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Approved Changes to Medicaid in Kentucky

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On January 12, 2018, the Centers for Medicare and Medicaid Services (CMS) approved a Section 1115 demonstration waiver in Kentucky, entitled "Kentucky Helping to Engage and Achieve Long Term Health" or KY HEALTH. The overall demonstration includes 2 major components: (1) a program called Kentucky HEALTH that modifies the state's existing Medicaid expansion and applies new policies to the current Medicaid expansion population, as well as most other adults covered by Medicaid; and (2) a Substance Use Disorder (SUD) program available to all Medicaid enrollees. Kentucky implemented a traditional Medicaid expansion, according to the terms set out in the Affordable Care Act (ACA), in January 2014. Subsequently, Governor Bevin, who ran on a platform to end the Medicaid expansion and dismantle the State-Based Marketplace, was elected in December, 2015. Post-election, the Governor instead decided to seek a Section 1115 waiver to change the state's traditional Medicaid expansion. On the same day that CMS approved Kentucky's waiver, Governor Bevin issued an executive order directing the state to terminate the Medicaid expansion if a court decides that one or more of the waiver provisions are illegal and cannot be implemented. This fact sheet summarizes key provisions of Kentucky's approved waiver. Specific details are included in Table 1.

Kentucky's waiver includes a number of provisions never before approved by CMS. For example:

- It marks the first demonstration to be approved that includes a work requirement (referred to as "community engagement") as a condition of eligibility (with eligibility suspended for non-compliance), following new guidance released by CMS on January 11, 2018.
- It allows for premiums of up to 4% of income, which exceeds the levels approved in any other waiver to date and those allowed in the Marketplace, both of which are capped at 2% of income.
- It includes multiple coverage "lock-out periods" of up to six months (two of which are new), including lock-outs for failure to timely renew eligibility or report a change in circumstances affecting eligibility (as well as a lock-out for non-payment of premiums for those with incomes between 100-138% FPL, that is already in effect in Indiana)
- It does not require CMS approval and the opportunity for public notice and comment on operational protocols that will be required to implement new waiver provisions that are complex and have significant implications for beneficiaries (instead, operational protocols for Kentucky HEALTH are only submitted to CMS for approval at state option).
- It specifies that the waiver terms and conditions can be revised to reflect changes that the HHS Secretary determines are "of an operational nature," without requiring submission of a waiver amendment, public notice and comment, or federal budget neutrality calculations.

Key provisions in the Kentucky HEALTH portion of the waiver applicable to most adults, including expansion adults and low-income parents, are:

- **Work Requirements:** Conditioning Medicaid eligibility on meeting and documenting a work requirement of 80 hours per month for most expansion adults and low-income parents and suspending eligibility for those who do not comply until they again meet the work requirement or complete a state-approved health or financial literacy course. Notably, CMS guidance prohibits states from using federal Medicaid funds for needed employment supports, such as child care, transportation, job training, etc.;
- **Premiums:** Requiring monthly premiums for most expansion adults and low-income parents, up to 4% of household income but at least $1.00, in lieu of copayments; requiring payment of the first premium before coverage is effective for those from 100-138% FPL (coverage is effective after expiration of the 60 day premium payment period for those below 100% FPL who do not pay a premium); removing the 90-day period to change health plans without cause after initial enrollment once the first premium is paid or the 60-day payment period expires;
- **Coverage Lock-Outs:** Disenrolling and locking out of coverage for up to six months: (1) those who are over 100% FPL and do not pay premiums within 60 days; (2) most adults who do not provide any documentation needed to timely renew eligibility; and (3) most adults who fail to timely report a change in circumstances affecting eligibility. Those subject to lockouts can re-enroll prior to 6 months if they pay all past due amounts and the current month's premium (for premium lockouts) and complete a state-approved health or financial literacy course;
- **Exemptions:** Varying the groups who are exempt from, or have good cause for not complying with, different waiver requirements. For example, people who are determined to be medically frail and former foster care youth are exempt from premiums, unless they wish to access an incentive account (described below), while pregnant women are both exempt from premiums and can have an incentive account without paying premiums. As another example, being evicted or homeless constitutes good cause for avoiding a 6-month lockout for failing to pay premiums, timely renew eligibility, or report a change in circumstances, but does not qualify as good cause for failing to meet the work requirement.
- **Deductible and Incentive Accounts:** Adding a deductible account and an incentive account to purchase additional benefits (moves vision, dental, and over-the-counter drugs from the regular benefit package to the incentive account for expansion adults; also offers limited reimbursement for gym memberships for all enrollees); enrollees must pay premiums to access the incentive account, can accrue funds by completing certain activities and are subject to account deductions as penalties for incurring various rule violations; and
- **Benefit Restrictions:** Eliminating retroactive eligibility for most adults, including expansion adults, low-income parents, and people who are medically frail; and waiving non-emergency medical transportation (NEMT) for all services for most expansion adults.

Key provisions in the SUD waiver program available to all Medicaid enrollees include:

- **IMD Payment Exclusion:** Waiving the IMD (institution for mental disease) payment exclusion for short-term SUD residential treatment services (with no day limit specified); and
- **NEMT:** Waiving NEMT for methadone treatment services (including for people who are medically frail).

Years of research and experience implementing Medicaid and CHIP point to coverage gains realized by simplified and streamlined processes and reductions in enrollment and retention of people who remain eligible for coverage when processes are complicated or require additional documentation or verification. Kentucky's waiver proposal anticipated that the demonstration would result in about 95,000 fewer Medicaid enrollees after implementation, as a result of beneficiary non-compliance with waiver policies, such as premiums and the work requirement, and, in later years, due to shifts to commercial coverage.

Separate from the provisions that apply to people who are determined "medically frail," Kentucky's waiver also requires the state to comply with the rights of people with disabilities under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and Section 1557 of the ACA. For example, the state must exempt people with disabilities from losing coverage if they cannot comply due to a disability-related reason and must offer reasonable modifications to program policies to enable them to comply.

Research points to gains in coverage and reductions in the uninsured, increases in access and health care utilization, and positive fiscal impacts as a result of the Medicaid expansion in Kentucky and other expansion states. Since implementing the ACA, Kentucky's nonelderly adult uninsured rate fell from 16.3% in 2013, to 7.2% in 2016, one of the largest reductions in the country, and nearly 462,000 adults are enrolled in Medicaid expansion coverage as of FY 2016.

The Kentucky waiver does not include any specific evaluation hypotheses or metrics related to the Kentucky HEALTH provisions, including those like the work requirement that have never before been approved and are likely to have significant implications for beneficiaries' ability to retain coverage for which they are eligible. While the waiver includes a multitude of exemptions for certain individuals and good cause exceptions (the details of which differ among specific waiver policies), as well as "state assurances" about implementation, these provisions are complex and will require administrative staff time and resources and sophisticated systems to implement. Despite the substantial consequences for beneficiaries and the administrative complexities of operationalizing new policies, submission and CMS approval of detailed operational protocols are not required and amendments or changes to the waiver terms may not be subject to full public notice and comment. Implementation of the Kentucky HEALTH provisions will begin in April, 2018, with full implementation by July, 2018. The implementation processes, whether there are adequate resources available, and the waiver's impact on eligible people and state administrative procedures and costs will be important areas to watch.

Table 1: Kentucky's Section 1115 Medicaid Expansion Demonstration Waiver	
Element	**Kentucky Waiver**

Overview:	The overall demonstration, called KY HEALTH, includes 2 major components:
	• (1) A program called Kentucky HEALTH, that modifies the state's existing Medicaid expansion by:
	  ○ Conditioning Medicaid eligibility on meeting and documenting a work requirement of 80 hours per month for most expansion adults and low-income parents and suspending eligibility for those who do not comply until they again meet the work requirement or complete a state-approved health or financial literacy course;
	  ○ Requiring monthly premiums for most expansion adults and low-income parents, up to 4% of household income but at least $1.00, in lieu of copayments and requiring payment of the 1st premium before coverage is effective for those from 100-138% FPL (coverage is effective after expiration of the 60-day payment period for those at or below 100% FPL who do not pay a premium);
	  ○ Disenrolling and locking out of coverage for up to six months: (1) those who are over 100% FPL and do not pay premiums within 60 days; (2) most adults who do not provide any documentation needed to timely renew eligibility; and (3) most adults who fail to timely report a change in circumstances affecting eligibility. Those subject to lockouts can re-enroll prior to 6 months if they pay all past due amounts and the current month's premium (for premium lockouts) and complete a state-approved health or financial literacy course;
	  ○ Removing the 90-day period to change health plans without cause after initial enrollment once the first premium is paid or the 60-day payment period expires;
	  ○ Eliminating retroactive eligibility for most adults, including people who are medically frail;
	  ○ Adding a deductible account and an incentive account to purchase additional benefits (enrollees must pay premiums to access the account, can accrue funds by completing certain activities, and are subject to account deductions as penalties for incurring various rule violations); and
	  ○ Waiving non-emergency medical transportation (NEMT) for all services for most expansion adults.
	• (2) A Substance Use Disorder (SUD) program available to all Medicaid enrollees that changes the SUD benefit package by:
	  ○ Waiving the IMD (institution for mental disease) payment exclusion for short-term SUD services; and
	  ○ Waiving NEMT for methadone treatment services (including for people who are medically frail).

Duration:	1/12/18 through 9/30/23. Partial implementation of Kentucky HEALTH begins 4/1/18 (for accrual of incentive account dollars, described below), with full implementation by 7/1/18.
Coverage Groups:	Kentucky HEALTH includes the adult expansion group, low-income parent/caretakers, those receiving Transitional Medical Assistance (TMA), pregnant women, and former foster care youth. Exemptions from specific policies are noted below.
Medical Frailty Determination:	People who are determined to be medically frail are exempt from several waiver provisions (noted below). The state will apply the federal definition of medical frailty, including people with disabling mental disorders; chronic SUD; serious and complex medical conditions; physical, intellectual, or developmental disabilities that significantly impact the ability to perform one or more activities of daily living; and those who meet Social Security disability criteria. The waiver also refers to the process in the state's alternative benefit plan (ABP). The ABP for low-income parents and other traditional populations currently specifies that individuals can self-identify as medically frail. However, no further detail about this process is provided in the waiver terms and conditions, which also provide that any operational protocol would be optional for the

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	state to submit to CMS for approval and incorporation into the waiver (as described below). (The ABP for expansion adults is silent about medical frailty.)
Coverage Renewals and Lock-Out:	Most adults (expansion, low-income parents and TMA) who fail to timely complete the annual eligibility renewal process (by not providing any required documentation after a 90-day grace period) will be disenrolled and locked out of coverage for up to six months, unless they verify good cause or cure the lock out as described below. Pregnant women, former foster care youth, and beneficiaries determined medically frail are exempt from this lock-out. In addition, people with disabilities cannot be disenrolled for failure to submit renewal paperwork if they needed but were not provided with reasonable modifications, under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and Section 1557 of the ACA, necessary to complete the process. The state shall use pre-populated forms and timely process applications to avoid further coverage delays once the lock-out period ends. The state also shall achieve successful ex parte renewal for at least 75% of Kentucky HEALTH adults, excluding those whose eligibility is suspended at renewal.
Lock-out for Failure to Timely Report Changes Affecting Eligibility:	Most adults (expansion adults, low-income parents, and TMA) who fail to report a change in circumstances that would have resulted in ineligibility within 10 days will be disenrolled and locked out of coverage for up to six months. Disenrolled individuals can cure the lock-out and re-enroll prior to six months (as described below) and receive pre-disenrollment safeguards (as described below). Pregnant women, former foster care youth, and beneficiaries determined medically frail are exempt from this lock-out.
Premiums:	Most adults (expansion adults, low-income parents, TMA, and those receiving Medicaid premium assistance for ESI) must pay monthly premiums. People who are medically frail, pregnant women, and former foster care youth are exempt from premiums, although former foster care youth and people who are medically frail can choose to pay premiums to access an incentive account (described below). Premiums shall not exceed 4% of household income, except that all non-exempt beneficiaries must pay a minimum of $1.00/month. The state may vary premium amounts on factors including, but not limited to, household income or length of time enrolled in Kentucky HEALTH, subject to the 4% household limit. Other bases for varying premiums should be consistent with how premiums vary in the state's commercial insurance market. Beneficiaries who meet the 5% aggregate household cap on premiums and cost sharing will pay $1.00 monthly premiums for the remainder of the calendar quarter. The state will determine premium amounts based on income at the eligibility determination and notify the beneficiary and health plan. The state must redetermine monthly premium amounts annually at renewal and any time the state is made aware of a change in household income, with new amounts effective on the 1st of the next month. The state may reduce a premium amount at any time. The state will annually evaluate the premium rates and amounts, and reserves the right to increase premium amounts up to the 4% of income limit in response to evaluation results. The state will notify CMS of upcoming premium changes through the demonstration annual report (described below) and will notify beneficiaries at least 60 days prior to implementing a premium change. Third parties (except health plans), such as non-profit organizations and providers, may pay premiums on a beneficiary's behalf. Provider or related entities must have criteria for making premium payments that are not based on whether beneficiaries will receive services from the provider. Health plans will send monthly invoices and collect premiums. Health plans can attempt to collect unpaid amounts, but may not report to credit agencies, place a lien on the enrollee's home, refer to debt collectors, file a lawsuit, or seek a court order to garnish wages. The state will not sell any unpaid obligations for collection by a third party. Unpaid amounts are collectible by the state, but re-enrollment is not conditioned on repayment except when curing a lockout (described below). Enrollees shall have an opportunity to review and seek correction of payment history. Enrollees will not be charged a higher premium due to nonpayment or underpayment in a prior month, although past due amounts will be separately reflected on subsequent invoices. Overpayments resulting from a change in circumstances will reduce the next month's premium. The state shall have a process to refund any premiums paid for a month during which the person

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	was ineligible for Medicaid. The state must suspend monthly invoices to enrollees whose eligibility is suspended for failure to meet the work requirement (described below) and send written notice to prevent overpayments.
Limitation on Changing Health Plans:	Beneficiaries may only change health plans for cause once the initial premium is paid or the 60-day payment period expires, until the beneficiary's next annual enrollment period (waives 90-day change period after initial plan enrollment; applies to all groups except pregnant women and former foster care youth). Individuals can select a health plan when applying or the state will auto-assign them to a plan.
Effective Coverage Date:	Waives 3-month retroactive coverage for most adults (expansion adults, low-income parents, and TMA), including people who are medically frail. Pregnant women and former foster care youth remain eligible for retroactive coverage. Requires most adults (expansion adults, low-income parents and TMA) to pay their first month's premium prior to the start of coverage unless they have been determined medically frail or presumptively eligible. Coverage begins on the first day of the month in which payment is received. Individuals below 100% FPL who are not medically frail, pregnant or former foster care youth and do not pay a premium within 60 days of the invoice have coverage effective on the first of the month in which the 60 day payment period expires. They also must make point of service copayments and do not have access to the My Rewards incentive account (described below). Those above 100% FPL who are not medically frail, pregnant or former foster care youth cannot enroll in coverage without a premium payment and must re-apply if the initial payment is not made within 60 days of the invoice. People exempt from premiums (those known to be medically frail at the time of application, pregnant women, former foster care youth) have coverage effective on the first of the month of application once determined eligible. Individuals (other than those determined presumptively eligible) can choose to make an initial premium prepayment (at an amount determined by the state, up to the maximum premium amount for those at 138% FPL) as part of the electronic application to expedite coverage. Once the individual is determined eligible for Medicaid, coverage will begin on the first of the month in which the initial premium pre-payment was made. However, once a premium pre-payment is made, the beneficiary may not change health plans except for cause prior to their next annual open enrollment period (waives 90-day period to change health plans after initial enrollment as described above). Premium prepayments can be refunded for those determined ineligible or for whom premium payments are not required, at the individual's request. Overpayments of the initial premium are credited to amounts due for the remainder of the benefit period, with any remaining amount refunded to the beneficiary. Anyone determined presumptively eligible continues coverage without a break as of the first of the month after the full Medicaid eligibility determination without having to first pay a premium. Instead, these enrollees have copays at state plan amounts and then have 60 days from their first premium invoice to make a payment. (Those over 100% FPL who are not medically frail, pregnant or former foster care youth and do not pay a premium within 60 days will be disenrolled and locked out for up to 6 months as described below.)
Consequences for Non-Payment of Premiums, including Disenrollment and Lock-Out or Copays:	As described above, premiums are a condition of eligibility for expansion adults, parents, TMA, and those receiving ESI premium assistance from 101-138% FPL unless medically frail. These groups will be disenrolled from coverage for non-payment of a premium after 60-days from the monthly invoice and not allowed to re-enroll for six months unless they cure the lockout (described below) or verify good cause (described below). People who are disenrolled for non-payment also will have dollars deducted from their incentive account (described below). They also are subject to safeguards prior to disenrollment (described below). People re-enrolling after a lock-out will not be required to pay past due premiums as a condition of eligibility. People subject to premiums at or below 100% FPL (unless medically frail or former foster care youth) will not be disenrolled for nonpayment but will be charged copays at state plan amounts, have dollars deducted from their incentive account (described below), and have their incentive account suspended (unable to accrue or use funds) up to 6 months. These individuals can return to paying premiums instead of copays and reactivate their incentive account before 6 months if they comply with the same requirements as are required to cure a lockout (see below); payment of

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	past-due premiums is not required to reactivate incentive accounts. Those determined to have good cause for non-payment will be eligible to resume premium payments instead of copays and access their incentive account in the first administratively feasible month.
Deductible Account:	Most adults (expansion adults, low-income parents, TMA, and former foster care youth) will have an account to which the state will contribute a $1,000 annual deductible to cover non-preventive healthcare services. Beneficiaries will receive monthly statements with the cost of utilized services and their account balance. If the deductible is exhausted before the end of the benefit year, enrollees will have access to covered services without unreasonable delay. If funds remain in the deductible account at the end of the year, enrollees can transfer up to 50% of the prorated balance (for months in which the person was enrolled and eligibility was not suspended) to their My Rewards incentive account (described below). Pregnant women and people receiving Medicaid as premium assistance for ESI will not have a deductible account.
Incentive (My Rewards) Account:	All adults (expansion adults, low-income parents, TMA, former foster care youth, and those receiving ESI premium assistance) will have a My Rewards incentive account if they are paying monthly premiums of at least $1.00. Pregnant women can have a My Rewards account without having to pay premiums. The incentive account may be used to access additional, prior authorized, benefits not otherwise covered once sufficient funds are accrued. These benefits include dental, vision, over the counter (OTC) medications, and limited reimbursement for the purchase of a gym membership for non-medically frail expansion adults, and only gym membership for all other adults (who instead continue to receive dental, vision and OTC medication in the state plan benefit package as described below). Vision, dental, and OTC medications are charged to the incentive account at the Medicaid fee-for-service rate and to the extent these services would have been covered under the state plan. For services that do not have a state plan rate, CMS must determine that the rate is cost effective and efficient. Expenditures for items and services covered under the incentive account must be determined by the Secretary to meet the federal definition of medical assistance. Enrollees can start accumulating dollars in their incentive account in April, 2018, (prior to full Kentucky HEALTH implementation in July, 2018). Account funds are not subject to an annual limit and can have a negative balance of up to $150, although beneficiaries will not have to make a monetary payment to the state for a negative account balance. Funds accrue, or are subject to deductions, as long as Medicaid eligibility is not suspended or disenrolled. Enrollees can earn incentive account funds by: - transferring 50% of any remaining deductible account funds each year (as described above) -completing state-specified healthy behaviors (no further detail provided); -completing work activities that exceed the 80 hour per month minimum requirement (described below); -not having a non-emergent ER visit during the benefit year; and -keeping all scheduled appointments in a year (based on a state evaluation of whether as a general matter enrollees subject to the demonstration are missing appointments). Enrollees will have incentive account funds deducted for: -each non-payment of premiums; -non-emergent use of the ER (amount may increase for each subsequent use), unless the enrollee contacts the health plan 24-hour nurse hotline before ER use. The enrollee must receive an appropriate medical screening exam, and the state must ensure that hospitals comply with enrollee education about appropriate alternative settings prior to deducting account funds; -each appointment missed without adequate notice of cancellation or good cause (not defined) (based on a state evaluation described above).
Work Requirement and Lock-Out:	Requires monthly documentation of 80 hours of work activities per month as a condition of eligibility for most adults ages 19-64. Beneficiaries cannot apply excess hours to future months. Beneficiaries who have not been subject to the work requirement in the past five years will have a three month period before being required to comply. The work requirement will be implemented on a regional basis.

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	Documentation is pursuant to the state's verification plan which currently does not directly address verification for the work requirement and prohibits self-attestation for verification of income. The only people exempt from "active" monthly documentation of meeting the work requirement are those who are meeting or exempt from TANF or SNAP work requirements, those enrolled in ESI premium assistance, and those who work at least 120 hours/month. Former foster care youth, pregnant women, one primary caregiver of a dependent minor child or adult who is disabled per household, people who are medically frail, those with an acute medical condition validated by a medical professional that would prevent them from complying, and full-time students are exempt from the work requirement. People with disabilities under the ADA/504/1557 also are exempt from the work requirement if unable to participate due to disability-related reasons (more detail below). Qualifying work activities include but are not limited to any combination of employment, job search, job training, education (related to employment, high school, college, graduate, ESL, vocational, etc.), volunteer work (community work experience, community service), caring for a non-dependent relative or other person with a disabling chronic condition, or participation in substance use disorder treatment. The state must make good faith efforts to connect enrollees to existing community supports that are available to assist in meeting the work requirement, including available non-Medicaid assistance with transportation, child care, language access services and other supports, and make good faith efforts to connect people with disabilities with services and supports necessary to enable them to comply. According to CMS guidance, Medicaid funds cannot be spent on employment support services. Those who fail to meet the required work hours for a month will have one month to cure their noncompliance (as described below). They also can request (at least 10 days before suspension) and verify good cause (as described below) or appeal the suspension before it takes effect. Otherwise, eligibility is suspended on the 1st of the month following the one month opportunity to cure, and the suspension lasts until the first of the month after the person cures the suspension (described below). Those with suspended eligibility at the time of annual renewal will be disenrolled unless they can show they meet the work requirement or are exempt in the renewal month. The state must assess areas that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas that lack public transportation to determine whether there should be further exemptions from the work requirement and/or additional mitigation strategies, so that the work requirement will not be impossible or unreasonably burdensome for beneficiaries to meet. The state shall provide timely written notice about when the work requirement begins, whether an enrollee is exempt and under what conditions the exemption would end, the specific work activities to satisfy and to cure noncompliance, information about resources that help connect beneficiaries to opportunities for activities that would meet the work requirement, community supports available to assist beneficiaries in meeting the requirement, how hours will be counted and documented, what gives rise to a suspension and how it could affect renewal, how to apply for good cause, how to appeal a suspension or good cause denial, and the explanation for good cause decisions.
Notice and Appeal Rights Required for All Lock-Outs/Eligibility Suspension:	The state shall provide advance notice and appeal rights prior to any disenrollment/eligibility suspension and lock-out, including the right to apply for Medicaid on a basis other than an expansion adult or low-income parent, the impact on the ability to access Marketplace coverage and premium tax credits, what to do if circumstances change creating eligibility for Medicaid on another basis, and implications for minimum essential coverage. During appeal hearings, individuals must have the opportunity to raise additional issues, including whether they should be subject to the lock-out, and to provide additional documentation during the appeals process. The state also shall provide written notice of the specific activities that qualify individuals for early re-enrollment during a lock-out period; the groups that are exempt from lock-outs; and the good cause exceptions to lock-outs (listed below).
Outreach and Education:	The state shall provide beneficiary education and outreach that supports compliance with renewals, such as through communications or coordination with state-sanctioned assisters, providers, health plans or other stakeholders.

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	The state also must conduct outreach and education to inform beneficiaries about how premiums should be paid, the potential impact of a change in income; the fact that premiums are determined based on monthly income; the deadline to report a change in circumstances affecting eligibility and the consequences for failing to do so; and how to re-enroll if disenrolled for non-payment. Health plan invoices also must contain this information.
Good Cause Exemptions to Lock Outs/Eligibility Suspension:	Enrollees have good cause and can re-enroll in coverage after an eligibility suspension due to failure to meet the work requirement or without waiting six months or completing the activities otherwise required to cure a lock-out (described below) for failure to timely renew eligibility, failure to timely report a change in circumstances leading to ineligibility, or failing to pay premiums if they can verify that they: -were unable to comply during the entire reporting/payment period because they were hospitalized, otherwise incapacitated (work requirement good cause instead requires "serious illness"), or a person with a disability under the ADA/504/1557; or, they are a person with a disability who either did not receive needed reasonable modifications or there were no reasonable modifications that would have enabled the individual to comply. Being out of town during the entire reporting period also is good cause for failure to report a change in circumstances; or -had an immediate family member living in the home become institutionalized or die (work requirement good cause instead specifies hospitalization or serious illness of immediate family member or birth or death of family member living with enrollee) during the reporting/payment period; or caretaking or other disability-related responsibilities for an immediate family member with a disability resulted in inability to comply; or -obtained or lost private coverage during the reporting period (applies only to lockouts for failing to timely renew or report change in circumstances); or -were evicted or homeless during the renewal reporting/payment period (does not apply to work requirement good cause); or -were a victim of a declared natural disaster (flood, storm, earthquake or serious fire) that occurred during the reporting/payment period (work requirement good cause specifies severe inclement weather including natural disaster); or -were a victim of domestic violence during the reporting/payment period (work requirement good cause specifies family emergency or other life-changing event such as divorce or domestic violence). This is a list of minimum good cause criteria.
Curing a Lock-Out/Eligibility Suspension to Re-enroll in Coverage:	Individuals who have been disenrolled and locked out of coverage for failing to pay premiums, renew eligibility, or report changes (and those under 100% FPL who lose access to their incentive accounts for failing to pay premiums) can cure the lock-out without waiting six months if they both (1) pay the premium for the 1st month of coverage to restart benefits; (2) if locked out (or lost access to incentive account) due to premium nonpayment, also make a one-time payment equaling premiums owed for each month in which they received healthcare coverage in the 60 days prior to the lockout; and (3) attend a state-certified health literacy or financial literacy educational course. However, the opportunity to cure a lockout (or reactivate incentive account) is limited to once per year per consequence type. Individuals who fail to meet the work requirement can avoid eligibility suspension by, in the month immediately following the month of noncompliance, (1) meeting the work requirement for the current month; and either (2) making up missing hours from the prior month, or (3) completing a state-approved health or financial literacy course (this option is available once/year). Individuals who go on to have eligibility suspended for failing to meet the work requirement can then cure the suspension by completing 80 hours of work activities in a 30-day period or a state-approved health or financial literacy course, The state shall ensure that the specific activities that qualify individuals to cure a lockout or eligibility suspension are available during a range of times and through a variety of means (e.g., online, in person) and at no cost to the individual.
Safeguards for Lockouts/ Eligibility Suspensions:	Before disenrollment and lock-out for failing to report a change in circumstances or to pay premiums, and before eligibility suspension for failing to comply with the work requirement, the state must determine the beneficiary ineligible for all other Medicaid pathways and review eligibility for other insurance affordability programs.

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	In addition, the state must offer an opportunity to provide additional clarifying information that an enrollee did report a change or had good cause before disenrollment and lockout for failure to report a change in circumstances affecting eligibility. Prior to disenrollment and lockout for nonpayment of premiums, the state also must notify the individual that they are able to request a medical frailty review, and the health plan must send at least 2 notices about the delinquent payment, the due date to avoid disenrollment, and the option for a medical frailty screening. Those who become pregnant or medically frail or eligible for Medicaid under another coverage pathway during the lockout period for nonpayment of premiums can re-enroll on that basis. While eligibility is suspended for failure to comply with the work requirement, those who become pregnant, meet an exemption from the work requirement (listed above), or become eligible for Medicaid through another pathway can re-enroll.
Benefits:	Expansion adults receive an alternative benefit package (ABP) as defined in a state plan amendment. Pregnant women, former foster care youth, people who are medically frail, low-income parents, and those receiving TMA receive the traditional state plan benefit package, which continues to include vision, dental, and over-the-counter (OTC) medications. These services are excluded from the expansion adult ABP and instead available through the My Rewards account (described above). No waiver of EPSDT for those under 21. Waives non-emergency medical transportation (NEMT) for most expansion adults. Those who are medically frail, 19 or 20 year olds entitled to EPSDT, former foster care youth, and pregnant women continue to receive NEMT for all services (see medical frailty exception for methadone NEMT below). Adds methadone to the state plan benefit package upon demonstration approval, but contingent on waiving NEMT for methadone services provided to all enrollees except children under 21, former foster care youth, and pregnant women (no medically frail exception). Upon CMS approval of an implementation protocol, the benefit package for all enrollees (both those in Kentucky HEALTH and others), will include SUD residential treatment, crisis stabilization, and withdrawal management services provided in IMDs (short term stays, no day limit specified).
Delivery System:	Continues to use existing capitated Medicaid managed care health plans for all populations statewide (except those in ESI premium assistance).
Reasonable Accommodations and Modifications for People with Disabilities:	The state must provide reasonable accommodations under the ADA/504/1557 to afford people with disabilities an equal opportunity to participate in the work requirement. The state also must provide reasonable modifications to the eligibility renewal process, the obligation to report a change in circumstances, and premium payment and work requirement protections and procedures to enable and assist people with disabilities under the ADA/504/1557. Reasonable modifications for the work program include but are not limited to assistance with demonstrating eligibility for good cause, appealing suspensions, documenting work activities and other documentation requirements, and understanding work requirement notices and program rules, and must include exemptions when non-compliance is due to a disability-related reason, modifications in the number of hours required, and provision of support services necessary for participation. The state must evaluate individuals' ability to participate in the work requirement and the types of reasonable modifications and supports needed. The state also must assess whether people with disabilities have limited job or other opportunities for reasons related to a disability and address those barriers. The state also must maintain a system that identifies, validates, and provides reasonable modifications for people with disabilities related to the obligations to report a change in circumstances, to pay premiums, and to comply with the work requirement.
Implementation Processes and Protocols:	The waiver only requires the state to submit operational protocols for the SUD provisions for CMS approval and incorporation into the waiver terms and conditions. A SUD implementation protocol is due within 120 days of demonstration approval. It should address the plan for meeting the following milestones: -within 12 months of demonstration approval: assess provider availability for key levels of care including those that offer medication-assisted treatment (MAT)

Table 1: Kentucky's Section 1115 Medicaid Expansion Demonstration Waiver	
Element	**Kentucky Waiver**
	-within 12-24 months of demonstration approval: establish a provider review process to ensure care is delivered based on evidence-based clinical treatment guidelines; require that residential treatment providers offer MAT onsite or facilitate offsite access -within 24 months of demonstration approval: service delivery for new IMD benefits; use of evidence-based SUD-specific patient assessment and placement criteria by health plans and providers; establishment of a utilization management approach for level of care and an independent process for reviewing placement in residential treatment settings; state-established residential treatment provider qualifications that meet nationally recognized standard; establish and implement policies to ensure residential and inpatient facilities link beneficiaries with community based services and supports after discharge -no timeframe specified: implement opioid prescribing guidelines and other interventions to prevent prescription drug abuse and expand naloxone access -according to separate protocol: milestones and metrics for SUD Health IT Protocols governing operation of Kentucky HEALTH, including the work requirement, premiums, healthy behaviors, and other provisions only will be submitted at state option.
Performance Metrics and Monitoring:	The state must submit proposed metrics for quarterly and annual monitoring reports within 120 days of implementation, which will be jointly identified with CMS. Metrics may include but are not limited to beneficiary engagement through the incentive account, work requirement initiatives, and coverage of SUD services. The state also must submit an SUD monitoring protocol within 150 days of demonstration approval, including reporting on each of the milestone areas in the implementation protocol and for each county, access to MAT, availability of MAT providers, the number of individuals accessing MAT including methadone, and the estimated cost of provided NEMT for accessing methadone. The SUD monitoring protocol also must include data collection, reporting and analytic methodologies for performance measures identified by the state and CMS, including timeframes and a baseline, target and annual goal for closing the gap.
Reports to CMS, Budget Neutrality, and Administrative Costs:	The state will submit to CMS 3 quarterly reports and 1 annual report each year and post them on the state website within 30 days of CMS approval. The reports must document: -any policy or administrative difficulties in demonstration operation, key challenges, their underlying causes and how they are being addressed, key achievements and to what conditions they can be attributed, any lawsuits, unusual or unanticipated trends, legislative updates, and any public forums held. -the impact of the demonstration in providing coverage to beneficiaries and people who are uninsured, and outcomes of care, quality, costs and access to care (may include beneficiary satisfaction surveys if conducted, and grievances and appeals). -the demonstration's financial performance including budget neutrality – the state will not be allowed to obtain budget neutrality savings from demonstration populations. -any results of evaluation hypotheses to date and a summary of the progress of evaluation activities including key milestones and challenges. -the actual number of eligible member months for demonstration populations. The state shall separately track and report administrative cost directly attributable to the demonstration (not included in budget neutrality).
Evaluation:	The state must begin to arrange for an independent party to conduct an evaluation upon demonstration approval. The state will submit a draft evaluation design to CMS for approval within 180 days of demonstration approval, a revised draft within 60 days of receiving CMS's comments, and will publish the evaluation design within 30 days of CMS approval. Each hypothesis must specify quantitative and qualitative research methodologies, proposed baseline

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	and comparison groups, proposed process and outcome measures, data sources and collection frequency, cost estimates, and timelines. The design will incorporate multiple stakeholder perspectives including but not limited to surveys of beneficiaries enrolled and no longer enrolled and national survey data. The interim evaluation is due (and should be posted for public comment with) when submitting an application for the waiver renewal or else 1 year prior to demonstration end. The final interim evaluation shall be posted to the state's website 60 days after receiving CMS comments on the draft. The draft summative evaluation is due to CMS within 18 months of the end of the initial waiver approval period, and the final summative evaluation is due within 60 days of CMS's comments and must be posted to the state's website within 30 days of CMS approval. Should CMS undertake a federal evaluation of the demonstration or any component, the state will cooperate fully and timely. The state also must conduct an independent mid-point assessment of the SUD provisions within 90 days after the third year of the demonstration and collaborate with health plans, providers, beneficiaries, and other key partners to examine progress toward milestones. The SUD implementation protocol must be modified for milestones at medium to high risk of not being achieved. The draft SUD evaluation design is due to CMS within 180 days of demonstration approval. Hypotheses should include initiation and compliance with treatment, utilization of ED and inpatient hospital services, reduction in key outcomes such as overdose deaths, effectiveness of MAT, interaction of MAT impact and access to NEMT and cost effectiveness of the IMD payment and NEMT waivers. Evaluation of the NEMT waiver shall include a beneficiary survey approved by CMS.
Process for Waiver Amendments:	Allows waiver terms and conditions to be revised to reflect changes that the Secretary determines are "of an operational nature" without requiring submission of a waiver amendment, public notice and comment, budget neutrality calculations, a detailed description of the amendment including the impact on beneficiaries, supporting documentation, data supporting evaluation hypotheses, and how the evaluation design will be modified if applicable. Waiver amendments are subject to guidance published in a 1994 Federal Register public notice, instead of the ACA public notice and comment process. The 1994 public notice requires the state to do one of the following: (1) hold at least one public hearing with time for comment on the "most recent working proposal"; (2) use a commission or similar process with an open public meeting in proposal development; (3) submit results from enactment of a proposal by the state legislature that includes an "outline" of the proposal; (4) provide for formal notice and comment of at least 30 days under the state administrative procedures act; (5) post a notice of intent to submit a proposal in newspapers of general circulation and provide a mechanism for receiving a copy of the proposal and at least 30 days to comment; or (6) any other similar process for public input that would allow an interested party to learn about and comment on the proposal contents.
Public Input:	Public forum required within six months of implementation and annually thereafter.
SOURCE: CMS Special Terms and Conditions, KY HEALTH 1115 Demonstration, #11-W-00306/4 and 21-W-00067/4, approval period Jan. 12, 2018 through Sept. 30, 2023, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.	