good cause exception for conditions such as hospitalization or other incapacitation of him or herself or an immediate family member, homelessness, being the victim of a natural disaster or domestic violence, and other conditions.

[7] The state is required to provide reasonable accommodations for beneficiaries with disabilities protected by federal statute. These include, when necessary, exemptions from participation when an individual is unable to meet the requirement for disability-related reasons, modification in the number of hours required, and provision of support services.

[8] Good cause exemptions must include, at minimum, certain circumstances that occur in the month in which the beneficiary failed to meet the requirements, including the beneficiary or an immediate family member has a disability or is hospitalized for a serious illness, the birth or death of a family member, severe inclement weather or a natural disaster, or a family emergency or life changing event (e.g., divorce or domestic violence).

[9] Beneficiaries who newly qualify for an exemption (e.g., become pregnant, or enroll full-time in school) or become eligible through a Medicaid eligibility pathway not subject to the requirements during a suspension period can reactivate their eligibility.

[10] While beneficiaries qualifying for Medicaid on the basis of disability are not included in the waiver and as such are not subject to the work and community engagement requirement, some individuals with disabilities qualify through a different eligibility pathway and may be subject to the requirement.

[11] Individuals age 19 and 20 subject to early and periodic screening, diagnostic, and treatment services, pregnant women, and former foster care youth continue to receive NEMT for all services including methadone treatment.

[12] Vision and dental services and over-the-counter medications are covered at the rate in the Medicaid fee-for-service schedule, and are limited in scope to what beneficiaries would receive if they were not receiving the alternative benefit plan. When members seek benefits using the rewards account, Medicaid-enrolled providers should follow prior authorization processes to ensure the account contains a sufficient balance. The service is not reimbursable if the account has insufficient funds. This applies only to members receiving the alternative benefit plan; members receiving the state plan package receive these services through their managed care organization.

[13] Additionally, the state can vary amounts based on household size or length of enrollment, or other circumstances. It can reduce the required amount at any time but may only increase it in response to evaluation results on an annual basis.

[14] Co-payment amounts will be equal to the co-payments schedule in the Kentucky Medicaid state plan.

[15] The state is required to provide beneficiaries with 10 days advance notice of any adverse action.

[16] The state is required to offer good cause exemptions for certain conditions, including hospitalization or other incapacitation of the beneficiary or an immediate family member, homelessness, being the victim of a natural disaster or domestic violence.

References

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