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# Re-approval of Kentucky Medicaid Demonstration Waiver

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**What did CMS do with regard to Kentucky's Demonstration Waiver?** On November 20, 2018, the Centers for Medicare and Medicaid Services (CMS) re-approved a Section 1115 demonstration waiver program called Kentucky HEALTH, as a component of the state's overall KY HEALTH ("Kentucky Helping to Engage and Achieve Long Term Health") demonstration.[1] The overall demonstration was originally approved on January 12, 2018, and includes 2 major components: (1) the Kentucky HEALTH program 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.[2] On June 29, 2018, a DC federal district court ruling set the Kentucky HEALTH program aside before implementation, which was scheduled for July 1, 2018, and sent it back to CMS for further consideration in response to a lawsuit brought by a group of Medicaid enrollees challenging the approval. CMS subsequently opened a new federal public comment period on the Kentucky HEALTH provisions and received approximately 8,585 "unique, substantive" comments.[3]

**Were there changes in the re-approved waiver?** The recent re-approval of the Kentucky HEALTH program is largely the same as the original approval with a few technical or minor changes. The re-approval also includes requirements for the state to submit implementation and monitoring protocols to CMS for approval as well as some evaluation hypotheses for the work requirement and other provisions that are likely to have significant implications for beneficiaries' ability to retain coverage for which they are eligible. The original waiver approval only required protocols for the SUD program and made submission of any Kentucky HEALTH protocols optional for the state.

**What is next?** The new implementation date for Kentucky HEALTH is set for April 1, 2019; however, the plaintiffs in the lawsuit could return to the DC federal district court to challenge CMS's re-approval. A final decision from the DC district court could be appealed to the DC Court of Appeals and eventually could ultimately go to the Supreme Court. At this time, it is not clear if whether or when the waiver re-approval will be challenged in court or if implementation would be postponed while litigation is pending. The DC federal court ruling did not affect the SUD provisions of the waiver, which are being implemented according to an October, 2018 implementation plan.

**What is the history of Medicaid expansion in Kentucky?** Kentucky originally 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. 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 20% in 2013 to 9% in 2016. Nearly 462,000 adults were enrolled in Medicaid expansion coverage as of FY 2016.

**What are the provisions in the waiver?** This fact sheet summarizes key provisions of Kentucky's approved waiver. Specific details are included in Table 1.

**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. Kentucky was the first state to receive waiver approval to condition Medicaid eligibility on meeting a work requirement following guidance released by CMS on January 11, 2018; however, implementation did not move forward as a result of the lawsuit challenging the approval.[4]
- **Premiums:** Requiring monthly premiums for most expansion adults and low-income parents, up to 4% of household income and 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. Premiums of 4% exceed the levels approved in any other waiver to date and those allowed in the Marketplace, both of which are capped at 2% of income.
- **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, those eligible for TMA, survivors of domestic violence 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).

**What to watch for?** As noted earlier, we will be watching to see if there is additional legal action in Kentucky (i.e. will the plaintiffs in the lawsuit return to the DC federal district court to challenge CMS's re-approval and then would CMS appeal that decision). Other milestones moving toward implementation include the submission of the implementation and monitoring protocols that are now required. If the waiver is implemented in April 2019, understanding the processes and procedures including beneficiary and provider outreach and education, new systems and reporting requirements will be important. We know from watching implementation of the new work requirements in Arkansas that these are large tasks and can be very difficult to reach enrollees to inform them of program changes.

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. While the total number likely to lose coverage may be under dispute, Kentucky's waiver proposal anticipated that the demonstration would result in 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. In Arkansas, the only state to implement a work requirement to date, over 12,000 people have lost coverage due to failure to comply with work or

reporting requirements as of November 2018. Litigation is pending in Arkansas. A November 8th letter to Secretary Azar from the Medicaid and CHIP Payment and Access Commission (MACPAC) raised concerns about disenrollment and the lack of an approved evaluation plan and asked for a pause in additional disenrollment. Understanding how many individuals lose coverage, the reasons for the coverage loss and if individuals gain employment with coverage or become uninsured are key questions for waiver evaluations in Arkansas and Kentucky.

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

| Element | Kentucky Waiver |
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| **Overview:** | The overall demonstration, called KY HEALTH, includes 2 major components:<br>• (1) A program called Kentucky HEALTH, that modifies the state's existing Medicaid expansion by:<br>o 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;<br>o 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);<br>o 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;<br>o 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;<br>o Eliminating retroactive eligibility for most adults, including people who are medically frail;<br>o 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<br>o Waiving non-emergency medical transportation (NEMT) for all services for most expansion adults.<br>• (2) A Substance Use Disorder (SUD) program available to all Medicaid enrollees that changes the SUD benefit package by:<br>o Waiving the IMD (institution for mental disease) payment exclusion for short-term SUD services; and<br>o Waiving NEMT for methadone treatment services (including for people who are medically frail). |
| **Duration:** | 1/12/18 through 9/30/23. Implementation of the Kentucky HEALTH components begins no sooner than 4/1/19. The SUD provisions are governed by a 10/5/18 implementation plan. |

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| **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). Information about Kentucky HEALTH put out on June 13, 2018 defines Medically Frail: as Medicaid recipients with a: serious and complex medical condition, significant difficulty performing activities of daily living, like eating and getting dressed, disabling mental health diagnosis, chronic substance use disorder, a diagnosis with HIV/AIDS, eligibility for Social Security Disability Insurance (SSDI), or chronic homelessness.<br><br>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.<br><br>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 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, survivors of domestic violence 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.<br><br>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 led to additional month(s) of coverage during which the person was ineligible 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, survivors of domestic violence and beneficiaries determined medically frail are exempt from this lock-out. |
| **Premiums:** | Most adults (expansion adults, low-income parents, and those receiving Medicaid premium assistance for ESI) must pay monthly premiums. People who are medically frail, pregnant women, former foster care youth, beneficiaries eligible for TMA, and survivors of domestic violence are exempt from premiums. Former foster care youth, people who are medically frail and those eligible for TMA can choose to pay premiums to access an incentive account (described below).<br><br>Premiums in lieu of copayments 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.<br><br>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 |

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| | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 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 and low-income parents), including people who are medically frail. Pregnant women and former foster care youth remain eligible for retroactive coverage. The effective date for those eligible for TMA is governed by the state plan.<br><br>Requires most adults (expansion adults and low-income parents ) 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. People who are medically frail, former foster care youth, TMA, survivors of domestic violence, or pregnant are not required to pay premiums to start or maintain coverage.<br><br>Individuals below 100% FPL who are not medically frail, pregnant, TMA, domestic violence survivors, 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 at state plan amounts and do not have access to the My Rewards incentive account (described below).<br><br>Those above 100% FPL who are not medically frail, pregnant, TMA, domestic violence survivors, 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.<br><br>People exempt from premiums (those known to be medically frail or domestic violence survivors 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. The coverage effective date for those receiving TMA is governed by the state plan.<br><br>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 |

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| | initial premium are credited to amounts due for the remainder of the benefit period, with any remaining amount refunded to the beneficiary.<br><br>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, TMA, domestic violence survivors, 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 and those receiving ESI premium assistance from 101-138% FPL unless medically frail, TMA, or a domestic violence survivor. 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 their incentive account balance reduced (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.<br><br>People subject to premiums at or below 100% FPL (unless medically frail, domestic violence survivor, or former foster care youth) and those eligible for TMA will not be disenrolled for nonpayment but will be charged copays at state plan amounts, have their incentive account balance reduced (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 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 required to and making monthly premium payments will have a My Rewards incentive account. Pregnant women can have a My Rewards account without having to pay premiums. Former foster care youth, survivors of domestic violence, and beneficiaries determined medically frail have the option to pay premiums to have access to the My Rewards account (to access benefits beyond those covered in the state plan like fitness-related services since these groups have access to state plan benefits including vision and dental).<br><br>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.<br><br>Enrollees can start accumulating dollars in their incentive account prior to full Kentucky HEALTH implementation. 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 |

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| | disenrolled.<br><br>Enrollees can earn incentive account funds by:<br><br>- transferring 50% of any remaining deductible account funds each year (as described above)<br><br>-completing state-specified healthy behaviors (no further detail provided);<br><br>-completing work activities that exceed the 80 hour per month minimum requirement (described below);<br><br>-not having a non-emergent ER visit during the benefit year; and<br><br>-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).<br><br>Enrollees will have incentive account funds deducted for:<br><br>-each non-payment of premiums;<br><br>-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;<br><br>-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. After Kentucky HEALTH implementation, new enrollees or those transitioning to Kentucky HEALTH will have at least 30 days before being required to meet the work requirement. The work requirement will be implemented on a regional basis.<br><br>Per information about Kentucky HEALTH put out on June 13, enrollees can report work hours online at CitizenConnect.ky.gov or by calling / visiting a local Kentucky Career Center. Enrollees are not required to upload supporting documents, but can provide them if available. The Commonwealth will check PATH Community Engagement hours, and enrollees could be required to provide documents as proof so enrollees can avoid having to find documents later by sharing them at the time of reporting.<br><br>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.<br><br>Former foster care youth, pregnant women, domestic violence survivors, 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 and reporting requirements. 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).<br><br>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.<br><br>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.<br><br>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 |

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| | 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 provide individuals whose eligibility is suspended with information on how to access primary and preventive care at no or low cost.<br><br>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.<br><br>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, the specific number of hours per month that an enrollee must complete and when and how the enrollee must report participation or requires an exemption or good cause, 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 demonstrate 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.<br><br>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.<br><br>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:<br><br>-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<br><br>-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<br><br>-obtained or lost private coverage during the reporting period (applies only to lockouts for failing to timely renew or report change in circumstances); or |

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| | -were evicted or homeless during the renewal reporting/payment period (does not apply to work requirement good cause); or<br><br>-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).<br><br>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.<br><br>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,<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>While eligibility is suspended for failure to comply with the work requirement, those who subsequently 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, survivors of domestic violence, 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.<br><br>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, survivors of domestic violence, and pregnant women continue to receive NEMT for all services (see medical frailty exception for methadone NEMT below).<br><br>Adds methadone to the state plan benefit package upon demonstration approval, but contingent on waiving |

| Table 1: Kentucky's Section 1115 Medicaid Expansion Demonstration Waiver | |
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| | NEMT for methadone services provided to all enrollees except children under 21, former foster care youth, and pregnant women (no medically frail exception).<br><br>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.<br><br>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.<br><br>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 requires the state to submit an Implementation Plan for the Kentucky HEALTH provisions to CMS no later than 90 days after approval of the demonstration for CMS approval and incorporation into the waiver terms and conditions. The implementation plan must include definitions and parameters and the state's strategic approach to implementing and milestones for key policies, including the work requirement, premiums, healthy behavior incentives, lock-outs for failure to timely renew eligibility or report changes affecting eligibility, and elimination of retroactive eligibility and NEMT. The implementation plan also must discuss application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.<br><br>The SUD implementation protocol and health information technology plan were approved by CMS on October 5, 2018. . |
| **Performance Metrics and Monitoring:** | The state is also required to submit a Monitoring Protocol for the Kentucky HEALTH provisions to CMS no later than 150 days after the approval of the demonstration. The monitoring protocol will described the qualitative and quantitative elements, data collection methods, and reporting timeframes for the state's quarterly and annual reports to CMS. CMS will provide a set of required metrics for key policies, including the work requirement, premiums, healthy behavior incentives, lockouts for failure to timely renew eligibility or report a change in circumstances, and elimination of retroactive eligibility and NEMT. For example, the metrics will cover enrollment, disenrollment, or suspension by specific demographics and reason, participation in qualifying work activities, access to care, and health outcomes.<br><br>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, |

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| | 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:<br><br>-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 issues or complaints identified by beneficiaries, any lawsuits, unusual or unanticipated trends, legislative updates, and any public forums held with a summary of all public comments received.<br><br>-the performance metrics described in the monitoring protocol (see above).<br><br>-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).<br><br>-the demonstration's financial performance including budget neutrality – the state will not be allowed to obtain budget neutrality savings from demonstration populations.<br><br>-any results of evaluation hypotheses to date and a summary of the progress of evaluation activities including key milestones and challenges.<br><br>-the actual number of eligible member months for demonstration populations.<br><br>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 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.<br><br>Hypotheses will include but are not limited to the following:<br><br>-for the work requirement, effects on enrollment and continuity of enrollment, employment levels, income, transition to private insurance, health outcomes, and Medicaid program sustainability.<br><br>-for premiums and healthy behavior incentives, effects on access to care and health outcomes.<br><br>-for elimination of retroactive eligibility, effects on enrollment and eligibility continuity, including for different subgroups such as individuals who are healthy, those with complex medical needs, prospective applicants, and existing beneficiaries in different care settings.<br><br>-for the demonstration as a whole and the key policies listed above, effects on health outcomes, financial impact (such as an assessment of medical debt and uncompensated care costs), and Medicaid program sustainability.<br><br>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 |

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| | to the state's website 60 days after receiving CMS comments on the draft.<br><br>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.<br><br>Should CMS undertake a federal evaluation of the demonstration or any component, the state will cooperate fully and timely.<br><br>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.<br><br>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:** | CMS reserves the right to amend the waiver terms and conditions to reflect changes "of an operational nature" without requiring the state to submit 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.<br><br>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, amended Nov. 20, 2018 https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf | |

# Endnotes

[1] CMS's cover letter refers to "approving Kentucky HEALTH as a component of the KY HEALTH demonstration." Letter from Paul Mango, Chief Principal Deputy Administrator and Chief of Staff, CMS Office of the Administrator to Carol H. Steckel, Commissioner, Dep't for Medicaid Servs., Commonwealth of Kentucky at 1, (Nov. 20, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf. The waiver terms and conditions indicate that these provisions are included in the KY Health demonstration as an amendment.

[2] The KY HEALTH waiver also provides authority for the state to cover former foster care youth who were in foster care in another state and to align Medicaid and CHIP renewals with employer-sponsored insurance (ESI) open enrollment periods for those receiving ESI premium assistance. CMS Waiver List, KY HEALTH 1115 Demonstration, #11-W-00306/4 and 21-W-00067/4, approval period Jan. 12, 2018 through Sept. 30, 2023, amended Nov. 20, 2018, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.

[3] Letter from Paul Mango, Chief Principal Deputy Administrator and Chief of Staff, CMS Office of the Administrator to Carol H. Steckel, Commissioner, Dep't for Medicaid Servs., Commonwealth of Kentucky at 11, (Nov. 20, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.

[4] In June, 2018, Arkansas became the first state to implement a Medicaid work requirement waiver. KFF, *An Early Look at Implementation of Medicaid Work Requirements in Arkansas* (Oct. 2018).