

Updated September 2016 | Fact Sheet

## Proposed Changes to Medicaid Expansion in Kentucky

In January, 2014, Kentucky implemented a traditional Medicaid expansion, according to the terms set out in the Affordable Care Act. Subsequently, Governor Bevin, who ran on a platform to end the Medicaid expansion and dismantle the State-Based Marketplace, was elected in December, 2015. Post-election, the Governor instead decided to seek a Section 1115 waiver to change the state's traditional Medicaid expansion, and on June 22, 2016, he released his proposed [waiver](#) called Kentucky HEALTH (Helping to Engage and Achieve Long Term Health). During an extended state level public comment period, from June 22 through August 14, 2016, the state received 1,428 comments on the waiver. Limited changes were made to the initial proposal, and on August 24, 2016, Governor Bevin officially submitted the [waiver application](#) to the Centers for Medicare and Medicaid Services (CMS), where it is now pending.

Kentucky's proposal includes a number of changes that would affect Medicaid expansion enrollees as well as traditional non-disabled Medicaid enrollees, including Section 1931 parents, pregnant women, and Medicaid and CHIP-eligible children. Specifically, Kentucky seeks Section 1115 waiver authority to modify the current terms of Medicaid coverage by:

- Imposing premiums on a sliding scale based on family income, ranging from \$1.00 per month for individuals with incomes below 25% FPL and up to a maximum of \$15.00 per month in the first two years of enrollment for those from 100-138% FPL, increasing beginning in year three;
- Requiring payment of the first premium before coverage is effective for those from 100-138% FPL (coverage would be effective after 60 days for those below 100% FPL who do not pay a premium);
- Disenrolling those above 100% FPL for failure to pay a premium after a 60 day grace period and barring re-enrollment for 6 months unless the beneficiary pays past due and current premiums and completes a financial or health literacy course;
- Requiring up to 20 hours per month of employment activities as a condition of eligibility for most adults;
- Prohibiting beneficiaries who do not timely renew Medicaid eligibility from re-enrolling in coverage for six months;
- Waiving non-emergency medical transportation for expansion adults;
- Adding a high deductible health savings account (funded by the state) to existing capitated managed care coverage and offering an incentive account to purchase extra benefits, funded through completion of specified health-related or employment activities and/or up to half of any remaining annual deductible funds;

- Requiring Medicaid premium assistance to purchase cost-effective employer sponsored insurance after the first year of Medicaid enrollment and employment for adults and their Medicaid and CHIP-eligible children; and
- Using federal Medicaid matching funds for short-term Institution for Mental Disease (IMD) services for non-elderly adults in certain counties.

Kentucky also plans to amend its benefit package for expansion adults by using the state employee health plan as a benchmark<sup>1</sup> and include a quality withhold and adjust capitation rates in its MCO contracts; these changes do not require waiver authority.

Unlike other states with approved Medicaid expansion waivers to date, Kentucky has an existing traditional expansion. On September 9, 2016, [CMS denied a waiver application from Ohio](#), another state that had successfully implemented a traditional expansion and subsequently sought to alter the terms under a waiver. CMS determined that Ohio’s proposal, including imposing premiums regardless of income and excluding individuals from coverage indefinitely until all arrears were paid, “[would undermine access to coverage and the affordability of care, and do not support the objectives of the Medicaid program.](#)” CMS also noted that Ohio’s proposed policy changes under the waiver “[would lead to over 125,000 people losing coverage each year](#)” compared to the state’s existing traditional expansion.

Similar to its response to Ohio’s waiver application, CMS could consider Kentucky’s successful implementation of its traditional Medicaid expansion to date, which is viewed as one of the [most successful ACA implementation experiences](#) among the states, during its review of Kentucky’s waiver application. Research points to gains in coverage and reductions in the uninsured, increases in access and health care utilization, and positive fiscal impact as a result of the Medicaid expansion in [Kentucky](#) and [other expansion states](#). Since implementing the ACA, Kentucky’s nonelderly adult uninsured rate fell from 18.8% in [2013](#), to 6.8% in [2015](#), one of the largest reductions in the country, and over [439,000 adults](#) have obtained coverage as of December 2015 as a result of the Medicaid expansion. Kentucky’s [waiver application](#) projects decreased Medicaid enrollment, with over 200,000 less member months in year 1 of the waiver, and over 1 million less member months in year 5 of the waiver, compared to continuing coverage without the waiver. These decreases in coverage are anticipated as a result of beneficiary non-compliance with waiver policies, such as premium payments and employment requirements, and, in later years, due to beneficiary shifts to commercial coverage.

Kentucky’s proposed waiver includes many provisions similar to those in [Indiana’s](#) Medicaid expansion waiver, which built on a pre-ACA demonstration in which Indiana had implemented a limited coverage expansion with a high-deductible health plan. CMS has indicated it may not approve additional waivers similar to Indiana’s before [evaluation](#) results for that program are available. Kentucky’s proposed waiver also includes provisions not approved to date in [other states](#), such as a work requirement and graduated premiums based on length of time in the program that will exceed Marketplace levels for those above 100% FPL.

Kentucky’s proposal waiver is open for federal level public comment through October 8, 2016. Then, CMS and the state typically negotiate the waiver terms. However, Kentucky’s application states that “[\[t\]his expansion will be maintained only under this demonstration waiver](#),” implying that the state may not be willing to alter its proposal. Table 1 describes the major elements of Kentucky’s proposed Section 1115 demonstration.

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

Element	Kentucky Waiver Proposal
<b>Overview:</b>	<p>Modifies the state’s existing Medicaid expansion by:</p> <ul style="list-style-type: none"> <li>• adding a high-deductible health savings account and an incentive account to existing capitated managed care coverage. Incentive account funds could be used to purchase enhanced benefits.</li> <li>• imposing premiums on most non-disabled adults on a sliding scale from \$1 to \$15 per month in lieu of copayments. Premiums for those above 100% FPL would be a condition of eligibility and increase beginning in the third year of enrollment.</li> <li>• disenrolling those above 100% FPL for failure to pay a premium after a 60 day grace period and barring re-enrollment for 6 months unless beneficiary pays premiums for grace period and reinstatement month and completes financial or health literacy course.</li> <li>• prohibiting those who do not timely renew Medicaid eligibility from re-enrolling in coverage for 6 months.</li> <li>• requiring work activity hours as a condition of eligibility for most adults.</li> <li>• waiving non-emergency medical transportation for expansion adults.</li> <li>• requiring those with access to cost-effective employer-sponsored insurance to receive premium assistance after the first year of enrollment and employment.</li> </ul>
<b>Duration:</b>	Request to implement 6 months following CMS approval for 5 years (plan to implement in the spring of 2017, except that work requirement may be phased in by county or region).
<b>Coverage Groups:</b>	<p>Would include the adult expansion group and all other non-disabled adult Medicaid beneficiaries in most waiver provisions. Would allow CHIP-eligible children to enroll in the same health plan for which their Medicaid-eligible parents are eligible under the waiver.</p> <p>Groups exempt from the waiver include former foster care youth up to age 26; individuals eligible for § 1915(c) home and community-based services waivers; individuals eligible for Medicaid due to a disability, including those with an SSI determination; individuals over age 65; and individuals residing in an institution, such as a nursing facility. Exemptions from specific policies are noted below.</p>
<b>Medical Frailty Determination</b>	Those in hospice, with HIV/AIDS, or receiving SSDI would be automatically considered medically frail. Other individuals could self-identify to their MCO, be identified to the MCO by a provider, or identified by the MCO based on a state-approved health risk assessment and claims data. In all of these cases, the MCO would review and approve the medical frailty designation based on objective criteria established by the state.
<b>Coverage Renewals and Lock-Out:</b>	Would implement an annual open enrollment period for most adults that would vary for each beneficiary depending on when they enrolled in the program (spanning three months prior to Medicaid eligibility expiration and three months following). If beneficiaries fail to renew coverage during this period, they would be required to wait six months before being permitted to re-enroll in coverage, unless the individual completes a financial or health literacy course. Would exempt pregnant women, children, and individuals determined medically frail from this provision.
<b>Premiums:</b>	Would impose sliding scale flat rate monthly premiums for most adults based on family income ranging from \$1 for those with incomes under 25% FPL and up to \$15 for individuals with incomes from 101-138% FPL in the first two years of enrollment. Premiums would be assessed based on family income rather than per person. Third

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	<p>parties such as non-profit organizations and providers may pay premiums on a beneficiary’s behalf. Children and pregnant women would be exempt from premiums.</p> <p>Seeks to impose increasing premiums for individuals with income greater than 100% FPL beginning with a beneficiary’s third year of enrollment, which would exceed the premiums that beneficiaries at this income level would face in the Marketplace (2% of income).</p>
<b>Effective Coverage Date:</b>	<p>Seeks to waive retroactive coverage for most adults (except for pregnant women and children) and requires individuals to pay their first month’s premium prior to the start of coverage. Individuals below 100% FPL who do not make a premium payment would have coverage start 60 days after they are determined eligible for Medicaid. Those above 100% FPL could not access coverage without a premium payment.</p> <p>The state would develop a process for individuals to make an initial pre-payment to expedite the start of coverage and expand presumptive eligibility sites to include county health departments and certain safety net providers to seek to minimize adverse effects of these waivers.</p>
<b>Disenrollment and Lock-Out for Non-Payment of Premiums:</b>	<p>Premiums are a condition of eligibility for those from 101-138% FPL unless medically frail. This group would be disenrolled from coverage for non-payment after a 60 day grace period and not allowed to re-enroll for six months unless they pay their past debt (2 months of premiums incurred during 60-day grace period); pay the premium for the reinstatement month; and participate in a financial or health literacy course.</p> <p>Individuals below 100% FPL and all those who are medically frail who do not pay premiums would be enrolled in coverage after the 60 day payment period expires and would lose \$25 from their incentive account (described below), and the incentive account would be suspended. In addition, those below 100% FPL who are not medically frail must pay state plan copayments for services received during the first 6 months of coverage. They can avoid these penalties before the expiration of 6 months by paying past-due premiums and completing a health or financial literacy course.</p>
<b>Co-Payments:</b>	<p>Beneficiaries who pay premiums would not have any co-payments.</p>
<b>Deductible Accounts:</b>	<p>Would establish an account to which the state would contribute a \$1,000 annual deductible that covers non-preventive healthcare services. Once the deductible is exhausted, Medicaid MCOs would cover additional services.</p>
<b>Incentive Accounts:</b>	<p>All adults under the waiver (including pregnant women and those receiving ESI premium assistance) would have an incentive account, which may be used to access additional benefits not otherwise covered, such as dental, vision, over the counter medications, and limited reimbursement for the purchase of a gym membership. Moving vision and dental services from the standard benefit package to the incentive account would be delayed for 3 months after waiver implementation to allow beneficiaries to accrue funds in the incentive account.</p> <p>Enrollees would accrue incentive account funds by transferring 50% of any remaining deductible account funds each year and/or completing specified health-related or community engagement activities, such as participating in community service or job training or a health risk-assessment or passing the GED exam. However, community service or job training activities only qualify for account incentive funds to the extent that those hours exceed the minimum work activity requirement hours (described below).</p>

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	<p>Incentive account funds would be deducted for non-emergency use of the emergency room (\$20 for the first visit, \$50 for the second visit, and \$75 for the third and subsequent visits). Beneficiaries also will be eligible for a \$20 incentive account contribution for each year in which they avoid unnecessary emergency room visits. The state may consider a similar program in which incentive account funds could be earned for keeping all appointments in a certain period and would be deducted for missed health care appointments.</p> <p>Former beneficiaries who remain employed and privately insured for 18 months could apply to receive the balance of their incentive account funds in cash, up to \$500.</p>
<b>Work Requirement:</b>	<p>Would require all “able-bodied” working age adults to participate in a work activity, such as volunteer work, employment, job search, job training, education, or caring for a non-dependent relative or person with a disabling chronic condition, beginning at 5 hours per week after three months of program enrollment as a condition of eligibility. The work activity requirement would increase up to 20 hours per week after the first year of enrollment. Failure to meet the required work hours would result in suspended benefits until the person complies for a full month.</p> <p>Would exempt children, pregnant women, individuals determined medically frail, students, and individuals who are the primary caregiver of a dependent from this requirement.</p>
<b>Benefits:</b>	<p>Seeks to waive non-emergency medical transportation for the adult expansion group.</p> <p>Seeks use Medicaid funds to cover out of pocket expenses (test fees) for completion of the GED exam for adults (both expansion and traditional Medicaid populations) without a high school diploma.</p> <p>Seeks to implement pilot program in 10 to 20 counties to obtain federal matching funds for behavioral health services provided in IMDs through a waiver of the federal payment exclusion for non-elderly adults with short-term residential stays up to 30 days.</p> <p>Would use state plan authority to elect the state employee health plan as the benefit benchmark for expansion adults but maintain all current state plan behavioral health services.</p> <p>Children, pregnant women, medically frail individuals, and non-expansion adults (Section 1931 parents) would continue to receive the Medicaid state plan benefit package. The waiver application is unclear about whether the state would continue to cover private duty nursing (see Endnote 1).</p>
<b>Delivery System:</b>	<p>Would continue to use existing capitated Medicaid managed care organizations for all populations statewide (except those in ESI premium assistance). Seeks waiver authority to eliminate 90 day health plan choice period upon initial MCO enrollment.</p>
<b>Employer-Sponsored Insurance Premium Assistance Program:</b>	<p>Would expand Medicaid premium assistance to include all adults who have access to cost-effective employer-sponsored insurance (ESI). Medicaid and CHIP-eligible children also would enroll in their parent’s ESI with premium assistance. Participation would be optional during the first year of Medicaid enrollment, and mandatory after the beneficiary’s second year of Medicaid enrollment and employment.</p> <p>Enrollees would receive an advance payment to cover the employee’s share of the premium before it is deducted from their paycheck. Enrollees would be subject to the</p>

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	same Medicaid premiums as other adults under the waiver, and the ESI premium reimbursement payment would be reduced by the amount of the beneficiary’s Medicaid premium. Individuals would receive Medicaid fee-for-service wrap-around coverage for benefits not covered and all cost-sharing under the employer plan.
<b>Financing:</b>	The state anticipates savings of approximately \$2.2 billion over the five-year waiver.
<b>Next Steps:</b>	The waiver is pending with CMS and open for a 30 day federal comment period.

## Endnotes

<sup>1</sup> The [waiver application](#) lists private duty nursing as not covered for expansion adults, although the state’s response to the public comments indicates that it will not remove private duty nursing from the benefit package, and the application indicates that the private duty nursing cut has been removed from the budget neutrality calculation. Compare page 24, Table 3.2.12(B) with pages 45 and 56 of the Kentucky waiver application submitted to CMS.