KyHealth Choices

Kentucky's Updated Medicaid Transformation Initiative

May 2, 2006

Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street
Frankfort, KY 40601
Voice: (502) 564-4321
Fax: (502) 564-0509

Kentucky

Table of Contents

The Transformation of Kentucky Medicaid

Executive Summary

In recent months, the Kentucky Cabinet for Health and Family Services (CHFS) has set the stage for a major transformation of the Kentucky Medicaid program. This transformation, entitled *KyHealth Choices*, began with the development of a strong infrastructure which included improvements to the MMIS (Medicaid Management Information System), pharmacy benefit administration and the Department's utilization management and clinical review process. The Commonwealth now seeks to continue this transformation by utilizing a multifaceted approach which will include measures from the recently passed Deficit Reduction Act of 2005 (DRA), as well as a variety of waivers from the Centers for Medicare and Medicaid Services (CMS). Once completed, Kentucky envisions a new Medicaid program that will improve the health status of those Kentuckians enrolled in the program and ensure a continuum of care and individual choice.

To accomplish this vision, Kentucky has worked in partnership with consumers, family members, advocacy organizations and providers to set two major goals:

1) Stretch resources to most appropriately meet the needs of members; and
2) Encourage Medicaid members to be personally responsible for their own health care.

Considering the number of members within the Kentucky Medicaid program and the amount of resources expended on their healthcare, it is imperative that services be provided in the most efficient and cost-effective manner possible. For that reason, Kentucky proposes to maximize its resources by developing varying benefit packages designed to meet the needs of the different populations served and to establish meaningful benefits based on best practice standards.

Additionally, Kentucky will ensure Medicaid is the payor of last resort by encouraging those Medicaid members who have access to private insurance

coverage or Medicare to utilize that option of coverage before Medicaid. Another strategy within this initiative will include strengthening the Commonwealth's Health Insurance Premium Program (HIPP), which determines whether it is more

cost-effective to assist individuals with access to private coverage in purchasing that coverage and using Medicaid to wrap-around those services.

Kentucky will leverage the commercial market creating both cost-savings and improved healthcare delivery system practices. This objective will be obtained by filing a state plan amendment to redesign the Kentucky Children's Health Insurance Program (KCHIP). The amendment will transform KCHIP from a Medicaid look-alike program to a stand alone program and bid out the provision of services to private insurance companies.

The vision of a transformed Kentucky Medicaid program includes the provision of care that is better integrated. Through *KyHealth Choices,* members will realize improved coordination of mental health, mental retardation/developmental disabilities, substance abuse services and physical health services.

Kentucky Medicaid recognizes that the individual can and should play a central role in purchasing and planning for their own health care needs. Through *KyHealth Choices* members will recognize the role they play in reducing healthcare cost by making more conscientious choices – choices that result in their continued wellness. Each member will be assisted by professional staff and will come to rely on Kentucky Medicaid to assure access to quality healthcare options in order to fulfill their wellness goals.

Perhaps one of the most exciting aspects of *KyHealth Choices* is the creation of Get Healthy Benefits. These benefits will allow individual members who have specific targeted diseases to access additional benefits by participating in certain healthy practices as identified by the Commonwealth. These benefits can be used toward accessing additional dental and vision services or obtaining nutritional or smoking cessation counseling.

KyHealth Choices will ensure that education and choice counseling is available to all Kentucky Medicaid members in an effort to assist them in making the best choice among benefit packages and will structure their benefit packages to assure a continuum of care to maximize the use of services provided in an individual's home.

KyHealth Choices will ultimately transform Kentucky Medicaid resulting in the better utilization of available resources, while at the same time ensuring members have the opportunity to make meaningful choices about their own healthcare. This transformation will allow the Commonwealth of Kentucky the opportunity to test new innovations which are imperative to the future success and sustainability of the Kentucky Medicaid program.

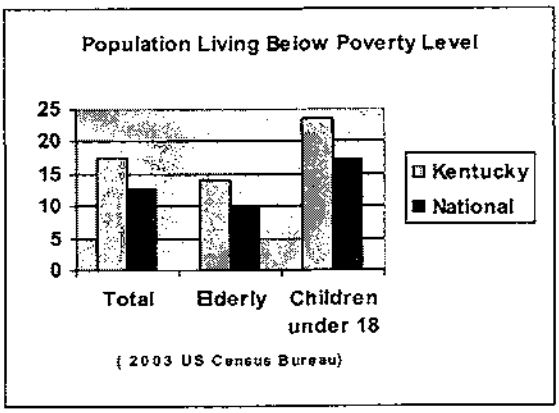
KyHealth Choices

Chapter One: Background

In January 2004, Governor Ernie Fletcher began his administration facing a significant deficit within the Kentucky Medicaid program. He immediately charged the Cabinet for Health and Family Services (CHFS) to develop opportunities to contain the escalating costs, while at the same time ensuring the quality provision of medically necessary services to the Commonwealth's most at-risk citizens. In less than 19 months, the Fletcher administration has conducted a thorough assessment of every program and service provided by Kentucky Medicaid. Through this process, areas were identified in which improvements and efficiencies could be obtained. Additionally, steps were initiated to modify the Medicaid infrastructure to better support a significant transformation of the entire system. The Commonwealth now seeks to continue this transformation by emphasizing the partnership between Kentucky Medicaid and each of its members through the *KyHealth Choices* transformation initiative.

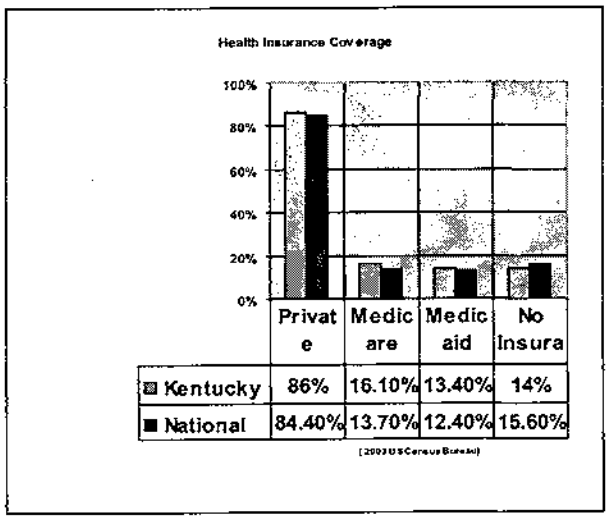
Kentucky Demographics

Recent data shows Kentucky to have one of the highest percentages in the nation of residents living below the poverty level. Unfortunately, a large portion of those living in poverty are the elderly and children, with Kentucky ranking 4th and 6th in the nation in these areas. Additionally, it is estimated that another 20% of the state's children live in families with incomes below 200% of the federal poverty level ($30,520 for a family of three). Kentucky ranks 47th in the nation in median household income, currently $34,368 compared to the national median household income of $43,564. Currently considered one of the least healthy states in the nation, Kentucky ranks at or near the top of all states in cancer and cardiovascular deaths per 100,000 residents, and ranks second in overall mortality. The state's obesity level is 6th in the nation while the incidence of diabetes ranks 7th.



Kentucky Health Insurance Status

Health insurance coverage in Kentucky closely mirrors the national average. U.S. Census Bureau statistics for 2003 indicate 84.4% of the U.S. population and 86% of Kentuckians were covered by some form of health insurance. Medicare and Medicaid coverage in Kentucky is slightly higher than the national average while private insurance coverage is identical. The number of Kentuckians without health insurance is slightly less than the national level, 14 to 15.6%; however, that still accounts for more than half a million Kentuckians without insurance coverage.

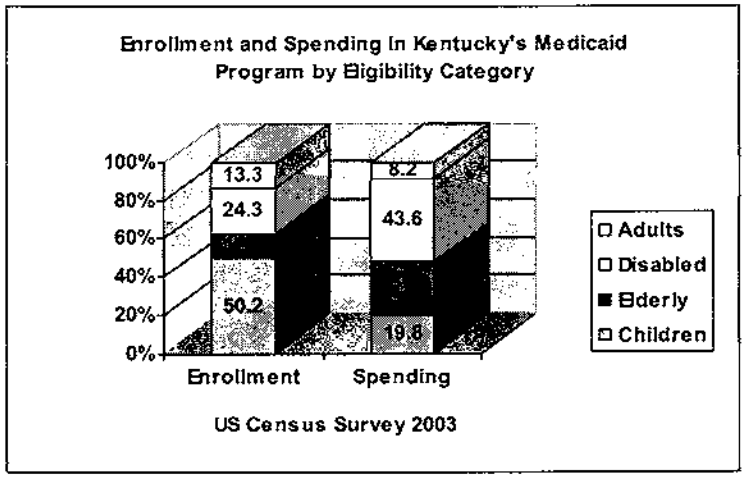


	Private	Medicare	Medicaid	No Insura
Kentucky	86%	16.10%	13.40%	14%
National	84.40%	13.70%	12.40%	15.60%

Kentucky Medicaid

The Kentucky Medicaid program was established in 1965 under Title XIX of the Social Security Act. The program is operated in much the same manner as other states, with the state taking the lead in structuring coverage, establishing nominal cost sharing, and making direct payments to providers. Currently, there are approximately 691,000 enrollees in the Kentucky Medicaid program, representing more than 15% of the state's total population, an increase of almost 3% in the last two years.

Kentucky Medicaid covers 1 out of every 2.5 births (44%) and provides health coverage to 1 out of every 3 children and 1 out of every 7 seniors over age 65. At the same time, Kentucky Medicaid spends a smaller portion of its budget on administrative costs than any other state Medicaid program.



The progress Kentucky has made to date in transforming its Medicaid program continues to be threatened by state budget problems.

Kentucky Medicaid's expenditures are consuming an ever increasing proportion of the Commonwealth's budget and currently accounts for approximately 22% of its annual expenditures, making it the second largest state budget item after education. Approximately 11.4% of Kentucky's state general fund dollars were expended on its Medicaid program in state fiscal year (SFY) 2005.

While progress has and is being made, there are also factors at work which serve to constrain and impede the Commonwealth's ability to make meaningful and enduring improvements to its Medicaid program. For example, current federal polices require each state's Medicaid benefit package be the same for all populations regardless of their need or medical condition. In addition, there are no incentives for our Medicaid population to assume personal responsibility for their use of services or for seeking services in the most cost-effective venue. Thus, these issues, along with federal cost containment initiatives currently underway have left the Commonwealth with a $425 million deficit that must be addressed. While *KyHealth Choices* will not address Kentucky's FY05-06 Medicaid budget deficit, it will transform the program to prevent future budget imbalances and ensure long term solvency.

Current Waivers

Sixteen counties in the Louisville region of Kentucky are currently operating under an 1115 waiver administered by Passport Health Plan. This waiver allows members residing in those counties to be served by a managed care organization. None of the members being served under Passport will be affected by *KyHealth Choices*.

In addition to Passport, Kentucky currently has four 1915 C waivers serving various populations within the Medicaid program as outlined below. Everyone currently served in a 1915 C waiver will be included in *KyHealth Choices*. The current 1915 C waivers are:

1. Acquired Brain Injury

   The Acquired Brain Injury (ABI) waiver was developed to serve Kentucky residents age twenty-one (21) to sixty-five (65) who have an acquired brain injury. These individuals receive inpatient services in a nursing facility, nursing facility/brain injury program, or are currently living in the community and have the potential for inpatient services in a nursing facility or nursing facility/brain injury program. Individuals served in the ABI waiver must meet the level of care criteria for placement in a nursing facility and whose services in a nursing facility would qualify for payment under the State Plan for Medical Assistance. The goal of the ABI waiver program is to rehabilitate and reintegrate individuals with an acquired brain injury into the community with the availability of existing community resources when discharged from the ABI waiver program. ABI services are not available to individuals who have congenital brain injuries. The acquired brain injury waiver has a capacity for

and serves 110 unduplicated members and maintains a waiting list of 83 individuals.

2. Home and Community Based (HCB) Waiver

   The Home and Community Based (HCB) waiver program was developed to serve Kentucky residents who are aged or disabled as an alternative to placement in a nursing facility. Individuals served by HCB must meet the level of care criteria for placement in a nursing facility and whose services in a nursing facility would qualify for payment under the State Plan for Medical Assistance. Any individual who is inpatient at a hospital, nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR), or who is enrolled in another Medicaid waiver or Medicaid-covered Hospice Program is excluded from eligibility. HCB has a total capacity of 17,050 unduplicated members and currently serves 11,598; HCB does not maintain a waiting list.

3. Supports for Community Living (SCL) Waiver

   The Supports for Community Living (SCL) waiver program was developed to serve Kentucky residents with mental retardation or developmental disability as an alternative to institutional care. These individuals must meet the level of care criteria for placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and whose services in an ICF/MR would qualify for payment under the State Plan for Medical Assistance. This program is designed to allow an individual to remain in or return to the community in the least restrictive setting. SCL services are not available to individuals receiving inpatient services in a hospital, nursing facility or ICF/MR. SCL currently serves 2,651 individuals but maintains a waiting list of 2,556.

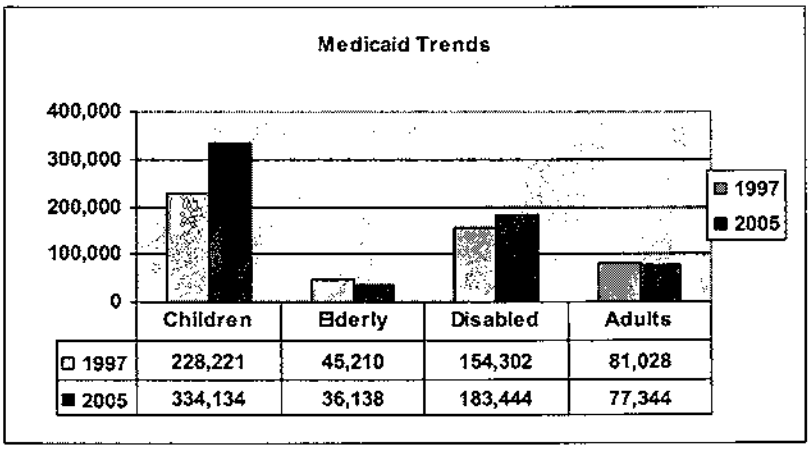
4. Model II Waiver

   The Model II waiver program was developed to serve Kentucky residents who are ventilator dependent as an alternative to hospital-based nursing facility care. These individuals must meet the level of care criteria for placement in a nursing facility and whose services in a nursing facility would qualify for payment under the State Plan for Medical Assistance. Model II waiver services are available to eligible individuals of any age in their homes. The waiver has a capacity of 100 unduplicated members and currently serves approximately 59 individuals.

Future Trends:

Kentucky has seen significant growth in the number of Medicaid members over recent years. In fiscal year 1997, there were 531,868 individuals receiving some or all of their healthcare under the Kentucky Medical Assistance Program. By January 2005, that number had risen to 686,925, with an end of fiscal year projection of 691,000. This is a growth rate of 29.92% over eight years. Kentucky's total population during the same period grew by just over 4%.

The number of disabled members has increased every year since 1997, averaging over 3,000 additional members annually. This resulted in an 18.88% between 1997 and 2005.



	Children	Elderly	Disabled	Adults
1997	228,221	45,210	154,302	81,028
2005	334,134	36,138	183,444	77,344

Children receiving services increased by 46.4% during the period, from 228,221 on June 30, 1997 to 334,134 on January 1, 2005. Of particular note is that this growth rate has accelerated over the past four years, growing from almost 259,000 in SFY 2000 to a projected total of more than 345,000 by the end of SFY 2005.

Surprisingly and in contrast to national trends, the aged category has shown a slight decrease over this same period, averaging 1,134 fewer members per year. On June 30, 1997 there were 45,210 aged participants, while on January 1, 2005 there were 36,138.

Also showing a decrease from 1997 to the mid-point of FY 2005 is the adult category, which declined by 4.6%. On June 30, 1997 there were 81,028 individuals receiving coverage as adults. By January 1, 2005 that had fallen to 77,344; however, the trend for this category since FY 2000 has been upward. There were 58,395 adult participants on June 30, 2000, which has increased each year to the current 77,344.

Kentucky is a Social Security Act Section 1634 (a) state. One consequence of this is that Supplemental Security Income (SSI) beneficiaries are automatically deemed as eligible for Kentucky Medicaid. This has a significant impact on this state's Medicaid program since Kentucky has one of the nation's highest per capita disability rates. As such, a disproportionate number of Medicaid beneficiaries are eligible due to approval of their disability claim and award of SSI benefits.

Recent Changes to the Infrastructure

In order to prepare the foundation for the major transformation identified in *KyHealth Choices*, significant changes to the Kentucky Medicaid infrastructure have occurred and continue to evolve. CHFS and the Department for Medicaid

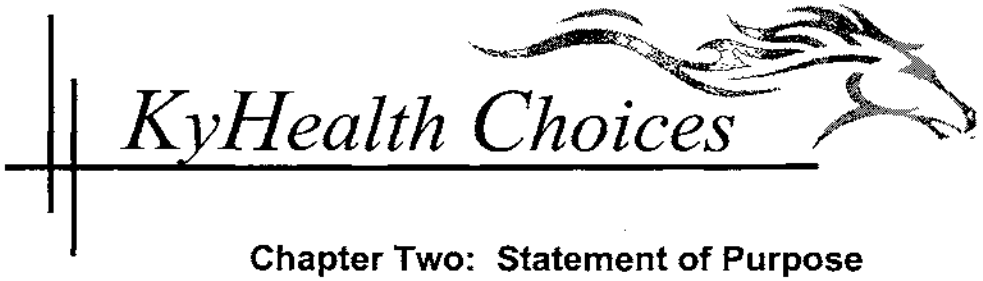
Services (DMS) have spent the last several months ensuring that essential programmatic and policy procedures and capabilities have been created. Most of the changes are already in place. The developments we have made to the infrastructure include the following:

- **Improved the MMIS (Medical Management Information System).**
  - Work with the new MMIS vendor to implement state of the art systems to allow reforms
  - Develop MITA (Medical Information Technology Architecture) aligned architecture
  - Implement client server technology

- **Utilized the Pharmacy Benefit Administrator (PBA) (First Health Services) to administer the pharmacy benefit for Medicaid members.**
  - The PBA will be responsible for:
    - Prior authorization
    - Pharmacy claims payment
    - Clinical criteria
    - Provider education and communications
    - Prospective drug review edits
    - Drug regimen review
    - Rebate management

- **Utilized the Kentucky Medicaid Administrative Agent (KMAA) to administer activities and policies established by the Commonwealth.**
  - The KMAA will develop and/or maintain:
    - Appropriate utilization management systems
    - Clinical review criteria
    - Practice guidelines for Disease Management Programs
    - Benefit packages
    - Care and Disease Management Programs
      - Examples:
        - Asthma Care Choices
        - Diabetes Care Choices
    - Tools and protocols for identifying and assisting members with special health care needs
    - Quality management systems
    - Provider relations management capability
    - Member relations management capability

- **Utilized the KMAA to work with the Commonwealth to manage the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, which will be renamed the "Children's Health & Prevention Program."**
  - Under existing state authority the KMAA will ensure that all T (treatment) services are medically necessary



Chapter Two: Statement of Purpose

The current Kentucky Medicaid system is costly, inefficient and incapable of meeting members' needs and therefore must undergo a sweeping and comprehensive, transformation of the daily operations and relationships of the program. *KyHealth Choices* will accomplish this transformation without a drastic reduction in eligibility or services to those in need.

The transformation, detailed in this multifaceted initiative, will ensure a continuum of care, increased flexibility, and individual choice while securing the solvency of Medicaid for future generations of Kentuckians.

During the development of *KyHealth Choices*, the state focused primarily on four guiding principles: quality and prevention, consumer empowerment and choice, personal responsibility, and community solutions. Additionally, various components and strategies within this initiative are structured around two major goals: stretch resources to more appropriately meet the needs of those enrolled in the Medicaid program and encourage Medicaid members to be personally responsible for their own health care. To accomplish these goals, the Commonwealth is committed to offering its Medicaid members a comprehensive array of options designed to deliver the services they need in the most efficient manner possible. Kentucky is also dedicated to ensuring that the services provided for members are of the highest quality and grounded in evidence based practices. Members will be encouraged to be involved in their own personal health care and prevention, and disease management and wellness programs will be emphasized.

Purpose

Transform the Kentucky Medicaid program by:

- ✓ *Improving the health status of those Kentuckians enrolled in the program;*
- ✓ *Ensuring a continuum of care;*
- ✓ *Guaranteeing individual choice;*
- ✓ *Ensuring the solvency of Kentucky Medicaid for future generations of Kentuckians*

KyHealth Choices will offer six fundamental elements:

1. Benefit Packages: Tailored benefit packages for specific populations will be provided to those enrolled in the Medicaid program. A total of four packages have been developed and will include services to meet basic medical and rehabilitative needs. In addition, benefit packages for those in need of long term care will increase the array of community based services. The long term care packages will include various levels of care where services will intensify

based on the level of need. A specific package, Family Choices, has been created to better serve children.

2. Cost Sharing and Service Limitations: Most members enrolled in *KyHealth Choices* will be required to share in the cost of many of the covered services. Co-pays and premiums will be incorporated throughout most of the plans; however, to encourage wellness and decrease dependence on acute services, preventive services will not require a co-pay. Preventive services include, but are not limited to, annual check-ups, vaccinations and pap smears. When a co-pay or coinsurance is required as part of the plan benefit structure, the provider will be responsible for collecting payment from individuals. Limitations on some services have also been included in the *KyHealth Choices.* However, all limitations are subject to be set aside based on medical need and approval by DMS.

3. Health Insurance Premium Program (HIPP): *KyHealth Choices* will also ensure that Kentucky Medicaid is the payor of last resort by establishing a program for members who have access to private insurance coverage to require them enroll in that coverage. *KyHealth Choices* will pay private insurance premiums and wrap around the commercial coverage with Medicaid services.

4. Integrated Care: Part of Kentucky's vision of a transformed Kentucky Medicaid program includes the provision of care that is better integrated. Members will realize improved coordination of mental health, mental retardation/developmental disabilities, substance abuse and physical health services. The Kentucky Medicaid infrastructure will be improved, using the best practice standards demonstrated in the commercial insurance market as its model, allowing for both cost-savings and improved healthcare delivery system practices.

5. Disease Management Programs: *KyHealth Choices* will develop disease management programs throughout the state to assist those with chronic illnesses such as pulmonary disease, cardiovascular disease, pediatric obesity and diabetes. Services will include assessments and educational information about the disease and treatment. Disease Management services have already been contracted through the KMAA.

6. Get Healthy Benefits: Get Healthy Benefits will be established to provide incentives to Medicaid members for healthy behaviors. These benefits will allow individual members who have specific targeted diseases to access additional benefits by participating in certain healthy practices as identified by the Commonwealth. Initially, disease conditions for participation in this program will be limited to pulmonary disease, diabetes and cardiac conditions, however, additions may be added later. Get Healthy Benefits will include additional dental and vision services or obtaining nutritional or smoking cessation counseling.

KyHealth Choices

Chapter Three: Public Input

The Cabinet for Health and Family Services (CHFS) values the unique expertise that can only be found through the individuals served, their families, advocates and community service providers. Prior to the actual drafting of *KyHealth Choices,* the Cabinet spent several months gathering information from the stakeholder community. The Undersecretary of the Cabinet and the Commissioners of the Departments for Mental Health and Mental Retardation and Medicaid Services met at least weekly, either jointly or separately, with various groups across the state to discuss issues and concerns regarding the Kentucky Medicaid program.

In addition, the Cabinet developed a strong relationship with a large coalition of advocacy organizations. Representatives from Advocates for Reforming Medicaid Services (ARMS) meet monthly with Cabinet officials to discuss updates and continuing needs within the program. The Cabinet has also utilized meetings with various statewide commissions, such as the Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities (HB 144) and the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnosis (HB 843) to gather additional input.

> *"I believe that every right implies a responsibility; every opportunity, an obligation; every possession, a duty."*
>
> *John D. Rockefeller, Jr.*

During the actual development of the *KyHealth Choices*, Cabinet staff met repeatedly with the membership of ARMS and another coalition of providers, consumers and family members, the Medicaid Consortium. Both groups are comprised of numerous advocacy organizations representing the poor, children, aged and individuals with disabilities. Human service providers and lobbyists are also members of ARMS and the Consortium. Moreover, the Cabinet has discussed ideas and alternatives with key legislators, the Kentucky General Assembly's Joint Committee on Health and Welfare and various experts in the Medicaid field.

The Cabinet made a concerted effort to seek assistance and input from the advocacy and provider community by creating a Medicaid team to draft the initial *KyHealth Choices* proposal. The team, comprised of four representatives each

from ARMS and the Medicaid Consortium, as well as lead staff from the Departments of Medicaid and Mental Health and Mental Retardation Services, literally entered into "Medicaid Boot Camp."

The team met every other day for three weeks to draft out the many and varied details for the initiative. In between meetings, the representatives were responsible for communicating with the various organizations and constituencies they represent to ensure adequate updates to the community and ongoing input into the planning and drafting process.

Since the initial drafting of *KyHealth Choices,* the Cabinet has continued its partnership with legislators and the consumer, advocacy and provider representatives. Several teams, with membership from all of the concerned parties, have been formed to assist Medicaid in implementing the various components of this initiative.

Chapter Four: Demonstration Design

KyHealth Choices is comprised of an array of key components with each component contributing to a comprehensive, consumer-centric continuum of care that is fiscally sound. The components are identified under two major goals as determined by the administration and other key stakeholders from throughout the state. The design of *KyHealth Choices* is based on these goals.

Goal One

Stretch resources to most appropriately meet the needs of members

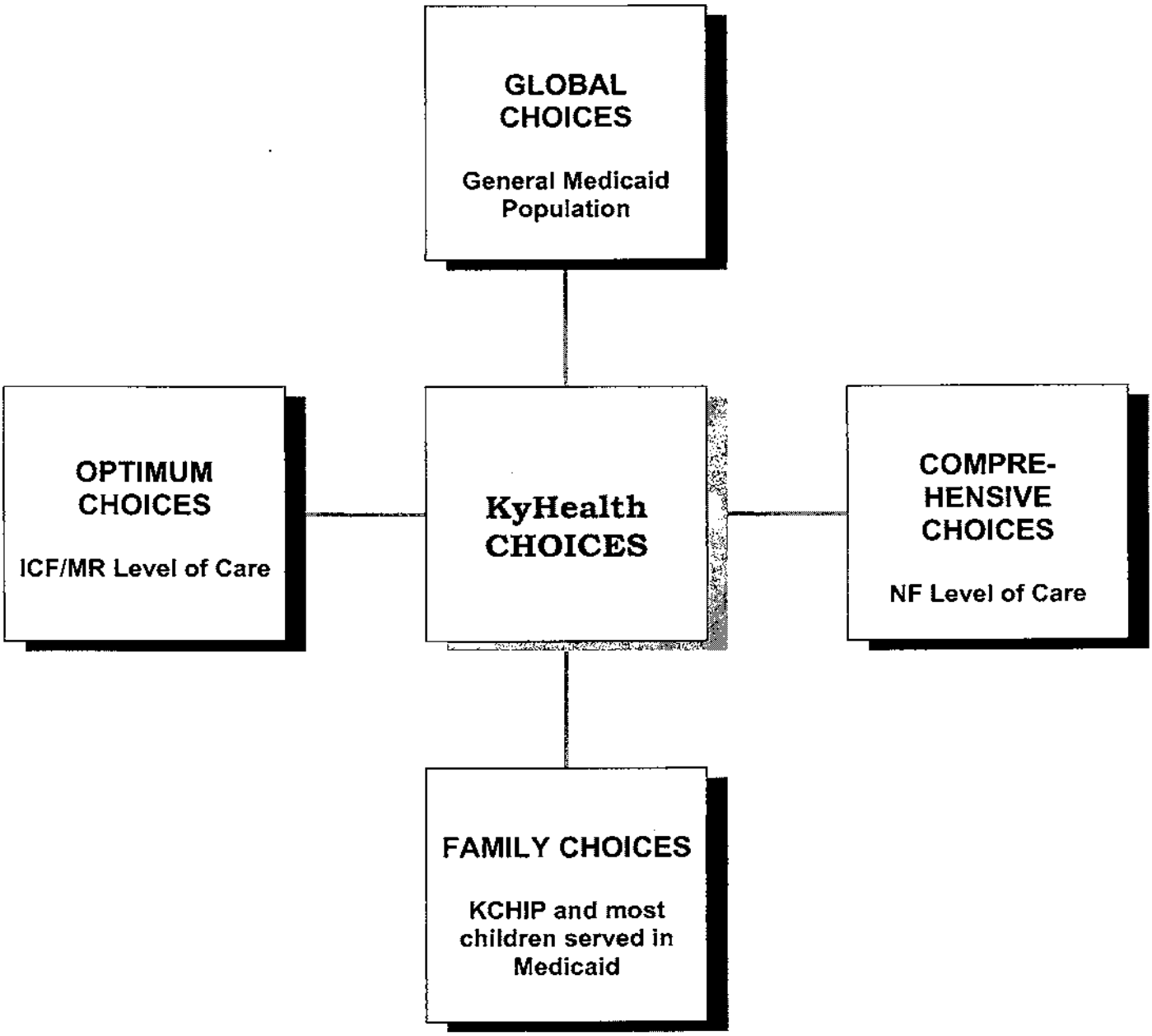
Considering the number of members and the amount of money expended on their healthcare, it is imperative that services are provided in the most efficient and cost-effective manner possible. This premise is true despite constraints beyond our state's control. For example, until the recent passage of the federal Deficit Reduction Act, Kentucky's Medicaid benefit package was required to be the same for all populations, regardless of medical condition or need. In addition, there are no financial incentives for our Medicaid members to conserve their use of services to those medically necessary or to seek services in the most cost-effective venue. These issues, along with federal cost containment initiatives, have left the Commonwealth with a $425 million deficit that must be addressed. While *KyHealth Choices* will not address Kentucky's FY05-06 Medicaid budget deficit, it will transform the program to prevent future budget imbalances and ensure long term solvency.

I. Varying Benefit Packages

To accomplish Goal One, *KyHealth Choices* establishes a variety of benefit plans to ensure quality healthcare coverage for its members. Coverage types will be based upon financial and categorical eligibility and will include, at a minimum, a standard benefit package for the Kentucky Medicaid program. The packages will allow for the offering of optional services targeted toward specific populations. Many disabled and long-term unemployed individuals will continue to receive care on a fee-for-service basis. In addition, special packages will be developed to ensure appropriate care for those who need long-term care. For some plans,

cost sharing in the form of co-pays and/or coinsurance, as well as premiums will be required on a sliding fee scale based on income. The following diagram illustrates the four benefit packages which will be offered in *KyHealth Choices*.

BENEFIT PLANS



Global Choices is the standard package provided for most Medicaid members and is the benchmark to which the other plans are compared. This plan provides basic medical services, including mental health services in inpatient and outpatient settings. Hearing and vision services will be limited to those 18 and under unless the service is Early Periodic Screening Diagnosis and Treatment (EPSDT) related in which case it will be offered until the member reaches age 21.

Two packages have been developed for those members needing long-term care services. The **Comprehensive Choices** plan will include all benefits in Global Choices and it will cover individuals who need a nursing facility (NF) level of care, are at risk of institutionalization and/or have been previously covered under the HCB Waiver, Model II or the ABI waiver. The plan will include NF level of care services and all services currently available under the current ABI, Model II and HCB waivers as well as nursing facility services.

Optimum Choices will cover disabled adults in need of ICF/MR level of care, are at risk of institutionalization and/or are currently being served in the SCL waiver. The plan will include all benefits in Global Choices and it will include ICF/MR level of care services such as all services under the current SCL waiver and the ICF/MR services. Optimum Choices will also include a new lower level of services aimed at keeping people in their homes longer. A waiting list will remain for some SCL services for this population.

The **Family Choices** package is designed for children and will serve those currently covered by the KCHIP program and some children currently served under the traditional Medicaid program. During Phase II of *KyHealth Choices,* the plan may be expanded to serve uninsured low-income parents of KCHIP children.

All benefit packages included in *KyHealth Choices* will be structured to assure a continuum of care to maximize the use of services provided in an individual's home. The standard package for *KyHealth Choices* will cover many important healthcare services, including doctor visits, hospital stays, habilitation, therapeutic, and behavioral health services. Medicaid services will be provided as they are today. Mental Health parity will be common to all benefit packages.

II. Covered Service Limitations

In order to provide additional or special services to the targeted populations, the *KyHealth Choices* benefit packages may vary the amount, duration and/or scope of certain services and may contain service-specific coverage limits, such as the number of visits or dollar cost. None of the visit or dollar cost limits are "hard" limits but rather are "soft" limits, where additional visits or services beyond the stated limit may be approved if medical necessity is demonstrated by a member's provider through a prior authorization process.

This process will work much like the current process that is in place for Kentucky Medicaid services that require prior authorization. When a member has exhausted a benefit for a particular service that has a limit, such as chiropractic care, the provider fills out a MAP-9 "Request for Prior Authorization for Health Services". The Request for Authorization includes the primary diagnosis and outlines the member's medical history or special circumstances that details the reason the member requires an override. The form is then faxed to Kentucky Medicaid. The override process in *KyHealth Choices* will mirror this current process.

Currently Kentucky Medicaid has a three-brand drug allowance policy per member, per rolling calendar month, which went into effect on April 19, 2005. Kentucky Medicaid's Pharmacy Benefit Administrator (PBA), First Health Services, administers the program. Under this program, all members may receive up to three brand drugs per month, and an unlimited number of generic drug prescriptions. There is an exception process to the three-brand drug allowance policy. For example, children (0 to the date of 19th birthday) are excepted from this process, and the drug insulin, used in the management of diabetes, is excepted from this process. Additionally, Kentucky Medicaid has an override process for members with specific medical conditions that necessitate more than three branded drugs per month. These "excepted" conditions are:

- Hemophilia
- HIV/AIDS
- Dementia
- Psychotic disorders
- Schizophrenic disorders
- Schizotypal personality disorders
- Bipolar disorders
- Acute therapy for migraine headaches
- Cancer
- Epilepsy
- Suppressive therapy for thyroid cancer
- Coronary artery/cerebrovascular disease (advanced atherosclerotic disease)
- Hyperlipidemia
- Hypertension with co-morbid type 2 diabetes with nephropathy or systolic heart failure
- Cardiac rhythm disorders
- Diabetes
- Metabolic syndrome
- End stage lung disease
- End stage renal disease (ESRD)
- Organ transplant
- Terminal stage of an illness
- Cystic Fibrosis

The current process notifies pharmacy providers at the point of sale, through hard messaging, when a member has exceeded the three brand name allowance. When the pharmacist receives the message, the pharmacist communicates with the treating prescriber(s) to determine alternative generic drugs that can be utilized in place of previously prescribed brand-drugs. If switching to a generic therapeutic alternative is not feasible in any of these instances, the pharmacist can override the limit using a submission clarification code to complete the processing of the claim.

In extreme life threatening situations, pharmacists are permitted to utilize their experience and clinical judgment to override the three branded drug allowance message to ensure the member is not denied pharmaceutical intervention due to communication delays with the treating prescriber.

Providers were notified of this policy prior to it going into effect, and Kentucky Medicaid's web site at http://chfs.ky.gov/dms/Pharmacy.htm provides information about the Medicaid Pharmacy Program and related topics such as the preferred drug list (First Health Services link/ Providers/ Documents), pharmacy provider letters, Pharmacy and Therapeutics Committee meetings and recommendations. Additionally, providers can call Kentucky Medicaid with questions.

All of the new *KyHealth Choices* benefit packages contain the same prescription drug limit of four drugs per month with a maximum of three of those drugs being brand drugs as is currently in place. As previously described, this limit is a "soft" limit and can be overridden when medical necessity is demonstrated. Additionally, the prescription limits in *KyHealth Choices* will not apply to those members who have been diagnosed with certain chronic conditions, just as the program is administered currently. This list includes, but is not limited to:

- High blood pressure and Type II diabetes at the same time
- Alzheimer's Disease
- Cancer
- End Stage Lung Disease
- End Stage Renal Disease (ESRD)
- Terminal Stage of an Illness
- Hemophilia
- HIV/AIDS
- Migraine Headaches
- Epilepsy
- Thyroid Cancer
- Heart Disease
- High Cholesterol
- Metabolic Syndrome
- Organ Transplant
- Diabetes

- Cystic Fibrosis

Atypical antipsychotic drugs will not count against the three brand maximum.

Limitations may apply to the four benefit packages identified in the *KyHealth Choices* initiative based on the needs of the identified population and individual needs. For example, the scope and quantity of services to be provided under the Comprehensive and Optimum Choices for individuals with long term care needs will be clearly identified in the member's comprehensive care plan. Only those services included in the care plan will be reimbursable by *KyHealth Choices*.

Services not covered under Medicaid and identified in the coverage section of *KyHealth Choices* will be the financial responsibility of the member if not funded by another payment source.

Once an individual is Medicare eligible, the Commonwealth will only pay the patient liability amount under Medicare for services covered by Medicare. Medicaid's payment shall not exceed the Medicaid allowable amount for that service.

All of the benefit packages will cover mandatory Medicaid services. Any services that are not included in the benefit packages, or that exceed those in a benefit package and have not been prior approved, will be considered non-covered services.

Benefit Grids

State Plan Covered Services

Mandatory Services
Inpatient Hospital (excluding inpatient services in institutions for mental disease)
Outpatient Hospital (including Federally Qualified Health Centers (FQHCs) and rural health clinics
Laboratory and x-ray
Certified pediatric and family nurse practitioners
Nursing facility services for beneficiaries age 21 and older
EPSDT services for children under age 21
Family planning services and supplies
Physicians' services
Medical and surgical services of a dentist
Home health services for beneficiaries who are entitled to nursing facility services
Nurse mid-wife services
Pregnancy-related services and service for other conditions that might complicate pregnancy
Durable Medical Equipment
60 days postpartum pregnancy related services

Optional Services
Chiropractic Services
Podiatry Services
Vision Services
Private Duty Nursing
Home Health Care Services
Dental Services
Physical Therapy
Occupational Therapy
Therapies for Speech, Hearing, and Language Disorders
Prescribed Drugs
Prosthetic Devices
Eyeglasses
Diagnostic Services
Screening Services
Preventive Services
Mental Health Rehab/Stabilization
Inpatient Hospital/Nursing Facility/ICF Services 65 and Older in IMD
ICF/MR
Inpatient Psychiatric Services – Under Age 21
Personal Care Services
Targeted Case Management
Primary Care Case Management
Hospice
Respiratory Care for Ventilator Dependent
Transportation Services
Nursing Facility Services – Under Age 21
Critical Access Hospital

GLOBAL CHOICES		
Benefit/Service	**Groups Without Cost-Sharing***	**Other Populations****
Medical Out-of-Pocket Maximum	$225 per 12 months	$225 per 12 months
Pharmacy Out-of-Pocket Maximum	$225 per 12 months	$225 per 12 months
Acute Inpatient Hospital Services	$0 co-pay	$50 co-pay per admission
Laboratory, Diagnostic and Radiology Services	$0 co-pay	$3 co-pay
Outpatient Hospital/ Ambulatory Surgical Centers	$0 co-pay	$3 co-pay
Physician Office Services	$0 co-pay	$2 co-pay
Behavioral Health Services	$0 co-pay	$0 co-pay
Allergy Services	$0 co-pay	$0 co-pay
Preventive Services	$0 co-pay	$0 co-pay
Emergency Ambulance	$0 co-pay	$0 co-pay
Dental Services Children under 21: Including but not limited to two cleanings per 12 months, one set of x-rays per 12 months, and extractions Adults 21 and over: One cleaning per 12 months, one set of x-rays per 12 months, and extractions	$0 co-pay	$2 co-pay

GLOBAL CHOICES		
Benefit/Service	**Groups Without Cost-Sharing***	**Other Populations****
Family Planning	$0 co-pay	$0 co-pay
Occupational Therapy Limited to 15 visits per 12 months	$0 co-pay	$2 co-pay
Physical Therapy Limited to 15 visits per 12 months	$0 co-pay	$2 co-pay
Speech Therapy Limited to 10 visits per 12 months	$0 co-pay	$1 co-pay
Hospice (non-institutional)	$0 co-pay	$0 co-pay
Non-Emergency Transportation	$0 co-pay	$0 co-pay
Chiropractic Services Children under the age of 21: Limited to seven visits per 12 months Adults age 21 and over: Limited to 15 visits per 12 months	$0 co-pay	$2 co-pay

GLOBAL CHOICES		
Benefit/Service	**Groups Without Cost-Sharing***	**Other Populations****
Prescription Drugs (For Members who do NOT have Medicare Part D) Limited to four prescriptions per month with a maximum of three brand	$0 co-pay	$1 co-pay generic $2 co-pay preferred brand 5% coinsurance for non-preferred brand
Emergency Room	$0 co-pay	5% coinsurance for non-emergent visits
Hearing Aids Limited to children under 21 only $1,400 maximum per ear every 36 months	$0 co-pay	$0 co-pay
Audiometric Services Limited to children under 21 only One audiologist visit per 12 months	$0 co-pay	$0 co-pay
Vision Services $200 maximum on eyewear per 12 months Limited to children under 21 only	$0 co-pay	$0 co-pay
Prosthetic Devices	$0 co-pay	$0 co-pay

GLOBAL CHOICES		
Benefit/Service	**Groups Without Cost-Sharing***	**Other Populations****
Home Health Services	$0 co-pay	$0 co-pay
DME	$0 co-pay	3% coinsurance not to exceed $15 per month
Early Periodic Screening and Diagnosis (EPSD)	$0 co-pay	$0 co-pay
Treatment (T) Services for Conditions Identified Through Early Periodic Screening and Diagnosis (EPSDT) Children under 21 only	$0 co-pay	$0 co-pay
Substance Abuse EPSDT only	$0 co-pay	$0 co-pay
Maternity Services Nurse mid-wife services, pregnancy-related services and services for other conditions that might complicate pregnancy and 60 days postpartum pregnancy related services	$0 co-pay	$0 co-pay
Podiatry Services	$0 co-pay	$0 co-pay
End Stage Renal Disease and Transplants	$0 co-pay	$0 co-pay

FAMILY CHOICES				
Benefit/Service	**Children of Caretaker Relatives**	**Categorically Needy Children**	**KCHIP Children – Medicaid Expansion Program**	**KCHIP Children – Separate CHIP Program**
Medical Out-of-Pocket Maximum	$225 per 12 months	$225 per 12 months	$225 per 12 months	$225 per 12 months
Pharmacy Out-of-Pocket Maximum	$225 per 12 months	$225 per 12 months	$225 per 12 months	$225 per 12 months
Acute Inpatient Hospital Services	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Laboratory, Diagnostic and Radiology Services	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Outpatient Hospital/ Ambulatory Surgical Centers	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Physician Office Services	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Behavioral Health Services	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Allergy Services	$0 co-pay	$0 co-pay	$0 co-pay	• $2 co-pay for office visit and testing • $0 co-pay for injections
Preventive Services	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay

FAMILY CHOICES				
Benefit/Service	**Children of Caretaker Relatives**	**Categorically Needy Children**	**KCHIP Children – Medicaid Expansion Program**	**KCHIP Children – Separate CHIP Program**
Emergency Ambulance	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Dental Services Including but not limited to two cleanings per 12 months, one set of x-rays per 12 months, and extractions	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Family Planning	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Occupational Therapy Limited to 15 visits per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Physical Therapy Limited to 15 visits per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Speech Therapy Limited to 15 visits per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Hospice (non-institutional)	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Non-Emergency Transportation	$0 co-pay	$0 co-pay	$0 co-pay	Not Covered

FAMILY CHOICES				
Benefit/Service	**Children of Caretaker Relatives**	**Categorically Needy Children**	**KCHIP Children – Medicaid Expansion Program**	**KCHIP Children – Separate CHIP Program**
Chiropractic Services Limited to seven visits per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Prescription Drugs	$0 co-pay	$0 co-pay	$1 generic $2 preferred 5% coinsurance for non-preferred brand prescriptions	$1 generic $2 preferred 5% coinsurance for non-preferred brand prescriptions
Emergency Room	$0 co-pay	$0 co-pay	5% coinsurance for non-emergency use	5% coinsurance for non-emergency use
Hearing Aids $1,400 maximum per ear every 36 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Audiometric Services One audiologist visit per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay

FAMILY CHOICES				
Benefit/Service	**Children of Caretaker Relatives**	**Categorically Needy Children**	**KCHIP Children – Medicaid Expansion Program**	**KCHIP Children – Separate CHIP Program**
Vision Services $400 maximum on eyewear per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Prosthetic Devices $1,500 maximum per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Home Health Services Limited to 25 visits per 12 months	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
DME	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Early Periodic Screening and Diagnosis (EPSD)	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay
Treatment (T) Services for Conditions Identified Through Early Periodic Screening and Diagnosis (EPSDT)	$0 co-pay	$0 co-pay	$0 co-pay	Not Covered
Substance Abuse EPSDT only	$0 co-pay	$0 co-pay	$0 co-pay	Not Covered

COMPREHENSIVE AND OPTIMUM CHOICES	
Benefit/Service	**NF Level of Care (including ABI, Model II, and HCB Waivers)**
Medical Out-of-Pocket Maximum	$225 per 12 months
Pharmacy Out-of-Pocket Maximum	$225 per 12 months
Acute Inpatient Hospital Services	$10 co-pay
Laboratory, Diagnostic and Radiology Services	$0 co-pay
Outpatient Hospital/ Ambulatory Surgical Centers	$3 co-pay
Physician Office Services	$0 co-pay
Behavioral Health Services	$0 co-pay
Allergy Services	$0 co-pay
Preventive Services	$0 co-pay
Emergency Ambulance	$0 co-pay

COMPREHENSIVE AND OPTIMUM CHOICES	
Benefit/Service	**NF Level of Care (including ABI, Model II, and HCB Waivers)**
Dental Services Children under 21: Including but not limited to two cleanings per 12 months, one set of x-rays per 12 months, and extractions Adults 21 and over: One cleaning per 12 months, and set of x-rays per 12 months, and extractions	$0 co-pay
Family Planning	$0 co-pay
Occupational Therapy Limited to 30 visits per 12 months	$0 co-pay
Physical Therapy Limited to 30 visits per 12 months	$0 co-pay
Speech Therapy Limited to 30 visits per 12 months	$0 co-pay
Hospice (non-institutional)	$0 co-pay

COMPREHENSIVE AND OPTIMUM CHOICES	
Benefit/Service	**NF Level of Care (including ABI, Model II, and HCB Waivers)**
Non-Emergency Transportation	$0 co-pay
Chiropractic Services Children under the age of 21: Limited to seven visits per 12 months Adults age 21 and over: Limited to 15 visits per 12 months	$0 co-pay
Prescription Drugs (For Member who do NOT have Medicare Part D) Limited to four prescriptions per month with a maximum of three brand	$1 co-pay generic $2 co-pay preferred brand 5% coinsurance for non-preferred brand
Emergency Room	5% coinsurance for non-emergent visits
Hearing Aids Limited to children under 21 only $1,400 maximum per ear every 36 months	$0 co-pay

COMPREHENSIVE AND OPTIMUM CHOICES	
Benefit/Service	**NF Level of Care (including ABI, Model II, and HCB Waivers)**
Audiometric Services Limited to children under 21 only One audiologist visit per 12 months	$0 co-pay
Vision Services $400 maximum on eyewear per 12 months Limited to children under 21 only	$0 co-pay
Prosthetic Devices	$0 co-pay
Home Health Services	$0 co-pay
DME	3% coinsurance to a maximum of $15 per month
Early Periodic Screening and Diagnosis (EPSD)	$0 co-pay
Treatment (T) Services for Conditions Identified Through Early Periodic Screening and Diagnosis (EPSDT) Children under 21 only	$0 co-pay

COMPREHENSIVE AND OPTIMUM CHOICES	
Benefit/Service	**NF Level of Care (including ABI, Model II, and HCB Waivers)**
Substance Abuse EPSDT only	$0 co-pay
Maternity Services Nurse mid-wife services, pregnancy-related services and services for other conditions that might complicate pregnancy and 60 days postpartum pregnancy related services	$0 co-pay
Podiatry Services	$2 co-pay
End Stage Renal Disease and Transplants	$0 co-pay

III. Appeals and Grievances

Any member of *KyHealth Choices* may appeal any denial of, or reduction in, services in the comprehensive care plan following the existing Medicaid appeal procedures established through the KMAA.

IV. Providers

Approved Kentucky Medicaid providers will provide all services included in a member's benefit package. Kentucky is currently implementing consumer directed options in the current HCBS, ABI and SCL waivers. This option, discussed in more detail under the long term care section of this proposal, will be continued and expanded under *KyHealth Choices*.

V. Reimbursement

Services will be reimbursed on a fee-for-service basis, utilizing fee schedules approved by the Cabinet for Health and Family Services (CHFS) and the Department for Medicaid Services (DMS). Claims will be submitted and reimbursed by the State's Fiscal Intermediary in accordance with requirements and fee schedules in effect for the program.

VI. Co-pays

KyHealth Choices will require some members to pay for certain pharmacy and non-pharmacy related services; co-pays will be based on income levels.

Co-pays are due to the provider at the time of service. Some *KyHealth Choices* members will not have to pay co-pay for any covered service if the member is:

- A child under the age of 18 covered by Medicaid;
- Pregnant;
- Receiving a Medicare-covered drug at a pharmacy that is a certified provider for Medicare;
- Receiving inpatient services in a nursing facility chronic disease or rehabilitation hospital, or intermediate-care facility for the mentally retarded, or is admitted to a hospital from such a facility;
- Receiving hospice care;
- Has reached the co-pay cap for the year. The co-pay cap for all plans is $225 per individual for pharmacy services and $225 per individual for all other medical services.

VII. KCHIP Redesign

Under *KyHealth Choices*, the Kentucky Children's Health Insurance Program (KCHIP) will be redesigned in two distinct phases. This approach will transform the program from a Medicaid administered program to a program potentially operated by a managed care organization. The new program services will be modeled after the Commonwealth of Kentucky's 2005 Enhanced Plan (formerly called PPO Option A) with a package(s) tailored toward providing the most applicable services for children.

Eligibility for Family Choices will include children with caretaker relatives, infants and children to under age 19 whose gross family income is not more than 200% FPL.

KyHealth Choices plans to select an insurer to operate the new program on an at-risk basis through a request for proposal (RFP) process on a monthly premium basis, unless the actuarial costs demonstrate that it would be more cost effective to build the infrastructure and administer the program within the Cabinet.

By leveraging the commercial market, KCHIP can tap into comprehensive disease management programs and case management initiatives that are already in place. Disease management vendors heavily court commercial carriers, and carriers receive numerous free educational materials and items such as glucometers that will be distributed to KCHIP members. DMS is unable to accept these kinds of items.

Using a commercial carrier will also enable KCHIP members to receive a membership identification card with the carrier's logo on it rather than a KCHIP card, potentially removing some of the stigma and/or potential barriers to care associated with state assistance programs.

The privatization will increase access to services. The private market offers more robust provider networks due to their ability to leverage providers, especially as related to areas of practice such as pediatrics and pediatric specialists, for which there is significant need within the KCHIP population.

The possibility may be explored in the future of expanding coverage to uninsured low-income parents and caretakers of children enrolled in Family Choices by allowing these individuals to pay the premium differential for a family plan and obtain coverage for themselves. It has been demonstrated that there is a greater likelihood that children will stay insured if their parents also have coverage.

VIII. Long-Term Care Redesign

Kentucky will spend $720 million dollars to serve 24,000 individuals in nursing homes during the current twelve month cycle. Additionally, thirty-eight percent of the entire budget for individuals with mental retardation or other developmental disabilities goes toward the institutional care of only two percent of the population. *KyHealth Choices* addresses both shortcomings in service availability and in inherent bias in the current funding mechanisms for long term care.

KyHealth Choices will provide adults with mental retardation and other developmental disabilities, acquired brain injuries, physical disabilities and the frail and elderly real choices to receive needed long-term care services in home and community-based settings. All individuals currently eligible for Medicaid and in receipt of long-term care services in a nursing facility or in one of Kentucky's four current 1915 C waivers (Supports for Community Living, Home and Community Based Services, Model II and Acquired Brain Injury) will participate in *KyHealth Choices*.

The primary goals of the long-term care plans are to provide members with an expansion of choices and with equal access to long-term care options (institutional and home-and community-based services with consumer-directed options) and to promote and provide early intervention for populations at-risk of institutionalization. Kentucky intends to accomplish these goals by continuing to build and expand upon its existing home and community based services while continuing to ensure the availability of high quality institutional based services.

Those individuals currently served under the home and community-based waiver, model waiver II and acquired brain injury waiver will be covered under the Comprehensive Choices plan. Those currently served under the Supports for Community Living Waiver will be provided coverage under the Optimum Choices Plan.

Both the Optimum and Comprehensive Choices plans will include various levels of care. The level of care for each member will be determined by individualized plans of care. The purpose of the plans of care is to create a seamless process which will allow an individual to move back and forth through the levels as their needs change. Optimum Choices will begin Phase I with three levels: Basic, Targeted and High Intensity. During Phase II a fourth level, Intermediate Care, will be added. Comprehensive Choices will begin Phase I with two levels of care: Basic and High Intensity. The plan will be expanded to include an Intermediate Level of Care during Phase II of the *KyHealth Choices*. Both plans will include consumer and self directed options as an alternative to traditional services.

The Basic Level of Care is the first level of care covered under both the Comprehensive and Optimum Choices packages in *KyHealth Choices*. Individuals served by the Basic Care Package will include physically disabled, medical needy and dual eligible adults who meet the Medicaid financial and clinical criteria for long term care. The Basic Level of Care Plan will include a

variety of individual service options from which the consumer can choose based on his or her specific needs. Individualized plans of care will be created for each member based on person centered planning principles which allow for self directed choices and personal responsibility for the member's medical care. Only one service, case management, will be required for Optimum and Comprehensive Choices. However, the amount of case management services will vary based on the comprehensive plan of care.

Those identified as needing a High Intensity Level of Care benefit under the Comprehensive and Optimum Choices will be entitled to services in a nursing facility/ABI, nursing facility or ICF/MR. High Intensity Level of Care benefits will serve physically disabled, medically needy and dual eligible adults who meet Medicaid long-term care eligibility standards.

During Phase I, the Optimum Plan will include a third level of care entitled the Targeted Plan of Care. This plan "targets" those individuals who would benefit from a less restrictive environment than the traditional ICF/MR but may need more care than can be offered by the Basic Plan. The Targeted Plan offers a three person community living component currently offered under the SCL waiver.

The Intermediate Care Package will be added to both the Comprehensive and Optimum Plans during Phase II of the initiative. The Intermediate Level of Care will include unique options such as enhanced residential living, home sharing, and other housing and support services.

IX. Consumer Directed Options

HB 116 from the 2004 legislative session required that CDO be offered for non-medical services to the Medicaid population. Research has shown that when consumers control their own Medicaid personal assistance services, they are more satisfied with their lives and their support services. For that reason, *KyHealth Choices* will offer Consumer Directed Options (CDO) for those Medicaid members who qualify for Optimum and Comprehensive Choices. The CDO for *KyHealth Choices* is initially designed as an alternative to the traditional service delivery model for non-medical services under the long-term care plans. *KyHealth Choices* will explore the option of providing CDO to the other plans at a later date.

Design and Goals

The consumer-directed option (CDO) was designed as an alternative to the traditional service delivery model. Individuals who elect and are eligible for the CDO may access non-medical and non-residential services via CDO and medical and residential services under the traditional model. The blended package allows consumers to pick and choose the options that best meets their needs. Services provided via the CDO may be cross walked to a service under the traditional service option. This enables consumers to terminate CDO services and

seamlessly transition back into the traditional service option with no lapse in access to services. The goal of the CDO is to increase consumer control and independence while providing greater flexibility in service delivery and increasing consumer satisfaction and quality of life.

Consumer Directed Option Criteria

To participate in consumer-directed service option the individual must meet the eligibility and financial requirements for *KyHealth Choices*. The individual must have the ability to self-direct their own care and understand the rights, risks and responsibilities of managing their own care within their benefit total. If unable to make decisions independently, the individual may designate a representative to assist them. The CDO will also be available to any consumer who is a minor child and whose legally-responsible parent or legal guardian elects to employ this option.

Services Available

Consumer Directed Option services are non-traditional Medicaid services such as goods and services. These services may include items for services for minor home adaptations to enable individuals to remain in their home. The services must be individualized to fit the individual's needs and utilized to reduce the need for personal care or other services.

Support Brokerage

Support brokerage is an administrative activity which is required for all individuals participating in the consumer-directed services option or who choose to receive a blend of services under the traditional and consumer directed option. Functions of support brokerage include providing information regarding alternatives to make informed choice; care planning which includes assisting with the development and revision of the individual plan of care utilizing the person centered planning process and guiding principles; authorizing services and additional funding if necessary; monitoring the plan of care and satisfaction with and quality of service provision; assisting with locating services and negotiating rates; offers practical skills training which includes hiring, training, scheduling and terminating service providers; development of and monitoring of the participant's emergency back up plan which may include arranging for the provision of emergency services if necessary; establishes participant's request for benefit total based on need, utilization and existing service limitations; helps the consumer ensure that his/her rights and safety are protected; evaluates the participant's health and safety needs; conduct quarterly reviews of participant's spending; and completing all necessary paper work. Additionally, activities such as providing technical assistance regarding managing the individual budget and spending and records management to participant's and service providers shall be included under this service. Support brokerage shall be available twenty-four (24) hours per day, seven (7) days per week. The support brokerage entity shall be independent of other service provision.

Assessment/Support Spending Plan Development/Reassessment
During initial implementation and phase in, the State Medicaid Agency will send notification to members regarding the CDO. Members that are interested in participating in CDO will notify state staff. State staff will meet with these individuals and families and assist them with accessing the CDO.

Also, individuals electing the CDO will be assessed at the time of their level of care assessment. As part of the assessment process, participants and/or their representative are provided information to make an informed decision as to the options available to them and how services will be received

Individuals choosing the CDO will be referred to a Support Broker and will work with the support broker and fiscal agent in order to efficiently manage allocated dollars. The support broker will assist with developing an individual plan of care.

Individual Budgets
The individual benefit total set for consumers will be based upon the support service needs identified in the POC/SSP and actual historical costs (previous two year's expenditures) which will be adjusted for any rate changes and the individual utilization rate which reflects the difference between authorized and delivered services. For new consumers or for consumers whose needs change the State will use the traditional person centered care planning process and the POC/SSP and set the benefit total based upon historical cost for the service and the statewide utilization rate. In the event a consumer's needs increase and this change results in an increase to the individual benefit total a budget revision will be requested and shall follow the same requirements for approval as the traditional service option for prior authorization.

Financial Management Activities
Financial Management activities will be delivered as an administrative activity and is required for all individuals participating in the consumer directed option. The Financial Management Agency will assist the consumer and/or their designated representative in managing and distributing funds contained in the consumer's individual benefit total and completion of all required state and federal tax and employment forms. Financial management activities include facilitation of the employment and payment of service providers; completing fiscal accounting functions and expenditure reports; withholding federal, state and local taxes from payment to service providers; establish employment packet and FEIN for each employee; ensuring all federal, state and local tax laws are complied with and accurate tax reporting; employment and wage laws are complied with; verifying that payment is made only for services identified and authorized in the consumer's POC/SSP; maintain an audit trail of disbursement of funds from the consumer's individual benefit total; and develop and maintain Medicaid agreements with each provider employed by the consumer.

Quality Assurance/Participant Protections
In order to fulfill the State's obligation to ensure health, welfare and safety of consumers, the State will provide appropriate oversight and monitoring. CDO

services will be subject to the same monitoring and quality assurance and improvement requirements as traditional Medicaid services.

Consumer satisfaction is currently monitored under the traditional service delivery option as part of the quality assurance process. The consumer surveys will include components for monitoring of consumer satisfaction under the consumer-directed option. Consumers, family members and caregivers will also be informed of the Medicaid Member Services 1-800 number.

Also, the State will require criminal background checks for all direct service staff hired by the consumer. These will be completed at no cost to the consumer. Consumers will be made aware of this at the time of enrollment. Additionally, consumers will be provided with the 1-800 number for reporting abuse, neglect, or exploitation and instructions on self-reporting.

X. Self-Directed Options

In addition to the CDO project within *KyHealth Choices,* Kentucky plans to explore the next step in self-direction. Kentucky plans to offer the ability for individuals with disabilities eligible for long term supports to craft a highly personal budget from their allocation that will expand upon Consumer Directed Options. This expansion entitled Self Directed Options has been applied for in the Optimum Choices 1115 waiver. Upon approval, Kentucky intends to amend the Comprehensive benefit plan to include the SDO option.

The self-directed option may include the following services/supports (in addition to any other services covered under this *KyHealth Choices* as long as they do not exceed the total allocation.

- Independent brokering assistance to plan, organize and support the implementation of the personal plan of care
- Financial management assistance
- Microenterprise/self-employment
- Employment support including job coach and co-worker support and training
- Mobility and communication technology assistance
- General adult educational services including applicable offerings at a community college, technical college or local education facility
- Personal and companion support for residential living in one's own place
- Community participation and support for social integration

Additional self-directed services may include other non-traditional Medicaid services such as goods and services including minor home adaptations and home and community supports such as attendant/companion, homemaking and personal care services to enable individuals to remain in their home. The services must be individualized and utilized to reduce the need for personal care or other services.

Individual allocations under SDO will be determined based on typical assessments common to all eligible beneficiaries but then discounted by 5%. Individuals and families will be encouraged to save even within these parameters by offering one half of any savings to be used at the end of that year for one-time purchases that advance any of the life goals included in the person's plan. An additional percentage of the savings will be escrowed in a risk pool for participants who may experience difficulty. The following year the beneficiary's allocation will be reduced by 100% of the savings from the previous year.

XI. Independent Case Management

Case Management or support broker services for those enrolled in CDO/SDO will be required for members enrolled in *KyHealth Choices.* Kentucky's goal is to eventually have a completely independent case management system. Service units will be determined by the plans of care. The Case Manager will be responsible for intake, assessment and reassessments, eligibility determination and the development and coordination of the individualized plans of care. Caseloads will be capped at 35 per case manager.

XII. Health Insurance Premium Program (HIPP)

Beyond varying benefit packages, the *KyHealth Choices* initiative will implement several other concepts devised to stretch Kentucky Medicaid resources. *KyHealth Choices* will develop mechanisms to strengthen the Health Insurance Premium Program (HIPP), the Commonwealth's program that determines whether it is more cost-effective to assist individuals with access to private coverage in purchasing that coverage and using Medicaid to wrap-around those services. Currently HIPP is woefully under utilized serving only fourteen Medicaid members statewide. HIPP will not be an option for those in the Family Choices Plan.

KyHealth Choices will develop two programs that will begin by educating eligibility and in-take workers about the existence of the HIPP program, and will require that Medicaid members who are identified as having access to ESI will be required to utilize the coverage, if it is more cost-effective for the Commonwealth. The second program will allow members to choose to "opt-in" to ESI coverage. Please note, members will not be required to "opt in" and members will not be forced out of Medicaid. After 90 days, members who have opted-in to ESI may reapply for services under the program.

KyHealth Choices will also ensure that Medicaid is the "payor of last resort" by requiring Medicare members to use that benefit coverage before using their Medicaid benefit. When members have ESI or other coverage, Medicaid will pay as the secondary payor up to the allowable amount. This assumes medical necessity has been determined and plan rules have been followed. Secondary payment only pertains to Medicaid covered services.

XIII. Integrated Care Delivery

The current mental health/mental retardation delivery system is fragmented with service availability, access, provider networks and fiscal resources varying greatly from region to region. *KyHealth Choices* will streamline the system of care, balance inequities in the system, integrate more closely with physical health and build accountability into the existing structure of regional planning entities.

Pursuant to KRS 210.375-485, Kentucky will utilize the existing 14 regional mental health planning authorities (community mental health/mental retardation centers) found throughout the state to plan and develop a full continuum of care for each region. The foundation for the integrated health care delivery system will begin by developing mechanisms to support and hold accountable the existing regional planning authorities for their statutory responsibility for planning services and monitoring budgets.

Each CMHC will be required to submit annual plans that will include an impact statement and mechanism for increasing the provider network. Clear standards, monitoring procedures and performance based contracting will be utilized to ensure accountability. While services will differ based on regional needs and utilization patterns, access and quality will be the same across the state. Core MH/MR benefits such as targeted case management, individual and group therapy, mental health rehabilitation and crisis stabilization will be required in every region. Core services will be provided without a member co-pay. However, through this demonstration, Kentucky plans to give the regional planning authorities flexibility to develop programs specific to their region with a focus on integration and collaboration with physical health providers. Flexibility will be allowed to determine co-pays for these additional covered services.

To ensure quality, *KyHealth Choices* will provide financial incentives combined with strict standards and performance measures for each region. Payments made to the CMHCs will be made on a capitated basis to further allow flexibility and innovation. Again, the Commonwealth will monitor the CMHCs to ensure that performance measures and access are achieved.

In addition, the *KyHealth Choices* will place requirements through contractual agreements to emphasize the coordination with physical health, particularly by targeting co-morbidities and working with the KMAA.

Services for individuals with mental health and substance abuse disorders will move toward a recovery oriented system. The recovery oriented system must function in a way that incorporates cardinal principles and should include certain essential components such as:

- Treatment services
- Crisis intervention
- Rehabilitation
- Case management

- Outreach and Engagement
- Wellness and Prevention
- Consumer and Family Education

XIV. Provider Education and Accountability

While much is said in today's insurance market about member education, responsibility and accountability, *KyHealth Choices* also acknowledges an equally strong need for education, responsibility and accountability for providers. Through *KyHealth Choices*, mechanisms will be set in place that will ensure Medicaid providers will be educated about evidence based practices. Provider knowledge of best practices will improve the quality of care and lead to more efficient program operation. In addition, providers will increasingly be held to performance-based contracts with clearly-established goals.

XV. Fraud/ Illegal Sale of Prescription Drugs

The state is seeking to disqualify for one year, *KyHealth Choices* members who have been convicted under state law of fraud against the Kentucky Medicaid program or convicted of the illegal sale of prescription drugs. In the event the member is incarcerated for such a conviction, the state seeks the discretion to apply this disqualification for a period of one year after the completion of the sentence.

Goal Two

Encourage Medicaid members to be personally responsible for their own health care

Kentucky Medicaid recognizes that the individual can and should play a central role in purchasing and planning for he\r own health care services. *KyHealth Choices* members will recognize the role they play in reducing healthcare cost by making more conscientious choices – choices that result in their continued wellness. Members will be assisted by professional staff and will come to rely on Kentucky Medicaid to assure access to quality healthcare options in order to fulfill their wellness goals.

To accomplish Goal Two, *KyHealth Choices* will implement the following objectives:

I. Get Healthy Benefits

One of the more innovative components of *KyHealth Choices* will be to establish Get Healthy Benefits to promote wellness, self-care and health management. This program will provide a direct incentive to enrollees to take an active role in their health and further the consumer driven model.

Eligibility
All members who have one of several targeted conditions will be eligible to access Get Healthy Benefits. DMS will provide information to members and providers regarding the benefits to all eligible members in the targeted populations.

In addition, the Commonwealth will establish a list of activities that will generate access to the benefits by exercising personal responsibility and participating in established healthy practices.

Benefits:

Initially, disease conditions for participation in this program will be limited to pulmonary disease, diabetes and cardiac conditions, however, additions may be added later. Get Healthy Benefits will include additional dental and vision services or obtaining nutritional or smoking cessation counseling.

II. Education

KyHealth Choices will assure education for Medicaid members in an effort to assist them in making the best choice of a benefit package. An educated consumer will be able to make informed choices regarding health care decisions. A series of educational programs will be directed at providing individuals and

their families with complete, unbiased information on the various benefit plans, eligibility and the type of services available in their community. In addition, Kentucky Medicaid will employ various media to provide outreach and education statewide with respect to the transformation of Kentucky Medicaid and *KyHealth Choices*. Outreach efforts will be targeted to current and potential members and healthcare professionals across the state. Consumer directed options will be discussed as a component of the plans. Educational outreach will include the following components:

- Client Education (benefits packages, new eligibility regulations, enrollment/ disenrollment, new cost-sharing requirements, etc.);
- Provider Education (benefit packages of programs, cost-sharing, payment systems, information systems, etc.);
- Managed Care Plan Education (all of the above plus new capitation rate setting, access issues, etc.);
- Staff Education (Kentucky Medicaid staff, other agencies involved in *KyHealth Choices*);
- General Public Education (Health education, outreach, media, etc.).

Additional needs for public education will be assessed and a plan developed utilizing extensive public input through an open meeting process throughout the state.

III. Choice Counseling

Consumer Directed Option
Members in the *KyHealth Choices* will be provided with choice counseling to aide them in determining if they wish to participate in the Consumer Directed Option program (CDO) for Optimum and Comprehensive Choices.

"Opt-In" Option
In addition, choice counseling will be provided to ensure eligible members can make a fully qualified decision regarding their option to voluntarily "opt-in" to ESI.

Choice counseling in both programs will provide information to individuals interested in either program, explain the concepts and provide contact information. Choice Counseling will be administered through an independent contractor.

IV. Disease and Care Management

Kentucky Medicaid has begun the development of disease management programs to assist those with chronic illnesses such as asthma, diabetes, depression and heart disease and *KyHealth Choices* will further the progression of these disease management programs. These programs offer numerous services and information. Educational materials and information will be distributed through mailings. The goal is to make these educational materials and information available via the World Wide Web, health fairs, and/or classes and

partnerships with pharmaceutical companies. Members will also have habitual telephone contact disease management nurses, so that regular assessments of current health status can be performed. Through these contacts, nurses can also provide educational information about particular diseases and treatments, and can coordinate member services through close contact with physicians.

Methods for identifying members appropriate for disease management programs include paid claims and pharmacy data. Kentucky Medicaid has also asked providers for their assistance in coordinating the implementation of these programs, and providers may make patient referrals to a program. Additionally, members themselves may self-refer.

Cardiac Disease Management Program

The Cardiac Disease Management Program was implemented the week of October 21, 2005, with the first initiative focusing on Heart Failure. The target population for this program includes members 20 years and older (including dual members of Medicare and Medicaid) identified with the diagnosis of Heart Failure, excluding the diagnosis of heart failure in conjunction with renal failure. The program utilizes the practice guidelines of The 2005 American College of Cardiology/American Heart Association for the Diagnosis and Management of Chronic Heart Failure in the Adult, and the American Heart Association's "Get With The Guideline^{sm}-Heart Failure."

The goals of the Cardiac Disease Management Program are to:

- Improve outcomes/quality of life
- Prevent/delay complications of Heart Failure
- Foster self-care/self management
- Promote continuity of care
- Promote efficient use of health care resources
- Strengthen provider/patient relationships
- Lower total costs of Heart Failure management with a reduction in hospital admissions, readmission's and ER visits

A report on the Cardiac Disease Management Program will be available for review at the end of the first year after implementation.

Diabetes Disease Management Program

According to recent statistics, diabetes is the fifth leading cause of death by disease in Kentucky (KY Annual Vital Statistics Report). Based on those statistics and internal claims analysis, the Department for Medicaid Services began the implementation of a Diabetes Disease Management Program in February 2005 in two pilot counties, Bell and Floyd. Our first step of that initiative was the collection and establishment of baseline data for the identified members of Bell and Floyd counties. Medicaid's regional RN consultants reviewed the medical records of Medicaid patients who

were identified as newly diagnosed Diabetics. Dual eligibles, KCHIP children, LTC members, and waiver program participants were excluded. Members were also identified through the use of claims and pharmacy data.

Once this identification was completed, an introduction letter, Diabetes information wallet card, (from the ADA) and a brochure encouraging the members to take an active role in the management of their diabetes was mailed to each identified patient. The letter also encouraged members to contact their primary care provider to schedule an appointment for evaluation and establishment of a plan of treatment plan.

Through participation in this program, members receive educational materials and information regarding what should happen at each doctor's visit, such as checking blood pressure and weight, performing a foot and eye exam, and receiving diabetes education and nutrition counseling. Members are also encouraged to take charge of their own health care by tracking their own personal health targets. For example, members are reminded to have their A-1-C check, cholesterol screening, and microalbumin check. *KyHealth Choices* will continue the development of the Diabetes Disease Management Program.

Pediatric Asthma Disease Management Program

Asthma is the most common chronic disease in children, and more than 70,000 children in Kentucky suffer from Asthma (2002 CDC). For that reason, asthma was one of the first diseases that Kentucky Medicaid chose to target for a disease management program because there is great opportunity to treat this disease more effectively and to develop programs that will help manage the high costs associated with it.

The Pediatric Asthma Disease Management Program kicked off in August of 2005 in three pilot counties: Perry, Pike, and Powell. A data base tool was developed for identification of diabetic members ages 5 to 17 that had hospitalizations with the diagnosis of Asthma, claims data showing ER utilization with the diagnosis of asthma, and use of asthma related medications. Members were also identified by reviewing drug patterns for frequent refills of short acting Beta 2 agonists.

Educational materials were mailed to the identified members at the end of August. Educational opportunities for providers were coordinated with Regional Nursing staff and the Public Health Departments.

The expected goals and outcomes of the Pediatric Asthma Disease Management Program are to:

- Improve the quality of life for children with asthma
- Educate the parent and child to be better prepared to manage asthma
- Prevent acute exacerbations of asthma episodes

- Promote the appropriate use of health care resources
- Decrease school absences
- Improve self-management of asthma

This program will be fully operational by February 1, 2006, through *KyHealth Choices.*

Pediatric Obesity Disease Management Program

The Department for Medicaid Services has begun the implementation of a Pediatric Obesity Disease Management Program called *"Weigh to Go"* in four pilot counties: Christian, Fayette, Pike and Warren. Members in the age range of 5 to 12 were identified through claims data using diagnosis codes. Members with chronic behavioral issues were excluded.

The program teaches parents about dietary choices and physical activity to maintain a healthy lifestyle, and assists them with teaching their child(ren) healthy behaviors. The program also helps parents learn more about the potential for childhood overweight prevalence and the health problems it may cause.

The goals of this program are to:

- Educate the parent and child regarding healthy nutrition choices
- Promote active physical activity
- Prevent medical complications/co-morbidities
- Improve quality of life for children
- Improve self-esteem

An introductory letter, nutrition questionnaire, and educational materials including *"Food for Thought"* and *"Parent Tips for Healthy Eating and Physical Activity"* were mailed to each member identified as being at risk for obesity. The letter encouraged members to contact their primary care provider to schedule an appointment for evaluation and establishment of a treatment plan. A report on the program will be available at the end of the first year after implementation. *KyHealth Choices* will continue the progression of this program.

V. Aging and Disability Resource Grant (ADRC)

Kentucky was recently awarded an Aging and Disability Resource Center (ADRC) grant from CMS and the Administration of Aging. This three year grant focuses on long-term supports and will create an efficient, responsive, and comprehensive information and referral system to assure clients are informed of all choices for long-term supports and incorporate a seamless system for client access to all long-term care supports. Through this grant it is expected that those participating in the long-term care services covered by Medicaid will experience seamless access to all long-term support services. Major objectives will be the completion of a comprehensive web base resource directory of public and private, traditional and non-traditional services to include housing,

employment opportunities and church and organizational resources and the development of critical pathways to assure informed choice. *KyHealth Choices* will build on the model and lessons learned from the ARDC grant with the intention to expand the focus to all Medicaid populations.

VI. Preventive Care

Kentucky will utilize the recommendations in the Guide to Clinical Preventive Services, 2005 from the U.S. Preventive Services Task Force Centers and The Advisory Committee on Immunization Practices (ACIP) for vaccination schedules and screenings.

Chapter Five: Implementation Plan

The Kentucky Department for Medicaid Services plans to begin implementation of *KyHealth Choices* in May 2006.

KyHealth Choices is a complete transformation of the Kentucky Medicaid System. As such, the Department of Medicaid Services must be restructured to ensure full implementation of this massive initiative.

I. *KyHealth Choices* Administration

DMS has appointed a project manager to provide oversight and ensure structure and coordination of the on-going activities of *KyHealth Choices*. In addition, DMS has restructured the Department to accomplish the following functions:

- Eligibility and Enrollment: Division of Administration and Financial Management/Eligibility Policy Branch
- Member Services: KMAA and Division of Claims Management
- Disease Management: Division of Medical Management and Quality Assurance and KMAA
- Payment Systems: (including information systems and reporting: Division of Administration and Financial Management
- Monitoring and Quality Assurance: Division of Medical Management and Quality Assurance
- Education: Divisions of Claims Management, Medical Management and Quality Assurance, Long Term Care and Community Alternatives and (KMAA).
- Finance: Division of Administration and Financial Management and Commissioner's Office Fiscal Staff Assistants.

Beginning with the administrative structure, the Department will accomplish the following tasks:

1) Administrative Structure

   a) Review the current administrative structure, including all contracted Medicaid representation in all state agencies;
   b) Identify, plan and implement changes needed in state agencies to administer the nuances of *KyHealth Choices;*

c) Consider multiple programs, multiple benefit packages, and client cost-sharing, and other complexities;
d) Develop and implement applicable interagency agreements that clearly define the roles and responsibilities of all persons and agencies involved;
e) Identify, plan, propose and implement the administrative rules necessary for the management of *KyHealth Choices.*
f) Lead a project team comprised of subject matter specialists from various state agencies including the Division of Aging, The Department of Mental Health and Mental Retardation Services and the Department of Community Based Services to monitor progress; and
g) Coordinate information system changes, work with other state agencies, providers, contractors and clients, to ensure that information, data and payment issues are addressed and necessary changes made to the systems, including testing of the systems by the implementation date.

2) Enrollment

a) Review current eligibility/enrollment systems and processes;
b) Develop policies on administration of enrollment caps;
c) Identify changes needed to accommodate the increased complexity of income tracking, a more complex premium structure, multiple programs, multiple benefits packages, client cost-sharing and other new requirements of *KyHealth Choices;*
d) Through the rulemaking process, identify, plan, propose and implement regulations necessary for the administration of eligibility determination, enrollment and disenrollment, data collection and data sharing for *KyHealth Choices*;

3) Delivery Systems/Provider Network

a) Review current delivery system/provider network;
b) Work with managed care plans and other providers to identify changes needed to accommodate the nuances implicit to any new program;
c) Project and plan for health care needs and access-to-care issues under *KyHealth Choices*;
d) Plan for alternatives. (If existing systems cannot be accommodated under the *KyHealth Choices* plan or if access-to-care issues require other alternatives);
e) Kentucky Medicaid will assess each of its respective delivery systems and current capacities, and determine if alternative systems are needed. If needed, alternative models will be considered and implemented;
f) Technical assistance will be afforded to providers to support their efforts to accommodate the *KyHealth Choices* program and maintain access to care.

4) Payment Systems/Information

a) Review current payment systems, information systems and data systems;
b) Identify, plan for, and implement changes needed to accommodate the nuances of *KyHealth Choices* (increased use of income information, multiple programs, client cost-sharing, and other issues);
c) Identify, plan for, and implement changes needed in both state and provider systems to share necessary information. Consider HIPAA and other constraints;
d) Review current reporting requirements and reporting capabilities. Identify new reporting needs for Kentucky Medicaid, federal, state, legislative and internal;
e) Build flexibility into MMIS and other systems for future reporting needs;
f) Identify, plan for, and perform other necessary programming changes.

5) Fiscal Issues

a) Negotiate budget neutrality terms;
b) Complete and update forecasts;
c) Capitation rate setting – utilize independent actuary, work with managed care plans, set capitation rates and enter into new contracts with managed care plans;
d) Build in flexibility and monitoring capacity to expand/contract the program based on funding available.

II. Timeline

The Proposed timeline and rollout process will occur as follows:

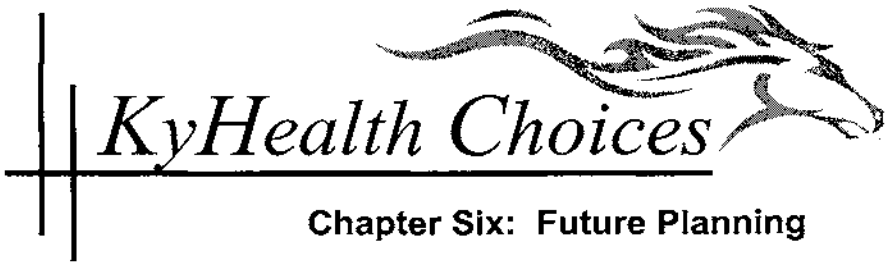
Phase One

Task	Timeline
Appoint project manager	December 1, 2005
Restructure the Department for Medicaid Services to prepare for implementation of *KyHealth Choices*	December 1, 2005 - December 15, 2005
All Medicaid members excluding those in the Passport program will be moved into KyHealth Choices.	May-July 2006
The Commonwealth will work with CMHCs to design service plans and goals for each of the 14 regions.	March – July 2006
Diabetes disease management program fully operational	April 3, 2006

RFP for Family Choices will be posted.	October 1, 2006
Begin implementation of regional behavioral service plans for the MH/MR CMHC regions.	August 1, 2006
Full implementation of disease management programs for diabetes, pulmonary disease, childhood obesity and cardiovascular disease will be finalized	October 1, 2006
Options to strengthen HIPP and the "opt-in" program will be rolled out state-wide.	April-July 2006
Get Healthy Benefits fully operational	October 1, 2006

Phase Two

Evaluate additional residential options such as group homes for those with acute medical needs for the MR/DD population	July 1, 2006-January 1, 2007
Add a "middle level of care" service package focusing on assisted living for the Nursing Facility level of care population.	July 1, 2007



Chapter Six: Future Planning

KyHealth Choices will be divided into two phases. During Phase II, should the funds become available, Kentucky plans to implement several unique initiatives. These initiatives will include the following:

- Augment personal care attendant and supported living programs to maintain the flexibility of the programs while stretching dollars. Expand on the Supported Living model.

- Expand disease management programs to include peer support and peer counseling services.

- Expand crisis stabilization to include individuals with mental retardation and other developmental disabilities

- Increase housing option and alternatives to institutionalization.

- Increase the physician payment fee schedule to recognize the increasing cost of providing healthcare services.

- Explore contracting dental services to a private dental carrier(s) for administration similar to commercially available carve out policies. Minimum benefits will be specified and the policy will be available as an added premium available for purchase by adult members. Children will automatically be enrolled in the plan.

- Increase the continuum of care for Optimum and Comprehensive Choices

- Continue evaluating options allowing individuals to be served in the least restrictive setting possible, i.e. supported living arrangements or their natural home.

- Reduce the number of people without insurance by offering, at a minimum, an in-patient and out-patient benefit to low-income Kentuckians who are currently uninsured. This will not be an expansion of Medicaid but a stand alone product focused on a network of publicly funded providers.