Kentucky HEALTH Program

Requirements Specification

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1 Kentucky Health Program Requirements

Section 1115 of the Social Security Act gives the Secretary of Health and Human Service the ability to approve projects that promote the objectives of Medicaid and Children's Health Insurance Program (CHIP) programs. Kentucky's Section 1115 Waiver is referred to as **Kentucky HEALTH: H**elping to **E**ngage & **A**chieve **L**ong **T**erm **H**ealth. This document outlines the general business requirements for technical implementation of the Kentucky HEALTH Program.

1.1 Implementation Schedule

Kentucky HEALTH is anticipated to go live January 1, 2018.

1.2 Program Benefits Packages and Categories

1.2.1 Kentucky HEALTH seeks to provide its members with a commercial health insurance experience in order to better prepare members to transition to commercial health insurance coverage. Consistent with this goal, Kentucky HEALTH will provide a benefit package consistent with the commercial market for the expansion population.

1.2.1.1 The Kentucky HEALTH benefit plan for the expansion population will be equivalent to the Kentucky State Employees' Health Plan, which provides a comprehensive commercial insurance benefit package.

All mental health and SUD services will be preserved.

Additional benefits such as dental services, vision services, and over the counter medications will be provided via the member's *My Rewards Account*.

Further, consistent with the goal of offering a commercial market experience, the State will not provide coverage for non-emergency medical transportation (NEMT) to the adult group, and will seek a waiver of this non-commercial benefit.

All 19&20 year olds enrolled in the expansion population will continue to receive all early and periodic screening, diagnostic, and treatment (EPSDT) services

1.2.2 Children, pregnant women, medically frail individuals, and any individuals eligible for Medicaid prior to the passage of the Affordable Care Act will be eligible to receive Medicaid State Plan benefits.

1.2.2.1 There will be no changes to State Plan benefits. The eligibility groups receiving State Plan benefits will continue to receive non-emergency transportation, as well as access to covered vision and dental services, in accordance with the State Plan rather than through the M*y Rewards Account*.

1.2.2.2 In addition, all children receiving services through the waiver and all 19 & 20 year olds in the Adult group will continue to receive all early and periodic screening, diagnostic, and treatment (EPSDT) services. **[Reference Eligibility Section 1.3].**

1.2.3 The Alternative Benefit Plan (ABP) coverage provided to the non-medically frail and non-pregnant individuals in the adult group will be based on the current Kentucky State Employees' Health Plan, which is a consumer-driven health plan administered by Anthem Blue Cross and Blue Shield of Kentucky, Inc.

1.2.3.1 The following benefits will not be provided on the Kentucky HEALTH Alternative Benefit Plan: Private Duty Nursing, Non-Emergency Medical Transportation, Hearing Exams (EPSDT exception), Hearing Aids (EPSDT exception).

1.2.4 My Rewards Account Benefit

1.2.4.1 Dental and vision services for non-pregnant and non-medically frail members in the adult group are considered non-covered services in Kentucky HEALTH. However, members covered by the Kentucky HEALTH ABP will be able to earn incentive dollars into My Rewards accounts to receive coverage for dental and vision services that are covered under the Kentucky State Plan. This benefit change will occur three months following the initial program implementation date to allow members additional time to accrue funds in their My Rewards Account, as these benefits are only provided through this account. Additional optional benefits, including over the counter

medications and gym membership, can also be accessed via this account. The *My Rewards Account* provides a benefit incentive program for individuals that meet health and Community Engagement goals **[Reference Community Engagement Section 1.14]**.

Benefit	Population	Covered by
Dental and Vision	• Adult Group	My Rewards
	• Children • Medically frail • Parents and Caretakers • Pregnant • Transitional Medical Assistance	Medicaid State Plan
	• 19/20 year old member in adult group	EPSDT
Enhanced Over-the-counter medications	• Adult Group • Medically frail • Parents and Caretakers • Pregnant • Transitional Medical Assistance	My Rewards
Health & fitness services		

1.2.5 Educational Support

Kentucky HEALTH will cover the costs of the member's out of pocket expenses associated with completion of the GED exam for any adult Kentucky HEALTH member without a high school diploma. This benefit will be available to the expansion adult group, as well as other adults on Kentucky HEALTH receiving State Plan benefits, as described above.

1.2.6 Employer Premium Assistance Program

Kentucky HEALTH includes an Employer Premium Assistance Program. Premium Assistance is mandatory for non-frail, non-pregnant adults, and parents and caretakers who have (1) been enrolled in Kentucky HEALTH for 12 months over a period of 5 years, 2) been employed by the same employer for 12 months, and have access to qualified employer sponsored insurance. All other Kentucky HEALTH populations may enroll optionally into qualified employer sponsored insurance. Enrolled individuals receive reimbursement from the state in accordance with the cost of their employer's premium less applicable deductions **[Reference Premium Assistance Section 1.16]**. Coverage for cost sharing on benefits and coverage of benefits not covered on the employer plan are wrapped to the ABP benefit package for non-frail and non-pregnant newly eligible adults and to the applicable current benefit package for all other enrollees. Premium Assistance enrollees have access to a My Rewards account in accordance with **[Reference My Rewards Section 1.12]**.

1.3 Eligibility

1.3.1 Kentucky HEALTH eligibility groups are determined based on current Modified Adjusted Gross Income (MAGI) financial eligibility requirements and non-financial household composition requirements.

1.3.2 Eligible Kentucky HEALTH Groups

Groups covered and determined as Kentucky HEALTH include:

- Expansion Adult Group (ADLT)

- Parents and Caretaker Relatives (PACA)
- Pregnant Women (PREG)
- Deemed Newborns (TP45)
- Infants and Children (CHL1, CHL2, CHL3, CHL4, CHEX)
- KCHIP Children (CHIP)
- Transitional Medical Assistance (TMA)

1.3.3 Kentucky HEALTH Excluded Groups

Individuals who belong to one of the Kentucky HEALTH eligibility groups in Section 1.3.2 above but fall into one of the conditions below will be excluded from Kentucky HEALTH:

- Medicare Dual Beneficiaries
- Institutionalized or Long Term Care
- Incarcerated Individuals

1.3.3.1 Groups ineligible for Kentucky HEALTH include:

- Aged Blind or Disabled Individuals (ABDM, QDWI, PTEW)
- SSI recipients (SSIR)
- 1915(c) Waiver Individuals (MICP, MWII, LTCM)
- Medicaid Works Disabled Individuals (MAWR)
- Former Foster Care (FCMA, FFCC)
- Department of Juvenile Justice (DJJM)
- State Supplementation Medicaid (SSPM)
- Adoption Assistance (ASMA)
- Transition from SSI- Ex parte (EXPT)
- Time Limited Medicaid for Aliens (EMCA, EMC1, EMC2, EMC3, EMC4)
- Low Income Medicare (QI1P, SLMB, QMBP)
- Spend down Medicaid (SPNM)
- Breast and Cervical Cancer Treatment Program (BCCTP)

1.3.4 Retroactive Eligibility

1.3.4.1 For Kentucky HEALTH, retroactive eligibility will remain available to pregnant women and children on intake and reapplication, limited to three full months from the application date or on reinstatement for the denied months provided they meet eligibility criterion for those months.

Example: Pregnant women applies on March 5, 2018. She will be eligible for coverage effective December 1, 2017.

1.3.4.2 Retroactive coverage will not be available for the Adult Group or Parent or Caretaker Relatives.

1.3.4.3 Retroactive coverage rules remain the same for non-Kentucky HEALTH individuals.

1.3.5 Effective Date of Eligibility on Application

1.3.5.1 Kentucky HEALTH eligible individuals will be deemed conditionally eligible for Kentucky HEALTH effective the date of the eligibility determination. This does not include Presumptively Eligible individuals, members who make a Fast Track payment, pregnant women and children, and those deemed Medically Frail.

Individuals that transition from Presumptive Eligibility have eligibility start date effective the first of the month of PE determination **[Reference Presumptive Eligibility Section**

1.7].

If the individual opts for Fast Track, their eligibility will be effective from the 1st of the month in which the pre-payment was made regardless of when their application is approved **[Reference Kentucky HEALTH Fast Track Section 1.5]**.

Pregnant women and children will be deemed eligible as of the first day of the month of application, with benefits effective three months prior to the application date, consistent with the retroactive eligibility policy described in **[Reference Retroactive Eligibility Section 1.3.4]**.

Confirmed Medically frail individuals determined eligible for Kentucky HEALTH will be enrolled effective the first day of the month of application **[Reference Medically Frail Section 1.6]**.

Example: A Medically Frail individual applies on May 5, 2018 but is not approved until June 3, 2018. This individual will have eligibility May 1, 2018.

1.3.5.2 No benefits will be available to individuals that are conditionally eligible.

1.3.5.3 Conditionally eligible Kentucky HEALTH members will have benefits effective the sooner of either (i) the first day of the month in which the first premium payment was made, or (ii) the first day of the month in which the 60 day payment period expired for individuals below 100% FPL, wherein they would be placed in a copay plan. [**Reference Conditional Eligibility Section 1.4].**

Example: An Expansion adult applies on May 15, 2018 but is not determined eligible until June 5, 2018. The member is considered conditionally eligible starting June. The first premium payment made by the individual is on July 16, 2018. This individual will be Conditionally Approved for the month of June, and approved benefits since July 1st, 2018.

1.3.5.4 Members enrolled in Medicaid prior to the January 1, 2018 transition date will be converted to Kentucky HEALTH with a Benefit Begin date of January 1, 2018. These converted members at that time do not become Conditionally Eligible.

1.3.6 Eligibility Factors

1.3.6.1 Eligibility factor indicators pertaining to Kentucky HEALTH individuals will need to be communicated amongst different entities including Managed Care Organizations (MCOs) and the Medicaid Management Information System (MMIS). These include:

- Benefit Package (State Plan, Alternative Benefit Package, and KCHIP)
- Pregnancy Indicator
- Conditionally eligible
- Termination/suspension due to Community Engagement
- Termination/suspension due to Cost Sharing non-compliance
- 6-month penalty period due to Cost Sharing
- 5% Cost Sharing Limit – Premium change to $1, copays waived
- My Rewards Status Indicator
- Copay/Premium Status
- Medically Frail Indicator
- Community Engagement Indicator

- Community Engagement hours
- Case Indicator (MCOs to receive case-level information)
- Cost Sharing Premium, as applicable.
- Premium Amount
- Premium Assistance Indicator, as applicable

1.3.7 Kentucky HEALTH Benefit Packages

1.3.7.1 Kentucky HEALTH individuals will be provided one of two Benefit Packages: the State Plan, or the Kentucky HEALTH Alternative Benefits Package (ABP) depending on the member's eligibility and characteristics.

1.3.7.2 The State Plan is consistent with current Medicaid Benefits. The Alternative Benefits Package will be benchmarked to the current State Employees' Health Plan. Please refer **[Reference Program Benefits Packages and Categories Section 1.2]** for additional details. The following are benefits packages for each Kentucky HEALTH eligibility group:

Kentucky HEALTH Group	Benefit Package
Adult Group	Kentucky HEALTH Alternative Benefit Plan
Adult Group: Medically Frail	Kentucky State Plan
Adult Group: Pregnant	Kentucky State Plan
Section 1931	Kentucky State Plan
Transitional Medical Assistance	Kentucky State Plan
Pregnant Women	Kentucky State Plan
Newborn Children	Kentucky State Plan
Children (< 19 years old)	Kentucky State Plan
CHIP	Kentucky State Plan
Premium Assistance	Employer Plan Benefits with FFS Wrap

There are further variations to the Kentucky State Plan copayments, premiums, and no cost sharing requirements as follows:

Benefits	Cost Sharing	Applicable Indicators (one or more may apply)
State Plan - Includes EPSDT for age 19 & 20	Copay	Low Income Parent Caretaker, TMA, 6-month penalty period
	Premium	Low Income Parent Caretaker, TMA, Optional Frail
	No Cost Share	Pregnant (Pregnancy Category), Frail, 6 month penalty period, 5% cost-share met (w/TMA or Low Income Parent Caretaker)
Kentucky HEALTH- Includes EPSDT for age 19 & 20	Copay	Adult, 6 month penalty period
	Premium	Adult
	No Cost Share	6-month penalty period, 5% cost-share met
Kentucky HEALTH Presumptive Eligibility- Includes EPSDT for age 19 & 20	Copay	N/A

Kentucky HEALTH Pregnancy, includes vision, dental, and EPSDT	No Cost Share	Pregnant (adult category), 6 month penalty period. EPSDT only applies if pregnant woman is 19 or 20 years old
State Plan < age 19	Current	<19
KCHIP	Current	<19
Suspended	N/A	Suspended - Non-Payment
	N/A	Suspended - CE
	N/A	Suspended - Incarcerated
Conditional	N/A	Conditional, Low income parent caretaker, Adult, TMA

1.4 Conditional Eligibility

1.4.1 Conditional eligibility is defined as the circumstance wherein an individual or family that is designated as Kentucky HEALTH eligible is approved for eligibility but benefits are not effectuated until the first payment to the managed care organization is made. An individual is deemed conditionally eligible when they have submitted the relevant information and documents needed to be determined as eligible, and have been approved for being enrolled in Kentucky HEALTH, but they have not completed their payment to fully enroll in the program.

1.4.2 Newly eligible adults, Section 1931 low-income parents and care takers become conditionally eligible. Children, medically frail adults, and pregnant individuals are all exempt from cost sharing and on application approval will directly be enrolled, consistent with the effective dates in Section 1.3.5

1.4.2.1 The 60 day payment deadline under conditional eligibility period begins on the day that the individual or family's eligibility has been approved - which does not necessarily have to be from the first of the month.

1.4.2.2 Individuals that are conditionally eligible may exit conditionally eligible status if: (1) they make a payment, thus approving their benefits (2) they do not make a payment in 60 days, thus approving or denying their benefits (based on their income against the FPL) or (3) they have a change in eligibility that waives their conditional eligibility status during the conditional period (e.g. the member becomes frail).

1.4.2.3 If the individual makes the payment within 60 days of being invoiced by the MCO, then the individual's insurance coverage begins the first of the month of payment in the premium plan. The date the payment is received must be within 30 days of the 60 day grace period mentioned above for benefits to start the month of payment. If payment is not received timely, coverage will not be effective and the individual must complete the appeals process for non-covered months.

Example: If an individual is made conditionally eligible on 3/9/2017, the individual has until 5/8/2017 to make a payment. If the individual makes the payment on 4/10/2017, then their coverage will begin on 4/1/2017 in the premium plan with the applicable benefit package for the member.

1.4.2.4 If an individual has a change in eligibility during the conditional period, for example is confirmed medically frail, then the conditional eligibility terminates and eligibility begins consistent with the individual’s new eligibility status.

1.4.2.5 During conditional eligibility, members are not covered, hence the conditionally eligible months are not counted as active months towards accrual of premiums. In this period, the member's My Rewards account is inactive. Benefits in My Rewards may only accrue once a payment is made and eligibility is approved. Likewise CE hours may only accrue and count towards the monthly requirement once payment has been

made.

1.4.2.6 For a member to move from conditionally eligible to approved status, they must make a payment within 60 days of being invoiced by the MCO. Should they not make a payment, the following applies based on their FPL level:

i. If they or their family is <100% FPL, they are enrolled onto the copay plan if payments aren't made within 60 days of being determined eligible.

Example: If an individual <100% FPL is invoiced by the MCO on 3/9/2017, the individual has until 5/8/2017 to make a payment. If the individual fails to make the payment by 5/8/2017, then they are placed on the copayment plan beginning 5/1/2017. Their 6-month non-payment penalty period will begin 5/1/2017.

ii. If they or their family is >100% FPL, then their application is immediately terminated and they do not attain any benefits. The individual or family may reapply in order to be considered for Kentucky HEALTH. The 6-month penalty period does not apply to initially conditionally eligible individuals – only to those who have started coverage.

Example: If an individual > 100% FPL is invoiced by the MCO on 3/9/2017 the individual has until 5/8/2017 to make a payment. If the individual fails to make the payment by 5/8/2017, then their conditionally eligible period ends and they have no coverage.

iii. Conditional eligibility status also applies to recertification. Standard conditional eligibility policies apply to those who apply for late recertification.

iv. In the event that an individual wants to change MCOs while they are still conditionally eligible and have not yet made a payment, the 60 days to pay from invoice date from MCO 1 still applies.

Example: An individual is made conditionally eligible on 3/9/2017; thus, they must make the first payment by 5/8/2017. The individual initially has signed up for receiving care from MCO A, but on 4/1/2017, wants to be enrolled with MCO B. The individual must still make the payment by 5/8/2017. The payment due date from MCO A must be communicated to MCO B.

1.5 Kentucky HEALTH Fast Track

1.5.1 Kentucky HEALTH Fast Track is an option to make an initial payment of $10 to the tentative MCO while an applications pends. If approved for Kentucky HEALTH, this payment allows the individual or family to start their coverage as early as the first of the month of application. The earliest they can start coverage alternatively would be the first of the month of application approval. Denying this option has no adverse effects on the applicant.

1.5.1.1 To be eligible for Fast Track, an applicant must first be eligible for Kentucky HEALTH under current eligibility rules. Both expansion adults and section 1931 parent and caretaker relatives can fast track. **[Reference Eligibility Section 1.3].**

1.5.1.2 The Fast Track process is only available online on the self-service portal. If individuals apply in-person or through walk-in, they can access their self-service account on the self-service portal in order to make a Fast Track payment. Payments are made by way of credit card or similar payment methods.

Fast Track payments can be made by the member after initial submission of their application during application pending status. Once the member is enrolled, a Fast

Track payment cannot be made by the member.

1.5.1.3 The high-level process for facilitating a Fast Track payment is as follows:

The individual applies for and is pended in the Adult or PACA Group. The individual may opt for Fast Track (FT) and has to select an MCO. This could occur as part of an initial application.

1.5.1.3.1.1 Only one MCO may be selected for a Fast Track payment. Families who choose multiple MCOs will not be able to make a Fast Track payment.

Should an applicant choose to make a FT payment, they will be directed to the MCO's payment portal to make the Fast Track payment.

i. The MCO will confirm the payment and record a reference number. The MCO that receives the payment will never receive a record of the other household members, who may have selected other MCOs.
ii. The MCO makes the payment information available with the reference number attached. The applicant/the applicant's household is locked in on the 1st of the month of payment for each MCO selection. This could be as early as the month of application.
iii. If the person is found eligible, the provider portal is updated and the MCO receives an 834 with the start date set at the first of the month that the Fast Track payment was made.
iv. When the Fast Track payment equals the amount of premium determined by eligibility for the household, the initial premium payment process is complete and the applicant and all household members with the MCO where the payment was selected have benefits that start effective the first of the month that payment was made.
v. When the credit card payment is for more than the premium determined by eligibility, the extra is applied as a credit towards future months.
vi. When the credit card payment is for less than the premium amount determined by eligibility, the MCO bills the member for the remaining amount. It is upon the individual to make the payment to remain eligible. The case is treated like any other premium payment, and the 60 days rule applies.

    Example: An applicant pays the $10 Fast Track payment and is determined to be eligible. If the premium payment determined by Eligibility is $1, the person does not need to make premium payment until month 11. Likewise, if the premium payment determined by Eligibility is $15, the member will be invoiced by the MCO for the remaining $5, and will have 60 days to make any pending payments or else face termination. However, the individual eligibility for benefits begins the 1st of the month of application due to the receipt of the fast track payment, notwithstanding the timing of the individual's payment of the additional $5.

vii. Should the case present itself where an application is pending and a Fast Track payment has been made but approval is only received in the next month, the member is now responsible for two months' worth of payments.

    Example: An individual applies 02/25 and makes a Fast Track payment. The individual is approved on 03/05. The person is eligible from 02/01, and is now responsible for premiums for the months of February and March, minus any premium payments covered by the $10 Fast Track payment.

viii. For an individual that made a Fast Track prepayment prior to being found eligible and was subsequently determined not to be eligible for Kentucky HEALTH (even

if eligible for another Medicaid category), the MCO will receive notice and the individual will be reimbursed on the credit card used for the Fast Track payment.

ix. For an individual that does not pay their Fast Track payment prior to being found eligible, the person will be considered conditionally eligible pending payment as normal.

x. Individuals who are covered under presumptive eligibility and apply for Kentucky HEALTH do not have the option to Fast Track.

xi. Individuals added as part of the existing plan through add a member case should not be eligible for Fast track payment. These individuals will be enrolled in the same family plan and the new premium if changed would be effective from next month. MCO will send payment invoice with new premium to the members and members should be responsible to pay the premium within 60 days else will be dis enrolled or move to Copay plan based on the household FPL.

For an individual that pays their premium invoice after being found eligible but before the expiration of the 60-day payment period, Eligibility will process this payment as a normal premium payment for conditional eligibility; i.e., benefits will begin the first day of the month in which the payment was received.

1.6 Medically Frail

1.6.1 Medically Frail individuals below 138% FPL are eligible to receive Medicaid State Plan benefits and are exempt from cost sharing when enrolled in Kentucky HEALTH.

1.6.2 Medically Frail individuals are identified the following ways:

- Self-identification
- Provider identification and referral to MCO
- MCO identification
- State Eligibility System Identification (SSDI, RSDI)

1.6.3 Certain populations are considered automatically Medically Frail, including individuals receiving hospice care, persons with HIV/AIDS, individuals receiving SSDI, or individuals who have been identified as Medically Frail in the last twelve months. These individuals are identified during the application process and begin receiving benefits on the first of the month in which they applied. Any individual determined Medically Frail status post-application (e.g. an enrolled member now receiving SSDI) becomes frail the first of the following month.

1.6.3.1 MCOs must be sent the frail status attestation, reason for frailty, and reconfirmation dates for Medically Frail in order to verify frail status. MCOs must confirm Medically Frail status for any individuals who self-identified within six-months or Medically Frail status is lost. Members are notified after MCOs have confirmed or denied their status. Those that have been denied Medically Frail status also receive information regarding the appeals process.

1.6.3.2 Members who are determined as Medically Frail through verification of SSDI coverage or HIV/AIDS will never lose their frail status.

1.6.3.3 Members who have been determined Medically Frail within the last 12 months are considered Medically Frail.

1.6.4 Other conditions may also qualify as Medically Frail and will be determined based on MCO review of medical history, claims, and provider input. If not identified as automatically Medically Frail, the

MCO will collect and review necessary information to make a determination.

1.6.4.1 A standard tool and process as set forth by the UM contract will be implemented for determining Medically Frail status by the MCOs. Medically Frail determinations can ultimately be appealed to the state and will be prepared and assisted by the UM. The UM contract will have oversight of the Medically Frail conditions and qualifications.

1.6.4.2 Qualifying conditions may include a disabling mental disorder, chronic SUD, serious and complex medical condition, or a physical, intellectual or developmental disability that significantly impairs the ability to complete activities of daily living. Individuals may appeal Medically Frail status using standard grievance and appeals processes.

Individuals maintain Medically Frail status during the appeals process only if they were receiving Medically Frail benefits before the appeals process. If they are appealing for not being found frail based on self-report and do not currently have Medically Frail benefits, they do not begin to receive those benefits at any point during the appellate process.

1.6.5 If a member's Medically Frail status changes after the initial application and review period, they may complete a self-report, which must then be confirmed by the MCO. The MCOs then review the new evidence of Medically Frail status and make a determination following the process outlined above for members are identified as Medically Frail at time of application. For self-reports that are not Activities of Daily Living or homelessness, the medically frail status must be verified by the MCO. Changes to benefits or cost sharing based on medically frail status are not effective until the first of the month after the MCO confirmation.

1.6.6 Individuals or families experiencing Chronic Homelessness or ADL will also be identified as Medically Frail for the first 6 months of enrollment. Members declare their status as homeless OR ADL and receive frail status for 6 months.

1.6.6.1 This 6 months of frail status is only available one time in 5 years.

1.6.6.2 During the 6 months the individual must complete an interview with a DCBS office. If DCBS confirms chronic homelessness the individual's frail status is extended for an additional 12 months. Continued chronic homelessness or another frail condition must be reconfirmed every 12 months.

1.6.6.3 MCO must confirm Medically Frail status for homeless or ADL who self-identified within six months.

1.6.7 Medically Frail individuals are automatically exempt from cost-sharing (including copayments and premiums), community engagement, and employment requirements. However, Medically Frail individuals may opt for cost sharing to activate My Rewards Account benefits. For those that have opted in, if they fail to make premium payment they lose access to My Rewards accounts but remain exempt from any copayments for healthcare services.

1.6.7.1 6 month penalty period is applicable to Medically Frail individuals that had opted for cost sharing and then haven't paid their premiums. This penalty period continues even when they opt out of cost sharing. In order to come out of this penalty, medically frail individuals would have to pay debt for a month and complete a health and financial literacy course.

1.6.8 Medically Frail status must be confirmed every 12 months, unless otherwise specified by the state.

1.6.9 Medically Frail status, and the associated benefits begin on the first of the month in which the

application, presumptive eligibility or conditional eligibility begins.

1.6.9.1 For individuals whose Medically Frail status is confirmed via claims, the frail status indicator and full Kentucky State Plan benefits begin the first of the month after confirmation.

1.7 Presumptive Eligibility

Presumptive Eligibility (PE) is an expedited process that allows qualified providers to enroll individuals into Medicaid services without the need to perform full verification of financial and non-financial requirements to receive eligibility. PE is based on personal assessment by qualified providers.

1.7.1 PE coverage is limited to one determination per individual per 12-month period from the conclusion of the PE coverage. However, there is an exception for presumptive eligibility for pregnant women, where coverage is limited to one determination per pregnancy. PE is time limited with coverage only lasting till the end of the 2nd month from PE determination, or longer if the application has been filed and the individual is pending determination.

Example: An individual is determined PE on May 8, 2018. The coverage of PE will be only effective until June 30, 2018.

1.7.2 Individuals enrolled in a presumptive eligibility category of assistance are not required to abide by the Kentucky HEALTH requirements. However, transition from PE to Kentucky HEALTH via a full Medicaid application does have certain eligibility considerations. Further, the type of PE determination will require Kentucky HEALTH approved benefit packages.

1.7.3 Presumptive Eligibility Groups with Kentucky HEALTH benefits

The following categories of PE are aligned to the new Kentucky HEALTH benefits packages:

Type of Assistance	Description	Benefit Package
PEAD	Presumptive Eligible Expansion Adult	Kentucky HEALTH ABP with Copay
PEPC	Presumptive Eligible- Parent Caretaker	Kentucky State Plan with Copay
PEC1	Presumptive Eligible Child	Kentucky State Plan
PEC2	Presumptive Eligible Child	Kentucky State Plan
PEC4	Presumptive Eligible Child	Kentucky State Plan
PEPR	Presumptive Eligible Pregnant	Kentucky State Plan*

*Presumptively Eligibly pregnant women only get ambulatory prenatal care. This is not impacted by implementation of Kentucky HEALTH.

1.7.4 Transition to Kentucky HEALTH

During the Presumptive Eligibility period the individual may submit a full application for Medicaid assistance. If the individual is determined eligible for Medicaid, they will maintain enrollment in the same Benefit Package as the PE determination but that month of coverage will be reclassified as coverage under the applicable Kentucky HEALTH category instead of presumptive eligibility. The effective date of eligibility will begin on the first of the month of application submission, overriding any presumptive eligibility coverage.

Example: On January 5, 2018, an individual is determined as PEAD. An application is submitted on February 2, 2018, with approval on February 15, 2018 for ADLT coverage. Effective February 1, 2018 the individual will be eligible for the Kentucky HEALTH Copay plan. Coverage form January 5th to January 31st will be in PEAD.

Individuals transitioning to standard Medicaid Eligibility will be required to comply with program requirements, including cost sharing and community engagement. However, the months where the individual was covered under presumptive eligibility will not be counted towards their total community engagement or cost sharing clock.

1.7.5 MCO Invoicing

If the individual transitions from PE to regular Medicaid eligibility, the MCO will invoice from the effective date of eligibility. The same cost-sharing rules and penalties, such as termination/suspension of benefits for FPL >100%, will apply to these individuals. MCOs do not invoice members during their PEAD period.

Failure to pay the premium for any non-medically frail or pregnant adult results in a 6 month non-payment penalty, regardless if the individual is still eligible due to having an income under 100% FPL.

Individual cannot change the MCO selected for the PE period however when individual determined fully eligible after the PE eligibility, they can choose a different MCO and change MCO prior to first premium payment or expiration of initial 60 days payment period.

1.7.6 Untimely submission of Medicaid Application

To transition from PE to Kentucky HEALTH without a period of conditional eligibility, the individual must submit their application prior to the end date of their presumptive eligibility. Failure to submit the application timely will require the individual to apply through standard means, with possibility of Conditional Eligibility.

> *Example*: An individual has a Presumptive Eligibility end date of March 31, 2018. The individual did not submit their application by this date. As a result, this individual no longer has coverage under Presumptive Eligibility, and to receive Medicaid coverage, they must apply as a new applicant.

1.7.7 Fast Track during Application while PE

There will be an option for the individual to submit a fast track payment while submitting a Medicaid application while being covered for Presumptive Eligibility. The Eligibility system will determine the dates of approval to avoid overwriting benefits and current MCO assignments. Once received at the MCO, the eligibility information will align the Fast Track payment to the first of the correct coverage month.

1.7.8 My Rewards Eligibility during PE

1.7.8.1 While being covered under Presumptive Eligibility the individual will not have access to My Rewards. During transition from PE to full eligibility, the individual may be eligible for My Rewards in the following conditions:

Transition for PE Pregnancy to Pregnancy category, provided the individual is greater than or equal to 19 years old.

Premium payment is made after the MCO invoice for transitioned Adults with a transition from the Kentucky HEALTH ABP – Copay to Kentucky HEALTH ABP - Premium. My Rewards would be activated first of the following month post payment.

Premium payment is made after the MCO invoice for transitioned Parent Caretaker Relatives and TMA with a transition from the State Plan - Copay to State Plan - Premium. My Rewards would be activated first of the following month post payment.

1.7.8.1.1.1 The 60 day period to pay for the premium plan will start effective the day of approval (e.g. when the MCO sends the invoice).

1.8 Cost Sharing

Cost sharing is one avenue by which Kentucky HEALTH aims to prepare participants for entry into the private healthcare market. Non-exempt individuals gain experience with commercial market cost share polices via one of two means: a premium plan, or a copayment plan. Kentucky HEALTH encourages individuals to participate in the premium plan, which provides cheaper and more consistent coverage than does the copayment plan.

1.8.1 The cost sharing requirements are based on an individual's circumstances such as age, medically frail status, pregnancy status, and other considerations. Many individuals, like Pregnant and medically frail individuals are exempt from cost sharing.

1.8.1.1 Once an individual is approved for cost sharing, they have 60 days to make their first payment.

1.8.2 Premium Plan

1.8.2.1 A premium is an amount to be paid for an insurance policy.

1.8.2.2 The monthly premium level is determined based on the tax household's FPL level. The income level and premium amount is communicated to the MCO in the eligibility determination and to the household in the eligibility notice.

1.8.2.3 The FPL and monthly premium levels are as follows:

Federal Poverty Level	Monthly Premium
<25%	$1
25-50%	$4
50-100%	$8
100-138%	$15

Eligibility determines premium amounts during the Kentucky HEALTH eligibility determination and provides this information to the member's MCO.

This same information will be populated on SSP and communicated to the member in an eligibility notice.

1.8.2.4 Premiums are based on the household income and is the same for the whole family. If the family is enrolled in multiple MCOs, they will have to pay the premium amount for each MCO.

Example: The household has 2 members, Husband and wife. The premium calculated for the household is $4. The husband is enrolled in MCO1 and wife is enrolled in MCO2 then Household has to pay the premium of $4 to both the MCO, in this case MCO1 and MCO2.

1.8.2.5 For individuals or families earning above 100% of the FPL, premiums change based on how long they are enrolled in Kentucky HEALTH, according to the sliding scale seen below:

Duration of Enrollment	Monthly Premium
0-24 months	$15
24-36 months	$22.50
37-48 months	$30.00

49+ months	$37.50

This sliding scale is calculated based on the individual with the longest non-exempt enrollment months; thus, the person who has been enrolled in Kentucky HEALTH the longest in the family is the one who determines the duration of enrollment.

> *Example*: An individual, as part of their family, has been enrolled in Kentucky HEALTH for 35 months and is the longest enrolled member in the family. The family's FPL is 112%, then on the 36th month of the individual's enrollment, the family's premium will increase from $22.50 to $30.00.

Individuals and families are expected to pay their premiums within 60 days of their initial enrollment in Kentucky HEALTH. Only after the first payment is made does the family move from *conditional eligibility* to being enrolled and covered by the premium plan. Failing to pay the premium within 60 days results in the family being penalized, depending on their income relative to the FPL:

1.8.2.6 Medically Frail Individuals

The eligibility system will always calculate the premium for medically frail individuals and send that information to them. Medically frail individuals may engage in cost sharing by paying premiums allowing them access to a My Rewards account. If the medically frail individual fails to make these premium payments, they lose access to their My Rewards account on the first day of the next administratively feasible month after being reported for non-payment to the eligibility system. These individuals are not financially penalized either in their My Rewards account or in their health plan, since by default they are not required to cost share.

1.8.2.7 Premium Assistance Individuals

Individuals participating in premium assistance have the cost sharing premium amount calculated and assigned. Individual will receive premium assistance reimbursement after deducting their assigned premium from ESI plan premium amount. These individuals are also eligible for My Rewards account.

1.8.2.8 Cost Sharing & My Rewards

Individuals and families on premium plans are eligible for My Rewards accounts. Their My Rewards accounts remain active as long as the individual or family makes timely payments. If an individual or family fails to make a payment and is <100% FPL, then they lose $25 from their My Rewards account and the account is suspended.

1.8.3 Copay Plan

In lieu of the premium plan, Kentucky HEALTH offers a copayment plan. A copayment is a form of cost sharing by which an individual is charged based on the treatment that they are getting (i.e. services received), instead of being covered under insurance. They are still provided access to healthcare, but each individual treatment has a different cost, instead of being almost or totally covered by a singular monthly premium payment. These copays are collected at the provider office, instead of by the Kentucky HEALTH MCO.

1.8.3.1 Transitioning to the Copay Plan

> Copayment plan enrollment is a result of the individual's failure to make premium payments or that the individual is transited from another eligibility category and has not yet had the opportunity to make copayments. Being enrolled on a copayment arises from one of two conditions:
>
> A conditionally eligible individual or family is one that has not yet made their first payment to Kentucky HEALTH's premium plan within 60 days of being deemed conditionally eligible. If this individual or family is below 100% FPL, they would move from being conditionally eligible to the copay plan effective the 1st day of the month in which the 60 days expires. This also results in starting 6 month penalty period. For

more details on 6 month penalty, **[Reference Non-Payment Section 1.9.2]**

An individual or family on a premium plan fails to make a premium payment to their Kentucky HEALTH plan. If this individual or family is below 100% FPL, they would move from the premium plan to the copay plan, from the first of the month in which they failed to make their premium payment.

Families on the copayment plan are allowed to add new family members. The new member would be added to the copay plan the first of the month of authorization. If the family makes a premium payment, then the members of the family not in a penalty period will be moved to the premium plan the first of the month *following* the payment of the premium.

Individuals transitioning from no cost share category to cost share category are initially enrolled in the copay plan with the option to pay a premium for 60 days.

Non-payment of this initial premium results in a 6-month penalty period. For more details on 6 month penalty, **[Reference Non-Payment Section 1.9.2]**

1.8.3.2 Transitioning from the Copay Plan to Premium Plan

Individuals who wish to move from a copayment plan to a premium plan have two options. Note that by default, those who are on copayment plan *must be <100% FPL,* since those earning more are automatically discontinued when they fail to make premium payments. The following are the means by which an individual can move to a premium plan:

The individual completes their 6 month penalty for failing to pay their premium(s). After this, once the individual pays a premium, they are re-enrolled into the premium plan from the first of the month after the payment. In this case, the individual's owed premium payments are erased, though the 6 month penalty *does not* affect their recertification date.

The individual can pay 2 months of premium debts, pay the premium for the forthcoming month, and complete a Health Literacy, Financial Literacy or Parenting course. If the individual makes the payment but does not pay the premium for the upcoming month, or if the individual does both but fails to take the HFL course, their coverage would be put on hold.

1.8.3.3 My Rewards & Copay Plan

Under the copayment plan, individuals do not have access to their My Rewards account. Members can only reactivate their My Rewards accounts if they end their penalties, either by completing the duration of the penalty or mitigating the impacts of the penalties by paying past premiums and finishing other requirements. This only applies to certain individuals as determined by eligibility based on FPL levels and cost sharing determination. There is no cost share plan for certain individuals. For more details on cost share variations **[Reference Kentucky Health Benefit Packages Section 1.3.7]**

1.8.4 Transition to Pregnancy Plan

Individuals who become pregnant while cost sharing are exempt from cost sharing thereafter. Once the individual attests to pregnancy, the individual is exempt from paying premiums from the first of the following month, during which the individual is enrolled in the state plan. Individuals who are pregnant and are ending their post-partum period with active my rewards accounts move to the premium plan. Those individual with suspended accounts move to the copay plan. Copay plan members not in a 6 month penalty period can reenter the premium plan by paying 1-month premium.

1.8.5 Copay application

As claims are reported to the MMIS, the MMIS will need to deduct the copay amount.

1.8.6 Premium Billing

1.8.6.1 During eligibility determination of an individual, eligibility will calculate the household premium based on the cost share rules.

1.8.6.2 Based on the individual selection of an MCO, eligibility sends the eligibility, plan and premium data to MMIS

1.8.6.3 MMIS will transfer Premium data to MCO as MCOs are responsible for premium billing and reporting on payment status.

1.8.6.4 MCO send invoice to the members for the payment of their premium.

1.8.6.5 Based on the member payment, MCO will report payment/non-payment indicator to eligibility system through MMIS.

1.8.6.6 Based on the Payment or non-payment indicator, Eligibility will take the necessary action.

1.9 Eligibility Suspensions

1.9.1 Members of Kentucky HEALTH are subject to three types of Eligibility Suspensions, They can be suspended for non-payment of premiums, suspended for non-compliance with CE, and have a penalty period applied for non-compliance with recertification.

1.9.2 Non-Payment

1.9.2.1 For those enrolled under Kentucky HEALTH, non-payment penalties would be imposed similar to commercial health plans in order to educate them about standard market policies.

1.9.2.2 Individuals that are cost sharing required will be invoiced by MCO for payment of their premiums.

1.9.2.3 For both Initial and Monthly Premium payments, individuals would get 60 days to make their payments. Individuals must be current on all payments by the end of the 60 day period.

1.9.2.4 Post 60 days, MCOs would send a no pay record based on which non-payment penalty rules would be applied.

1.9.2.5 The penalties would be applied considering their type of assistance, medical frailty and income which would be compared with the federal poverty limit.

1.9.2.6 On receipt of non-payment post 60 days, the following actions would be taken on a household:

Pregnant individuals and children would not be impacted by the penalty period since they are not under cost share.

1.9.2.6.1.1 Medically frail individuals are not impacted unless they have decided to pay the optional premium to gain access to My Rewards account. Non-payment would result in the suspension of their My Rewards account.

1.9.2.6.1.2 To reactivate their My Rewards account, they have to pay any debt accrued and take a Health and Financial Literacy class.

Members with Income under 100% FPL and not making their payment within 60 days

will be transferred to the copay plan. Their My Rewards Account would be deactivated, penalty deduction of $25 would be applied, and they enter into a 6-month penalty period.

1.9.2.6.1.3 To reactivate their My Rewards account and continue coverage under the Premium Plan, they have to pay any debt accrued, pay one month of premium forward, and take a Health and Financial Literacy class.

Members with Income above 100% FPL and not making their payment within 60 days will enter into a 6-month suspension penalty period and their My Rewards count deactivated with a $25 deduction.

1.9.2.6.1.4 To reenter into the Premium Plan, the member must pay past debts, pay one month of premium forward, and take a Health and Financial Literacy.

For more detail on Early Re-Entry to premium enrollment [**Reference Early Re-entry Section 1.23**].

1.9.2.7 Following is a detailed explanation of non-payment penalty impacts on an individual level:

Cost sharing required members who are not medically frail and have annual income > 100% FPL:

1.9.2.7.1.1 Would be dis-enrolled from the premium plan post 60 day grace period.
1.9.2.7.1.2 A 6 month disenrollment sanction would be applied on them.
1.9.2.7.1.3 Would have their eligibility terminated effective 1st of the following month.
1.9.2.7.1.4 Would have their MY Rewards account suspended if monthly premiums are not paid. If they haven't paid their initial premiums then they would continue to be ineligible for My Rewards.

Cost sharing required members that are not medically frail that have annual income < 100% FPL:

1.9.2.7.1.5 Would be dis-enrolled from premium plan and would be enrolled in Copay plan under the 6 month penalty period.
1.9.2.7.1.6 Their eligibility would not be terminated. They would move from conditionally eligible to approve under copay plan.
1.9.2.7.1.7 Their My Rewards would continue to be inactivated due to non-payment.
1.9.2.7.1.8 If monthly premium payment isn't made, then $25 would be deducted from their My Rewards account and it would be suspended.

Medically frail individuals who opted for cost sharing:

1.9.2.7.1.9 Would have no change on their eligibility status i.e. they will continue to be approved.
1.9.2.7.1.10 Would be provided normal enrollment and coverage under State plan. No cost sharing or copayments required.
1.9.2.7.1.11 My Rewards account would be inactive or suspended. Hence they would not be able to accrue funds/use funds from this account. [**Reference My Rewards Account Section 1.12**].

For details on how the individual can come out of Penalty period and early re-enter, [**Reference Early Re-entry Section 1.23**].

1.9.2.8 In a case of households that continue enrollees with different status, the non-payment rules apply on an individual basis would exclude pregnant women, children and

medically frail individuals.

1.9.3 Community Engagement

1.9.3.1 Individuals that do not complete Community Engagement Requirements are subject to suspension.

1.9.3.2 The community engagement module sends information to the eligibility system in benefind with their community engagement statuses of all the members per month.

1.9.3.3 Eligibility could be terminated due to non-compliance with Community Engagement hours. Community Engagement is not required for the following individuals:

Children

Pregnant women

Medically Frail individuals

Primary caregivers

Adults working 30+ hours/week

Full Time Students

1.9.3.4 Adult members mandated to complete community engagement hours would have the following requirements to be compliant:

Eligibility Period	Required Engagement Hours
1-3 months	0 hours per week
4-6 months	5 hours per week
6-9 months	10 hours per week
9-12 months	15 hours per week
12+ months	20 hours per week

The total enrollment time period has a look-back period of 5 years (i.e. enrollment in Kentucky HEALTH is does not have to be continuous in order to complete the Eligibility Period calculation). Suspension and CE exemption months do not count towards calculation of enrolment time period.

1.9.3.5 If a certain member does not complete his required hours:

Member has one month to make up CE hours missed in the past month and complete the hours requirement for the current month.

1.9.3.5.1.1 Member needs to be notified (e.g. an adverse action notice) that they will be suspended at the end of the current month if they do not complete CE hours.

Members may not carry an hour deficit into a second month.

Members can get a pass on making up said hours by completing a health literacy, financial literacy or parenting course. They may only do so once in a Benefit year (12 months).

If hours are not made up, eligibility updates the person for not meeting the required hours, and the member benefits are suspended starting the first of the following month.

The self-service and provider portals are updated with Kentucky HEALTH suspension

status. The applicable MCO is also informed with the suspension status and reason.

Communication is also sent to the member informing them of suspension.

The member's eligibility stays suspended in Kentucky HEALTH until the end of the member's 12 month recertification period.

A member may reactivate benefits in Kentucky HEALTH by fulfilling one month's hour requirement. Once this takes place, the member's status is changed to active and the member is once again enrolled into Kentucky HEALTH. The effective date is the first day of the month following the completion of required hours.

Non-compliance would result in a correspondence being sent to the member

While in suspension, community engagement hours do not accrue.

If suspended members do comeback, they have a 5 year lookback on their CE requirements since last eligible.

> *Example:* If a person eligible for KY HEALTH has a CE requirement for 10 hours a week and does not complete the requirements for CE for May 2017. The member is suspended staring July 2017, and reapplies in January 2018. Once found eligible, she will have to complete 10 hours of CE per week and will not start anew. She will only be allowed to start anew if she reapplies to join in June 2021

1.9.3.5.12 For more details on Community Engagement, [**Reference Community Engagement Section 1.14].**

1.9.4 Recertification Compliance

1.9.4.1 Recertification occurs annually for all Kentucky HEALTH individuals from their initial enrollment. In advance of eligibility end date, notice will be sent to individuals to initiate the recertification process.[1]

Members deemed not eligible for Kentucky HEALTH through this process are disenrolled at benefit period end date, their My Rewards Account is suspended and denial and appeal rights are sent. Once recertification paperwork is completed and received on time and individual is determined to remain eligible for Kentucky HEALTH.

Individual in premium plan will be reauthorized for another benefit period in premium plan.

Individual in copay plan and in penalty period will remain enrolled in copay plan.

Individuals in a 6 month penalty period will have the penalty period continue to apply until the 6 months has been passed. For more details on Recertification 6 months penalty**, [Reference Recertification/Redetermination Section 1.18].**

Individual in premium assistance program will be reauthorized for another benefit period in premium assistance.

Individual who is >100% FPL and in Kentucky HEALTH suspension period will remain

[1]

ineligible until 6 month re-enrollment period ends or early re-entry option is taken.

Individual who is >100% FPL and in Kentucky HEALTH Suspension status during the Recertification period, will get terminated status during eligibility determination run on Recertification end date.

1.9.4.2 If individual fails to complete recertification paperwork on time:

Individuals who are pregnant, children, or medically frail will have normal Medicaid recertification non-compliance policy applied to them.

Individuals who do not submit recertification paperwork within 3 months of benefit end date or complete the financial or health literacy course for early re-entry or meet State defied exception will be required to wait 6 months until they are permitted to enroll in Kentucky HEALTH.

For more details on Recertification/Redetermination process, 6 month Penalty, Cure and Re-entry, [**Reference Recertification/Redetermination Section 1.18**].

1.10 Adding Individuals to an Existing Plan

1.10.1 Families may add individuals to their plan. The additional family member - provided they fulfil the requirements of being eligible for cost sharing - is covered under the plan the first of the month in which their eligibility was determined provided they enroll in the same plan

1.10.2 If the addition of a family member impacts the family's tax household status and thus their income relative to the FPL, the premium will have to be recalculated. The premium change then becomes effective the first of the following month.

Example: if an individual is added to a family on 3/12/2017, and they become eligible on 3/20/2017, then the individual will be covered from 3/01/2017. If the family's income changes from 55% FPL to 45% FPL, then the change in premium from $8 to $4 will happen from 4/01/2017.

1.11 Deductible & Deductible Account

1.11.1 All plans will include an annual calendar year basis $1,000 deductible that applies to non-preventive care. This deductible will be fully funded by an administrative deductible account that may not be used for any other purposes besides payment for claims by the MCO. Pregnant individuals and children do not have deductibles on their plans and thus are not eligible for deductible accounts.

1.11.1.1 Individuals who become pregnant while enrolled will have their account frozen during the pregnancy. Individuals who enter the program while pregnant will not have an account until they finish their 60 day post-partum period.

1.11.2 Members will not pay for this deductible out of pocket, rather the deductible is tracked and paid against the administrative deductible account. Once the deductible is paid, the MCO covers the rest. Deductible account funding is incorporated in capitation and not via a separate financial transaction.

1.11.3 MCO will provide explanation of benefits (EOB) to members regardless of the deductible account status.

1.11.4 MCOs will provide monthly statements to members.

1.11.5 Members will receive monthly account statements detailing their expenses paid for by the deductible account in order to help them manage their expenses and transition into commercial

insurance.

MCOs will report Deductible Account Balances to the MMIS to provide for the new balance to be transferred to a new MCO in the event that the member changes MCOs.

1.11.6 Claims Reimbursement

The claims process for using the deductible account to settle payments for services rendered will be as following:

1.11.6.1 Member uses non-preventative service.

1.11.6.2 MCO pays the claim in full to the service provider and deducts the claim amount from the deductible account for the member.

1.11.6.3 MCO will send to the member a monthly statement.

1.11.6.4 Deductible accounts are a tracking mechanism, not an actual account or financial transaction.

1.11.6.5 At the end of a benefit period, members who have a balance remaining on their deductible account have the opportunity to transfer up to 50% of their remaining deductible account into their My Rewards Account. This will be according to the following process:

Members receive a new deductible account worth $1000 during the first day of the benefit period.

90 days after 12 month period expires, MCOs send the remaining amounts in the deductible accounts to Eligibility.

Once the 12 month period expires and the claim run-out period (90 days) ends, the rollover amount is calculated as up to 50% of the remaining balance in the deductible account.

In case the individual is not enrolled for the full benefit year, the prorated deductible rollover amount will be calculated based on the enrolment months.

Eligibility calculated deductible rollover amount is communicated to MRA.

Any claims received after this 90 day period are still processed but not tracked against the deductible account. The member receives a new deductible account worth $1000 on 1/1 the following year.

Balances may rollover to frozen My Rewards accounts, provided the members account is not frozen for a penalty reason.

The deductible account aligns with the members benefit periods and follows the member through certifications and suspensions.

Example: A member enrolls in KY HEALTH on 01/01/2018. They use $200 in non-preventative care treatments reducing their deductible balance to $800. They stop making premium payments and is suspended from 07/01/2018-09/01/2018. They follow procedure and recertify on 10/01/2018. The deductible account continues at $800 and the 12 month period doesn't start over. There is two months left before the member may carry 50% of unused portions over to their My Rewards Account.

1.11.7 Pregnant members

1.11.7.1 Members that become pregnant during their enrollment period have their deductible account frozen while they are pregnant. Similar to someone that is suspended, their

deductible account follows them through the pregnancy

1.11.7.2 There shall be a formula used to determine MRA rollover for pregnant woman whose pregnancy ends mid benefit year. Said formula is TBD.

If members move MCOs, their deductible account moves with them.

Example: If a person starts with MCO1 and moves to MCO2 within the same year while only having $500 remaining on their deductible balance, MCO2 will receive the transfer member with $500 in deductible balance. MCO1 will have to provide monthly updates of the member balance for 90 days to ensure claim run out is properly accounted for. Claims deductions form the account by MCO1 in the 90 days after the transfer are communicated to MCO2.

1.11.8 Preventative vs. non-preventative

1.11.8.1 Services that count as preventative are designated by the state and based on USPSTF and CDC age and gender appropriate services. These services do not apply towards the deductible account.

1.11.8.2 Disputes of what constitutes as preventative/non-preventative spending are handled by the MCOs

1.12 My Rewards Account

1.12.1 All Kentucky HEALTH members, with the exception of children, will be provided a My Rewards Account (MRA), which may be used to access an array of enhanced benefits not otherwise covered in the member's base benefit plan, such as dental benefits, vision services, over the counter medications, and limited reimbursement for the purchase of a gym membership. While these benefits are not required to be offered to beneficiaries under federal Medicaid law, these benefit enhancements will be available through the My Rewards Account. The status of these accounts may be active or suspended. Copay plan members will have a non-active My Rewards Account. Eligibility will determine who has active or suspended My Rewards Account based on member characteristics and payment information reported from the MCOs. Eligibility will make the information available on the account and the provider portal will display My Rewards Account information.

1.12.2 Accessing Account Balances

1.12.2.1 Members can access account balances through My Rewards Account and Self Service Portal once eligibility designates member is eligible for My Rewards. My Rewards Account will function as a Health Reimbursement Account (HRA) model. The balance accrual is an accounting mechanism and does not involve financial transactions.

Additional options for delivery of member balances may be defined in the future. Some options include call centers, IVR, or text.

1.12.2.2 My Rewards will provide access for members to view Account balances and

transactions.

My Rewards will provide member statements and allow member to check My Rewards Account status over the phone.

My Rewards will allow member online access to their account.

My Rewards will provide account balances to Eligibility for display within the Eligibility Self Service Portal.

Eligibility will display My Rewards account balances within the member Self Service Portal.

1.12.3 Holding Account Balances for Covered Services

1.12.3.1 Providers will have the ability to reserve My Rewards funds to apply to Vision and Dental services. The provider portal will be updated to display that vision and dental is via My Rewards and provide an interface to reserve funds. Provider may reserve funds and must enter a code for service to be performed; dollar amounts for covered service will be loaded. Amount will be reserved if applicable, and it will be reserved for 30 days. Providers will have ability to clear out / cancel reserved balances.

Example: Provider informs MRA of member's future visit to participating vision provider for prior authorization via the Provider Portal. If sufficient funds are available and requested benefit is an approved FFS vision benefit, My Rewards funds are reserved for Dental/Vision visit and participating provider is notified of approval and sufficient MRA funds. If balance is insufficient, request is denied. Member visits participating provider and receives FFS vision benefit. Provider bills MMIS for FFS service provided. MMIS pays participating provider for member's visit with reserved funds from My Rewards. If insufficient balance is received, MMIS does not pay the claim and notifies My Rewards. My Rewards deducts funds from Account and updated balance is available for member to view & access.

1.12.4 Payment of Claims

1.12.4.1 Payment of member claims via the My Rewards Account will need to be reported as a financial transaction

1.12.4.2 MRA coordinates with MMIS to pay claims and communicate account deductions for covered services such as dental, vision and OTC benefits. My Rewards must process claims for covered services where there is a sufficient balance in the account. Financial elements are to remain a function of MMIS.

1.12.4.3 My Rewards must allow for billing of claims by providers. Providers are responsible for submitting claims once they provide a service. Claims sent to MRA must include billing information and detail. If the service provided is not a covered service for MRA, the claim will be rejected. If there are insufficient funds, provider will not receive payment.

Once participating Dental or Vision Provider provides approved FFS service to member, Provider submits claim to MMIS.

MMIS with applicable claim edits for covered populations at fee-for-service (FFS) rates validates FFS Dental & Vision claims for My Rewards beneficiaries and provides

Payment for approved enhanced benefits to participating provider and provides correspondence to member.

MMIS will check with My Rewards on balance prior to paying where there is not a hold within 30 days.

MMIS notifies My Rewards of released funds.

My Rewards deducts funds from members' My Rewards account and updates balance.

Example: Individual seeks services via My Rewards Account. Provider confirms eligibility for services. If member is eligible, services are provided (limited to benefits offered by provider) and provider submits claim for reimbursement. The claim is then paid to the provider at Medicaid rates. Communication is sent to member on account balance and claims detail through My Rewards.

Vision & Dental Example: Provider submits dental claim for $50. If dental claim is a covered service for MRA and member has $150 MRA balance, claim undergoes standard claim process and is paid in full. New MRA balance is $100. If dental claim is a covered service for MRA but member only has $50 MRA balance, service is denied due to insufficient funds. If claim is not a covered service for MRA, claim is rejected as non-covered service.

Prescription OTC TBD

1.12.5 Accrual of Rewards

1.12.5.1 Members will be able to accrue funds in the My Rewards Account upon completion of specified health-related or community engagement activities, such as participating in community service or job training activities **[Reference Qualifying Activities Section 1.12.5.4]**.

1.12.5.2 Members will be able to utilize these funds to personalize their benefits by selecting from certain enhanced benefit options, up to the accrued balance in their account.

1.12.5.3 Entities will always send qualified activities even if My Rewards account is suspended. If My Rewards account is active for member with qualified activities, the account is credited with amount for applicable activity and self-service portal will then be updated with relevant information.

My Rewards determines if the activity is qualified (e.g. member has not received credit for activity in the applicable timeframe). The activities and the time frames allowed will be determined by the State.

My Rewards will be updated with the current status through Community Engagement reports.

Activities completed through Department of Public Health (DPH)/Certified Providers will be reported to Community Engagement.

MCOs will report activities completed through providers to My Rewards.

My Rewards will receive completed activities from CE and MCOs and determine applicable My Rewards earning dollar value.

My Rewards will receive reports from all sources and validate reported records against My Rewards to determine if the individual is eligible to get credit for that class/activity –

this includes determining when an individual is not eligible for a subsequent credit for a previously completed activity of the same category.

Example: Member completes health literacy course through the Department of Public Health (DPH). DPH reports activity to Community Engagement. My Rewards receives proof of completed activity from Community Engagement and My Rewards checks to see if member is eligible to have funds applied for that activity (e.g. have they already completed the activity and received the benefit within the allowed timeframe). Upon successfully verification of activity, My Rewards allocates reward funds to member's MRA. Member views MRA account status and balance through portal and member receives monthly statement showing My Rewards account activity.

1.12.5.4 Qualifying Activities

Qualifying activities are designed to improve member health or to increase community engagement such as participating in volunteer work, public service opportunities, or job search and training activities. Any Community Engagement work completed is logged into the My Rewards account. If a member does above the required hours of community engagement, then the bonus awarded is based on the 'overtime' hours completed.

Example: Community Engagement module requires 20 hours but member completes 25 hours. The bonus is based on the 5 hour excess and is logged into MRA.

A full list of qualifying activities and the associated dollar amounts can be found in the table below:

Community Engagement Activities		Health Incentive Activities	
Activity	Earned $*	Activity	Earned $*
Register with Career Center and complete job needs assessment	$150 (one-time only)	Complete health risk assessment with MCO	$25 (Q1, limit 1/yr.)
Participate in qualifying community service activity (including caretaking services)	$10 per event (max. $50/yr.)	Complete diabetes, cardiovascular, or other chronic disease management, or weight management course	$50 per course
Complete job skills training or training with career coach	$25 per course (max. $50/yr.)	No inappropriate ER Visits within 12 mo.	$20 per year
Complete job search activities	$10 per month	Sign non-smoking pledge & participate in smoking cessation activity	$50 per course
Employment-related education or GED-prep classes	$25 per course (max. $50/yr.)	Sign drug-free pledge & participate in drug addiction counseling services	$50 per activity
Passing GED exam	$50 (one-time only)	Complete well-child, preventive dental exam, or vision screening for dependent child	$10 per activity (max. $40/yr.)

1.12.6 Deductions from account

1.12.6.1 Eligibility determines the need a $25 penalty deducted from My Rewards. Eligibility will communicate to the individual that their My Rewards account is suspended and

that there is a $25 dollar penalty deduction from the account.

Eligibility will notify MMIS of a member's My Rewards Eligibility.

MMIS will provide My Rewards eligibility to MCOs and My Rewards.

My Rewards will respond to changes in eligibility and apply or remove account suspensions.

My Rewards will deduct a $25 penalty when a member's account is suspended due to non-payment.

After the initial non-payment penalty My Rewards will take no deductions or allow no accruals to suspended account.

Member has 30 days to activate the account so that award can be added to the account. Within 30 days if the account gets activated, the award will increase the balance.

My Rewards will store account balances and reinstate My Rewards Account for members who re-enter within 5 years.

1.12.6.2 If the individual's My Rewards account has more than $150 negative balance, the penalty deduction would not be applied.

1.12.6.3 Penalties can be applied until a negative $150 is achieved.

1.12.6.4 Only ER penalties can make the MR account go negative.

1.12.6.5 Inappropriate ER Utilization **[Reference Non-Emergency Use of ER Section 1.13]**

Inappropriate ER utilization refers to the utilization of ER for non-emergency conditions. Per the process detailed in the non-emergency use of the ER has occurred.

If the individual has an active My Rewards account a penalty deduction would be applied based on the number of inappropriate ER visits. If an individual has a suspended My Rewards account, the deduction is not applied.

My Rewards keeps track of how many penalties have been applied and take the appropriate penalty. Penalties are applied on a 12 month enrollment period (within a calendar year) and reset each year.

Number of Inappropriate ER Visits	Penalty Deduction Applied
1	$20
2	$50
3 or more	$75

1.12.6.5.1.1 MCOs will provide non-urgent use of hospital emergency room (ER) and non-payment to My Rewards.

1.12.6.5.1.2 My Rewards will track non-urgent use of hospital emergency room (ER) and non-payment occurrences and calculate penalty amount.

1.12.6.5.1.3 My Rewards will deduct penalty amount from members' My Rewards account.

1.12.6.5.1.4 My Rewards will not complete a deduction if the penalty deduction would take the account below $150.

Example: Member uses ER benefit. MCO determines benefit use to be a non-urgent use of ER benefit. My Rewards is notified of inappropriate benefit use. If the individual has an active My Rewards account, My Rewards determines how much penalty to apply and a penalty deduction is applied based on the number of inappropriate ER visits. My Rewards notifies Member of penalty deduction and views MRA account status and balance through portal.

1.12.6.6 Non-payment

Members in the Copay plan do not have active My Rewards Accounts. Neither benefits nor penalties apply to non-active accounts. Members in the Premium Plan can have their accounts suspended due to non-payment reasons. MCO information on non-payment of the premiums will affect My Rewards eligibility

1.12.7 Member Reimbursement

1.12.7.1 Membership reimbursement is applicable to members with active MRA and pays for covered services. An itemized receipt is needed for proof of payment to MRA. Member reimbursement paid need to be reported back for inclusion on the CMS 64 to claim match on the services provided. If the reimbursement is covered, MRA would be checked to determine if sufficient funds are available for the reimbursement. A member is reimbursed if there are sufficient funds available. Otherwise, the member may receive a partial reimbursement. Member reimbursement needs to be logged and tracked to the CMS 64.

My Rewards provides access for member to view account balance.

Member receives benefit from non-participating Dental or Vision Provider or Wellness provider or purchases OTC covered benefit & provides payment to provider.

My Rewards provides access for member to submit manual claim for approved FFS Dental & Vision service and wellness & OTC benefit covered items.

My Rewards validates account balance funds and places hold on funds at applicable FFS rate or wellness or OTC benefit value and provides manual claim to MMIS.

1.12.7.1.1.1 *FFS Dental & Vision benefits*: MMIS with applicable claim edits for covered populations at fee-for-service (FFS) rates validates FFS Dental & Vision claims for My Rewards beneficiaries and provides Reimbursement for approved enhanced benefits to member and provides correspondence to member.

1.12.7.1.1.2 W*ellness, OTC benefit covered items & Premium Assistance ESI Dental*: MMIS with applicable claim edits for covered populations at My Rewards wellness & OTC benefit maximums validates wellness & OTC claims for My Rewards beneficiaries and provides Reimbursement for approved enhanced benefits to member and provides correspondence to member.

MMIS notifies My Rewards of member reimbursement.

My Rewards deducts funds from members' My Rewards account and updates balance.

Example: Member accrues My Rewards funds. Member reviews My Rewards balance and determines if they have accrued a sufficient balance to redeem desired covered My Rewards benefit. Member purchases eligible wellness benefit (ex. Gym

Membership). Member submits claim (proof of wellness benefit purchased and proof of payment) to My Rewards. My Rewards provides claim to MMIS. MMIS reimburses member up to the maximum benefit for MRA wellness benefit. Upon notification of reimbursement, My Rewards deducts funds from member's MRA and updated balance is available for member to view & access.

1.12.7.2 Wellness Benefit

Health and Wellness benefits have a reimbursement limit estimated at $20 a month. Members may enroll in their preferred gym or fitness center.

There are no limitations on specific gyms and memberships are reimbursed by the month for each specific MRA. It may be a single or family memberships and it may be pre-paid for one year.

1.12.7.2.1.1 My Rewards will reimburse members for wellness benefits up to $20/month.

Example: Individual signs up for a gym membership for $15 a month. Member submits all proof of payment and explanation of service. MRA receives the request and sees that sufficient funds are available. The member is reimbursed for $15 membership. If member does not submit all documentation and receipts, member will receive a notice of incomplete request and no reimbursement. If reimbursement is not covered, member will receive a notice for non-covered service. If there are insufficient funds available, member will receive notice of explanation on insufficient funds and a reimbursement of current balance available.

1.12.7.3 Vision & Dental Reimbursement

My Rewards does not reimburse dental and vision for individuals eligible for state plan benefits. For all others, vision and dental claims must go through My Rewards Account via standard process.

For individuals in premium assistance, vision and dental claims can be reimbursed using My Rewards for non-state plan benefits. Claims, if approved for covered service, would be paid at the Medicaid rate.

Example: An individual seeks services and has $20 copay. There is a claim for $100 and the provider bills ESI. The $20 copay is billed to Premium Assistance and the Medicaid rate is $60. The provider will receive $80 from ESI.

Example: For non-premium assistance, an individual seeks dental services. Provider submits dental claim of $50. My Rewards Account balance is $150. Claims billing details are sent to My Rewards Account. $50 claim is paid to provider and $100 is left in the My Rewards Account balance.

1.12.8 Application for account balance

1.12.8.1 Each year the full remaining prior year balance of the My Rewards Account will roll-over to the subsequent year to be used for the purchase of qualifying enhanced benefits. Former members who remain commercially insured without Medicaid for at least 18 months may apply to receive the balance remaining in their My Rewards Account, up to $500r Even if member is disenrolled for non-payment, member can

still collect My Rewards pay-out.

My Rewards facilitates eligibility verification from Eligibility.

MMIS receives verification requests and provides eligibility verification to My Rewards.

My Rewards calculates pay-out amount for My Rewards account balance (up to $500) when successful eligibility & application are received.

My Rewards notifies MMIS of approved pay-out application and up to $500 of My Rewards account balance value.

MMIS issues check for My Rewards account balance (up to $500) to member who submits successful application for transition out of Medicaid and provides correspondence to member.

My Rewards closes My Rewards Account.

Example: Member completes My Rewards activities. My Rewards receives proof of completed activity and allocates reward funds to member's MRA. Member becomes employed and transitions out of Medicaid to commercial health insurance for 18 months. Member requests a "payout" from their My Rewards balance. Member completes form attesting they have maintained commercial coverage. If member does not provide verification, My Reward denies balance payout request. Eligibility confirms to My Rewards that member has not been enrolled in Medicaid for 18 months. My Rewards provides balance, not to exceed $500, to MMIS. MMIS issues check to member.

1.12.8.2 In the case of Non-Payment, Accounts would be frozen. It does not reset. However, members can reactivate their account by:

If member is in a penalty period, member can take a class and make whole payment of premiums. If member is not in a penalty period, member does not have to take the class but payment must still be made **[Reference Eligibility Suspensions Section 1.9]**.

My Rewards Account should always coincide with premium payments.

My Rewards reinstates account balance for citizens who re-enter Medicaid with a 5 year look back period, provided the account had not been closed due to pay out.

Eligibility notifies MMIS of a member's My Rewards Eligibility.

MMIS provides My Rewards eligibility to MCOs and My Rewards and reactivates link on Provider Portal.

My Rewards will respond to changes in eligibility and reinstate account balances for members who re-enter within 5 years.

My Rewards closes My Rewards Account after 5 years of member disenrollment.

1.13 Non-Emergency Use of ER

The purpose of the Non-Emergent use of ER is to provide an incentive for members to seek the most appropriate treatment setting for their care.

1.13.1 Non-Emergent ER Plan Criteria

Members enrolled in the premium plan will use My Rewards Criteria to determine inappropriate use of the ER.

1.13.1.1 When a premium plan member has an ER claim the MCO will run the claim against the states criteria using medical diagnosis (IDC-10) to determine if the visit is subject to the My Rewards deduction. The state has established a list of approximately 400 diagnosis that indicate non-emergent us of the ER. The list will be provided to the MCOs to identify My Rewards penalties for the ER.

1.13.1.2 If the diagnosis shows that the visit is subject to the My Rewards deduction the claim will be paid per normal procedures and there will be no penalty applied to the My Rewards Account.

1.13.1.3 If the diagnosis shows that the visit was Non-Emergent the MCO will need to verify if the member contacted the 24 hour nurses hotline.

If the member did not call the hotline before going to the ER, the MCO will need to notify My Rewards, via file that the member had a penalty visit and then the claim will be paid.

If the member did call the 24 hour nurses hotline, no penalty will be applied and the MCO will report that the penalty is waiver for the visit.

1.13.1.4 Members who are not enrolled in the premium plan will use the current criteria for applying copayments to determine inappropriate use of the ER.

An $8 copayment will be deducted from the member's claims when a visit is determined to be non-emergent. Hospitals will be asked to make a good faith effort to collect copayments for inappropriate ER utilization to remain PE providers.

1.13.2 Non-Emergent ER Follow-up Appointments Bonus and ER Annual Bonus

1.13.1.5 If advised by the ER physician, members will need to follow-up with their primary care provider within 30 days of the ER visit. The MCO will report, via file, that the member had a primary care visit within 30 days of the ER visit. After the ER follow-up My Rewards will credit the member account $10.

1.13.1.6 Members who have been enrolled in the program for 12 months and have an active My Rewards Account will be reviewed. If the member has Zero deductions for inappropriate ER visits in that 12 month period their My Rewards Account will be credited $20.

1.14 Community Engagement

1.14.1 Community Engagement Eligibility – Determine applicability of CE requirement

1.14.1.1 Application - Community Engagement (CE) requirement should be calculated for all members of Kentucky HEALTH

1.14.1.2 CE Exemption - The following members are exempt from the community engagement requirement. CE exempt members do not accrue CE hour requirements for eligibility months in an exempt status **[Reference Accrual Section 1.14.3.1]**. Exemption reason and exemption end date must be captured for each member with a CE exemption.

Pregnant women - If a Member is pregnant, the CE exemption reason is 'Pregnant' and the exemption end date is the last day of the month in which the member's 60 day post-partum coverage expires.

Children under 19 - If a Member is under 19, the CE exemption reason is 'Age' and the

exemption end date is the last day of the month in which the Member turns 19.

Primary caregivers of a dependent - If a Member is determined to be a primary caregiver of a dependent, the CE exemption reason is 'Primary Caregiver' and the CE exemption end date is the date of the Member's annual eligibility recertification.

Medically Frail - If a Member is determined medically frail, the CE exemption reason is 'Frail' and the exemption end date is aligned with the annual medically frail reassessment date.

Full time student - If a Member is full time student, the CE exemption reason is 'Full Time Student' with estimated graduation date and the CE exemption end date is the end of current semester. The definition of a full time student will be determined based on a school by school basis by requiring certification of full time status from enrolled school. The CE exemption remains for entire normal period of class attendance, vacation and recess. The CE exemption ends upon graduation, suspension, expulsion, drop out, or failing to register for the next normal school term (not including summer school).

1.14.1.3 CE Deemed Satisfied - The following members are deemed to be satisfying the community engagement requirement. Members in this status continue to accrue CE hour requirements **[Reference Accrual Section 1.14.3.1]**. For all Kentucky HEALTH members who are deemed to satisfy and meet the CE requirement, the reason and end date must be captured for each member deemed to satisfy the CE requirement.

SNAP Recipient - A Member who is also receiving SNAP benefits is deemed to meet the CE requirement, unless the member is exempt from the SNAP work requirement solely due to either age (age 50 or older). The CE satisfaction reason is "SNAP" and the end date is the date of the Member's annual eligibility recertification. **[Reference Section 1.14.2]**.

TANF Recipient - A Member who is also receiving TANF benefits is deemed to meet the CE requirement, unless the member is exempt from the TANF work requirement solely due to age (age 60 or older). The CE satisfaction reason is "TANF" and the end date is the date of the Member's annual eligibility recertification. **[Reference Section 1.14.2]**.

Premium Assistance Participant - All members enrolled in the premium assistance option are deemed to meet the CE requirement while enrolled in employer sponsored insurance (ESI) through the premium assistance program. The CE satisfaction reason is "ESI" and the end date is the date of the Member's annual eligibility recertification.

Full Time Employment - Members who are employed more than 30 hours per week are deemed to meet the CE requirement. The CE satisfaction reason is "Employed" and the end date is six months from the last date of full time employment verification.

Temporary Good Cause Exception - Members failing to complete required CE hours in a given month due to one of the following good cause exceptions, are deemed to satisfy the CE requirements for the month in which the good cause exception occurred. Good cause exceptions are determined by the CE module on a month by month basis with appropriate documentation required from the member. Temporary good cause exceptions may include: (i) hospitalization or illness of participant or family, (ii) death of a family member; (iii) inclement weather; (iv) family emergency or other life-changing event (i.e. divorce).

1.14.1.4 Prior to the expiration of a CE exemption or a CE satisfaction reason, the eligibility module must check for additional CE exemptions or CE satisfaction reasons prior to the application of the

CE hour requirements.

1.14.1.5 Eligibility module makes information about CE exemptions (including status and reason) or CE satisfaction (including status and reason) available for consumption by community engagement module, MMIS, Self-Service portal, and the MCO. MCO will receive the CE exemption or CE satisfaction status and reason via MMIS on Form 834.

1.14.1.6 Employment information and verified work hours will also be made available by eligibility for community engagement module, MMIS and Self-Service portal

1.14.1.7 Member notifications must specify CE status and applicable reasons for exemption status. Member adverse action notification is required if CE exemption or CE satisfaction is lost.

1.14.1.8 Following checks for CE exemptions and CE satisfaction reasons, the eligibility module will calculate CE requirements in accordance with **[Reference Section 1.14.3]**.

1.14.2 Community Engagement Requirements Eligibility - SNAP/TANF Recipients and Exemptions

1.14.2.1 If a member is exempt from the SNAP or TANF work requirements only due to age (SNAP age 50 or older & TANF age 60 or older), the Kentucky HEALTH CE requirements apply.

1.14.2.2 If a member enrolled in SNAP resides in one of the 8 counties with a pilot project, special requirements may apply.

1.14.2.3 If a Kentucky HEALTH member is enrolled in SNAP and/or TANF and does not meet any of the conditions outlined in **[Reference Section 1.14.2]**, then receipt of SNAP or TANF is considered to be meeting the Kentucky HEALTH CE requirement.

1.14.2.4 Eligibility module makes information of SNAP/TANF status available for consumption by CE module, MMIS, Self-Service portal, and the MCO.

1.14.3 Community Engagement (CE) requirements for applicable members

1.14.3.1 Accrual - A members required CE hours accrue quarterly based upon the length of active enrollment in Kentucky HEALTH in a non-CE exempt category over the last 5 years as follows:

If length of enrollment is between 0-3 months, CE required is 0 hrs/week

If length of enrollment is between 4-6 months, CE required is 5 hrs/week

If length of enrollment is between 7-9 months, CE required is 10 hrs/week

If length of enrollment is between 10-12 months, CE required is 15 hrs/ week

If length of enrollment is 13 months or more, CE required is 20 hrs/ week

1.14.3.2 Calculation - Beginning from the members first month of enrolment in Kentucky HEALTH, all months of active Kentucky HEALTH enrollment (fully enrolled and receiving benefits) over a 5 year period count towards calculating the CE hour requirements, except as set forth in the next section.

1.14.3.3 Excluded Months - The following member months do not count towards the calculation of CE hour requirements:

Non-Kentucky HEALTH - Months in which a member was enrolled in a non-Kentucky HEALTH Medicaid eligibility categories, including presumptive eligibility, are not included. Only months in Kentucky HEALTH enrollment count for purposes of calculating CE requirements.

Pre-Implementation - Medicaid enrolled months prior to the implementation date of Kentucky HEALTH do not count towards the calculation. The 5 year look back period described in the previous section does not include any months before the date of

Kentucky HEALTH implementation.

Exempt Status - Months in which a member met a CE exempt status, as defined in the previous section, are not included in the calculation of the CE requirements.

Conditional Status - Months in which a member was determined conditionally eligible for Kentucky HEALTH, and not yet fully enrolled with benefits, are not included in the calculation of the CE requirements.

Suspended Status - Months in which a member was suspended from Kentucky HEALTH without active benefits are not included in calculating CE requirements

1.14.3.4 Re-Calculation - CE hour requirements must be evaluated on a monthly basis for all members with less than 20 hours/week of CE requirements. Once the CE hours required reaches 20 hours/week, the CE hour requirement will remain constant and only need evaluation if the member becomes exempt. The hours don't have to be "recalculated" on a monthly basis, but the underlying applicability of CE requirements should be reviewed

1.14.3.5 Notice - Members must receive initial notification of their CE hour requirements, as well as each time a change in the CE hour requirements occur.

1.14.3.6 Tracking - Individuals can report the completion of qualifying community engagement and employment activities through the CE module. Verification from partner organizations is optional, but not required.

1.14.4 Consumption of CE Status

1.14.4.1 Information about CE status and CE hour requirements should be available on the CE module, self-service portal, provider portal (HealthNET) and MMIS.

1.14.4.2 MCO CE Communication.

Members CE status and required CE hours must be provided by MMIS to the MCO's on the 834, on at least a monthly basis for the current month. The MCO's may send communication and outreach to members based on CE status received from MMIS.

Information received by the CE module regarding member good cause exceptions involving incidents that may invoke third party liability (TPL) must be provided by MMIS to MCOs for purposes of pursuing TPL payments.

1.14.4.3 CE Module Responsibility. The CE module is responsible for:

Notifications - The CE module is responsible for sending notifications to members about their CE status and CE hour requirement.

My Rewards Account Coordination - The CE module is responsible for alerting the My Rewards Account module on member CE activities by type and CE status, on at least monthly basis for the current month.

Non-Compliance Communication - The CE module is responsible for sending member CE status to the eligibility module only in the event the CE requirements are not met along with reasons.

Good Cause Exceptions - The CE module is responsible for reviewing and granting temporary good cause exceptions, in accordance with **[Reference Section 1.14.1.3.5]**. Members who are not compliant with their CE hour requirements but who otherwise meet the requirements of a temporary exemption will not be subject to suspension, and will be deemed to satisfy the CE requirement for the month of the good cause

exception.

1.14.5 Kentucky HEALTH Eligibility Suspension for CE Non-Compliance

1.14.5.1 CE status for all members who fail to meet CE requirements on a monthly basis have to be sent from CE module to eligibility system with CE met indicator as 'No' and reason as 'Failure to report sufficient hours'.

1.14.5.2 Notification - The member will be notified of the pending Kentucky HEALTH suspension following non-compliance with CE hour requirements. Member adverse action notifications must specify the CE hour deficit, ability to cure (as specified in the section below) and the date of suspension of not cured.

1.14.5.3 Ability to Cure CE Non-Compliance - In the month immediately following member non-compliance, members will have the opportunity to avoid Kentucky HEALTH suspension for CE non-compliance by completing only one of the compliance opportunities listed below.

Making Up Hours - Members must make up the deficit hours (CE hours not completed in prior month) and be current on all hours for current month by the last day of the month following the non-compliant month to avoid the Kentucky HEALTH suspension.

1.14.5.3.1.1 For example, if the member is required to complete 20 hours per month of CE hours, but was short 5 hours at the end of February, the member would be required to complete 25 hours of CE by the end of March to avoid a suspension.

Re-Entry Course - In the alternative to making up the deficit hours, the member may choose to complete a re-entry course (i.e. health literacy course) and be current on all hours by the end of the month following the non-compliant month. The re-entry course for suspension avoidance is only available one time per 12 months (aligned with benefit period). The CE module must send information on completion of the re-entry course to the eligibility module to clear the suspension.

1.14.5.3.1.2 For example, if the member is required to complete 20 hours per month of CE hours, but was short 5 hours at the end of February, the member could complete a re-entry course plus the 20 hours of CE by the end of March to avoid a suspension.

Members who work more hours than required in a month do NOT have the ability to carry the excess hours forward to future months.

1.14.5.4 Suspension. Eligibility module should suspend the member's eligibility for KY HEALTH effective the first day of the month following the non-compliance month, if the CE non-compliance is not cured in accordance with the above section.

Eligibility module must send notification to member about their suspension status.

CE module, Self-Service portal, Provider portal (HealthNET) and MMIS should be updated with member's suspension status.

Any notifications sent to the member must be available in self-service portal and provider portal.

1.14.5.5 MMIS must issue the 834 containing member Kentucky HEALTH suspension status and the reason for the suspension to the MCO. The 834 must specify if the member has been suspended to allow the MCO to conduct outreach to impacted members.

1.14.5.6 Length of Suspension. Eligibility in Kentucky HEALTH will remain in a suspended status until one of the following occurs:

Disenrollment/Termination. If the member is in a suspended status at the time of the

member's 12 month recertification period, the member will be disenrolled from Kentucky HEALTH.

Reactivation. If the member reactivates coverage in accordance with the below section, the member will be reenrolled in Kentucky HEALTH.

1.14.6 Eligibility Reactivation Following Suspension for CE Non-Compliance

1.14.6.1 Reactivation Hours. To re-activate coverage, a member in a suspended status must fulfill one month of CE requirements prior to re-enrollment.

The number of hours required to lift the suspension will be equal to the number of CE hours required for the member in the month of enrollment immediately prior to the effective date of the suspension.

1.14.6.2 Effective Date of Reactivation. Benefits will be re-activated effective the first day of the month following the completion of CE hours required to reactivate coverage.

The eligibility module will unsuspend member coverage upon confirmation from CE module about the fulfillment of CE requirements by the member.

The 834 should be sent to Managed Care Organization (MCO) by MMIS about the member's unsuspended status and the effective date of benefit reinstatement.

The MCO must send an invoice for premium payment immediately upon receiving notice of the member's unsuspended status.

Member coverage and full benefits should be re-activated in the same payment plan (i.e. premium plan or co-payment plan) the member was enrolled in prior to suspension.

1.14.6.3 Notification. Member should be notified about the reactivation of coverage in Kentucky HEALTH. This notice should contain the current unsuspended status, date of reactivation of KY Health benefits, and required number of CE hours for continued enrolment.

Member notification should be available in Self-Service portal.

Self-Service portal, Provider portal (HealthNET) and MMIS should be populated with member's unsuspended status.

1.14.7 Member loss of employment

1.14.7.1 CE Hours. Members who lose their full time/part-time job (20+ hours/week) will be required to complete their required CE hours as a condition of eligibility beginning in the month following job loss.

The number of required CE hours will be calculated in accordance with **[Reference Section 1.14.3]**, and the months the member was deemed to satisfy the Kentucky HEALTH CE requirement due to employment are included in the calculation.

1.14.7.2 Grace Period Month. Kentucky HEALTH will allow for a one month grace period following loss of employment ONLY if the member completes a career assessment in the first month following the loss. The completion of the assessment is deemed to satisfy one month of CE hour requirements.

Members who do not complete the career assessment in the month following job loss will be required to complete all of their required CE hours through qualifying community engagement activities. Members who fail to complete these hours will be subject to the

suspension process set forth in **[Reference Section 1.14.5]**.

1.14.8 Suspension – Reactivation Timeline

1.14.8.1 The CE module must evaluate on the last day of the month, if member has completed the required CE hours for that month.

1.14.8.2 If the member has not completed all required CE hours in a prior month, member should receive notification that they must complete the remaining hours from the previous month, or, in the alternative, the member may choose to take a re-entry course (i.e. health or financial literacy). Regardless of which option the member chooses to cure the CE hour deficit, the member must also be current on the CE requirements by the end of the month following the non-compliant month in order to avoid suspension.

1.14.8.3 Members have one month to make up for missed hours prior to suspension. Members cannot carry an hour deficit into a second month.

1.14.8.4 Members have the opportunity to take a re-entry class rather than making up for missed hours only one time per 12 months (aligned with the benefit period).

The CE module must send information on completion of the re-entry course to the eligibility module to clear the suspension.

The CE module will track the use and type of re-entry course, as members may not repeat a re-entry course to clear a different penalty and may not clear the same penalty type two times in the same 12 month period.

1.14.8.5 Notification about impending suspension in the case of non-fulfillment of CE requirements should be available in Self-service portal, Provider portal. MCO's should be notified about the notice to the member.

1.14.8.6 Member eligibility is suspended effective the first day of the next administratively feasible month following notification that the member has not met the CE requirements.

1.14.8.7 Kentucky HEALTH suspended members who contact DCBS should be referred to the CE module or connected via member self-service portal.

1.14.8.8 During the suspension period, benefits are not available, even during appeal. If the appeal is sustained, benefits may be available retroactively.

1.14.8.9 CE module must evaluate if the suspended member meets requirements for the current month. If the requirements are met, eligibility status should be unsuspended effective the first day of month following completion of the hours.

1.14.8.10 Eligibility remains suspended for those members who have not met one month of CE hour requirements during their suspension period to reactivate coverage. To clarify, only one month is required to reactivate coverage. The member is not responsible for completing or otherwise making up hours for months in a suspended status.

1.14.8.11 Eligibility is terminated at the end of the recertification period if the member remains in a Kentucky HEALTH suspension as of the date of recertification.

1.14.8.12 After the member is terminated at the end of recertification period, the member may re-enter Kentucky HEALTH without advance completion of CE hours. The number of CE hours required will not reset, but will be determined based on the number of active months of enrolment in Kentucky HEALTH in accordance with **[Reference Section 1.14.3]**. There is no upper limit to the number of times a

member can be suspended or terminated.

1.14.9 Maintaining Eligibility Timeline

1.14.9.1 All requirements are covered in Suspension – Reactivation Timeline **[Reference Section 1.14.8]**

1.14.10 MCO Process – Member Suspension

1.14.10.1 During the member suspension period, the following rules will apply:

No benefits are available to the member, either through the MCO or Fee-For-Service

CE Hours do not continue to accrue during the member's suspended status

Provider portal shows the status of the member as Suspended due to CE

1.14.10.2 CE module continues to check (at least monthly) if the member has completed the CE requirements. If the CE requirements are complete, member eligibility should be re-activated effective the first day of the following month and the MCO should be notified.

1.14.10.3 MCO will be required to invoice the member immediately upon notification in order to invoice the member prior to the effective date of benefit reinstatement.

1.14.11 Scenario: Loss of SNAP/TANF (Flow 12) (Example: Member at 5 hours CE requirements, (months 4-6) loses SNAP/TANF))

1.14.11.1 When members enrolled in Kentucky HEALTH and SNAP/TANF lose their membership in SNAP/TANF, CE requirements for this member are calculated by counting all of the months over a 5 year period that the member was actively enrolled in Kentucky HEALTH with benefits but not otherwise "exempt" **[Reference Section 1.14.1]**.

In this sample scenario, the member will be required to fulfill 5 CE hours per week beginning the first day of the month following loss of SNAP/ TANF as the member is in 4th or 5th or 6th qualifying month of enrollment in Kentucky HEALTH. Enrollment in SNAP/TANF is considered to meet the requirement but does not exempt the member from CE requirements.

1.14.11.2 Members receiving SNAP benefits are deemed to meet CE requirements, unless the member is exempt from the SNAP work requirement solely due to age (50 or older). Members who are deemed to meet CE requirements, will continue to accrue increasing CE hour requirements, but they are not required to complete the hours as a condition of eligibility unless they lose the SNAP status.

1.14.11.3 Members receiving TANF benefits are deemed to meet CE requirements, unless the member is exempt from the TANF work requirement solely due to age (60 or older). Members who are deemed to meet CE requirements, will continue to accrue increasing CE hour requirements, but they are not required to complete the hours as a condition of eligibility unless they lose the TANF status.

1.14.11.4 Prior to the expiration of their CE satisfaction status, the eligibility system should check for additional exemptions or satisfaction reasons prior to the effective date of the CE requirements as a condition of eligibility.

1.14.12 Scenario: Member becomes pregnant (Flow 13) (Member at 10 hours CE requirements, (months 6-9))

1.14.12.1 If a member becomes pregnant, the CE exemption reason should be set to 'Pregnant' and the exemption end date should be 60 days after due/delivery date and postpartum is complete. Exemption details should be sent to CE module, MMIS, Self-Service portal and Provider portal.

1.14.12.2 The eligibility module should send member data to the CE module during final 30 days of the member's postpartum period. The CE hours requirement will restart at the previous level, since hours

do not accrue during exemption status. In this example, the women would be required to meet 10 hours/week upon the completion of postpartum period, unless she meets another CE exemption or CE satisfaction reason.

1.14.12.3 If the member is a primary caregiver of a dependent after the postpartum period, the member will be exempted from the CE hour requirements due to caregiver status.

1.14.12.4 If the member is not a primary caregiver of a dependent after the postpartum period and returns to work, the CE requirement indicator should be set to yes and the CE hours remain at 10 hrs/week which will be the same as the CE hours when she became pregnant. Exempt months are not counted for CE hour calculation.

1.14.12.5 If the member became pregnant when she enrolled in Kentucky HEALTH and the member's CE hour requirements were at 0 hours/week, then the members CE hour requirements may stay at 0 hours/week upon completion of her postpartum period.

1.14.12.6 Prior to the expiration of their CE exemption status, the eligibility system should check for additional exemptions or satisfaction reasons prior to the effective date of the CE requirements as a condition of eligibility.

1.14.13 Scenario: Member is medically frail (Flow 14) (Member at 10 hours CE requirements, (month 6-9))

1.14.13.1 If a member becomes medically frail, the CE exemption reason should be set to 'Frail' and exemption end date should be the end date of the frail confirmation as detailed **[Reference Section 1.14.6]**. Exemption details should be sent to CE module, MMIS, Self-Service portal and Provider portal.

1.14.13.2 When a member is informed that they are losing their frail status at adverse action, Eligibility module should send member data on medically frail status to CE module, MMIS, Self-service and Provider portal.

1.14.13.3 All changes in medically frail status will be effective the first day of the month following the expiration of frail status.

1.14.13.4 If a member changes the medically frail status before the 12 months expiration of frail status, the change in the status will be effective the first day of the month following. In this situation, CE would have to react to the eligibility indicator from the MCO

1.14.13.5 CE hour requirements will start at 10 hours/week upon the completion of medically frail status. CE requirement would be applicable effective the first day of the month following loss of medically frail status.

1.14.13.6 Prior to the expiration of their CE exemption status, the eligibility system should check for additional exemptions or satisfaction reasons prior to the effective date of the CE requirements as a condition of eligibility.

1.14.14 Scenario: Member turns 19 (Flow 15) (Member at 0 hours CE requirements)

1.14.14.1 If a member turns 19, CE requirement indicator should be set to yes and updated status should be sent to CE module, MMIS, Self-service and Provider portal.

1.14.14.2 Member should be notified about CE requirements 30 days in advance of turning age 19.

1.14.14.3 CE requirements will apply effective the first day of the month after the member turns 19. Member starts at 0 CE hours and accrues at standard timeline in accordance with **[Reference Section 1.14.3]**.

1.14.14.4 Prior to the expiration of their CE exemption status, the eligibility system should check for additional exemptions or satisfaction reasons prior to the effective date of the CE requirements as a

condition of eligibility

1.14.15 Scenario: Eligibility terminated for another reason (Member at 10 hours CE requirements, (month 6-9))

1.14.15.1 Eligibility of member should be terminated for non-payment of premium. Notifications (before and after termination) should be sent to the member

1.14.15.2 If a member reapplies, found eligible and exempted from CE, the exemption reason should be reported to MMIS, CE module, Self-service and provider portal.

1.14.15.3 If a member reapplies, found eligible and not exempted from CE, 10 hours of CE will be applied to the member's first month of eligibility in Kentucky HEALTH.

1.14.15.4 The member has a lookback period of 5 years and the earliest member could lose eligibility or coverage is in 2 months after enrollment.

1.14.16 Profiles

1.14.16.1 Individual Profile Management

Educational Qualifications – Member will have an option to specify their earned degrees, diplomas and certifications

Employment History and Current employment details – Member will have an option to specify past employers, employment dates, Industry and current employment details

Employable Skills – Member will have an option to specify current employable skills

Vocational Training History – Member will have an option to specify past vocational trainings attended, training dates and acquired skills

Areas of Interest – Member will have an option to specify areas of interest

Employment Barriers - Member will have an option to indicate employment barriers

Member will be able to upload a new resume or download an existing resume

Member will be able to create a system generated resume within CE module by providing the following information:

1.14.16.1.1.1 Employment History
1.14.16.1.1.2 Contact Information
1.14.16.1.1.3 Education
1.14.16.1.1.4 Profile
1.14.16.1.1.5 Preferences

Member will be able to view profile (Identity, Contact & Demographic information) in CE

module.

1.14.16.2 Business Partner Profile Management

Business Partner will be able to view their organization profile in CE module

Business Partner will be able to view member's profile in CE module

1.14.16.3 Staff Vendor Profile Management

Staff Vendor will be able to view their profile in CE module

Staff Vendor will be able to view member's profile in CE module

1.14.17 Opportunity Management and Registrations

1.14.17.1 Business Partner will be able to create new opportunities in CE module

1.14.17.2 Members will be able to search and register for any available opportunities until the opportunity start date

1.14.17.3 Member must receive an email notification upon successful registration

1.14.17.4 Member will be able to cancel the registration for an opportunity with no penalty. An email cancellation confirmation should be sent to the member.

1.14.17.5 Members can walk-in to take part in the opportunity. Registration is not mandatory

1.14.17.6 If a member doesn't attend an opportunity after registering, there will be no penalty

1.14.17.7 Business Partner must provide documented proof upon completion of the opportunity by the member

1.14.17.8 Member reports CE participation hours in one of the following ways:

Self report hours and provide proof of completion in CE Module

<Define an offline process for the individual to report CE hours by calling <actor is TBD>

1.14.17.9 *Approval process for CE participation hours for the opportunities present in CE Module*:

Business Partner will receive an email notification requesting review of CE participation hours and approval

Once CE participation hours are approved, Members dashboard in CE module will reflect the total number of CE hours completed to-date. Approved hours will also be sent to Self-Service portal

1.14.17.10 *Approval process for CE participation hours for the opportunities outside of CE Module*:

<Since these opportunities are not tracked in CE module, who will validate and approve these hours?>

Once CE participation hours are approved, Members dashboard in CE module will reflect the total number of CE hours completed to-date. Approved hours will also be sent to Self-Service portal

1.14.17.11 *Business Partner cancels an opportunity* – If a business partner cancels an opportunity, a cancellation email should be sent to all registered members

1.14.17.12 CE module must send a summary notification with the number of CE hours completed on

a periodic basis to the member

1.15 Education and Training

1.15.1 Kentucky Health members can take educational classes for two purposes: My Rewards Credit and for early re-entry from a penalty period. Community Engagement will coordinate with certified providers for course registration. The state will define course criteria and the qualified providers. MCOs may submit courses for approval. Courses to clear a penalty period must be delivered in person OR be online with a quiz. Courses take to meet a penalty period requirement may only be taken once every 12 months per course. Each type of penalty period may only be cleared once every 12 months.

1.15.1.1 Education and Training - Penalty

Individual can only take each penalty period course once every 12 months, and can only waive each type of penalty period once every 12 months.

Individual may register for course online to clear a penalty period. Once a course is completed the provider enters in individual course completion into tracking system.

Course completion are communicated to the eligibility System – penalty period may be cleared if other criteria met.

1.15.1.2 Education and Training – My Rewards Credit

Individual may register for courses for My Rewards credit subject to applicable limits.

Course provider enters individual course completion into tracking system.

Course completion communicated to eligibility and passed through to My Rewards for account credit.

1.15.1.3 Education and Training – Community Engagement

The individual is able to register and take certain courses to accrue community engagement hours. The community engagement module is responsible for coordinating with certified providers for the individual to take a course.

The community engagement module allows individuals to register for courses, track courses, and track course completions.

Information regarding course completion is provided to the eligibility system which then provides this information to My Rewards account.

An individual may elect to take a course for the purpose of avoiding suspension or re-entering into the Kentucky HEALTH program due to non-compliance. A course can be taken only once for each reason in a calendar year (3 times total in a year).

1.15.1.3.1.1 A course may be used to avoid suspension due to Community Engagement.
1.15.1.3.1.2 A course may be used to clear a non-payment penalty.
1.15.1.3.1.3 A course may be used to clear a re-enrollment penalty for untimely recertification.

1.16 Premium Assistance

Kentucky HELATH members who have access to employer-sponsored health insurance (ESI) through an employer may eligible for Premium Assistance (PA). After 12 months of KY HEALTH enrollment and 12 months of employment with access to compatible ESI, members are mandatorily required to enroll in PA if the ESI is compatible & cost-effective for the entire household. Additionally, members not mandated to enroll in PA but have access to ESI, can opt-in for a PA eligibility determination. Once the member's ESI details are received, Premium Assistance will determine if the ESI plan(s) is compatible with PA.

Active Premium Assistance enrollees will receive ESI premium reimbursement from the Commonwealth minus their KY HEALTH cost share requirement, full access to their ESI network, covered out-of-pocket expenses and a My Rewards Account to earn incentive dollars for enhanced benefits.

1.16.1 Premium Assistance Benefits

- Each enrolled member will receive a My Rewards Account.
- Member can accrue dollars in My Rewards by completing applicable activities.
- Family members enrolled in ESI are exempted from CE requirements.
- Benefit Surcharge- Members premium reimbursement amount reduced by $1 unless provide proof exclusion for elective abortion.
- Benefits- Premium Assistance benefits are wrapped to the package for which the individual is eligible in the Kentucky HEALTH.

1.16.2 Member Application & ESI Compatibility Evaluation

1.16.2.1 If the member is eligible for KY HEALTH and has reported Employment and/or access to ESI, eligibility will solicit the member to opt-in to a PA evaluation following post-eligibility determination

1.16.2.2 During the mandatory enrollment period, eligibility will require the member to be evaluated for PA if they have reported TPL ESI and/or employment during their Medicaid application

Member is required only after 12 months of employment, 12 months of KY HEALTH enrollment and ESI is cost-effective for entire household. ESI is optional for employee if employee only tier is cost effective but family tier is not cost effective

1.16.2.3 The member is not required to enroll in PA until their ESI has been determined compatible with PA

1.16.2.4 Unemployed individuals, Individuals working < 30+ hours/week, pregnant women, children and medically frail individuals are not required to verify their ESI coverage

If ESI information is unavailable and if individuals are working > 30+ hours/week:

1.16.2.4.1.1 An RFI is generated for their ESI verification through their employer. They are given 10 days to verify. Non-completion of this document does not have negative impacts in the first year, but does have negative impacts once the member meets the 12 months employed and 12 months enrolled qualifications.

1.16.2.4.1.1.1 Where the employer is enrolled in the employer portal, this notice does not need to be generated unless employer fails to verify.

1.16.2.4.1.2 In the event that the individual does not verify ESI, a communication is sent to the employer for optional enrollment into the employer portal, unless already enrolled.

1.16.2.5 Eligibility populates PA form with Employment & ESI details provided in Medicaid

application and sends form to member

Note: Premium Assistance committee & policy team to determine alternate Employer process to provide ESI benefit & rates details (TBD)

1.16.2.6 Member completes Premium Assistance form and provides corresponding ESI documentation al (multiple channels are available – online, mail, fax, in-person)

1.16.2.7 Eligibility initiates workflow for PA state team to review form & member provided ESI documentation

1.16.2.8 State Premium Assistance team reviews PA form, ESI documentation & determines compatibility of ESI plan(s) and tier(s)

Note: State to identify actuarial service/tool to facilitate ESI plan/rate compatibility check (TBD)

1.16.2.9 State Premium Assistance team updates PA ESI Evaluation workflow with results of plan comprehensiveness & cost-effectiveness

Note: workflow includes inputting the ESI details (via screens) into the Premium Assistance module

1.16.2.10 Premium Assistance correspondences and notices (including timeline) to be defined in design sessions (TBD)

1.16.3 Enrollment into Premium Assistance

1.16.3.1 Eligibility receives results of ESI plan compatibility

1.16.3.2 Eligibility determines ESI Premium Assistance amount

Premium Assistance amount = Employee ESI Premium Contribution – KY HEALTH Cost Share requirement

1.16.3.3 If ESI is available but not cost effective, individuals can choose to enroll in ESI. Per policy decision, individuals may optionally enroll in non-cost-effective ESI and to be reimbursed at the cost effective level provided the difference does not make them exceed their 5% of income limit.

1.16.3.4 If ESI is available and cost effective but individuals are either not employed for 12 months (< 12 months) or if they are not enrolled in KY HEALTH for up to 12 months, they could optionally either enroll in ESI and receive Premium Assistance or continue with KY HEALTH plan up until 12 months.

1.16.3.5 Eligibility notifies member of PA eligibility results and Instructions including Next Steps to enroll in ESI and Member Reimbursement process

1.16.3.6 An ESI Special Enrollment period is granted when individual becomes newly eligible for Medicaid premium assistance.

1.16.3.7 Member enrolls in ESI Premium Assistance & Wrap Around for member's corresponding eligibility

Timeline & PA effective dates to be defined by PA subcommittee during detailed design. PA may include retro eligibility effective dates

1.16.3.8 Eligibility provides updated member eligibility and enrollment to MMIS

1.16.3.9 MMIS receives eligibility and enrollment and updates all applications with member's latest eligibility

Upon verification of ESI, individuals would be fully transitioned into Kentucky HEALTH

Premium Assistance effective the first of the next month.

1.16.3.10 Impact on Family Coverage

If ESI is available and is cost effective for the entire family, then they have to mandatorily enroll in ESI else their benefits will be terminated. Exceptions would include pregnant women, children and medically frail individuals.

If ESI is available but is not cost effective for the entire family, then it is optional for the employee to enroll in it as well.

- Example: In a case of a married couple if the husband qualifies for mandatory enrollment and wife is either not eligible for ESI or if ESI coverage is not cost effective to include spouse, then the enrollment options are:
  - Husband can enroll in ESI and wife enrolls in KY HEALTH. This family will be subject to two premium payments.
  - Or both enroll in KY HEALTH
  - Or both can choose to be enrolled in ESI but be reimbursed at the cost-effective level, provided that the difference is not greater than 5% of quarterly income

1.16.4 Initial Member Premium Reimbursement

1.16.4.1 Once ESI is verified and member is enrolled in ESI, they are fully enrolled in Kentucky HEALTH Premium Assistance.

1.16.4.2 The member is compensated in advance as well as reimbursed for initial ESI enrollment in instances of retro effective dates.

1.16.4.3 Premium payment may include catch up amount if ESI effective date and Kentucky HEALTH premium assistance eligibility date is different.

1.16.4.4 When a payment or reimbursement is made to a Medicaid member, the system must record the transaction in accordance with CMS 64 reporting requirements

1.16.5 Ongoing Advance Premium Payments to Member

1.16.5.1 Pending policy decision regarding the frequency and timeline for ongoing PA ESI verification process (TBD)

1.16.5.2 Member or employer have to provide ongoing ESI verification (e.g. paystubs showing premium payment) on a monthly or per pay period basis for ongoing advanced premium payment.

1.16.5.3 Monthly reconciliation amount can be determined by reviewing previous month's paystub showing premium contribution.

1.16.5.4 Based on actual premium paid by the member till date, the reconciliation amount would be adjusted and it would be reflected in the next month's check.

1.16.5.5 Premium payments may include both positive and negative adjustments for retro effective changes to the member's ESI enrollment

1.16.5.6 Pending policy decision regarding the payment frequency. Options include monthly or would be aligned based on employer pay periods (TBD)

1.16.5.7 If member receives a premium payment and eligibility later determines the member was not enrolled in ESI, then this amount would be claimed back from the member via a benefit recovery process. Process is to be defined in design sessions with the

PA subcommittee (TBD)

1.16.5.8 Premium payments will also include reimbursement for out of pocket expenses and wrap around benefits (TBD)

1.16.5.9 When a payment or reimbursement is made to a Medicaid member, the system must record the transaction in accordance with CMS 64 reporting requirements

1.16.6 ESI Claims Processing & Payment

1.16.6.1 Claim processing & payments would differ based on the type of provider.

1.16.6.2 PA members can choose to see both Medicaid and ESI network providers.

1.16.6.3 If a PA member with ESI sees a Medicaid provider, the provider must bill at the Fee-for-Service (FFS) rates.

1.16.6.4 If an individual receives service from a Medicaid provider who is also an ESI In-Network provider, then the claim is paid fee-for-service via current Medicaid processes.

Only covered benefits are wrapped to the individual enrolled in ESI from Kentucky HEALTH (e.g. if an individual pays cost share on a benefit that is covered in ESI but not in Kentucky HEALTH, then that benefit is not wrapped to the individual).

Example: Upon providing service to an individual enrolled on KY HEALTH premium assistance, the provider would first bill ESI. Where the ESI plan does not cover the entire claim, for example applies $100 to the deductible, the Medicaid enrolled provider will then submit a claim to Kentucky HEALTH premium assistance. This claim will be paid via the current FFS processes at the Medicaid contracted rate. The provider may not hold the enrollee liable for any difference between the Medicaid rate and the ESI rate, for example for the $100 assigned to the deductible above, if the Medicaid rate is $80 then the provider accepts this as payment in full.

1.16.6.5 If service is received from non-Medicaid provider but an ESI In-Network Provider, then member would have to pay the provider directly and seek reimbursement from Medicaid. However,

Example: For a $100 service, provider would bill ESI which would be applied to the ESI deductible account. Member would have to pay $100 and then submit the proof of this payment and ESI coverage explanation of benefits showing proof that the service was covered to KY HEALTH Premium Assistance. Upon validating the verification, $100 would be reimbursed to the member via check next month provided that the service is a covered KY HEALTH service.

1.16.6.6 If service is received from an ESI out of Network provider then the claim is denied if the service is not covered by Medicaid. If it is covered by Medicaid then it would be paid based on Medicaid rates. Out of network ESI claims will only be paid where it is a Medicaid wrap service and not covered by ESI plan.

1.16.6.7 When a payment or reimbursement is made to a Medicaid member, the system must record the transaction in accordance with CMS 64 reporting requirements

1.16.6.8 Pending design decision regarding process for managing ESI pharmacy benefit claims (TBD)

1.16.6.9 Medicaid Appeals process would have to be defined when individuals need to enroll

in KY HEALTH if their employer does not allow SEP (TBD).

1.16.7 Proposed Employer Premium Assistance Role

1.16.7.1 Pending policy and design decision regarding the employer's role within PA and functionality available within KY HEALTH systems (TBD). The below section outlines the proposed employer functions as recommended by the PA subcommittee

1.16.7.2 Provide ability for employer to identify employees on their roster

1.16.7.3 Provide ability for employer to provide ESI plan details including plan benefit design, rates by tier, employee contribution requirements for each rate tier, employer benefit plan year & employer open enrollment period

1.16.7.4 Provide ability for employer to verify an employee is actively employed & enrolled in the ESI plan

1.16.7.5 Employer Plan Registration

If employer is registered in portal then annual checks (timelines TBD) are made to reconfirm if the plan continues to be cost effective and comprehensive.

1.16.7.5.1.1 During annual renewal, employers will need to update existing information in their ESI plans including changes in premium rates and/or benefits design.

If employer plan is no longer cost effective then individuals are notified and they are no longer mandated to be enrolled in this ESI.

Individual continues to be enrolled in ESI if the plan continues to be cost effective.

If employer is not registered in portal then a check would be made to see if any information on the employer plan already exists in the database within the last 12 months of individual/family Enrollment

If the employer registers for the program and provides the ESI data needed, then the premium rates and benefits design from the employer are used to determine if the ESI plans are cost effective and meet basic benefit requirements. Individuals are optionally or mandatorily enrolled based on if they have been enrolled in KY HEALTH for > 12 months and employed with the same employer for > 12 months.

If data is not available, then individuals are asked to provide verified details on the plan via the Premium Assistance Member form. The form is submitted to the state, which determines if requirements are met in terms of cost effectiveness and benefits coverage.

1.17 5% Cost Sharing Limit

1.17.1 Per CMS guidance and regulations, cost sharing is limited to five percent of the MAGI household's income per quarter.

1.17.2 The limit can be exceeded in two ways, either through premiums paid as part of the cost sharing analysis in the eligibility system, or through claims analysis in the Medicaid Management Information System (MMIS).

1.17.2.1 The case premium is set for $1 when the 5% limit is reached.

1.17.2.2 When 5% limit is hit, copays are not applicable for the rest of the quarter for copay

plan members.

1.17.3 Individuals with $0 income need to have the cost share no indicator set from the State.

1.17.4 The eligibility system analyses the MAGI household income to determine if the limit has been reached and adjusts the premium amount accordingly for the remainder of the quarter.

Example: A MAGI household has a monthly premium of $15. In the first month eligibility determines that the household has not exceeded the limit. However, eligibility determines that months 2 and 3 premiums would exceed the limit. When determined, the eligibility system establishes the premium amount for months 2 and 3 at $1. Completing the picture, in month 4 the eligibility system re-establishes the $15 premium amount.

1.17.5 When claims data indicated that the MAGI household has exceeded the five percent limit through copay, the MMIS sends indicators to the eligibility system. This indicator is considered as part of the eligibility determination when the MAGI household attempts to move from the copay plan to premium plan. The applicable premium becomes $1.

1.17.6 If the family moves to premium plan, the MMIS information is used to determine the premium amount and quarterly duration.

1.17.6.1 The 5% limit does not segregate the households by plan type

Example: If a household has members on both the premium and copay plans, and a member on the copay plan reach the 5% limit, then the premiums of the premium plan members need to be adjusted accordingly.

1.18 Recertification/Redetermination

Recertification is a yearly process for Medicaid recipients to recertify their household information to allow the eligibility system to determine if the household as well as all the individuals in the household are still eligible for benefits.

1.18.1 Certification Period

1.18.1.1 The certification period is set for 12 months from the first month of eligibility, not including any retroactive eligibility.

1.18.1.2 Presumptive eligibility is time limited therefore does not have a recertification period.

Example: An individual is determined eligible on February 5, 2018, however is conditionally eligible as the initial payment has not been made. The individual makes their first premium payment for the month of March 2018. The recertification period is thus February 28, 2019.

1.18.1.3 When a new individual is added to an existing case in the middle of the certification period, the new individual's recertification will align to the other existing certification period for the case members.

Example: A new adult is added to a case with a certification end date of January 31, 2019 on May 15, 2018. Once the adult is deemed eligible, their certification end date will also be January 31, 2019, though their benefit period will start at May 1, 2018.

1.18.2 Passive Renewal

1.18.2.1 The household has the option to participate in passive renewal at the time of application intake and prior to eligibility disposition.

1.18.2.2 If the household enrolls into passive renewal, the case will automatically be re-

determined for eligibility by accessing Federal and State data information. Information captured includes verification of income and household status.

1.18.2.3 The passive renewal process takes place in the beginning of the month of certification end date. If a discrepancy between reported data and federal and state data is detected, a request for information (RFI) is sent to household with a due date of the recertification end date.

The member will have 30 days from the renewal to respond.

1.18.2.4 Failure to complete the RFI by the requested date will be treated as a failure to complete recertification, causing denial of on-going benefits, disenrollment from Managed Care, and possible re-enrollment penalties **[Reference Eligibility Suspensions Section 1.9]**.

1.18.3 Recertification Notices

1.18.3.1 The case is informed of upcoming recertification on the first of the month prior to recertification end date if the household did not choose to participate in passive renewal.

Example: The certification end date is January 31, 2019. The recertification packet will be mailed on December 1, 2018.

1.18.3.2 If the case has not started their recertification by the 15th of the certification end month, a reminder notice is sent to household.

Example: The certification end date is January 31, 2019 and the case has yet to initiate a recertification. A reminder notice will be triggered on January 15, 2019.

1.18.4 Reapplication prior to Certification End Date

1.18.4.1 If an individual on a case has suspended enrollment, due to non-participation in community engagement or due to non-payment of premiums, resulting in termination of eligibility, the individual may typically reinstate benefits when necessary conditions are met to lift the penalty.

1.18.4.2 However, if the certification end date is 45 or less days away, and the individual is currently has suspended enrolment and terminated eligibility, they will be required to initiate a reapplication rather than a reinstatement to regain benefits.

Example: An individual was terminated for non-payment of premiums effective June 2018. The individual paid the necessary back payments and completed the Health and Financial Literacy course on August 15, 2018. The individual's certification end date is August 31, 2018. In this situation, the individual must perform a reapplication rather than a reinstatement. After eligibility is re-determined a new certification period will begin.

1.18.5 Failure to Complete Recertification for Kentucky HEALTH

1.18.5.1 If a case does not complete a recertification timely all members on that case are subject to disenrollment and denial of on-going benefits.

1.18.5.2 Exceptions are made for pregnant women and deemed newborns (TP45). These groups will still maintain coverage and will have an automatic extension to their recertification end date as described below:

Group	Certification Change	Example
PREG	The certification end date will be extended to the end of the month of their post-partum period	Projected Post-Partum: May 15, 2019 New certification end date is May 31,2019
TP45	The certification end date will be extended 3 months from the previous date	Initial Certification End Date: May 31, 2019 New Certification End Date: August 31, 2019

1.18.6 3-month Recertification Extension and 6-month Penalty

1.18.6.1 If a member is dis-enrolled and denied due to failure to provide recertification information on a timely basis, the member will be given an extension of 3 months to submit recertification or RFI documentation in a timely manner to reapply and re-enroll into Kentucky HEALTH without any penalty.

Example: If the individual was denied effective January 1, 2020 due to failure to complete a recertification of December 31, 2019. The individual will be given until March 31, 2020 to reapply and submit recertification or RFI details.

1.18.6.2 Upon eligibility determination, the individual is subject to conditional eligibility rules and effective coverage date depending on the group they are determined for and when the reapplication is approved. Under policy review.

1.18.6.3 Failure to submit proper documentation during the 3-month extension period will result in a 6-month disenrollment penalty, preventing the individual from being approved. The penalty will begin effective the first month after the 3-month extension.

Member may re-enter per the early re-entry policies during this period. Refer to recertification penalty period.

Example: If a dis-enrolled individual was initially required to recertify on December 31, 2019 and failed to reapply by March 31, 2020 while in extension period, then they will be subject to a reenrollment penalty from April 1, 2020 until August 31, 2020.

1.18.6.4 Penalties will not be applied/enforced against individuals who are identified as Medically Frail, children, or pregnant women. Individuals may also re-enroll during the penalty period through the Early Re-entry option **[Reference Early Re-entry Section 1.23]**.

Example: An individual was penalized from April 1, 2020 until August 31, 2020, but was deemed medically frail on May 15, 2020. If the individual reapplies on May 20, 2020 and meets all other financial and non-financial requirements for coverage, that individual will be approved with an effective coverage date of May 1, 2020.

1.19 Open Enrollment

1.19.1 Selecting an MCO during Open Enrollment

1.19.1.1 If the member remains eligible for KY Health after completing their re-certification paperwork, they will receive an Open Enrollment period.

1.19.1.2 During Open Enrollment, members have an opportunity to actively select an MCO including switching to a new MCO.

1.19.1.3 During the Open Enrollment period there are no restrictions on the allowable changes.

1.19.1.4 If the citizen does not actively select an MCO, an MCO will be automatically assigned

[Reference MCO Assignment Section 1.22].

1.20 MCO Benefit Effective Date

1.20.1 Timely completion for re-enrollment requirements ensures no gap in coverage for KY Health member meaning once their existing 12-month benefit period ends, the new 12-month benefit period and MCO benefit is active.

1.20.2 When re-enrollment materials are completed timely and the member remains eligible for KY Health, their MCO benefit becomes effective according to the following:

1.20.2.1 Pregnancy Plan – Effective immediately following prior 12-month enrollment.

1.20.2.2 Child Plan – Effective immediately following prior 12-month enrollment.

1.20.2.3 Medically Frail Plan – Effective immediately following prior 12-month enrollment.

1.20.2.4 Co-Pay Plan - Effective immediately following prior 12-month enrollment.

1.20.2.5 Premium Plan – Effective immediately following prior 12-month enrollment.

1.20.2.6 Premium Assistance – Effective immediately following prior 12-month enrollment.

1.21 Member Transition into Kentucky HEALTH

1.21.1 Member transition into Kentucky HEALTH occurs in January 2018 as part of a 'big bang' approach. All individuals identified in the expanded Medicaid population group will have eligibility rerun on their case. This benefit calculation does not reset the case recertification date.

1.22 MCO Assignment

1.22.1 MCO assignment is the process of assigning a MCO to an individual either through the auto-enrollment process or through self-assignment by the individual through the shopping portal. A MCO is assigned to individuals who are determined to be conditionally eligible or already enrolled. After initially being assigned to a MCO, an individual has opportunities to change to a new MCO.

1.22.2 MCO Change

MCO change is the process of changing an individual's MCO after its initial assignment. This change requires termination of records sent to the old MCO and fully eligible records to be sent to the new MCO. Any penalties, such as My Rewards suspension periods, will follow members to the new MCO and former MCO can still pursue debt. Allowable MCO changes are as follows:

1.22.2.1 MCO Change Prior to Initial Premium Payment

New members are able to request for a MCO change through SSP or through case worker change. Changes to MCO are allowed as long as benefits are not effective. Once the policy takes effect, members will be unable to change their MCO, regardless of pay, until the next open enrollment period.

Example: New member changes MCO prior to having activated benefits from an MCO changes MCOs. The MCO is successfully changed.

1.22.2.2 MCO Change during Open Enrollment

Members are able to change their MCOs during open enrollment period. Members are also able to continue with their current MCO. Change will be

effective in the member's next benefit period.

1.22.2.3 MCO Change Due to Just Cause Change

Just Cause policies and procedures will apply under Kentucky HEALTH. MCO changes due to Just Cause will take effect first of the following month or first of second month if processed after the cut-off date.

1.22.2.4 MCO Change Following Presumptive Eligibility Determination

Members that are PE eligible and files application at a timely manner are able to call for a MCO change. MCO change is effective first of the following month.

1.22.2.5 MCO Change Due to Change in Eligibility Category

Members with changes in eligibility from non-Kentucky HEALTH into Kentucky HEALTH are able to request a change in MCO prior to making their first premium payment. Once premium is paid, they will be enrolled and can no longer make other MCO changes.

Non- Kentucky HEALTH members transitioning to Kentucky HEALTH are assigned into either the State Copay plan or Kentucky HEALTH ABP copay plan provided they are cost share required. Enrollee submits a MCO change request and makes his payment within 60 days. Enrollee is now enrolled in new MCO.

1.22.3 Auto-Enrollment

1.22.3.1 If member does not self-select a MCO through the shopping portal, that member would be auto-assigned to a plan based on the following decision hierarchy:

If the member is in a locked-in program, that member will be assigned to the lock-in plan.

If an enrolled individual makes the premium payment, the individual will be assigned to the MCO to which the premium payment was made.

If an individual's family members are covered and already has a MCO, the individual will be assigned to the same MCO as the rest of the family members.

If a member has been enrolled in a MCO for the last six months, the member will be assigned to that previous MCO.

If the member is none of the above, MCO will use the round-robin process to assign an MCO; rotating with preference to the smallest MCO.

Auto-enrollment does not apply to members in suspension period unless they hit their recertification date.

1.23 Early Re-entry

Based on certain eligibility criteria, members enter a six-month suspension period for either non-payment of premiums or for not completing their community engagement requirements. During this period, they are not approved for Medicaid or Kentucky HEALTH benefits. In order to restore benefits, an individual must meet certain requirements that allow for Early Re-entry, a process by which suspended Kentucky HEALTH members become approved for Medicaid benefits enabling

them to re-enroll in the program. When members re-enter, they regain access to their initial plan and My Rewards Account benefits that were available to them prior to the start of the six-month penalty period.

1.23.1 Early re-entry requirements include the following:

1.23.1.1 For recertification suspensions, the individual must take a Health and Financial Literacy course.

1.23.1.2 For non-payment suspensions, to restore the benefit the individual must complete a health literacy/financial literacy/ parenting course(s) and pay any applicable debt up to two months and one month forward. Note, members that do not have debt only have to pay one month forward.

1.23.1.3 A member may re-enter due to community engagement non-compliance in three ways.

Complete a Health and Financial Literacy course prior to the enrolment suspension.

Complete missed hours and current month hours prior to the enrolment suspension.

If already suspended, the member must complete a whole month's worth of hours to lift suspension for the following month.

1.23.2 The eligibility system determines whether the individual has completed all 'Early Re-entry' requirements.

1.23.3 If the early re-entry activities are complete the Eligibility system will perform one of two possible actions.

1.23.3.1 Remove the enrolment suspension if fully suspended.

1.23.3.2 Switch the individual from a copayment plan to a premium plan.

1.23.4 If the member is in a penalty period at recertification, eligibility will deny ongoing benefits and disenroll the individual from their MCO.

1.23.4.1 The member will receive a denial notice with appeal rights listed.

1.23.4.2 A denial notice will appeal rights will also be generated from the member during reapplication if the member is in a penalty period.

1.24 Kentucky HEALTH for Medically Frail

1.24.1 Kentucky HEALTH members may be deemed medically frail or chronically homeless through a combination of MCO determinations, eligibility information, and self-attestation.

1.24.1.1 A member may self-attest to being Medically Frail through the self-service application.

The member may only self-attest once every 5 years.

The member will be deemed Medically Frail for 6 months if the member self attests.

MCOs must confirm Medically Frail status for homeless and ADL who self-identified within six-months or Medically Frail status is lost. All other self-identified members have to be confirmed within 30 days by MCO, prior to receiving benefits. Members are notified after MCOs have confirmed or

denied their status. Those that have been denied Medically Frail status also receive information regarding the appeals process.

Members declaring homelessness, are reviewed during an interview process by DCBS using criteria defined in the Chronic Homelessness Final Rules.

1.24.1.2 The member is deemed medically frail if it is verified the member is in an in-home hospice.

The member will be deemed Medically Frail for the duration of in home hospice care.

1.24.1.3 The member is deemed medically frail if the member received Social Security Disability Income (SSDI) or indicated as disabled through the BENDEX interface.

The member is deemed medically frail for the duration of 12 months from the most recent SSDI or BENDEX record.

1.24.1.4 The member is deemed medically frail if the member is matched against the Ryan White interface for HIV/AIDS.

The member will be deemed medically frail for the duration of 12 months from the most recent Ryan White interface record.

1.24.1.5 The member is deemed medically frail if a Medical Review Team (MRT) determination designates the individual as disabled.

The member will be deemed medically frail until the end date of the MRT record.

1.24.1.6 The member is deemed medically frail through if determined frail by the member's MCO through analysis of member claims.

The indication of medically frail will pass from the MCO to MMIS and to eligibility.

The member is deemed medically frail for 12 months from the latest indication of medically frail from the MCO.

1.24.2 Medically frail members are enrolled into the State Plan.

1.24.2.1 If the Medically frail member makes premium payments the member will be enrolled into the State Plan with Premiums. The member will be eligible for My Rewards.

1.24.2.2 If the Medically frail member does not make premium payments the member will be enrolled in to the State Plan with no cost sharing requirements. The member will not be eligible for My Rewards.

1.24.2.3 Medically frail will have access to deductible accounts.

1.24.3 The member is coverage is effective based on the case mode.

1.24.3.1 If medically frail is determined during Intake, the member will be covered from the first of the month of application of after eligibility approval.

1.24.3.2 If medically frail is determined while the member is in conditional eligibility, the member will be effective from the first of the month of medically frail determination.

1.24.3.3 If medically frail is determined while the member is currently active the change in

plans will be effective the first of the next month.

1.24.4 Medically Frail members will not be provided retroactive eligibility.

1.24.5 Medically Frail members are exempt from Community Engagement requirements.

1.24.6 Medically Frail members are consider Cost Share optional.

1.24.6.1 Medically Frail members that fail to make premium payment lose access to My Rewards accounts but remain exempt from any copayments for healthcare services.

1.24.7 Medically Frail members are exempt from the 6 month re-enrollment penalty for untimely recertification.

1.24.7.1 There will not be a $25 penalty against My Rewards for non-payment for Medically Frail members.

1.24.7.2 To regain access to My Rewards for non-payment of premium, the member must complete a Health and Financial Literacy course and make one month of premiums. My Rewards will be reactivated the next month.

1.24.8 Medically Frail individuals are automatically exempt from cost-sharing (including copayments and premiums), community engagement, and employment requirements.

1.24.8.1 However, Medically Frail individuals may opt into a premium plan to activate My Rewards Account benefits.

For those that have opted in, if they fail to make premium payment they lose access to My Rewards accounts but remain exempt from any copayments for healthcare services.

1.24.9 Members that lose frail status are also moved from the state plan on to Kentucky HEALTH ABP, whereby members that pay premiums shall be placed on the premium plan, and those who don't shall be placed on the copay plan.

1.25 Kentucky HEALTH for Children

1.25.1 Eligible Kentucky HEALTH Groups

Groups covered and determined as Kentucky HEALTH for children include:

- Newborns (TP45)
- Children under 19 (CHL1, CHL2, CHL3, CHL4, CHEX)
- KCHIP Children (CHIP)

1.25.2 Children are not subject to any benefit or cost sharing changes under Kentucky HEALTH and receive their current benefit package and cost sharing.

1.25.3 Retroactive eligibility will only be available to children on intake or reapplication, limited to three full months from the application date.

Example: Child applies on March 5, 2018. Child will be eligible for coverage effective December 1, 2017.

1.25.4 Retroactive benefits are also applicable during Reinstatement for all the denied months in the past within the same recertification timeline provided all other eligibility criterion are met.

1.25.5 MCO Benefit Effective Date: Children will be deemed eligible as of the first day of the month of application, with benefits effective three months prior to the application date (if requested),

consistent with the retroactive eligibility policy **[Reference Retroactive Eligibility Section 1.3.4]**.

1.25.6 Children continue to receive 90 day MCO choice period.

1.25.7 Recertification policies would be as is in the system currently and would continue the same way until they age out and become eligible for Kentucky HEALTH.

1.25.8 Children will be enrolled in the State Plan with no Cost Sharing.

1.25.8.1 Children will not have access to a deductible account.

1.25.9 Children are exempt from Community Engagement.

1.25.10 Children do not have My Rewards Account access.

1.26 Kentucky HEALTH for Pregnant

1.26.1 Eligibility

1.26.1.1 Pregnant women in the range 0-195% FPL are eligible for Kentucky HEALTH and are exempt from cost sharing requirements.

Adults can be pregnant but are not transferred to pregnant category until recertification.

1.26.1.2 Pregnant women are not required to make a premium payment prior to the start of benefits. The MCOs will not send premium invoices to pregnant women.

Since Pregnant women are not are not cost share required, the ESI mandate is not applicable.

1.26.2 Effective Date and Retroactive Coverage

1.26.2.1 Pregnant women will be deemed eligible as of the first day of the month of application, with benefits effective three months prior to the application date, consistent with the retroactive eligibility policy. Copayment policies are not applicable to pregnant women.

1.26.2.2 Retroactive eligibility will be available to pregnant women on intake or reapplication, limited to three full months from the application date.

Example: Pregnant women applies on March 5, 2018. She will be eligible for coverage effective December 1, 2017.

1.26.2.3 Retroactive benefits are also applicable during Reinstatement for all the denied months in the past within the same recertification timeline provided all other eligibility criterion are met.

1.26.2.4 Pregnant women will not be billed and are exempt from non-payment penalties and will continue to receive Medicaid State Plan benefits.

1.26.2.5 If other household members in the case are subject to premiums, the pregnant member is exempt from non-payment penalties enforced upon other members of the case.

1.26.2.6 If a woman becomes pregnant while in a penalty period, she will not regain access to the My Rewards Account.

1.26.3 An Expansion Adult that reports pregnancy maintains a pregnancy indicator to correctly determine the correct Federal Medicaid Assistance Percentage (FMAP).

1.26.3.1 The FMAP differs for new eligible pregnant individuals and individuals that reports pregnancy while previously eligible as an Expansion Adult (ADLT) or Section 1931

Adult (PACA).

1.26.3.2 During Recertification if the member is still pregnant the member will transition to the Pregnancy Type of Assistance, therefore modifying the FMAP.

1.26.3.3 Upon the end of pregnancy, including the post-partum period, the member will transition back to the necessary category of assistance based and plan based on income.

If the member transitions to the ADLT category and has active My Rewards the member will be enrolled into the Kentucky HEALTH ABP- Premium.

If the member transitions to the ADLT category and has suspended/inactive My Rewards the member will be enrolled into the Kentucky HEALTH ABP- Copay.

If the member transitions to the PACA category and has active My Rewards the member will be enrolled into the State Plan- Premium.

If the member transitions to the ADLT category and has suspended/inactive My Rewards the member will be enrolled into the State Plan- Copay.

1.26.4 Individuals who become pregnant while enrolled in Kentucky HEALTH and participating in cost sharing are exempt from cost sharing thereafter. Once the individual verifies her pregnancy, she is exempt from paying premiums from the first of the following month.

1.26.5 Deductible Account

1.26.5.1 Pregnant individuals do not have deductibles on their plans and thus are not eligible for deductible accounts.

1.26.5.2 Individuals who become pregnant while enrolled will have their account frozen during the pregnancy. Individuals who enter the program while pregnant will not have an account until they finish their 60 day post-partum period. Similar to someone that is suspended, their deductible account follows them through the pregnancy.

1.26.5.3 There shall be a formula used to determine MRA rollover for pregnant woman whose pregnancy ends mid benefit year. Said formula is TBD.

1.26.6 Recertification

1.26.6.1 If the member is pregnant during recertification and has not completed the recertification by the end date, her recertification end date is pushed to the end of the month of the pregnancy due date with a 60 day post-partum period.

1.26.7 Community Engagement

1.26.7.1 Pregnant women are exempt from Community Engagement and Employment requirements. They do not need to satisfy any criteria to indicate active community participation.

1.26.7.2 Community engagement hours do not accrue during pregnancy or the 60 day post-partum period.

1.26.8 My Rewards Account

1.26.8.1 Pregnant women are eligible for a My Rewards Account, provided the individual is above the age of 18.

1.26.8.2 If the member is pregnant in a non-payment penalty period the individual will still have

a suspended My Rewards account.

To activate My Rewards the member must complete a Health and Financial Literacy Course.

The eligibility system will automatically reactivate My Rewards upon the end of the non-payment penalty if the member is still pregnant.

1.26.8.3 They will be able to obtain reward dollars for all Kentucky HEALTH My Rewards Account eligible activities, including completion of activities important to promoting healthy babies and families such as completion of prenatal care visits and recommended well-child visits for Kentucky HEALTH enrolled children.

1.27 Kentucky HEALTH for Section 1931 Low-Income Parents and Caretakers (PACA)

1.27.1 Section 1931 Low Income Parents and Caretakers refer to adult individuals that provide care to a dependent and fall at or below the MA standard of need for a given household size.

1.27.1.1 The eligibility system assigns these individuals as PACA. Referred to PACA in the rest of this section.

1.27.1.2 PACA members will always have a household FPL below 100%.

1.27.2 A PACA individuals that are not defined as Medically Frail must meet the same eligibility criteria as Expansion Adults (ADLT) including:

- Community Engagement Requirements **[Reference Community Engagement Section 1.14]**
- Cost Sharing Requirements **[Reference Cost Sharing Section 1.8]**
- Timely Recertification Requirements **[Reference Recertification/Redetermination Section 1.18]**
- ESI Mandate **[Reference Premium Assistance Section 1.16]**

1.27.3 Eligible PACA members will be enrolled into the State Plan.

1.27.3.1 For initial applicants, PACA members will be subject to conditional eligibility periods.

1.27.3.2 Upon payment of initial premium, the member will be moved the State Plan-Premium.

My Rewards will be activated for these members.

1.27.4 Failure to pay the premium in 60 days will move the member into the State Plan-Copayment.

1.27.4.1 My Rewards will not be activated in these scenarios.

1.27.4.2 To activate My Rewards the member must complete a qualifying Health and Financial Literacy Exam and make one month premiums.

1.27.5 PACA members are subject to the standard 12 month recertification period.

1.27.5.1 Failure to complete recertification will result in disenrollment from the selected MCO with a 3 month extension.

1.27.5.2 Failure to return recertification during the 3 month extension will result in a 6-month

re-enrollment penalty, with standard early re-entry criteria.

1.27.6 PACA members will be eligible for a Deductible Account through their MCO.

1.27.7 PACA members are not eligible for retroactive eligibility.

1.28 Kentucky HEALTH for Transitional Medical Assistance

1.28.1 Section 1931 individuals (PACA) that report income above the MA standard of need may be eligible for Transitional Medicaid Assistance (TMA).

1.28.1.1 The Eligibility system defines this as a separate type of assistance noted as TMA.

1.28.2 To qualify for TMA the member must have been fully enrolled and not suspended in the State Plan under the PACA type of assistance for at least 3 of the past 6 months.

1.28.2.1 If the member was enrolled for fewer than 3 months the member is evaluated for assistance under ADLT or deemed fully ineligible for Medicaid Assistance.

1.28.3 TMA coverage lasts up to 12 months and is broken into two 6-month phases.

1.28.3.1 First 6 month phase requires that the individual meets the 3 month enrollment criteria.

There is no maximum income limit check during this phase.

1.28.3.2 To qualify for the second 6 month phase the member must have been enrolled all 6 months and must have an FPL at or under 185% FPL.

Failure to meet the either condition will re-evaluate the member for other MA assistance.

Changes in income that exceed 185% during the second 6 month phase will redetermine the individual's eligibility.

1.28.3.3 After completion of the 12 months of TMA, the member is re-evaluated for eligibility based on other factors including income, and non-financial situations at the time of determination.

The completion of the 12 months is considered the recertification date for TMA members, with applicable recertification penalties.

1.28.4 The member will be enrolled into the same State Plan, either Copayment or Premium, that the member had under the PACA Type of Assistance.

1.28.4.1 Members will maintain the same Deductible Account and Deductible Account balance.

1.28.4.2 The member will also carry over My Rewards status that was previously maintained under the PACA type of assistance.

Members enrolled into the Copayment State Plan will have inactive or suspended My Rewards.

Members enrolled into the Premium State Plan will have active My Rewards.

1.28.5 Failure to make premium will result in a non-payment penalty but will not suspend the individual's enrollment.

1.28.5.1 My Rewards will be suspended for non-payment with a $25 penalty.

1.28.6 Community Engagement requirements will apply for TMA members with applicable

suspension and re-entry criteria **[Reference Community Engagement Section 1.14]**.

1.29 Member Self-service Portal

1.29.1 The benefind self-service portal is used to display certain pertinent information regarding the following:

1.29.1.1 Premium amounts.

1.29.1.2 A link to a particular MCO enabling Fast Track payments.

1.29.1.3 Community engagement expected hours and actual hours.

1.29.1.4 Suspension status and Reason.

1.29.1.5 My Rewards Account balance.

1.30 Provider portal

1.30.1 The provider portal is used to display certain pertinent information regarding the following:

1.30.1.1 Display if vision and dental is covered via MCO or my rewards.

1.30.1.2 Have a link to my rewards benefit.

1.30.1.3 Display suspension types.

1.30.1.4 Display copays, where applicable.

1.30.1.5 Display different benefit packages.

1.30.1.6 Display My Rewards Account status.

1.30.1.7 Interface with account to allow providers to reserve funds in PA process.

1.30.1.8 Display conditional status.

1.30.1.9 Display suspension status and reason.

1.31 Appeals

1.31.1 Early Re-entry Appeals: If the eligibility system determines that early re-entry activities are not complete, then a denial notice is sent to the individual along with appeal rights.

1.31.2 The individual can file an appeal to contest the eligibility decision.

1.31.2.1 If an appeal is filed, the individual continues the suspension period.

The appeals regarding completion of courses may need to seek verification from respective course providers. Members can also provide their own documentation of payment and course completion for verification during the appeals process.

1.31.2.2 If an appeal is filed, a notice is sent to MCO and they are consulted to provide records for premium payments, health and financial literacy courses that the individual has participated in and completed.

1.31.3 Upon verification by MCO, if it is found that necessary reenrollment requirements are not met, then the suspension period continues and a notice is sent to the individual.

1.31.4 Once, the MCO verifies premium payments and completion of health and financial literacy courses, then the individual is reenrolled in his/her specific premium payment plan on the

dates specified in the appeal decision in order to avoid any loss of coverage gap.

1.32 Use Cases

1.32.1 Draft Use Cases were developed during work flow sessions to support Kentucky HEALTH requirements.

1.33 Reports

The following operational reports will be provided on TBD basis to provide for operational monitoring of Kentucky HEALTH.

1.33.1 Eligibility and Benefits

1.33.1.1 Report of Modified Adjusted Gross Income (MAGI) financial status

1.33.1.2 Benefit package (State Plan or alternative benefit package)

1.33.1.3 Pregnancy indicator

1.33.1.4 Conditionally eligible

1.33.1.5 Termination/suspension due to Community Engagement

1.33.1.6 Termination due to Cost Sharing compliance

1.33.1.7 6 month penalty period due to cost sharing

1.33.1.8 5% Cost Sharing Limit

Quarterly individual or family income

Quarterly individual or family eligible medical claims

Self-report of additional medical expenses

1.33.1.9 My Rewards Status Indicator

1.33.1.10 Copay/Premium Status

1.33.1.11 Medically Frail Indicator

1.33.1.12 Community Engagement Indicator and hour limit

1.33.1.13 Case indicator

1.33.2 Presumptive Eligibility

1.33.2.1 All individuals considered presumptively eligible

1.33.2.2 All individuals who have moved out of presumptive eligibility

1.33.3 Premium Assistance

1.33.3.1 Annual report of qualified ESI plans with individual and family rates assessed

separately

1.33.3.2 Member employment duration with current employer

1.33.3.3 Work participation hours to identify those who work more than 30 hours per week

1.33.3.4 Verification of employment for advance reimbursement purposes

1.33.3.5 Report of proof of enrollment and deduction via pay stubs

1.33.4 Eligibility Suspensions

1.33.4.1 All suspensions

1.33.4.2 Paid and unpaid premiums

1.33.4.3 Completed and uncompleted CE hours

1.33.4.4 CE hours and premium payments that have been back-paid

1.33.4.5 Health and financial literacy courses completed

1.33.5 Cost Sharing

1.33.5.1 Statements for members reflecting deductible account balance

1.33.5.2 Remaining deductible account at end of benefit period (as eligible for My Rewards Account roll-over)

1.33.5.3 MCO report of Medically Frail verified status

1.33.5.4 Chronically homeless verification

1.33.6 My Rewards Account

1.33.6.1 Accrued MRA dollars

1.33.6.2 Frozen MRAs

1.33.6.3 MRA deductions

1.33.7 Non-Emergency Use of ER

1.33.7.1 Nurse hotline calls within 24 hours of ER visit

1.33.7.2 All ER visits and claims codes

1.33.7.3 Follow-up primary care visit

1.33.8 Community Engagement

1.33.8.1 Monthly report of community engagement or work participation hours

1.33.9 Education and Training

1.33.9.1 Completed health and financial literacy courses

1.33.10 5% Cost Sharing Limit

1.33.10.1 Quarterly reports of individual or family income

1.33.10.2 Quarterly reports of all costs paid by individual or family

1.33.11 Recertification/Redetermination

Annual recertification report including income level, plan selected, Medically

Frail, pregnant and other indicators

1.33.12 Kentucky HEALTH for Medically Frail

1.33.12.1 Medically Frail verification by MCO

1.33.13 Appeals

1.33.13.1 Open appeals processes

1.33.13.2 Closed appeals processes

1.34 Test Plan

1.34.1 Performance Testing

1.34.2 Security Testing

1.34.3 System Integration Testing

1.34.4 User Interface Acceptance Testing