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REGULATIONS COMPILER

STATEMENT OF EMERGENCY

907 KAR 1:604E

This emergency administrative regulation is being promulgated to remove copayment requirements for 1915(c) waiver enrollees and members receiving services within long-term care facilities, waive Medicaid copayments under circumstances relating to an emergency declaration, clarify additional circumstances where the department may waive cost-sharing in response to an actuarial analysis if federal approval is received, clarify that pregnant women are fully exempt from Medicaid copayments, remove references to a nonfunctioning federal waiver, and clarify that managed care organizations may reduce or eliminate copayments for their enrollees. This emergency administrative regulation is needed pursuant to KRS 13A.190(1)(a)2. to prevent a loss of federal and state funds, and pursuant to KRS 13A.190(1)(a)4. to protect human health. This emergency administrative regulation shall be replaced by an ordinary administrative regulation. The ordinary administrative regulation is identical to this emergency administrative regulation.

Andy Beshear
Governor

Eric Friedlander, Acting Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Emergency Amendment)

907 KAR 1:604E. Recipient cost-sharing.

RELATES TO: KRS 205.560, 205.6312, 205.6485, 205.8451, 319A.010, 327.010, 334A.020, 42 C.F.R. 430.10, 431.51, 447.15, 447.20, 447.21, 447.50, 447.52, 447.54, 447.55, 447.56, 447.57, 457.224, 457.310, 457.505, 457.510, 457.515, 457.520, 457.530, 457.535, 457.570, 42 U.S.C. 1396a, 1396b, 1396c, 1396d, 1396o, 1396r-6, 1396r-8, 1396u-1, 1397aa -1397jj

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6312(5), 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.50-447.90, 457.535, 457.560, 42 U.S.C. 1396r-6(b)(5)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. KRS 205.6312(5) requires the cabinet to promulgate administrative regulations that implement copayments for Medicaid recipients. This administrative regulation establishes the provisions relating to Medicaid Program copayments.

Section 1. Definitions. (1) "Community spouse" means the individual who is married to an institutionalized spouse and who:

(a) Remains at home in the community; and

(b) Is not:

1. Living in a medical institution;

2. Living in a nursing facility; or

3. Participating in a 1915(c) home and community based services waiver program.

(2) "Copayment" means a dollar amount representing the portion of the cost of a Medicaid benefit that a recipient is required to pay.

(3) "Department" means the Department for Medicaid Services or its designee.

(4) "Dependent child" means a child, including a child gained through adoption, who:

(a) Lives with the community spouse; and

(b) Is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(5) "DMEPOS" means durable medical equipment, prosthetics, orthotics, and supplies.

(6) "Drug" means a covered drug provided in accordance with 907 KAR 23:010 for which the Department for Medicaid Services provides reimbursement.

(7) "Enrollee" means a Medicaid recipient who is enrolled with a managed care organization.

(8) "Federal Poverty Level" or "FPL" means guidelines that are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

(9) "KCHIP" means the Kentucky Children's Health Insurance Program.

(10) "Managed care organization" or "MCO" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined by 42 C.F.R. 438.2.

(11) "Medicaid Works individual" means an individual who:

(a) But for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B)

would be considered to be receiving supplemental security income;

(b) Is at least sixteen (16), but less than sixty-five (65), years of age;

(c) Is engaged in active employment verifiable with:

1. Paycheck stubs;

2. Tax returns;

3. 1099 forms; or

4. Proof of quarterly estimated tax;

(d) Meets the income standards established in 907 KAR 20:020; and

(e) Meets the resource standards established in 907 KAR 20:025.

(12) "Nonemergency" means a condition that does not require an emergency service pursuant to 42 C.F.R. 447.54.

(13) "Office visit for behavioral health care" means a visit to a clinician or prescriber in which a:

(a) Diagnosis of a behavioral health condition is made;

(b) Treatment decision related to the diagnosis of a behavioral health condition is continued; or

(c) Prescription for a behavioral health condition is:

1. Initially issued; or

2. Renewed.

(14) "Recipient" is defined by[~~in~~] KRS 205.8451(9).

(15) "Visit" means:

(a)1. An encounter; or

2. A series of encounters that are performed on the same date of service at the same physical location;

(b) Between a recipient or enrollee and a health care provider during which time a covered service is delivered; and

(c) A service that occurs:

1. In person; or

2. Via telehealth if authorized by 907 KAR 3:170.

Section 2. Copayments. (1) The following table shall establish the:

(a) Copayment amounts that a recipient shall pay, unless the recipient is exempt from cost sharing pursuant to Section 3(1) and (2) of this administrative regulation; and

(b) Corresponding provider reimbursement deductions.

Benefit	Copayment Amount
Acute inpatient hospital admission	$50
Outpatient hospital or ambulatory surgical center visit	$4
Emergency room for a nonemergency visit	$8
DMEPOS	$4
Podiatry office visit	$3
Chiropractic office visit	$3
Dental office visit	$3
Optometry office visit	$3
General ophthalmological office visit	$3

Physician office visit	$3
Office visit for care by a physician assistant, an advanced practice registered nurse, a certified pediatric and family nurse practitioner, or a nurse midwife	$3
Office visit for behavioral health care	$3
Office visit to a rural health clinic	$3
Office visit to a federally qualified health center or a federally qualified health center look-alike	$3
Office visit to a primary care center	$3
Physical therapy office visit	$3
Occupational therapy office visit	$3
Speech-language pathology services office visit	$3
Laboratory, diagnostic, or radiological service	$3
A Medicaid or KCHIP beneficiary who is younger than nineteen (19) years of age	$0
Brand name drug	$4

Generic drug	$1
Brand name drug preferred over generic drug	$1
Pharmacy product class: certain antipsychotic drugs	$1
Pharmacy product class: contraceptives for family planning	$0
Pharmacy product class: tobacco cessation	$0
Pharmacy product class: diabetes supplies, blood glucose meters	$0
Pharmacy product class: Diabetes supplies, all other covered diabetic supplies	$4 for first fill, $0 for second fill and beyond, per day
Pharmacy patient attribute: pregnant	$0
Pharmacy patient attribute: long-term care resident	$0
Pharmacy patient attribute: under eighteen (18) years of age	$0
KI-HIPP participant	$0
[~~Kentucky HEALTH: Medically~~	~~$0~~

~~Frail~~	
~~Kentucky HEALTH: Former Foster Care Youth up to 26 years of age~~	~~$0~~
~~Kentucky HEALTH: enrollee current on premiums~~]	~~$0~~

(2) The full amount of the copayment established in the table in subsection (1) of this section shall be deducted from the provider reimbursement.

(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

Section 3. Copayment General Provisions and Exemptions. (1)(a) A Medicaid or KCHIP beneficiary who is younger than nineteen (19) years of age shall be exempt from the copayment or cost-sharing requirements established pursuant to this administrative regulation.

(b) A beneficiary receiving services via a 1915(c) home and community based waiver shall not be subject to cost-sharing established pursuant to this administrative regulation.

(c) A beneficiary receiving services in a long term care facility shall not be subject to cost-sharing established pursuant to this administrative regulation.

(d) In response to a declared emergency relating to or rationally related to healthcare or public health, the department may waive or direct the waiving of all required cost-sharing for all Medicaid beneficiaries or any subpopulation of Medicaid beneficiaries not already exempted from this administrative regulation, including a geographic or age-related subpopulation.

(e) In response to a contracted actuarial analysis demonstrating cost-effectiveness or cost-neutrality, the department may waive or direct the waiving of all cost-sharing for all Medicaid

beneficiaries or any subpopulation of Medicaid beneficiaries not already exempted from this administrative regulation, including a geographic or age-related subpopulation. As necessary, the department shall seek federal financial participation and approval to implement this paragraph.

(2)(a) A copayment shall not be imposed for a service, prescription, item, supply, equipment, or any type of Medicaid benefit provided to a foster care child or a pregnant woman.

(b) The department shall impose no cost sharing for an individual or recipient who is exempt pursuant to 42 C.F.R. 447.56.

(c) A provider shall not deny services to a recipient who:

1. Makes less than or equal to 100 percent of the federal poverty level even if the recipient cannot pay any required cost-sharing; or

2. Makes more than 100 percent of the federal poverty level if:

a. The recipient cannot pay any required cost sharing; and

b. The provider does not have a policy that applies to all patients that allows for denial of services upon nonpayment of a cost sharing obligation.

(3) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined by[~~in~~] 42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor, or agent of a pharmaceutical manufacturer, shall not make a copayment for a recipient.

(4) A parent or guardian shall be responsible for a copayment imposed on a dependent child under the age of twenty-one (21).

(5)(a) Any amount of uncollected copayment by a provider from a recipient with income above 100 percent of the Federal Poverty Level at the time of service provision shall be considered a debt to the provider if that is the current business practice for all patients.

(b) Any amount of uncollected copayment by a provider from a recipient with income at or

below 100 percent of the Federal Poverty Level at the time of service provision shall not be considered a debt to the provider.

(6) A provider shall:

(a) Collect from a recipient the copayment as imposed by the department for a recipient in accordance with this administrative regulation or have a written process for attempting to collect the copayment;

(b) Not waive a copayment obligation as imposed by the department for a recipient; [~~and~~]

(c) Document each attempt to collect the copayment or collect a copayment at the time a benefit is provided or at a later date not to exceed six (6) months from the date of provision of the service; and

(d) Not collect a copayment from an enrollee for a service or item if a copayment is not imposed for that service or item.

(7) Cumulative cost sharing for copayments for a family with children who receive benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be limited to five (5) percent of the annual family income.

(8) In accordance with 42 C.F.R. 447.15 and 447.20, the department shall not increase its reimbursement to a provider to offset an uncollected copayment from a recipient.

Section 4. Premiums for Medicaid Works Individuals. (1)(a) A Medicaid Works individual shall pay a monthly premium that is:

1. Based on income used to determine eligibility for the program; and

2. Established in paragraph (b) of this subsection.

(b) The monthly premium shall be:

1. Thirty-five (35) dollars for an individual whose income is greater than 100 percent but no

more than 150 percent of the FPL;

2. Forty-five (45) dollars for an individual whose income is greater than 150 percent but no more than 200 percent of the FPL; and

3. Fifty-five (55) dollars for an individual whose income is greater than 200 percent but no more than 250 percent of the FPL.

(2) An individual whose family income is equal to or below 100 percent of the FPL shall not be required to pay a monthly premium.

(3) A Medicaid Works individual shall begin paying a premium with the first full month of benefits after the month of application.

(4) Benefits shall be effective with the date of application if the premium specified in subsection (1) of this section has been paid.

(5) Retroactive eligibility pursuant to 907 KAR 20:010, Section 1(3), shall not apply to a Medicaid Works individual.

(6) If a recipient fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.

(7) A Medicaid Works individual shall be eligible for reenrollment upon payment of the missed premium providing all other technical eligibility, income, and resource standards continue to be met.

(8) If twelve (12) months have elapsed since a missed premium, a Medicaid Works individual shall not be required to pay the missed premium before reenrolling.

Section 5. Provisions for Enrollees. A managed care organization:

(1) Shall not impose a copayment on an enrollee that exceeds a copayment established in this administrative regulation; and

(2) May impose on an enrollee:

(a) A lower copayment than established in this administrative regulation; or

(b) No copayment.

Section 6. Freedom of Choice. (1) In accordance with 42 C.F.R. 431.51, a recipient who is not an enrollee may obtain services from any qualified provider who is willing to provide services to that particular recipient.

(2) A managed care organization may restrict an enrollee's choice of providers to the providers in the provider network of the managed care organization in which the enrollee is enrolled except as established in:

(a) 42 C.F.R. 438.52; or

(b) 42 C.F.R. 438.114(c).

Section 7. Appeal Rights. An appeal of a department decision regarding the Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

Section 8. [~~Applicability of KAR Title 895. If eligible for Kentucky HEALTH, an individual subject to this administrative regulation shall also comply with any applicable requirements established pursuant to KAR Title 895.~~

~~Section 9.~~] Federal Approval and Federal Financial Participation. The department's copayment provisions and any coverage of services established in this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation; and

(2) Centers for Medicare and Medicaid Services' approval.

Section 9[~~10~~]. This administrative regulation was found deficient by the Administrative Regulation Review Subcommittee on May 13, 2014.

907 KAR 1:604E

REVIEWED:

3/12/2020
Date

Lisa Lee, Commissioner
Department for Medicaid Services

APPROVED:

3/12/2020
Date

Eric Friedlander, Acting Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:604E
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the cost sharing requirements and provisions for the Kentucky Medicaid program.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the cost sharing requirements and provisions for the Kentucky Medicaid program.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the cost sharing requirements and provisions for the Kentucky Medicaid program.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the cost sharing requirements and provisions for the Kentucky Medicaid program.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment to this administrative regulation exempts 1915(c) Medicaid members and Medicaid members who receive services within a long-term care facility from Medicaid co-pays, waives co-payments under circumstances relating to an emergency declaration, and clarifies additional circumstances where the department may waive copayments in response to an actuarial analysis if any needed federal approval is received. The amendment also more clearly exempts pregnant women from co-pays to reflect current department practice and interpretation of federal regulation. The amendment also will allow for a managed care organization to reduce or eliminate an enrollee's requirement to pay a copay, and prohibit a provider from collecting a copayment for a service or item if a copayment is not imposed. The amendment also removes references to the Kentucky HEALTH program in the table of copayments.
(b) The necessity of the amendment to this administrative regulation: The amendments to this administrative regulation are necessary to clarify Medicaid policy relating to copayments and to clarify Medicaid policy relating to Medicaid cost-sharing and declared emergencies.
(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by clarifying departmental copayment policy relating to copayments administered by managed care organizations.
(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the statutes by instituting a clear policy on the use of copayments.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All Medicaid recipients who may be subject to cost sharing may be affected by the amendment as well as Medicaid providers for whose services cost sharing is applied. The department estimates that up to 800,000 Medicaid members may be impacted by this administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Enrollees, recipients, and providers will be able to benefit from reduced or eliminated cost sharing if approved by an MCO.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Enrollees and recipients will have to pay copayments as listed in this administrative regulation, unless waived or reduced by an MCO.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Enrollees and recipients will be able to fully access Medicaid benefits, and providers will be able to charge for services provided.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) anticipates costs of no more than $170,000 as a result of the amendments to this administrative regulation.

(b) On a continuing basis: The Department for Medicaid Services (DMS) anticipates costs of no more than $170,000 as a result of the amendments to this administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds from general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding will be necessary to implement the amendment.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendments to this administrative regulation neither establish nor increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is applied in that some Medicaid recipients are exempt (by federal regulation or law) from most cost sharing obligations.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:604E
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(14), 42 U.S.C. 1396o, 42 C.F.R. 447.50 through 447.90, 42 C.F.R. 447.15 and 447.20, and 42 C.F.R. 438.108

2. State compliance standards. KRS 205.520(3) and KRS 194A.050(1).

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(14) authorizes a state's Medicaid program to impose cost sharing only as allowed by 42 U.S.C. 1396o. 42 U.S.C. 1396o establishes categories of individuals for whom a state's Medicaid program may not impose cost sharing as well as cost sharing and premium limits.

   42 C.F.R. 447.50 through 447.60 also establishes limits on cost sharing (based on income of the given Medicaid eligibility group); Medicaid populations exempt from cost sharing (children, pregnant women, institutionalized individuals for example); services exempt from cost sharing (emergency services, family planning services to child-bearing age individuals); prohibition against multiple cost sharing for one (1) service; a requirement that state Medicaid programs do not increase a provider's reimbursement by the amount of cost sharing; and a requirement that managed care organizations' cost sharing must comply with the aforementioned federal regulations.

   42 C.F.R. 438.108 establishes that a managed care organization's cost sharing must comply with the federal cost sharing requirements for Medicaid established in 42 C.F.R. 447.50 through 42 C.F.R. 447.90.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 1:604E
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be affected by the amendment to this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. Federal regulations 42 C.F.R. 447.50 through 42 C.F.R. 447.90, 42 C.F.R. 447.15 and 447.20 authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.
   (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) anticipates costs of no more than $170,000 as a result of the amendments to this administrative regulation.
   (d) How much will it cost to administer this program for subsequent years? The Department for Medicaid Services (DMS) anticipates costs of no more than $170,000 as a result of the amendments to this administrative regulation.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-): ____
Expenditures (+/-): ____
Other Explanation: ____