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

907 KAR 20:005. Medicaid technical eligibility requirements not related to a modified adjusted gross income standard or former foster care individuals.

RELATES TO: KRS 205.520, 205.6481-205.6497, 341.360, 42 C.F.R. 435, 403, 45 C.F.R. 233.100, 8 U.S.C. 1101, 1153(a)(7), 1157, 1158, 1182(d)(5), 1231(b)(3), 1253(h), 1522, 1612, 1613, 1622, 1641, 38 U.S.C. 101, 107, 1101, 1301, 1304, 5303A, 42 U.S.C. 402, 416, 423, 1382c, 1383c, 1395i, 1396a

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(1)(a)(84)(D), 1396a(a)(10), (r)(2), ~~[1396b(f),]~~1396d(q)(2)(B), 1397aa, 1397bb

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the technical eligibility requirements of the Medicaid Program except for individuals whose Medicaid eligibility standard is a modified adjusted gross income or for former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Individuals to whom the technical eligibility requirements in this administrative regulation apply include children in foster care; aged, blind, or disabled individuals; and individuals who receive supplemental security income benefits.

Section 1. The Categorically Needy.

(1) An individual receiving Title IV-E benefits, SSI benefits, or an optional or a mandatory state supplement shall be eligible for Medicaid as a categorically-needy individual.

(2) The following classifications of persons shall be considered categorically needy and eligible for Medicaid participation as categorically needy:

(a) A child in a foster family home or private child-caring facility dependent on a governmental or private agency;

(b) A child in a psychiatric hospital, psychiatric residential treatment facility, or intermediate care facility for individuals with an intellectual disability beginning with day thirty-one (31) of the child's stay in the psychiatric hospital, psychiatric residential treatment facility, or intermediate care facility for individuals with an intellectual disability;

(c) A child in a subsidized adoption dependent on a governmental agency;

(d) A qualified severely impaired individual as specified in 42 U.S.C. 1396a(a)(10)(A)(i)(II) and 1396d(q), to the extent the coverage is mandatory in this state;

(e) An individual who loses SSI benefit eligibility but would be eligible for SSI benefits except for entitlement to or an increase in his or her child's insurance benefits based on disability as specified in 42 U.S.C. 1383c;

(f) An individual specified in 42 U.S.C. 1383c who:

1. Loses SSI benefits or state supplement payments as a result of receipt of benefits pursuant to 42 U.S.C. 402(e) or (f);

2. Would be eligible for SSI benefits or state supplement payments except for these benefits; and

3. Is not entitled to Medicare Part A benefits;

(g) A disabled widow, widower, or disabled surviving divorced spouse, who would be eligible for SSI benefits except for entitlement to an OASDI benefit resulting from a change in the definition of disability;

(h) A child who:

1. Was receiving SSI benefits on August 22, 1996; and

2. Except for the change in definition of childhood disability would continue to receive SSI benefits; or

(i) A person with hemophilia who would be eligible for SSI benefits except that the individual received a settlement in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation".

(3) The classifications of persons listed in this subsection shall be considered categorically-needy and eligible for Medicaid participation as limited by the provisions of this subsection.

(a) A family which correctly received Medicaid for three (3) of the last six (6) calendar months, and would have been terminated from receipt of AFDC using AFDC methodologies in effect on July 16, 1996 as a result of new or increased collection of child or spousal support, shall be eligible for extended Medicaid coverage for four (4) consecutive calendar months beginning with the first month the family would have been ineligible for AFDC.

(b) A family which would have been terminated from AFDC assistance using the AFDC methodologies in effect on July 16, 1996 because of increased earnings, hours of employment, or loss of earnings disregards shall be eligible for up to four (4) months of extended Medicaid.

(c)

1. Except as provided in subparagraph 3 of this paragraph, an individual in an institution meeting appropriate patient status criteria who, if not institutionalized, would not be eligible for SSI benefits or optional state supplement benefits due to income shall be eligible under a special income level which is set at 300 percent of the SSI benefit amount payable for an individual with no income.

2. Except as provided in subparagraph 3 of this paragraph, eligibility for a similar hospice participant or similar participant in a 1915(c) home and community based waiver program for individuals with an intellectual disability or the aged, blind, or disabled shall be determined using the method established in subparagraph 1 of this subsection.

3. Eligibility of an individual in an intermediate care facility for individuals with an intellectual disability (ICF IID) or supports for community living for an individual with an intellectual disability or a developmental disability waiver meeting appropriate patient status criteria whose gross income exceeds 300 percent of the SSI benefit amount shall be determined by comparing the cost of the individual's care to the individual's income.

Section 2. Citizenship and Residency Requirements.

(1) The citizenship requirements established in 42 C.F.R. 435.406 shall apply.

(2) Except as established in subsection (3) or (4) of this section, to satisfy the Medicaid:

(a) Citizenship requirement, an applicant or recipient shall be:

1. A citizen of the United States as verified through satisfactory documentary evidence of citizenship or nationality presented during initial application or if a current recipient, upon next redetermination of continued eligibility;

2. A qualified alien who entered the United States before August 22, 1996, and is:

a. Lawfully admitted for permanent residence pursuant to 8 U.S.C. 1101;

b. Granted asylum pursuant to 8 U.S.C. 1158;

c. A refugee admitted to the United States pursuant to 8 U.S.C. 1157;

d. Paroled into the United States pursuant to 8 U.S.C. 1182(d)(5) for a period of at least one (1) year;

e. An alien whose deportation is being withheld pursuant to 8 U.S.C. 1253(h), as in effect prior to April 1, 1997, or 8 U.S.C. 1231(b)(3);

f. Granted conditional entry pursuant to 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;

g. An alien who is granted status as a Cuban or Haitian entrant pursuant to 8 U.S.C. 1522;

h. A battered alien pursuant to 8 U.S.C. 1641(c);

i. A veteran pursuant to 38 U.S.C. 101, 107, 1101, or 1301 with a discharge characterized as an honorable discharge and not on account of alienage;

j. On active duty other than active duty for training in the Armed Forces of the United States and who fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d);

k. The spouse or unmarried dependent child of an individual described in clause i. or j. of this subparagraph or the unremarried surviving spouse of an individual described in clause i. or j. of this subparagraph if the marriage fulfills the requirements established in 38 U.S.C. 1304; or

l. An Amerasian immigrant pursuant to 8 U.S.C. 1612(a)(2)(A)(v); or

3. A qualified alien who entered the United States on or after August 22, 1996 and is:

a. Granted asylum pursuant to 8 U.S.C. 1158;

b. A refugee admitted to the United States pursuant to 8 U.S.C. 1157;

c. An alien whose deportation is being withheld pursuant to 8 U.S.C. 1253(h), as in effect prior to April 1, 1997, or 8 U.S.C. 1231(b)(3);

d. An alien who is granted status as a Cuban or Haitian entrant pursuant to 8 U.S.C. 1522;

e. A veteran pursuant to 38 U.S.C. 101, 107, 1101, or 1301 with a discharge characterized as an honorable discharge and not on account of alienage;

f. On active duty other than active duty for training in the Armed Forces of the United States and who fulfils the minimum active duty service requirements established in 38 U.S.C. 5303A(d);

g. The spouse or unmarried dependent child of an individual described in clause e. or f. of this subparagraph or the unremarried surviving spouse of an individual described in clause e. or f. of this subparagraph if the marriage fulfills the requirements established in 38 U.S.C. 1304;

h. An Amerasian immigrant pursuant to 8 U.S.C. 1612(a)(2)(A)(v); or

i. An individual lawfully admitted for permanent residence pursuant to 8 U.S.C. 1101 who has earned forty (40) quarters of Social Security coverage; and

(b) Residency requirements, the applicant or recipient shall be a resident of Kentucky who meets the conditions for determining state residency pursuant to 42 C.F.R. 435.403.

(3) A qualified or nonqualified alien shall be eligible for medical assistance as provided in this paragraph.

(a) The individual shall meet the income, resource, and categorical requirements of the Medicaid Program.

(b) The individual shall have, or have had within at least one (1) of the three (3) months prior to the month of application, an emergency medical condition:

1. Not related to an organ transplant procedure; and

2. Which shall be a medical condition, including severe pain, in which the absence of immediate medical attention could reasonably be expected to result in placing the

individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(c)

1. Approval of eligibility shall be for a time limited period which includes, except as established in subparagraph 2 of this paragraph, the month in which the medical emergency began and the next following month.

2. The eligibility period shall be extended for an appropriate period of time upon presentation to the department of written documentation from the medical provider that the medical emergency will exist for a more extended period of time than is allowed for in the time limited eligibility period.

(d) The Medicaid benefits to which the individual is entitled shall be limited to the medical care and services, including limited follow-up, necessary for the treatment of the emergency medical condition of the individual.

(4)

(a) The satisfactory documentary evidence of citizenship or nationality requirement in subsection (2)(a)1 of this section shall not apply to an individual who:

1. Is receiving SSI benefits;
2. Previously received SSI benefits but is no longer receiving them;
3. Is entitled to or enrolled in any part of Medicare;
4. Previously received Medicare benefits but is no longer receiving them;
5. Is receiving:
   a. Disability insurance benefits under 42 U.S.C. 423; or
   b. Monthly benefits under 42 U.S.C. 402 based on the individual's disability pursuant to 42 U.S.C. 423(d);
6. Is in foster care and who is assisted under Title IV-B of the Social Security Act, which is codified as 42 U.S.C. 621 through 628b; or
7. Receives foster care maintenance or adoption assistance payments under Title IV-E of the Social Security Act, which is codified as 42 U.S.C. 670 through 679c.

(b) The department's documentation requirements shall be in accordance with the requirements established in 42 U.S.C. 1396b(x).

(5) The department shall assist an applicant or recipient who is unable to secure satisfactory documentary evidence of citizenship or nationality in a timely manner because of incapacity of mind or body and lack of a representative to act on the applicant's or recipient's behalf.

(6) An individual shall be determined eligible for Medicaid for up to three (3) months prior to the month of application if all conditions of eligibility are met.

Section 3. The Medically Needy Who Qualify Via Spenddown. A medically needy individual who has sufficient income to meet the individual's basic maintenance needs may apply for Medicaid with need determined in accordance with the income and resource standards established in 907 KAR 20:020 through 907 KAR 20:045, if the individual meets:

(1) The income and resource standards of the medically needy program established in 907 KAR 20:020 and 907 KAR 20:025; and

(2) The technical requirements of the appropriate categorically needy group identified in Section 1 of this administrative regulation.

Section 4. Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, Specified Low-Income Medicare Beneficiaries, and Medicare Qualified Individuals Group 1 (QI-1).

(1) Coverage shall be extended to a qualified Medicare beneficiary as specified in 42 U.S.C. 1396a(a)(10)(E):

(a) Subject to the income limits established in 907 KAR 20:020:

(b) Subject to the resource limits established in 907 KAR 20:025; and

(c) For the scope of benefits specified for a QMB in 907 KAR 1:006.

(2) A QMB shall:

(a) Be eligible for or receive Medicare Part A and Part B benefits;

(b) Be determined to be eligible for QMB benefits effective for the month after the month in which the eligibility determination has been made; and

(c) Not be eligible for QMB benefits:

1. Retroactively; or

2. For the month in which the eligibility determination was made.

(3) A qualified disabled and working individual shall be eligible under Medicaid for payment of the individual's Medicare Part A premiums as established in 907 KAR 1:006.

(4) A specified low-income Medicare beneficiary shall be eligible under Medicaid for payment of the Medicare Part B premiums.

(5) A Medicare qualified individual group 1 (QI-1) shall be eligible for payment of all of the Medicare Part B premium.

Section 5. Technical Eligibility Requirements. The technical eligibility factors for an individual included as categorically needy under Section 1 of this administrative regulation shall be as established in this section.

(1) The following shall meet the requirements of a child in accordance with 907 KAR 20:001, Section 1(19):

(a) A child in foster care;

(b) A child in a private institution;

(c) A child in a psychiatric hospital;

(d) A child in a psychiatric residential treatment facility; or

(e) A child in an intermediate care facility for individuals with an intellectual disability.

(2) An aged individual shall be at least sixty-five (65) years of age.

(3) A blind individual shall meet the definition of blindness as contained in 42 U.S.C. 416 and 42 U.S.C. 1382c relating to Retirement, Survivors, and Disability Insurance or SSI benefits.

(4) A disabled individual shall meet the definition of permanent and total disability as established in 42 U.S.C. 423(d) and 42 U.S.C. 1382c(a)(3) relating to RSDI and SSI benefits.

(5)

(a) Using AFDC methodologies in effect on July 16, 1996, a family who loses Medicaid eligibility solely because of increased earnings or hours of employment of the caretaker relative or loss of earnings disregards may receive up to four (4) months of extended medical assistance for family members included in the medical assistance unit prior to losing Medicaid eligibility.

(b) The family shall meet the eligibility and reporting requirements for the benefit period established in this subsection.

(c) The benefit period shall begin with the month the family would have become ineligible for AFDC using AFDC methodologies in effect on July 16, 1996.

1. To be eligible for this transitional benefit period, the family shall:

a. Have correctly received Medicaid assistance in three (3) of the six (6) months immediately preceding the month the family would have become ineligible for AFDC using AFDC methodologies in effect on July 16, 1996;

b. Have a dependent child living in the home; and

c. Report earnings and child care costs no later than the 21st day of the fourth month.

2. If the family no longer has a dependent child living in the home, medical assistance shall be terminated the last day of the month the family no longer includes a dependent child.

(6) An applicant who is deceased shall have eligibility determined in the same manner as if the applicant were alive to cover medical expenditures during the terminal illness.

(7)

(a) An individual shall be determined eligible for Medicaid for up to three (3) months prior to the month of application if all conditions of eligibility are met and the applicant is not enrolled in a managed care organization.

(b) The effective date of Medicaid shall be the first day of the month of eligibility.

(8)

(a) Benefits shall be denied to a family for a month in which a parent with whom the child is living is, on the last day of the month, participating in a strike, and the individual's needs shall not be considered in determining eligibility for Medicaid for the family if, on the last day of the month, the individual is participating in a strike.

(b) A strike shall include a concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) or any concerted slowdown or other concerted interruption of operations by employees.

Section 6. Institutional Status.

(1) An individual shall not be eligible for Medicaid if the individual is a:

(a) Resident or inmate of a nonmedical public institution except as provided in Section 7 of this administrative regulation;

(b) Patient in a state tuberculosis hospital unless he or she has reached age sixty-five (65);

(c) Patient in a mental hospital or psychiatric facility unless the individual is:

1. Under twenty-one (21) years of age;

2. Under age twenty-two (22) if the individual was receiving inpatient services on his or her 21st birthday; or

3. Sixty-five (65) years of age or over; or

(d) Patient in an institution for mental diseases, unless the individual has reached age sixty-five (65).

(2) In accordance with subsection (1)(c) of this section, if an individual is receiving services in a mental hospital or psychiatric facility at the time the individual reaches twenty-one (21) years of age and the services remain medically necessary for the individual, the individual shall remain eligible for the services until the individual reaches age twenty-two (22) years of age.

Section 7. Emergency Shelters or Incarceration Status.

(1) An individual or family group who is in an emergency shelter for a temporary period of time shall be eligible for medical assistance, even though the shelter is considered a public institution, under the following conditions:

(a) The individual or family group shall:

1. Be a resident of an emergency shelter no more than six (6) months in any nine (9) month period; and

2. Not be in the facility serving a sentence imposed by the court, or awaiting trial; and

(b) Eligibility for Medicaid shall have existed immediately prior to admittance to the shelter or it shall exist immediately after leaving the shelter.

(2) An inmate shall be eligible for Medicaid during the period of time the inmate is admitted to a hospital if the inmate:

(a) Has been admitted to a hospital;

(b) Has been an inpatient at the hospital for at least twenty-four (24) consecutive hours; and

(c) Meets the Medicaid eligibility criteria established in this administrative regulation.

Section 8. Justice Involved Children or Youth.

(1) A justice involved child or youth who is within thirty (30) days of their scheduled release date shall be eligible for Medicaid as established pursuant to 42 U.S.C. 1396a(1)(a)(84)(D) and 1397bb.

(2) Covered services for justice involved youth shall be provided by reentry organizations authorized and approved by the department and may include:

(a) The Department for Juvenile Justice;

(b) The Department of Corrections; or

(c) Local jails; or

(d) An approved third-party contractor that assists one (1) of the entities in paragraphs (a) through (c) of this subsection in delivering services pursuant to this section.

Section 9. Application for Other Benefits.

(1) Except as provided in subsection (2) of this section, as a condition of eligibility for Medicaid, an applicant or recipient shall apply for each annuity, pension, retirement, and disability benefit to which the applicant or recipient is entitled, unless the applicant or recipient can show good cause for not doing so.

(a) Good cause shall be considered to exist if other benefits have previously been denied with no change of circumstances or the individual does not meet all eligibility conditions.

(b) Annuities, pensions, retirement, and disability benefits shall include:

1. Veterans' compensations and pensions;
2. Retirement and survivors disability insurance benefits;
3. Railroad retirement benefits;
4. Unemployment compensation; and
5. Individual retirement accounts.

(2) An applicant or recipient shall not be required to apply for federal benefits if:

(a) The federal law governing that benefit specifies that the benefit is optional; and

(b) The applicant or recipient believes that applying for the benefit would be to the applicant's or recipient's disadvantage.

(3) An individual who would be eligible for SSI benefits but has not made application shall not be eligible for Medicaid.

Section 10. ~~[Section 9.]~~ Assignment of Rights to Medical Support. By accepting assistance for or on behalf of a child, a recipient shall be deemed to have made an assignment to the cabinet of any medical support owed for the child not to exceed the amount of Medicaid payments made on behalf of the recipient.

Section 11. ~~[Section 10.]~~ Third-party Liability as a Condition of Eligibility.

(1)

(a) Except as provided in subsection (3) of this section, an individual applying for or receiving Medicaid shall be required as a condition of eligibility to cooperate with the cabinet in identifying, and providing information to assist the cabinet in pursuing, any third party who may be liable to pay for care or services available under the Medicaid Program unless the individual has good cause for refusing to cooperate.

(b) Good cause for failing to cooperate shall exist if cooperation:

1. Could result in physical or emotional harm of a serious nature to a child or custodial parent;
2. Is not in a child's best interest because the child was conceived as a result of rape or incest; or
3. May interfere with adoption considerations or proceedings.

(2) A failure of the individual to cooperate without good cause shall result in ineligibility of the individual.

(3) A pregnant woman with income up to 195 percent of the federal poverty level established annually by the United States Department of Health and Human Services pursuant to 42 U.S.C. 9902(2) shall not be required to cooperate in establishing paternity or securing support for her unborn child.

Section 12. ~~[Section 11.]~~ Provision of Social Security Numbers.

(1) Except as provided in subsections (2) and (3) of this section, an applicant or recipient of Medicaid shall provide a Social Security number as a condition of eligibility.

(2) An individual shall not be denied eligibility or discontinued from eligibility due to a delay in receipt of a Social Security number from the United States Social Security Administration if appropriate application for the number has been made.

(3) An individual who refuses to obtain a Social Security number due to a well-established religious objection shall not be required to provide a Social Security number as a condition of eligibility.

Section 13. ~~[Section 12.]~~ Applicability. The provisions and requirements of this administrative regulation shall:

(1) Apply to:

(a) Children in foster care;

(b) Aged, blind, or disabled individuals; and

(c) Individuals who receive supplemental security income benefits; and

(2) Not apply to an individual whose Medicaid eligibility is determined:

(a) Using the modified adjusted gross income standard pursuant to 907 KAR 20:100; or

(b) Pursuant to 907 KAR 20:075.

LISA D. LEE, Commissioner
ERIC C. FRIEDLANDER, Secretary

APPROVED BY AGENCY: December 20, 2024

FILED WITH LRC: December 23, 2024 at 12:15 p.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on March 24, 2025, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by March 17, 2025, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends virtually will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until March 31, 2025. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-7476; fax 502-564-7091; email CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person:Jonathan Scott or Krista Quarles

(1) Provide a brief summary of:

(a) What this administrative regulation does:
This administrative regulation establishes technical eligibility requirements for Kentucky's Medicaid program for children in foster care; aged, blind, or disabled individuals; and individuals who receive supplemental security income (SSI) benefits.

(b) The necessity of this administrative regulation:
This administrative regulation is necessary to establish Medicaid program eligibility requirements in accordance with federal law and regulation and as authorized by KRS 194A.030(2) which establishes the Department for Medicaid Services as the commonwealth's single state agency for administering the federal Social Security Act.

(c) How this administrative regulation conforms to the content of the authorizing statutes:
This administrative regulation conforms to the content of KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing Medicaid program technical eligibility requirements in accordance with federal law and as authorized by KRS 194A.030(2).

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes:
This administrative regulation assists in the effective administration of KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing Medicaid program technical eligibility requirements in accordance with federal law and as authorized by KRS 194A.030(2).

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation:
The amendments allow incarcerated children or youth to receive targeted services 30 days prior to release. A citation to the specific targeted services required to be provided pursuant to federal law is also provided. In addition, departmental authority to provide covered services through reentry organizations is established.

(b) The necessity of the amendment to this administrative regulation:
This amendment is necessary to add a federal requirement to cover incarcerated youth as contained in the 2023 Consolidated Appropriations Act.

(c) How the amendment conforms to the content of the authorizing statutes:
This amendment conforms to the content of the authorizing statutes by implementing a federally required new group of recipients.

(d) How the amendment will assist in the effective administration of the statutes:
This amendment assists with the affective administration of the statutes by implementing a new group of recipients required by federal law.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation:

DMS anticipates that 250 incarcerated youth could be eligible for these services during the course of a year.

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

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment:

No action is required, regulated entities will be able to bill and receive a higher reimbursement.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3):

Regulated entities will experience no new costs in complying with this administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3):

Recipients will be able to participate in the expanded reimbursement now available for this waiver.

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

(a) Initially:

DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

(b) On a continuing basis:

DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation:

Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment:

Neither an increase in fees nor funding will be necessary to implement the amendments.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees:

The amendment does not establish or increase any fees.

(9) TIERING: Is tiering applied?

Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FISCAL IMPACT STATEMENT

(1) Identify each state statute, federal statute, or federal regulation that requires or authorizes the action taken by the administrative regulation.

KRS 194A.030(2), 194A.050(1), 205.520(3).

(2) Identify the promulgating agency and any other affected state units, parts, or divisions:

Department for Medicaid Services is the promulgating agency, other agencies have not been identified.

(a) Estimate the following for the first year:

Expenditures:DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

Revenues:The Department does not anticipate revenues as a result of this administrative regulation.

Cost Savings:The Department does not anticipate cost savings as a result of this administrative regulation.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?

DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

(3) Identify affected local entities (for example: cities, counties, fire departments, school districts):

N/A

(a) Estimate the following for the first year:

Expenditures:DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

Revenues:The department does not anticipate revenues as a result of this administrative regulation.

Cost Savings:The department does not anticipate cost savings as a result of this administrative regulation.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?

DMS does not expect additional expenditures, revenues, or cost savings for local entities as a result of this regulation.

(4) Identify additional regulated entities not listed in questions (2) or (3):

Enrolled providers providing services to this new eligibility group.

(a) Estimate the following for the first year:

Expenditures:DMS does not anticipate additional expenditures for regulated entities.

Revenues:Participating providers will benefit from reimbursement for this service.

Cost Savings:The department does not anticipate cost savings as a result of this administrative regulation.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?

DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6. Revenues: Participating providers will benefit from increased reimbursement. Cost Savings: The department does not anticipate cost savings as a result of this administrative regulation.

(5) Provide a narrative to explain the:

(a) Fiscal impact of this administrative regulation:
DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

(b) Methodology and resources used to determine the fiscal impact:
The consensus forecasting group established the Medicaid baseline budget and included the provisions of CAA Section 5121 in their estimations.

(6) Explain:

(a) Whether this administrative regulation will have an overall negative or adverse major economic impact to the entities identified in questions (2) - (4). ($500,000 or more, in aggregate)
The administrative regulation will not have a major economic impact – as defined by KRS 13A.010 – on regulated entities.

(b) The methodology and resources used to reach this conclusion:
This administrative regulation will provide additional reimbursement for providers treating justice involved youth.

FEDERAL MANDATE ANALYSIS COMPARISON

(1) Federal statute or regulation constituting the federal mandate.
42 C.F.R. part 435

(2) State compliance standards.
KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

(3) Minimum or uniform standards contained in the federal mandate.
General categorical, and optional eligibility requirements for the Medicaid program are established.

(4) Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?
The amendment will not impose stricter than federal requirements.

(5) Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.
The amendment will not impose stricter than federal requirements.