

Issue Brief

KyHealth Choices: What It Means for Children

Background

In 2006, significant changes were made to Kentucky's Medicaid program as the result of the Deficit Reduction Act (DRA) passed by Congress. DRA included unprecedented provisions that enabled states to restructure their Medicaid programs by designing plans modeled on commercial health insurance coverage. DRA also allowed states increased flexibility in shifting costs to Medicaid beneficiaries and limiting benefits as measures to cut down on state spending. Kentucky's Medicaid program, now called KyHealth Choices, consists of four benchmark plans aimed at addressing the individual needs of each Medicaid beneficiary, while saving the state money. After two years of KyHealth Choices, this issue brief will provide the most recent information about the program as it relates to children and will address certain issues that will require additional attention to ensure that access to health care services is not jeopardized.

The Four Plans of KyHealth Choices

Global Choices: The basic program in Kentucky that covers the general Medicaid population.

Family Choices: Medicaid plan for children including KCHIP members.

Optimum Choices: Covers Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care for individuals with mental retardation and developmental disabilities.

Comprehensive Choices: Covers members who are elderly and in need of a nursing facility level of care and individuals with acquired brain injuries.

Source: Cabinet for Family and Health Services, Department for Medicaid Services; KyHealth Choices Fact Sheet, <http://chfs.ky.gov/dms/KyHealthchoices.htm>

Revised July 2008

Author

Makeda Harris
mharris@kyyouth.org

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KENTUCKY YOUTH ADVOCATES

11001 Bluegrass Pkwy., Suite 100
Jeffersontown, KY 40299
(502) 895-8167

www.kyyouth.org

As of May 2008 there were 306,029 children enrolled in KyHealth Choices.¹ While *most* of them have been placed in the Family Choices plan, a smaller portion of children are covered under the other plans. Global Choices is Kentucky's basic Medicaid plan and includes mandatory populations covered under federal law (pregnant women, foster children, medically fragile children, disabled and elderly persons receiving SSI and families living below TANF eligibility levels). Children with mental or physical disabilities that meet eligibility criteria to participate in one of the three existing 1915c Medicaid waivers have been placed in the Comprehensive Choices or Optimum Choices plans.²

Under the DRA changes, a redesign of KCHIP was also planned. Phase I would have created a separate program for the Medicaid expansion component of KCHIP that serves children up to 150 percent of the federal poverty line, and model the separate program after the states enhanced plan for state employees. Children enrolled in KCHIP living between 151 and 200 percent of the federal poverty level would also be in this separate plan. In Phase II, the Kentucky Department for Medicaid Services (DMS) would choose a private insurer to operate the program. However, this redesign plan was later found to be minimally cost effective after an independent actuarial analysis of this redesign plan. The Department for Medicaid Services has not shared any recent information regarding a plan to redesign KCHIP.³

Medicaid and KCHIP children living in Jefferson County and the surrounding area are not enrolled in KyHealth Choices plans, but instead belong to the Passport Health Plan. Both Medicaid/KCHIP plans, however, are administered by the Kentucky Department for Medicaid Services. The Passport Health Plan is the operating name for University Health Care, Inc., a Medicaid managed care plan established in 1997 that serves sixteen counties of Kentucky (Jefferson, Oldham, Trimble, Carroll, Henry, Shelby, Spencer, Bullitt, Nelson, Washington, Marion, Larue, Hardin, Grayson,

Meade, Breckinridge). Passport children consist of approximately one fourth of the all children enrolled in Medicaid and KCHIP in the state.

“Soft” Limits and Children

No increases in cost-sharing for children under the age of 19 years old enrolled in Medicaid were imposed under KyHealth Choices. However, children enrolled in KCHIP are charged co-payments for prescription drugs and visits to the emergency room (see Appendices B and C). Families with children enrolled in KCHIP whose income is between 151 and 200 percent of the federal poverty level (also referred to as KCHIP Phase III) are also responsible for a \$20 monthly premium per family.

The issue of benefit limits, however, is less straightforward and will require continued monitoring to ensure that children's access to health care services is not negatively impacted. Kentucky's Department for Medicaid Services states that there are no “hard” limits on the number or type of medical services under KyHealth Choices. However, there are “soft” limits for some services beyond basic and preventive care. A “soft” limit is defined as a request submitted by a Medicaid provider to waive the benefit limits of a health service for a Medicaid patient if it is deemed medically necessary.⁴ If proven medically necessary these “soft” limits can be circumvented with prior authorization (PA). However, how families and providers perceive “soft” limits versus hard limits, or the impact of these limits on children's ability to receive services in a timely and efficient manner, have yet to be fully determined.

To add to the confusion, limits that exist for some children's services differ between KyHealth Choices plans. For example, in regards to vision services, the maximum limit on eyewear for members in the Global Choice plan is \$200 per twelve months, with a maximum amount of \$150 paid for one pair of glasses. However, family Choices members have a maximum of \$400 vision services per

twelve months, with a maximum amount of \$150 paid for one pair of glasses. As mentioned, these limits can be waived through a prior authorization process. Yet still, they pose unnecessary problems for children enrolled in Global Choices who need vision benefits that exceed the soft limit.

Another remaining concern includes limits, and PA requirements, for ancillary and home health services for children enrolled in KyHealth Choices. Kentucky's Department for Medicaid Services defines an ancillary service as "a direct therapy service for which a separate charge is customarily made."⁵ Clarification on limits and PA requirements for ancillary services is especially important for families with children with developmental or physical disabilities that need such services to help maintain their highest level of functioning that extends beyond restorative or rehabilitative services. When KyHealth Choices was first implemented in 2006, the limits on these services were set at 15 per year for physical therapy (PT) and occupational therapy (OT) and 10 per year for speech therapy (ST). These limits were eventually removed for children enrolled in KyHealth Choices. While therapies required authorization prior to KyHealth Choices, it must also be in an "approved setting." However, this is not clearly defined for KyHealth Choices members.⁶

Home health services for children require prior authorization, but limits differ between plans. Children enrolled in Family Choices are limited to 25 visits per calendar year, whereas children enrolled in Global Choices are not. Home health services are imperative for some children that have extraordinary medical needs, disabilities or chronic health conditions. According to the National Association of Children's Hospitals and Related Institutions (NACHRI), limits on home health services "greatly impact the ability of children with congenital anomalies and other serious developmental and medical conditions to live at home and achieve their full developmental potential."⁷ Therefore, it is important that children with special needs are placed in the

most appropriate plan under KyHealth Choices and mechanisms must be in place to ensure they receive the care they need is not hindered by confusing policies.

Regular monitoring and evaluation of KyHealth Choices, along with ongoing communication with families and providers is also necessary to ensure that children do not inadvertently suffer from limits imposed on adult services. A focus group report released by Kentucky Youth Advocates, "In the Dark: Families Share Their Experiences with KyHealth Choices", revealed that a lack of information regarding KyHealth Choices plans posed a barrier for some families in accessing health care for their children.⁸ Existing information gaps among KyHealth Choices members, providers and pharmacists resulted in some children not receiving prescription drugs they needed in a timely manner due to unnecessary PA requests and confusion regarding prescription drug limits. Some families were told they could not get prescriptions filled for their children (most of who were being treated for behavioral or developmental disabilities) because of a limit on prescription drugs of four per month with a maximum of three name brand names. However, this limit does not apply to children under 19 years of age. Name brand drugs are also not listed as requiring prior authorization for children.

EPSDT and EPSDT Special Services

It is equally important for members and providers to understand the relationship between "soft" limits and EPSDT (Early Periodic Screening, Diagnosis and Treatment) in KyHealth Choices. While the Deficit Reduction Act (DRA) provided states with more flexibility in restructuring their Medicaid programs, it did not give states the ability to change or limit the services through EPSDT, a program proven to be essential in providing adequate healthcare to low-income children.

EPSDT is a federally mandated program covering children under the age of 18 that receive Medicaid. With an emphasis on preventive care, EPSDT is a comprehensive healthcare plan that provides early and periodic medical, vision, hearing and dental screenings and immunizations. In addition to regular preventative check-ups, the early screening and diagnosis provided under EPSDT serves an important role in identifying physical and mental conditions and following up with the necessary treatment. EPSDT is vital in detecting conditions that may affect mental and physical development early in a child's life.

EPSDT is divided into two separate components under KyHealth Choices. The first being the screening and diagnosis (EPSD) and the second is focused on treatment aspect of the program (T). The treatment component is referred to as EPSDT Special Services. EPSDT Special Services is defined as a program that "allows coverage for items or services which are medically necessary and which are not covered somewhere else in Medicaid".⁹

Because EPSDT was designed to focus on diagnosis and treatment just as much as it is on preventive care and check-ups, it is important that every Medicaid eligible child receives both components of the program. Moreover, it is mandated by the federal government that children enrolled in Medicaid receive the benefits of all aspects of the program. Yet, the level of knowledge KyHealth Choices families have regarding EPSDT services and EPSDT Special Services remains unclear.

Enforceability and Opt-Out Provision

The issue of "enforceability" should be adequately explained to families, providers and pharmacists to ensure that services for the most vulnerable children are not denied. Families should also know and understand their choice to opt-out one of the benchmark plans and return to the basic Medicaid plan (now called Global Choices). This is particularly important for mandatory populations, some of who are currently enrolled in

Comprehensive and Optimum Choices instead of Global Choices.

Under DRA, states can deny Medicaid coverage to anyone who cannot pay an imposed fee for service allows providers to refuse to provide a service, and allows pharmacists to refuse to dispense prescriptions to a beneficiary that cannot pay a co-payment or other cost-sharing amount. However, this "enforceability" provision does not apply to beneficiaries that live below 100 percent of the federal poverty level (\$17,600 for a family of three). When KyHealth Choices was first implemented, beneficiaries living below 100 percent of the federal poverty level were also subjected to the enforceability provision but the regulation was later changed. Providers or pharmacies cannot refuse to provide a service or prescriptions to beneficiaries that live below 100 percent of the federal poverty level. Pharmacies are also required by federal law to provide a 72-hour emergency supply of any drug that would cause the member to be hospitalized or in jeopardy if it were not dispensed if denied. This should be properly communicated to providers, pharmacists and families to prevent any confusion or delay in services.

Federal law requires that certain populations (i.e., elderly persons, pregnant women and persons with disabilities) have a choice of remaining in one of the specially designed KyHealth Choice plans or remaining in the regular Medicaid plan (Global Choices). However, the choice of remaining in a plan or opting out to return to Global Choices was never clearly conveyed to KyHealth Choices members. During implementation of KyHealth Choices, beneficiaries were placed in benchmark plans without offering them a choice and letters sent to members failed to provide a clear explanation of the differences between the plans.

Conclusion

The Deficit Reduction Act of 2005 (DRA) passed by Congress gave states more flexibility in designing their Medicaid plans than ever before. This allowed Kentucky to build upon its existing Medicaid reform efforts and design KyHealth Choices – a program consisting of four benchmark plans tailored to meet enrollees’ health needs. Although DRA enabled states to increase cost-sharing and impose more limits on benefits to all enrollees, KyHealth Choices did not impose significant cost-sharing or limits on a large array of children’s benefit services. However, independent research suggests that new artificial limits or “soft” limits on some services for children have caused some confusion among KyHealth Choices members and the medical community. This in turn, has negatively impacted access to health care services.

No comprehensive evaluation of KyHealth Choices and children enrolled in the program has been shared with the public by the Cabinet for Health and Family Services. Yet, it remains clear that continuous monitoring, as well as an effective communication plan for families and the medical community is imperative to ensure that children receive all the services they are entitled to.

Endnotes

- 1 Personal correspondence with Kentucky Department for Medicaid Services. June 2008.
- 2 The 1915c waivers consist of the Acquired Brain Injury (ABI), Supports for Community Living (SCL) and the Home and Community Based (HCB) waivers. The waivers provide coverage to individuals with mental or physical developmental disabilities receiving long-term care services in community settings under Medicaid.
- 3 Personal correspondence with Kentucky Department for Medicaid Services. May 2007.
- 4 *KyHealth Choices Fact Sheet*. Cabinet for Health and Family Services, Department for Medicaid Services. <http://chfs.ky.gov/dms/kyhealthchoices.htm>. Accessed May 2007.
- 5 Cabinet for Health and Family Services, Department for Medicaid Services. <http://www.lrc.ky.gov/kar/907/001/023.htm>. Accessed May 2008.
- 6 *KyHealth Choices Member Handbook (2007)*. Cabinet for Health and Family Services, Department for Medicaid Services. <http://chfs.ky.gov/dms/kyhealthchoices.htm>. Accessed May 2008.
- 7 The National Association of Children’s Hospitals and Related Institutions (2005). Fact Sheet: 50-State Analysis of Adult Medicaid Benefits Shows Children Need Federal Guarantee of EPSDT Coverage. Available at: <http://www.childrenshospitals.net/AM/Template.cfm?Section=Accomplishments1&Template=/CM/HTMLDisplay.cfm&ContentID=20854>. Accessed May 2008.
- 8 Harris, M. (2008). *In the Dark: Families Share Their Experiences with KyHealth Choices*. Kentucky Youth Advocates. Available at: <http://www.kyyouth.org>.
- 9 *EPSDT*, Cabinet for Health and Family Services, Department for Medicaid Services. <http://chfs.ky.gov/epsdt.htm>. Accessed May 2007.

Appendix A KyHealth Choices Coverage for Children Enrolled in Global Choices (18 and under, ≤ 100% FPL)¹

Services	Benefit Limits?	Prior Authorization Re-quired?	Co-payments?
Regular Office Visits	No	No	No
Emergency Room Visits	No	No	No
Prescription Drugs	No	Yes (for certain name brand and non-preferred drugs)	No ²
Basic Dental Services	Yes (two cleanings per 12 months; 1 set of x-rays per 12 months)	Yes (for x-rays, orthodontic services and other services outside of preventive care)	No
Basic Vision Services	Yes (Global Choices: \$200 for one pair of glasses per twelve months; 1 eye exam per calendar year)	No	No
Allergy Services	No	No	No
Hearing Aids	Yes (not to exceed \$800 per ear every 36 months)	Yes	No
Home Health	No	Yes	No
Speech Therapy	No	Yes (if covered under EPSDT Special Services or home health)	No
Physical Therapy	No	Yes (if provided under EPDST Special Services or home health)	No
Occupational Therapy	No	No	No
Ambulance transportation in emergencies	No	No	No
Non-emergency transportation	No	No	No
EPSDT Special Services	No	Yes (must be medically necessary)	No

¹ Children that are part of the federal mandatory Medicaid population (foster children, medically fragile children or disabled children) have been placed in the Global Choices plan. All others have been placed in Family Choices

² Adults are limited to 4 prescriptions per month with a maximum of 3 name brand names. This 4 prescription limit does not apply to children under 19. Name brand prescription drugs for children are also not listed as requiring prior authorization.

Appendix B
**KyHealth Choices Coverage for KCHIP Children Enrolled in Family Choices
(18 and under (101% - 150% FPL))**

Services	Benefit Limits?	Prior Authorization Re-quired?	Co-payments?
Regular Office Visits	No	No	No
Emergency Room Visits	No	No	\$6 cap
Prescription Drugs	No	Yes (for certain name brand and non-preferred drugs)	\$1 generic \$2 preferred \$3 for non-preferred brand Rx
Basic Dental Services	Yes (two cleanings per 12 months; 1 set of x-rays per 12 months)	Yes (for x-rays, orthodontic services and other services outside of preventive care)	No
Basic Vision Services	Yes (\$400 maximum for two pairs of eyewear per twelve months; 1 eye exam per calendar year for all children)	No	No
Allergy Services	No	No	No
Hearing Aids	Yes (not to exceed \$800 per ear every 36 months)		
Home Health	Yes (25 visits per calendar year)	Yes	No
Speech Therapy	No	Yes (if covered under EPSDT Special Services or home health)	No
Physical Therapy	No	Yes (if covered under EPSDT Special Services or home health)	No
Occupational Therapy	No	Yes	No
Ambulance transportation in emergencies	No	No	No
Non-emergency transportation	No	No	No
EPSDT Special Services	No	Yes (must be medically necessary)	No

Appendix C

KyHealth Choices Coverage for KCHIP Children, 18 and under (151% - 200% FPL)

Services	Benefit Limits?	Prior Authorization Re-quired?	Co-payments?
Regular Office Visits	No	No	No
Emergency Room Visits	No	No	\$6 cap
Prescription Drugs	No	Yes (for certain name brand and non-preferred drugs)	\$1 generic \$2 preferred \$3 for non-preferred brand Rx
Basic Dental Services	Yes (two cleanings per 12 months; 1 set of x-rays per 12 months)	Yes (for x-rays, orthodontic services and other services outside of preventive care)	No
Basic Vision Services	Yes (\$400 maximum for two pairs of eyewear per twelve months; 1 eye exam per calendar year for all children)	No	No
Allergy Services	No	No	\$2 for office visit and testing
Home Health	Yes (25 visits per calendar year)	Yes	No
Speech Therapy	No	Yes (if covered under home health)	No
Physical Therapy	No	Yes (if covered under home health)	No
Occupational Therapy	No	Yes	No
Ambulance transportation in emergencies	No	No	No
Non-emergency transportation	Not covered	Not covered	Not covered
EPSDT Special Services	Not covered	Not covered	Not covered

* KCHIP children living between 151-200% percent poverty level must pay \$20 per month premium.