



ANSWERED QUESTIONS

Eligibility and Enrollment

Q: Will children or any other KY HEALTH populations be automatically renewed or will everyone need to go through the full application process annually?

A: The redetermination process will not change with Kentucky HEALTH. Just like now, Kentucky HEALTH will use electronic data resources to check if a person is still eligible for the program. If there is enough information to confirm that the person is eligible, that person's eligibility will be automatically renewed. If there is not enough information to confirm, or if the information shows that the person may not be eligible for Kentucky HEALTH, a pre-populated renewal form will go to the beneficiary, asking for additional information. Beneficiaries who get a request for additional information will need to provide the information within the redetermination period. (Catherine Easley)

Q: Is the requirement to report changes in eligibility now a 30 day period instead of 10 days? Would someone mainly have to report a change in income that puts them above 138% FPL or also changes that would put them in a different premium bracket between 0-138% FPL?

A: Reporting requirements for Kentucky HEALTH will remain the same as they are today. Kentucky HEALTH beneficiaries will need to report changes within 30 days, and they will need to report any change that could impact eligibility, including changes in household size and income. These changes could impact the amount the beneficiaries have to pay each month and the penalties they face if they do not pay their premiums. Beneficiaries will only face lock-out if they fail to report a change that made them ineligible for Medicaid. Catherine Easley

Q: Will the 3-month enrollment window be the same for everyone or rolling based on an individual's original enrollment date? Wondering how that might affect families with varying enrollment dates.

A: The policies haven't changed regarding redetermination, so will be same as it is now. Further, as is the process today, once the individual's redetermination date has passed, if necessary information was not received, the individual will be terminated, but will have an additional 90-day period from that date of termination to provide the required redetermination paperwork in order to regain eligibility. The timing of this will be no different than it is today. Catherine Easley

Q: I remember hearing that some traditional Medicaid members were moved into the expansion population during the last administration. I would assume that may affect whether certain parents can get NEMT and also dental/vision benefits. Is there a breakdown of parents covered under expansion vs. traditional?



RUNNING LIST OF WAIVER QUESTIONS

6/27/18

A: Eligibility is determined in accordance with federal guidelines. Individuals who qualify as expansion adults under these guidelines (which have not changed) will not have access to NEMT and will have access to vision and dental through their My Rewards Account. (Catherine Easley)

Q: With the various lock-out periods, will those always be limited to individuals above 100% FPL? I know that's the case with premium payments, but wondering if someone making 100% FPL or less could be locked out of coverage for not completing CE, not re-enrolling within the 90-day window, or not reporting a change in eligibility.

A: No. The premium penalty period is the only penalty period where someone may still receive medical benefits if they are under 100% FPL. The other penalty periods are applied regardless of FPL. (Catherine Easley)

Q: Will MAGI still be used to determine income eligibility? How will the 30-day reporting requirement work with seasonal or annualized income?

A: Seasonal income will be treated the same way as under MAGI. However, community engagement hours will differ, so that if an individual has seasonal employment, during the time when that employment is on hold, an individual who has an 80-hour per month requirement will need to find another qualifying community engagement activity in which to participate. (Kristi Putnam)

Q: If coverage begins on the first day of the month the premium is paid, would this provide up to 30 days of retro coverage?

A: Coverage will be issued back to the first day of the current month in which a premium payment is made. So technically yes, coverage could go back 30 days if premium payment is made on the 31st of a month. However, coverage will not be issued retroactively for a prior month EXCEPT for members who are receiving as a child, former foster care youth up to age 26, or a pregnant woman. (DCBS)

Q: Will Presumptive Eligibility requirements or the PE enrollment process change? If so, how?

A: Individuals serving a Kentucky HEALTH suspension will not be eligible for Presumptive Eligibility. (DCBS)

Q: Will this lead to fewer individuals able to enroll through PE?

A: We don't know of any restrictions on PE other than for those serving a penalty. (DCBS)

Q: How long will the "fast track" enrollment process take? Will financial documentation be required? Will healthcare services be covered the same day as enrollment?



RUNNING LIST OF WAIVER QUESTIONS

6/27/18

A: The Fast Track option, and the requested MCO is selected during the intake process. Applicants then have the ability to go online and submit their Fast Track payment. Enrollment will begin as early as the first day of the application month, if the Fast Track payment is submitted during the application month. The Fast Track payment is communicated via the MCO. (DCBS)

Q: Will Emergency Medicaid still be available for those with critical needs who may not be able to complete the enrollment process?

A: Yes (DCBS)

Q: Will member notification of reporting requirements only be provided in written form?

A: Members are notified upon application and recertification the requirements for reporting changes timely. Members are provided this information on the Rules and Responsibilities page provided with their signed application at intake and recertification, and this is also explained to the client if applying with a DCBS caseworker. (DCBS)

Q: How will individuals with limited literacy or English proficiency be notified?

A: Language services are offered through DCBS for individuals who need assistance translating notices or communicating with a DCBS worker. (DCBS)

Q: How will a change in income or employment status be reported?

A: Member may report changes by contacting a DCBS office, calling the DCBS Call Center, entering the change on the self-service portal, or by mailing the verification of a change to the DCBS mailroom. As many members will be interacting with the Kentucky Career Centers they may be aware of a change prior to DCBS. Career Coaches can now report a change in circumstances for a member via KEE Suite. (DCBS)

Q: How will the reporting requirements be tracked and enforced?

A: The date a change is reported is captured by the eligibility system. If the date is greater than 30 days in the past it will determine if the member received benefits they were not eligible for. (DCBS)

Q: How will "intentionally fraudulent member actions" be defined and determined?

A: In regards to the Report A Change penalty, individuals who fail to report a change timely (within 30 days of the change occurring) that results in receiving benefits they were ineligible for, it will be considered potential fraud and initiate the lockout period. This is determined when a DCBS Claims worker refers the individual to OIG for investigation. (DCBS)

Q: What will be the appeal process for those who believe they have been wrongly disenrolled?



RUNNING LIST OF WAIVER QUESTIONS

6/27/18

A: Individuals can appeal eligibility decisions related to Kentucky HEALTH policy through writing or on the benefit Self-Service Portal. Managed Care Organizations will have their own appeals process for issues related to the deductible account and plan coverage. My Rewards will handle appeals for claims processing. The process for appeals and the ability to continue receiving benefits throughout the appeal process will vary depending on the appeal reason. (DCBS)

Q: Since there is no retroactive coverage, will individuals filing an appeal keep their coverage until their appeal is heard and a decision issued?

A: This will vary depending on what the member is appealing:

- Members may appeal a suspension for non-payment however, the member will remain suspended throughout the appeal. If the appeal is overturned the member could be eligible for retroactive benefits.
- Members who appeal suspension for Community Engagement can continue to receive benefits if the appeal is requested prior to the suspension taking effect. If the member does not request an appeal until they are suspended due to Community Engagement non-compliance they will not be able to continue to receive benefits. If the appeal is overturned the member may be given retroactive coverage.
- Members may appeal an increase in premium however, the member will continue to be invoiced the new premium amount throughout the appeal process.
- Members may appeal a change in their benefit package from Medicaid State Plan to the Alternative Benefit Plan (ABP). If the appeal is requested within 10 days from the date of the change the member can remain on the Medicaid State Plan until the appeal process is complete and a hearing determination is made.
- Individuals losing Medically Frail status are eligible to continue to receive as Medically Frail if the appeal is requested within 10 days of the discontinuance. (DCBS)

Q: Are individuals going to be disenrolled if they make more than \$640 in a 2-week period (temporarily above 138% FPL)?

A: If the change is not representative of ongoing income it is not required to be reported. Normal fluctuations income is not considered as a change in circumstance, this includes a change in worker hours which will not exceed 30 days, and a 5th or periodic paycheck. (DCBS)

Q: Are members subject to lock-outs when there are other household changes that affect KY HEALTH "Type of Assistance" eligibility, rather than just income change over the Medicaid limit 138%? Specifically moving from under 55% to over 75%? Or from under 100% to 125% (as examples)?

A: The Report A Change lock out will only be applied when a Cost Share required member fails to report a change within 30 days and the failure to report a change results in the member receiving



RUNNING LIST OF WAIVER QUESTIONS

6/27/18

additional months of Medicaid eligibility in which they were not eligible for. Changes that keep a member Medicaid eligible, but change the member's Type of Assistance will not result in a Report A Change lock-out being applied. (DCBS)

Q: If a member is granted a six-month Medically Frail Exemption due to homelessness, but acquires their own residence before those six months are over, then is that member required to report the residence change? Is there a lock-out penalty if they do not?

A: Members are required to report changes in address within 30 days. Failure to report the change of address most likely will not cause a loss of benefits, therefore a lock-out penalty will not be applied. (DCBS)

Q: What is the income limit for an adult to be considered in the Parent and Caretaker Relative (PACA) type of assistance? What will benefit package look like for those individuals vs. "expansion" adults? Are there any suspensions/penalties that apply to PACA adults related to PATH and/or premiums?

A: Being in the PACA type of assistance is determined by the MA Scale found in [Volume IVB](#), Section 2910(E) of the DCBS Operation Manuals. Individuals in the PACA category were eligible for Medicaid prior to expansion, and will have access to the state benefit plan (dental, vision and NEMT services still covered). However, these members will be subject to premium and PATH requirements and their associated penalties. (Confirmed with Lee Guice)

Q: What are the differences between suspension, penalty, and lockout?

A: Penalties, Suspensions, and Lockouts are outlined as follows:

- Community Engagement Penalties--the individual is placed in suspension (remains eligible, but no access to benefits through the MCO) until they take a re-entry course or complete 80 hours. The suspension is not limited to six months. If no action is taken to cure the suspension, then the member's eligibility ends on their recertification date.
- The Premium Non-Payment Penalty is a six month penalty. The individual can end it by taking the re-entry course, paying back premiums, and paying one month forward.
 - The 6-month penalty is a Suspension (remains eligible, but no access to benefits through the MCO) of all benefits for individuals with income over 100% FPL.
 - The 6-month penalty is a Copay Pay Plan enrollment for those at or below 100% FPL. If no action is taken on the non-payment penalty above, the penalty will continue until the member makes one payment forward.
 - For those over 100% FPL in a suspension, eligibility will end on their recertification date.
 - For those at or below 100% FPL, they will stay in copay plan (with no My Rewards Account) until the member makes one payment forward (even after recert).

(KHV note: the two sets of bullets for Premium Non-Payment Penalty appear to be contradictory, and seem to indicate the suspension can be either shorter or longer than six months, depending on the household's payments and length of time until redetermination month. KVH is following up with the Cabinet for a response.)

- Recertification period (no action taken 90 days after cert period end):
 - The loss of eligibility on the recertification date with the 90 day period to submit the information is not a change from current practice.
 - The only new policy is the addition of the 6 month lock out period after the expiration of the 90 day period.
- Report a Change Penalty:
 - This penalty only applies to those who are no longer eligible for Medicaid due to the change (i.e. change in income above 138% FPL). Therefore, the loss of eligibility would occur today and is in accordance with Medicaid policy.
 - The only new policy is the addition of the 6 month lockout period for individuals who failed to report these types of big eligibility changes timely.

(KVH note: a reduction in household size may also cause a household's income to exceed the 138% FPL limit)

- Voluntary Withdrawal Penalty:
 - 6-month lockout applies, but there is the ability to get a good cause exemption. The penalty is intended to prevent people from withdrawing prior to the imposition of a non-payment penalty. Applies to members with a cost-sharing requirement (premiums or copays).

(Source: Kristi Putnam)

Q: Will a Medicaid member have the ability to appeal a suspension status?

A: From a previous answer regarding appeal rights: Members may appeal a suspension for non-payment; however, the member will remain suspended throughout the appeal. If the appeal is overturned the member could be eligible for retroactive benefits. Members who appeal suspension for Community Engagement can continue to receive benefits if the appeal is requested prior to the suspension taking effect. If the member does not request an appeal until they are suspended due to Community Engagement non-compliance they will not be able to continue to receive benefits. If the appeal is overturned the member may be given retroactive coverage. (DCBS)

Q: On the eligibility notices mailed in May/June, will they include instructions to login to Citizen Connect/KOG?

A: Not on the notices. (Answered at May Stakeholder Advisory Forum)

Medically Frail

Q: How will Medically Frail individuals opt in to paying premiums? Will they be billed with the option to pay or not (ignore the bill), or have to request to opt in first?

A: All individuals in Kentucky Health will be billed, but those with optional premium payments (Medically Frail, pregnant, former foster youth) can choose not to pay them. DMS is providing MCOs with detailed instructions regarding invoicing requirements. (Medicaid Provider Forum, 4/26/18) *UPDATE: Although there was some confusion at the May Stakeholder Forum regarding whether these members would be billed at all, the original answer has been confirmed. Members designated Medically Frail and former foster youth will receive an invoice, but it should include language stating that payment is optional.*

Q: Who will determine and approve a determination of medical frailty?

A: There are three ways a person can be determined medically frail:

1. Managed care organizations (MCOs) can make a medically frail determination based on historical claims data.
2. A person may self-report that he or she is medically frail. Medically frail status is then verified by the MCO.
 - People may also self-report if they need help with activities of daily living or if they experience chronic homelessness. Kentucky HEALTH leadership is working with a database of homelessness information so we can proactively identify people who are chronically homeless and make sure they are determined medically frail.
3. A medical provider may fill out a form verifying that a patient is medically frail. The form is submitted to the MCO.

The first round of medically frail determinations based on existing data in the MCOs' systems is complete. A person's status (medically frail or not medically frail) is available to DCBS field staff on Worker Portal (IEES) and to MCOs. Individuals may call their MCO to find out if he/she will be considered medically frail for Kentucky HEALTH. (source: Answers to March/April Stakeholder Forum questions)

Q: What criteria will be used to determine who is "medically frail"?

A: See above.

Q: Persons experiencing chronic homelessness, interpersonal violence survivors, and refugees (for 12 months from date of entry) can self-attest for the MF designation, but what will the self-attestation process look like prior to 7/1? To whom would the individual self-attest? Must all

individuals self-attest through a Medicaid provider as indicated in recent Provider Forums, or will there be other, faster routes to a MF determination?

- A: KVH has learned that questions related to MF self-attestation have been built into the benefind system. There are two parts to the benefind system: worker portal (used by DCBS staff) and self-service portal (members can log in to report changes and manage eligibility activity). It is our understanding that at this point, questions relating to interpersonal violence were not added to the self-service portal, meaning individuals needing this designation will need to call DCBS or an assister. Also, the “gatepost question” that leads to the self-attested questions is confusing: “Are you in good health?”. This may lead some individuals to miss the self-attestation questions altogether. Suggestions to reword this question and to ensure interpersonal violence questions appear on the self-service portal have been provided to the Cabinet. (Information provided at 5/24/18 KHBE update meeting) **UPDATE: Refugees and survivors of domestic and interpersonal violence will not be officially considered Medically Frail due to a ruling by CMS, but will be treated in the same manner; there will be no PATH or premium requirements, and they will receive State Plan benefits. See associated KVH blog post [here](#).**

Q: Will an individual deemed Medically Frail due to homelessness automatically lose his/her MF status as soon as he/she gains housing, or will there be a transition period?

- A: An individual’s Medically Frail protection will continue for 12 months regardless of this change in circumstances. (June 7 Stakeholder Forum)

Premiums & Cost Sharing

Q: Since CMS has given KY the option of increasing premiums up to 4%, does that change the Cabinet's original plan to increase premiums for people over 100% FPL after 2 years or will you be sticking with the graduated premiums that were in the proposed plan? (from \$15/month up to \$37.50)

- A: The flexibility granted by CMS does not change the Cabinet's original plan. Rather it gives the Commonwealth the authority to change premiums (not to exceed 4% of household income) based on evaluation data and/or other factors, including but not limited to length of enrollment. Again, no changes are contemplated at this time. (Catherine Easley)

Q: Will ABAWDs still be charged escalating premiums after two years of coverage?

- A: The CMS waiver approval does state that the “state will annually evaluate the premium rates and amounts, and reserves the right to increase a premium amount within the limitations set forth in these STCs in response to evaluation results on an annual basis.” Further, the STCs also provide: “The state may vary premium amounts for beneficiaries, including (but not limited to) based on household income or the length of time a beneficiary is enrolled in Kentucky HEALTH, subject to the

4 percent of household income limit on premiums.” This gives the state the authority to modify amounts over time, even based on length of enrollment, as long as the amounts do not go over the federal out-of-pocket cost limits. The state will notify beneficiaries of a premium adjustment at least 60 days prior to implementing the premium adjustment. The premium policies apply to all individuals who have premiums to pay. (Catherine Easley)

Q: Will folks be able to pay the premiums with an automatic withdrawal to prevent missing a payment? If not, will you be able to make payments online? (question from a Medicaid member)

A: From the Cabinet’s “Answers to March/April Stakeholder Forums” received 5/8/18:

Beneficiaries make premium payments to their MCO. We have requested that MCOs create many different ways for people to pay their premiums.

- How does an individual make a payment to their MCO (i.e. online, via mail, etc.)?

MCO	Mail	Online	IVR - Interactive Voice Response (Telephone)	In-Person	Mobile App	Automatic Draft Withdrawal (Bank Withdrawal)	ACH	Automatic Payroll Deduction
Aetna	x	x	x	x		x		x
Anthem	x	x	x	x	x	x	x	x
Humana	x	x	x	x	x			
Passport	x	x	x	x				x
Wellcare	x	x	x	x	x	x	x	

- What are the acceptable forms of payment (i.e. cash, credit, check)?

MCO	Cash	Check	Money Order	Credit Card	Debit Card	EFT
Aetna	x	x	x	x	x	x
Anthem	x	x	x	x	x	x
Humana	x	x	x	x	x	x
Passport	x	x	x	x	x	x
Wellcare	x	x		x	x	x

Q: Will end of pregnancy, release from jail/prison, aging out of KCHIP, loss of Medically Frail protection, etc. open a special enrollment period to enroll in the same MCO as the household, (if household is mixed MCO) to prevent having to pay multiple premiums? Right now the SEP ends May 31, but will the above mentioned groups have their own SEP to change their MCO outside of Medicaid Open Enrollment to prevent multiple premium payments?

A: Staff from DMS as well as Deloitte trainers agreed it would be a “good cause” reason to switch the MCO outside Open Enrollment with current processes; i.e. member would have to request via DMS for approval of MCO change. (Lee Guice; Amber Click) *(Note: KVH and others will review policy manuals when issued to confirm these good cause reasons.)*

Q: How will the state or MCOs manage the pre-payment for those not yet determined eligible? How would this work if they were ultimately determined ineligible?

A: It is KVH's understanding that there will be a "fast-track" option for payment of premiums. Households may choose to pay premiums prior to eligibility determination so their benefits start the first of the month in which eligibility is established. If the household is ultimately found ineligible, premiums are to be returned to the household within 30 days. *(Update: the fast-track payment will be \$10, regardless of anticipated premium; households will be billed the difference, if necessary, upon approval. Also, the \$10 must be paid with some kind of credit or debit card, which can include pre-paid cards)*

My Rewards

Q: Will Medically Frail and Former Foster Youth have My Rewards accounts?

A: Yes, but only if they opt to pay premiums. BH Committee

Q: Is there a list of the types of activities available and the points (dollars) earned for each?

A: A list of approved activities and associated reward amounts has been posted to the Kentucky HEALTH website [here](#).

Q: What dental/vision services will be covered under MCOs rather than through My Rewards? At the Frankfort Provider Forum, it was stated there would be a list of procedures meeting criteria for regular payment through the MCO, even for members who receive general services for dental and vision through their My Rewards accounts (example: treatment for glaucoma or cataracts as opposed to a general vision exam).

A: Lists of dental ([here](#)) and vision ([here](#)) services provided through My Rewards has been posted to the Kentucky HEALTH website. Other Medicaid-covered services related to oral health and vision should be covered through a member's MCO.

ESI

Q: Did I understand correctly from the FAQs that the provider network would be wrapped by Medicaid so that if the employer plan has a narrower network, the employee can still see any participating Medicaid provider?

A: The beneficiary's ESI plan has its own provider network. As long as the service is covered by the ESI plan, the beneficiary must use a provider that is in-network for that plan. If there is a service that is not covered by the ESI plan, but it would normally be covered by Medicaid, the beneficiary can go to any Medicaid provider to get the service. (Catherine Easley)

Community Engagement**Q: Is a dependent under 19 or under 6 years old?**

A: One adult per household in Kentucky HEALTH may qualify as a primary caregiver if that adult has a dependent child under age 19 or provides care for a dependent adult who is disabled. However, some Kentucky HEALTH beneficiaries may also have SNAP or TANF benefits. In this case, the SNAP or TANF exemptions would take precedence. These programs provide exemptions for individuals living in the household with a minor dependent under 19 or who have primary caregiving responsibility for a dependent child under age 6. Therefore, if Kentucky HEALTH beneficiaries are exempt from work requirements through SNAP, they will also be exempt from community engagement/work requirements for Kentucky HEALTH. (Catherine Easley)

Q: Will the "good cause" exceptions for domestic violence, etc., be treated like a general exemption or more narrow and time-limited? For instance, if a woman leaves an abusive spouse and can't work or pay premiums for a few months while she's staying at a shelter and trying to get her life in order, would she need to apply for a good cause exception monthly or would she only be able to get a good cause exception granted a limited number of times?

A: Good cause is a way to avoid non-compliance penalties if there was a good cause reason for failure to comply with program requirements. The good cause exception can apply to the current month or past months, but currently the system does not apply it to future months. We have asked for the system to be adjusted for Kentucky HEALTH in order to apply good cause prospectively. There is no limit on the number of times someone may qualify for a good cause exception. (Catherine Easley) *UPDATE: Since this question was answered, the Cabinet conceded that survivors of domestic and interpersonal violence should be deemed Medically Frail to shield them from Kentucky HEALTH requirements. Although CMS has ruled these individuals cannot be officially considered Medically Frail, the Cabinet will treat them in the same manner; there will be no PATH or premium requirements, and they will receive State Plan benefits. See associated KVH blog post [here](#).*

Q: For those with fluctuating hours due to seasonal employment (farm, construction, landscaping, etc.), will they be required to report periods when they are not working and be required to meet CE hours?

A: Seasonal income will be treated the same way as under MAGI. However, community engagement hours will differ, so that if an individual has seasonal employment, during the time when that employment is on hold, an individual who has an 80-hour per month requirement will need to find another qualifying community engagement activity in which to participate. (Kristi Putnam)

Q: How is the Head of Household being determined at rollout of PATH requirements?

A: This question should have read “how is ‘primary caregiver’ being determined at rollout of PATH requirements?” On or before July 1, the benefind system will default to the head of household (individual who made the application for the household). If a family wants to change that designation, they will need to request a change through DCBS. (answered at June 7 Stakeholder Advisory Forums) *UPDATE: We have heard conflicting information about whether there is an automatic designation or action must be taken by the member. We will update this as we learn more.*

Special Populations

Q: In the case of Kentucky's refugee-eligible populations, how would community engagement and employment requirements fit in with long-standing, federally prescribed requirements?

A: Refugees will be considered Medically Frail for 12 months following their date of entry. (Kristi Putnam) *UPDATE: Refugees will not be officially considered Medically Frail due to a ruling by CMS, but will be treated in the same manner; there will be no PATH or premium requirements, and they will receive State Plan benefits. See associated KVH blog post [here](#).*

OPEN QUESTIONSEligibility and Enrollment

Q: When a change in circumstances is reported to a Career Coach, does that trigger an action for DCBS, or can it be verified by the Career Coach? If DCBS must take the action, how is the change communicated from the Career Coach to DCBS?

(note: Assume changes are sent to DCBS for further action, awaiting confirmation)

Q: Due to the time-limited nature of penalties, suspensions, etc. and the need to quickly address appeals, what actions will the Cabinet be taking to ensure appeals decisions are rendered in a timely fashion?

Medically Frail

Q: How long will it take to obtain a Medically Frail designation when sought through an attestation with a provider? Will MCOs be required to meet a certain time frame??

Q: What is the appeals process? What will coverage be like while awaiting a hearing and final order?

(NOTE: From a previous answer from DCBS on appeals: Individuals losing Medically Frail status are eligible to continue to receive as Medically Frail if the appeal is requested within 10 days of the discontinuance. Also: Members may appeal a change in their benefit package from Medicaid State Plan to the Alternative Benefit Plan (ABP). If the appeal is requested within 10 days from the date of the change the member can remain on the Medicaid State Plan until the appeal process is complete and a hearing determination is made. It is unclear if this applies to new "denials" of a Medically Frail designation or only those losing a previous designation. KVH will follow up with the Cabinet for response.)

Q: Will there be retroactive eligibility for someone who is covered under Kentucky HEALTH, but is deemed medically frail and moves back to the "state plan"?

Q: How will an emergency be defined, and who will make that determination? How will the State ensure that it is objective and accurate?

Q: What is the status of matching persons in the Homeless Management Information System (HMIS) with Medicaid members in order to automate the identification of persons experiencing chronic homelessness?

Q: Scenario: an individual, who is suspended due to failure to complete PATH requirements or make premium payments, presents to a provider and needs immediate services. The individual has a condition that likely will make them Medically Frail (the specific scenario was an individual

needing immediate entry into a residential SUD treatment facility). What will the process be to ensure coverage for the immediate provision of services? The provider can submit a MF attestation form immediately, but how will they be assured coverage/payment if the MF attestation process isn't complete until the following month?

Special Populations

- Q: How many people currently on waiver waiting lists would be affected by these changes? Will they be considered medically frail? Will most/all of them be automatically determined as MF?
- Q: How many adults would be affected by therapy limits?
- Q: Will there be any changes to the "dire needs" process?

Premiums & Cost Sharing

- Q: If retro-eligibility is eliminated, can a Medicaid member who has been locked-out of coverage legally be charged premiums for months of service in which they did not receive Medicaid-reimbursable care? Related: If an individual was paying copayments during a penalty period due to failure to pay premiums, can a member be charged for past months of premiums while they were under the copay plan?
- Q: How will the State ensure that co-pays don't exceed 2% and 5% caps of total income?
- Q: Is there a family plan option or is cost-sharing always based on individuals?
- Q: How will the State ensure that the cost of Medicaid coverage will never be more than a subsidized QHP for someone with an income of 139% FPL?

My Rewards

- Q: How were activities and reward amounts determined?
- Q: Who will determine if someone has missed too many appointments without enough notice or good cause? And what criteria will be used to make this determination?
- Q: What happens if someone gets penalized for "inappropriate use" of the ER or a missed appointment and does not have sufficient funds in their rewards account to pay? Would there be a debt to the State or MCO? (NOTE: My understanding is that this does not create a debt, but does pose an additional barrier to access services only received through My Rewards. There is supposed to be a "floor" established.)

Q: How will the deductible account and My Rewards account be designed? Who will pay for them and manage them? How will they be integrated with each other and with benefind?

Q: Members can earn dollars for preventive dental care, but can all members receive this benefit, or will some need to use My Rewards to get the preventive service?

ESI

Q: In terms of employer-sponsored health plans, how will the State address issues of narrow networks, limited formularies, and different appeals or prior authorization requirements? Will Medicaid cover any/all of these limitations?

Q: How will HSA and blended ESI coverage impact providers and provider networks?

(Note: may be similar to answered question; will get confirmation)

Q: How many companies offer qualifying ESI coverage for the income-eligible population (i.e., their combined costs and the costs of added wrap-around services are less than the cost of the state providing an MCO plan to the beneficiary)?

Community Engagement

Q: How will communities be assessed to determine whether they will have the necessary infrastructure and resources for community engagement, work requirements and education classes? And what will be done to assist communities that don't?

Q: (Related to question above) STC 48 (j), Community Engagement State Assurances, requires an assessment of "areas" with high unemployment, limited economies/educational opportunities, and lack of public transportation in order to inform further exemptions or mitigation strategies to ensure participation will not be "unreasonably burdensome". This assessment is required to occur prior to implementation of the community engagement requirement. (1) How has Kentucky defined "areas" for purposes of this assessment? (2) Is information available regarding the state's assessment of these areas?

Q: Most counties in Kentucky have received a waiver of SNAP (Food Stamps) work requirements because there are not enough jobs available. Will Medicaid members living in these counties have their community engagement requirement waived for the same reason? *(Note: SNAP work requirement waivers have now been lifted in all counties other than the 8 Promise Zone counties in the Southeast)*

Q: Will there be an exemption for those who do not have reliable transportation, are living in an area without available work or volunteer opportunities, have been convicted of a felony, or are facing other hardships?



RUNNING LIST OF WAIVER QUESTIONS

6/27/18

- Q: Will people be provided with the equivalent of "paid time off" for holidays, vacation, sick time, and/or family leave? Or will they be required to work 52 weeks a year?**
- Q: What would be the impact of the community service requirement on nonprofit organizations in the state in terms of their capacity to handle the influx of new workers as well as the jobs and wages of low-income employees of those organizations who will now have to compete with unpaid labor?**
- Q: Liability insurance coverage for organizations?** *(note: the state carries such insurance for SNAP and TANF work program participants)*
- Q: Assistance to organizations with required background checks?**
- Q: How will compliance with the Fair Labor Standards Act be determined?**
- Q: Will there be flexibility on switching which parent is granted the dependent caregiver exemption as family dynamics change?**
- Q: Will persons receiving SNAP always be deemed meeting the CE requirement in Kentucky HEALTH?** *(note: STC 45 states those "meeting" SNAP/TANF or those exempt in those programs will be deemed to satisfy the KY HEALTH requirements, but if someone is not meeting those requirements and not exempt, however short a period, how does that interact with KY HEALTH CE requirements?)*
- Q: Will persons aged 50+ and receiving SNAP (exempt from SNAP Employment and Training requirements) be required to participate in Kentucky HEALTH CE?** *(note: see above-- appears the answer here should be "no")*
- Q: Will there be any circumstance in which meeting the SNAP work requirement or being exempt from it does not meet Kentucky HEALTH CE?** *(note: see above)*
- Q: Will there be any circumstance at all in which a SNAP *recipient* will be required to meet the Kentucky HEALTH CE requirement?**
- Q: If an individual is working at say WalMart and they are routinely scheduled for 24 to 28 hours and they are cut back to 16-18 for a period of time, do they have to volunteer or find a second job to meet the 20 hour per week requirement?**