CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Amendment)

907 KAR 1:604. 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, [~~447.53,~~] 447.54, 447.55, 447.56, 447.57[~~447.59~~], 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, 2014 Ky. Acts ch. 117, Part I.G.3.b.(10)

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[~~447.82~~], 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[~~couple's~~] 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) "KCHIP - Separate Program" means a health benefit program for individuals with eligibility determined in accordance with 907 KAR 4:030, Section 2.

(11) "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 in 42 C.F.R. 438.2.

(12) "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.

(13) "Nonemergency" means a condition which does not require an emergency service pursuant to 42 C.F.R. 447.54[~~447.53~~].

(14) "Nonpreferred brand name drug" means a brand name drug that is not on the department's preferred drug list.

(15) "Preferred brand name drug" means a brand name drug:

(a) For which no generic equivalent exists which has a more favorable cost to the department; and

(b) Which prescribers are encouraged to prescribe, if medically appropriate.

(16) "Preventive service" means:

(a)1. All of the preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF); or

2. All approved adult vaccines, including their administration, recommended by the Advisory Committee on Immunization Practices;

(b) Preventive care and screening for infants, children, and adults recommended by the Health Resources and Services Administration Bright Futures Program Project; or

(c) Preventive services for women recommended by the Institute of Medicine.

(17) "Recipient" is defined in KRS 205.8451(9).

(18) "Transitional medical assistance" or "TMA" means an extension of Medicaid benefits in accordance with 907 KAR 20:005, Section 5(5).

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) 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
[~~Generic prescription drug~~]	[~~$1~~]
[~~Preferred brand name drug~~]	[~~$4~~]
[~~Nonpreferred brand~~	[~~$8~~]

~~name drug~~]	
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 drug	$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 Frail	$0
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 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.

(2)(a)[~~(a) Except for a foster care child, a recipient shall not be exempt from paying the eight (8) dollar copayment for a nonpreferred brand name drug prescription.~~

~~(b)~~] 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.

(b)[~~(c) Except for the mandatory copayment referenced in paragraph (a) of this subsection,~~] The department shall impose no cost sharing for an individual or recipient who is exempt pursuant to 42 C.F.R. 447.56.[~~the following:~~

~~1. A service furnished to an individual who has reached his or her 18th birthday, but has not turned nineteen (19), and who is required to be provided medical assistance under 42 U.S.C.~~

~~1396a(a)(10)(A)(i)(I), including services furnished to an individual with respect to whom aid or assistance is made available under Title IV, Part B (42 U.S.C. 620 to 629i) to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under Title IV, Part E (42 U.S.C. 670 to 679b), without regard to age;~~

~~2. A preventive service;~~

~~3. A service furnished to a pregnant woman;~~

~~4. A service furnished to a terminally ill individual who is receiving hospice care as defined in 42 U.S.C. 1396d(o);~~

~~5. A service furnished to an individual who is an inpatient in a hospital, nursing facility, intermediate care facility for individuals with an intellectual disability, or other medical institution, if the individual is required, as a condition of receiving services in the institution under Kentucky's Medicaid Program, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;~~

~~6. An emergency service as defined by 42 C.F.R. 447.53;~~

~~7. A family planning service or supply as described in 42 U.S.C. 1396d (a)(4)(C); or~~

~~8. A service furnished to a woman who is receiving medical assistance via the application of 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa).~~

~~(2) The department has determined that any individual liable for a copayment shall:~~

~~(a) Be able to pay a required copayment; and~~

~~(b) Be responsible for a required copayment.~~]

(3) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined 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) Any amount of uncollected copayment by a provider from a recipient shall be considered a debt to the provider.

(6)[~~(a)~~] A provider shall:

(a)[~~1.~~] Collect from a recipient the copayment as imposed by the department for a recipient in accordance with this administrative regulation;

(b)[~~2.~~] Not waive a copayment obligation as imposed by the department for a recipient; and

(c)[~~3.~~] Collect a copayment at the time a benefit is provided or at a later date.[~~(b) Regarding a service or item for an enrollee in which the managed care organization in which the enrollee is enrolled does not impose a copayment, the provider shall not collect a copayment from the enrollee.~~]

(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[~~447.82~~], 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 subsection (2) of this section.

(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 shall[~~:~~

~~(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 Title 895 KAR. If eligible for Kentucky HEALTH, an individual subject to this administrative regulation shall also comply with any applicable requirements established pursuant to Title 895 KAR, including 895 KAR 1:010[~~Effective Date. The cost sharing provisions and requirements established in this administrative regulation shall be effective beginning January 1, 2014~~].

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 10. This administrative regulation was found deficient by the Administrative Regulation Review Subcommittee on May 13, 2014.

CAROL H. STECKEL, Commissioner
ADAM M. MEIER, Secretary
APPROVED BY AGENCY: March 15, 2019
FILED WITH LRC: March15, 2019 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on May 28, 2019, at 9:00 a.m. in Suites A & B, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by May 20, 2019, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until May 31, 2019. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Chase Coffey, Executive Administrative Assistant, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone: 502-564-6746; fax: 502-564-7091; email CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Chase Coffey

(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 amendments to this administrative regulation synchronize co-pay exemptions with federal regulations, include additional co-pays and categories of co-pays, and prohibit MCOs from waiving or reducing Medicaid copays. The amendments also exempt Medicaid and KCHIP beneficiaries

from paying copayments, and update the amount and types of copayments required for beneficiaries to pay. The amendments exempt various types of Kentucky HEALTH beneficiaries, including the medically frail, pregnant women, former foster youth, and individuals who are current on Kentucky HEALTH premiums.

(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 how certain co-pays should be charged for certain types of visits at certain types of providers.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by implementing a copayment requirement, synchronizing co-payment exemptions with the federal regulations, and updating certain copayments.

(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 and updating certain 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 are not exempt from cost sharing will be affected by the amendment as well as Medicaid providers for whose services cost sharing is applied.

(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 and recipients will be required to remit a copayment when accessing a Medicaid service and that requirement cannot be waived or reduced by an MCO. Providers of services for which cost sharing is imposed will be required to impose cost sharing when providing the given service and recipients are responsible for paying cost sharing.

(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. Providers may experience administrative costs resulting from a Medicaid recipient refusing to pay a copayment obligation.

(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 no additional costs as a result of the amendments to this administrative regulation.

(b) On a continuing basis: The Department for Medicaid Services (DMS) anticipates no additional costs 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 amendment to this administrative regulation neither establishes

nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is applied in that some Medicaid recipients are exempt (by federal regulation or law) from most cost sharing obligations.

FEDERAL MANDATE ANALYSIS COMPARISON

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

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, and this administrative regulation 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 no additional costs 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 no additional costs 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: