Medicaid Alternative Benefit Plan

Medicaid Alternative Benefit Plan: General Information

State/Territory name: Kentucky

Transmittal Number: 18-0001

General Information:

Submission Title:

short (under 100 characters) label used to identify this submission in the web application

KY ABP

Description:

The purpose of this SPA is to change the approved adult group coverage to match that of Kentucky's approved 1115 waiver, moving routine dental and vision to the My Rewards Account and removed Non-emergency medical transportation.

☑ Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

ABP Screening Statements to Indicate Required Forms

Select one of the following options for eligibility group coverage:

- ◉ **The population group for this Alternative Benefit Plan includes only** the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act. *If the state selects this option, the state must complete form ABP2a to indicate agreement to voluntary benefit package selection assurances for the adult group.*
- ○ **The population group for this Alternative Benefit Plan includes the adult group under section 1902 (a)(10)(A)(i)(VIII) of the Act, and also includes other groups.** *If the state selects this option, the state must complete forms ABP2a and ABP2b to indicate agreement to voluntary benefit package selection assurances for the adult group and voluntary enrollment assurances for other eligibility groups.*
- ○ **The population for this Alternative Benefit Plan does not include the adult group under section 1902 (a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2b to indicate agreement to voluntary enrollment assurances for these eligibility groups.*

☑ Enrollment is mandatory for some or all participants. *If selected, the state must complete form ABP2c to indicate agreement to mandatory enrollment assurances.*

Specify the number of **benchmark** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP5, and ABP8 for each benchmark benefit package.* 1

Specify the number of **benchmark-equivalent** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.* 0

Medicaid Alternative Benefit Plan: File Management Summary

State/Territory name: Kentucky

Transmittal Number: 18-0001

Form Code	Form Name	Uploaded Form Count
ABP1	Alternative Benefit Plan Populations	1

Form Code	Form Name	Uploaded Form Count
ABP2a	Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	1
ABP2b	Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	0
ABP2c	Enrollment Assurances - Mandatory Participants	1
ABP3	Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package	1
ABP4	Alternative Benefit Plan Cost-Sharing	1
ABP5	Benefits Description	1
ABP6	Benchmark-Equivalent Benefit Package	0
ABP7	Benefits Assurances	1
ABP8	Service Delivery Systems	1
ABP9	Employer Sponsored Insurance and Payment of Premiums	1
ABP10	General Assurances	1
ABP11	Payment Methodology	1

Medicaid Alternative Benefit Plan: File Management Detail

Form ABP1: Alternative Benefit Plan Populations

ABP1 Forms List

Form
Please provide a short description of this ABP1 form:
Uploaded Form Name: Date Uploaded:
ABP1 - Alternative Benefit Plan Populations.pdf

Support Documents

Document

Form ABP2a: Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a Forms List

Form
Please provide a short description of this ABP2a form:
Uploaded Form Name: Date Uploaded:

Form
ABP2a - Voluntary Benefit Package Selection Assurances.pdf

Support Documents

Document

Form ABP2b: Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2b Forms List

Form

Support Documents

Document

Form ABP2c: Enrollment Assurances - Mandatory Participants

ABP2c Forms List

Form
Please provide a short description of this ABP2c form:
Uploaded Form Name: Date Uploaded:
ABP2c - Enrollment Assurances - Mandatory Participants.pdf

Support Documents

Document

Form ABP3: Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3 Forms List

Form
Please provide a short description of this ABP3 form:
Uploaded Form Name: Date Uploaded:
ABP3 - Selection of Benchmark Benefit Package or Benchmark Equivalent Package

Support Documents

Document

Form ABP4: Alternative Benefit Plan Cost-Sharing

ABP4 Forms List

Form
Please provide a short description of this ABP4 form:
Uploaded Form Name: Date Uploaded:
ABP4 - Alternative Benefit Plan Cost-Sharing.pdf

Support Documents

Document

Form ABP5: Benefits Description

ABP5 Forms List

Form
Please provide a short description of this ABP5 form:
Uploaded Form Name: Date Uploaded:
ABP5 - Benefits Description.pdf

Support Documents

Document

Form ABP6: Benchmark-Equivalent Benefit Package

ABP6 Forms List

Form

Support Documents

Document

Form ABP7: Benefits Assurances

ABP7 Forms List

Form
Please provide a short description of this ABP7 form:
Uploaded Form Name: Date Uploaded:
ABP7 - Benefits Assurances.pdf

Support Documents

Document

Form ABP8: Service Delivery Systems

ABP8 Forms List

Form
Please provide a short description of this ABP8 form:
Uploaded Form Name: Date Uploaded:
ABP8 - Service Delivery Systems.pdf

Support Documents

Document

Form ABP9: Employer Sponsored Insurance and Payment of Premiums

ABP9 Forms List

Form
Please provide a short description of this ABP9 form:
Uploaded Form Name: Date Uploaded:
ABP9 - Employer Sponsored Insurance and Payment of Premiums.pdf

Support Documents

Document

Form ABP10: General Assurances

ABP10 Forms List

Form
Please provide a short description of this ABP10 form:
Uploaded Form Name: **Date Uploaded:**
ABP10 - General Assurances.pdf

Support Documents

Document

Form ABP11: Payment Methodology

ABP11 Forms List

Form
Please provide a short description of this ABP11 form:
Uploaded Form Name: **Date Uploaded:**
ABP11 - Payment Methodology.pdf

Support Documents

Document

Medicaid Alternative Benefit Plan: Tribal Input

State/Territory name: **Kentucky**

Transmittal Number: **18-0001**

☐ **One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☐ **The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner. ***States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:***

☐ **Indian Tribes**

☐ **Indian Health Programs**

☐ Urban Indian Organization

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Indicate the key issues raised in Indian consultative activities:

☐ Access

Summarize Comments

Summarize Response

☐ Quality

Summarize Comments

Summarize Response

☐ Cost

Summarize Comments

Summarize Response

☐ Payment methodology

Summarize Comments

Summarize Response

☐ Eligibility

Summarize Comments

Summarize Response

☐ Benefits

Summarize Comments

Summarize Response

☐ Service delivery

Summarize Comments

Summarize Response

☐ **Other Issue**

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Kentucky**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST = the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

18-0001

Proposed Effective Date

07/01/2018 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2018	$0.00
Second Year	2019	$0.00

Subject of Amendment

Kentucky is submitting this SPA to align the current Adult Group benefits to the benefits of the approved 1115 waiver.

Governor's Office Review

- ◉ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:
- ○ **No reply received within 45 days of submittal**
- ○ **Other, as specified**

  Describe:

Signature of State Agency Official

Submitted By: **Sharley Hughes**

Last Revision Date: **Apr 23, 2018**

Submit Date: **Apr 23, 2018**