

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 9:005

Department for Medicaid Services
Amended After Comments

(1) A public hearing regarding 907 KAR 9:005 was not requested and; therefore, not held.

(2) The following individuals submitted written comments regarding 907 KAR 9:005:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Kathy Adams, Director of Public Policy	The Children's Alliance; Frankfort, KY
Peggy Roark, Parent Representative and SIAC Chair	State Interagency Council (SIAC); Frankfort, KY

(3) The following individuals from the promulgating agency responded to comments received regarding 907 KAR 9:005:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Neville Wise, Deputy Commissioner	Department for Medicaid Services
Dr. Allen Brenzel, Clinical Director	Department for Behavioral Health, Developmental and Intellectual Disabilities
Jill Hunter, Director	Department for Medicaid Services, Division of Health Care Facilities Management
Stuart Owen, Regulation Coordinator	Department for Medicaid Services

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Insert Definition of "Face-to-Face" to Allow for Diagnostic and Assessment Services to be Delivered Via Telemedicine

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended "that a definition of face-to-face be added to include telemedicine as "face-to-face" or that this provision is clarified to allow for telemedicine to count as the face-to-face specialty evaluation, as it is currently allowed and needs to continue due to the shortage of medical professionals in some areas of the state."

(b) Response: DMS is revising the diagnostic and assessment services definition by

incorporating an evaluation performed via telemedicine as follows:

“(5) “Diagnostic and assessment services” means at least one (1) face-to-face specialty evaluation or specialty evaluation performed via telemedicine of a recipient’s medical, social, and psychiatric status”

Additionally, DMS is inserting the following definition of telemedicine in the Definitions section of the administrative regulation:

“(22) “Telemedicine” means the use of electronic information and telecommunications technologies to support long-distance clinical health care.”

(2) Subject: Revise Diagnostic and Assessment Definition

(a) Comment: Kathy Adams, Direct of Public Policy of the Children’s Alliance, recommended “that the definition of diagnostic and assessment services as including “testing and interviewing” be rewritten as including “interviewing and evaluating or testing” as “testing is not always necessary.”

(b) Response: DMS is revising the language in an “amended after comments” regulation as follows:

“(a) Include: ~~testing and interviewing~~;
1. Interviewing and evaluation; or
2. Testing;”.

⋮

(3) Subject: Revise Intensive Treatment Services Definition

(a) Comment: Kathy Adams, Direct of Public Policy of the Children’s Alliance, recommended that the definition of intensive treatment services be re-arranged as follows in order to clarify that “severe and persistent” does not apply to intellectual disability.”

(7) “Intensive treatment services” means a program:
(a) For a child:
1. With a severe emotional disability; and
a. A ~~severe and persistent aggressive behavior~~, intellectual disability, a severe and persistent aggressive behavior, or sexually acting out behavior; or

(b) Response: DMS is revising the language in an “amended after comments” regulation as follows:

“a. An~~[A severe and persistent aggressive behavior,~~] intellectual disability, a severe and persistent aggressive behavior, or sexually acting out behavior; or”.

(4) Subject: Qualified Mental Health Professional/Behavioral Health Professional and

Behavioral Health Professional under Clinical Supervision

(a) Comment: Kathy Adams, Direct of Public Policy of the Children’s Alliance, expressed concern that all services must be provided by a qualified mental health professional “when certain services or skills may be performed by other certified, trained and qualified staff.” Ms. Adams requested that the Department for Medicaid Services (DMS) “review all lines where a QMPH is identified to ensure this is the level of staff needed.”

(b) Response: DMS is filing an “amended after comments” regulation which adds behavioral health professionals and behavioral health professionals acting under clinical supervision to the group of authorized practitioners of individual therapy, family therapy, group therapy, substance abuse education and crisis intervention. DMS is not adding mental health associates (as practitioners) as requested.

Additionally, DMS is inserting the definitions of behavioral health professional used in 907 KAR 3:030 and behavioral health professional under clinical supervision used in 907 KAR 3:030.

(c) Comment: Kathy Adams, Direct of Public Policy of the Children’s Alliance, stated the following:

“1. **Page 18, Line 21** – Suggest **Section 4(1)(c)** be re-written to include Behavioral Health Professional (BHP) and BHP under clinical supervision. Delivery of services listed in subparagraph (a) 7,8,9, 11 or 13 should not be restricted to delivery only by a QMHP, but should also allow other qualified professionals to deliver these services, especially in regards to substance abuse education and crisis intervention. Suggest Section 4(1)(c) be re-written as specified in red font below:

(c) A Level I PRTF service listed in subparagraph (a)7, 8, 9, 11, or 13 shall be provided by a qualified mental health professional, mental health associate, behavioral health professional as defined by 907 KAR 3:030(2) or behavioral health professional under clinical supervision as defined by 907 KAR 3:030(3); or.”

(d) Response: DMS is revising the requirement in an “amended after comments” regulation by adding behavioral health professionals and behavioral health professionals acting under clinical supervision to be authorized practitioners of individual therapy, family therapy, group therapy, substance abuse education and crisis intervention. DMS is not adding mental health associates (as practitioners) as requested.

Additionally, DMS is inserting the definitions of behavioral health professional used in 907 KAR 3:030 and behavioral health professional under clinical supervision used in 907 KAR 3:030.

(e) Comment: Kathy Adams stated the following:

2. **Page 19, Line 10** - Suggest **Section 4(2)** be re-written to include Behavioral Health Professional (BHP) and BHP under clinical supervision. Delivery of services listed in subparagraph (a) 7,8,9, 11 or 13 should not be restricted to delivery only by a QMHP, but should also allow other qualified professionals to deliver these services, especially in regards to substance abuse education and crisis intervention. Suggest Section 4(2) be re-written as specified in red font below:

(2) A Level II PRTF service listed in subparagraph (a)7, 8, 9, 11, or 13 shall be provided by a qualified mental health professional, mental health associate, behavioral health professional as defined by 907 KAR 3:030(2) or behavioral health professional under clinical supervision as defined by 907 KAR 3:030(3).

(f) Response: DMS is revising the requirement in an “amended after comments” regulation by adding behavioral health professionals and behavioral health professionals acting under clinical supervision to be authorized practitioners of individual therapy, family therapy, group therapy, substance abuse education and crisis intervention. DMS is not adding mental health associates (as practitioners) as requested.

Additionally, DMS is inserting the definitions of behavioral health professional used in 907 KAR 3:030 and behavioral health professional under clinical supervision used in 907 KAR 3:030.

(5) Subject: Psychiatric Services Definition

(a) Comment: Kathy Adams, Direct of Public Policy of the Children’s Alliance, recommended that the phrase “as necessary” be added to paragraph (e) of the psychiatric services definition as follows:

“(e) Consulting with another physician, an attorney, police, school **staff**, a treatment program **staff**, or other organization **staff** regarding the recipient’s care and treatment, **as necessary**.”

Ms. Adams recommended that the paragraph be reworded “because consulting with these individuals is not applicable or appropriate for all clients.” She recommended that “staff” be added to “school”, “treatment program” and “other organization staff” for clarification.

(b) Response: DMS is amending the language as follows:

“(e) Consulting, if determined to be necessary by the psychiatrist responsible for providing or overseeing the recipient’s psychiatric services, with another physician, an attorney, police, [a] school staff, a treatment program staff, or other organization’s staff[organization] regarding the recipient’s care and treatment; and (f) Ensuring that the psychiatrist responsible for providing or overseeing the

recipient's psychiatric services has access to the information referenced in paragraph (e) of this subsection.

(6) Subject: Treatment Plan Definition [Section 1(21)(c)5.]

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended that the requirement that discharge criteria "for each of the requested services" be deleted as it is unnecessary for each service.

(b) Response: DMS is deleting the language as requested in an "amended after comments regulation.

(7) Subject: Define Review Agency

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended that the term "review agency" be defined and recommended the following definition:

"Review agency means the Department or entity under contract with the Department that determines a Medicaid recipient's eligibility for PRTF I or II services when the Medicaid recipient is not enrolled in a managed care organization."

(b) Response: DMS is inserting a similar but modified definition, in concert with the request, in an "amended after comments regulation. DMS's definition reads as follows:

"Review agency" means the:

(a) Department if the Medicaid recipient is not enrolled in a managed care organization; or

(b) Entity under contract with the department if the Medicaid recipient is not enrolled in a managed care organization."

(8) Subject: Clarify MCO Access to Records

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended that Section 2(6)(e)7. "be changed to clarify that the MCO only has access to records for clients that they serve and not all Medicaid clients served by PRTFs." Ms. Adams recommended the following revision:

"The managed care **organization that serves the recipient under their contract with the department.**"

(b) Response: DMS is clarifying the policy as follows in an "amended after comments" regulation:

"A managed care organization with whom the department has contracted if the recipient is enrolled with the managed care organization."

(9) Subject: Specify How Admissions are Prior Authorized and by Whom

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended that Section 3 specify how admissions are prior authorized and by whom are they prior authorized.

(b) Response: DMS is inserting language in an "amended after comments" regulation to establish that a prior authorization on behalf of DMS will be performed by a review agency and that a prior authorization by a managed care organization (MCO) will be performed by an MCO or an entity under contract with an MCO. The process can evolve depending on various factors and DMS does not wish to elaborate on the process in an administrative regulation as it would be bound to the particular process even though better or more efficient processes could emerge.

(10) Subject: Re-Title Section 4 from "Covered Services and Coverage Criteria" to "Covered Services"

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended that Section 4 be re-titled "Covered Services" rather than "Covered Services and Coverage Criteria" as the section does not established coverage criteria.

(b) Response: DMS is amending the title in an "amended after comments" regulation as requested.

(11) Subject: Section 4(1)(a) Prior Authorization Statement

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended that Section 4(1)(a) be rewritten because as currently written "it requires each service to be prior authorized, which is not correct." Ms. Adams added, "The admission is prior authorized, each service is not." Ms. Adams offered a revision.

(b) Response: DMS is amending the language in an "amended after comments" regulation as requested as follows:

"(a) The following services shall be **available to a recipient covered under Section 3 of this administrative regulation, [prior authorized]** and meet the requirements established in paragraph (b) of this subsection."

(12) Subject: Treatment Plan Development Weekly Requirement

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended that Section 4(1)(a)2. - which due to language in Section 4(1)(b)3. is required to be performed weekly - be rewritten because "treatment plan development is not done weekly." Ms. Adams requested that the language be revised as follows:

“2. Treatment plan development, **review or revision.**”

(b) Response: DMS is revising the language as requested in an “amended after comments” regulation.

(13) Subject: Family Therapy Weekly Requirement

(a) Comment: Kathy Adams, Direct of Public Policy of the Children’s Alliance, recommended that Section 4(1)(a)8. - which due to language in Section 4(1)(b)3. is required to be performed weekly -be rewritten to state that family therapy shall be offered (weekly) but cannot be provided if family members do not appear.

(b) Response: DMS is revising the language in an “amended after comments” regulation as follows:

“8. Family therapy **or attempted contact with family.**”

(14) Subject: Substance Abuse Education Requirements/Section 4(1)(b)3.

(a) Comment: Kathy Adams, Direct of Public Policy of the Children’s Alliance, recommended that Section 4(1)(a)11. - which due to language in Section 4(1)(b)3. is required to be performed weekly – should not be required to be performed weekly as it is not required for all recipients. Ms. Adams stated that the services “should be provided in accordance with the child’s assessed needs and treatment plan.”

(b) Response: In an “amended after comments” regulation, DMS is inserting a new statement for subsection (1) which reads as follows:

“(1)(a) There shall be a treatment plan developed for each recipient.
(b) A treatment plan shall specify the amount and frequency of services needed.

Additionally, DMS is deleting Section 4(1)(b)3., which states the following, from the regulation:

“3. Provided at least once per week, except for diagnostic and assessment services which shall have no weekly minimum requirement.”

(c) Comment: Kathy Adams stated, “Why is 902 KAR 20:320 referenced in this Section? It does not appear relevant.”

(d) Response: 902 KAR 20:320 does contain Level I and II PRTF education requirements; however, as it does not establish substance abuse education requirements DMS is deleting the requirement as requested.

(15) Subject: Crisis Intervention Requirements/Section 4(1)(b)3.

(a) Comment: Kathy Adams, Direct of Public Policy of the Children’s Alliance, stated, “Crisis intervention is not always necessary or provided weekly (we hope it isn’t.)”

(b) Response: In an “amended after comments” regulation, DMS is inserting a new statement for subsection (1) which reads as follows:

“(1)(a) There shall be a treatment plan developed for each recipient.
(b) A treatment plan shall specify the amount and frequency of services needed.

Additionally, DMS is deleting Section 4(1)(b)3., which states the following, from the regulation:

“3. Provided at least once per week, except for diagnostic and assessment services which shall have no weekly minimum requirement.”

(16) Subject: Level I PRTF Service Requirement in Section 4(1)(b) and 4(1)(b)3.

(a) Comment: Kathy Adams, Direct of Public Policy of the Children’s Alliance, stated, “Too broad as written, especially if required weekly.”

(b) Response: In an “amended after comments” regulation, DMS is inserting a new statement for subsection (1) which reads as follows:

“(1)(a) There shall be a treatment plan developed for each recipient.
(b) A treatment plan shall specify the amount and frequency of services needed.

Additionally, DMS is deleting Section 4(1)(b)3., which states the following, from the regulation:

“3. Provided at least once per week, except for diagnostic and assessment services which shall have no weekly minimum requirement.”

(17) Subject: Section 4(1)(b)2.

(a) Comment: Kathy Adams, Direct of Public Policy of the Children’s Alliance, stated the following:

“When tied to (b) above, it appears that all of the Level I PRTF services in (a) must be described in the recipient’s treatment plan.” Ms. Adams recommended that the language be revised as follows:

2. **If included in the recipient’s current treatment plan,** described in the recipient’s current treatment plan.

(b) Response: DMS is revising the language as requested in an “amended after comments” regulation.

(18) Subject: Section 4(1)(d)2.

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, stated the following:

"When tied to (b) above, it appears that all of the Level I PRTF services in (a) must be described in the recipient's treatment plan." Ms. Adams recommended that the language be revised as follows:

2. **If included in the recipient's current treatment plan**, described in the recipient's current treatment plan.

(b) Response: DMS is revising the language as requested in an "amended after comments" regulation.

(19) Subject: Section 5(2)(b)1.

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended that the language be rewritten as follows:

"1. Requires intensive treatment services ~~is a child with a severe emotional disability.~~"

(b) Response: DMS does not understand why "child with a severe emotional disability" should be deleted as a requirement stated in KRS 216B.450(5)(b)2. is that a Level II PRTF service recipient has "a severe emotional disability." DMS is not amending the language as requested.

(20) Subject: Specify Party Who Re-Evaluates for Patient Status Criteria/Specify Criteria

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended that Section 6(2)(a) "be re-written to specify 'who' re-evaluates the recipient every 30 days and determines if the recipient continues to meet PRTF I patient status criteria.

(b) Response: DMS is revising the language in an "amended after comments" regulation to establish that a re-evaluation shall be performed by the department's review agency for a recipient who is not enrolled with a managed care organization or by a managed care organization or entity under contract with a managed care organization to perform re-evaluations if the recipient is enrolled with a managed care organization.

(c) Comment" Kathy Adams recommended that DMS "specify 'what criteria is used for the re-evaluation.'"

(d) Response: DMS is revising the language in an "amended after comments" regulation by referring to Section 5(2) which establishes patient status criteria.

(21) Subject: Section 6(2)(b) Language Should be Deleted

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended that "of care" be deleted from Section 6(2)(b) as follows as "the sentence doesn't make sense."

"(b) A Level I PRTF shall complete a review of each recipient's treatment plan ~~of care~~ shall at least once every thirty (30) days."

(b) Response: DMS is deleting the language as requested in an "amended after comments" regulation.

(22) Subject: Section 6(2)(c)1. Revision

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended, "that Section 6(2)(c)b. be changed to read:

1. Dated signatures of appropriate staff, **and, if present for the treatment plan meeting,** the dated signature of the parent, guardian, legal custodian or conservator;"

Ms. Adams stated, "Unfortunately, parents (et al) often do not show up for treatment plan meetings. The PRTF should be expected to invite the parent (et al) to the treatment plan meeting, obtain their signature on the treatment plan if the parent attends, or mail the parent a copy of the treatment plan if the parent does not attend."

(b) Response: DMS is revising the language as follows in an "amended after comments" regulation:

"(c) The review referenced in paragraph (b) of this subsection shall include:

1. Dated signatures of:

a. Appropriate staff; and

b. If present for the treatment plan meeting, dated signatures of a[,] parent, guardian, legal custodian, or conservator;"

(23) Subject: Timeline for Initial Review

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance recommended changing the deadline for a PRTF to complete an initial review of services and treatment provided to a recipient [addressed in Section 6(3)] from "no later than the third (3rd) day following an admission" to no later than the "**fifth (5th) business day** following an admission" Ms. Adams stated that "Three days is not reasonable."

(b) Response: DMS is revising the requirement to "no later than the third (3rd) **business** day" DMS thinks it is critical for the child's benefit to conduct a review soon after admission.

(24) Subject: Bed Reserve Days

(a) Comment: Kathy Adams, Director of Public Policy of the Children's Alliance, recommended changing Section 8(1) as follows:

"(1) The department **shall** cover a bed reserve day for a recipient's absence from a Level I or II PRTF if:".

Ms. Adams stated, "The department should be expected to pay for bed reserve days if the conditions in (a) and (b) are met."

(b) Response: DMS is keeping the word "may."

(c) Comment: Kathy Adams recommended that Section 8(1)(b) be deleted and stated the following:

"Payment of bed reserve days should not be based upon occupancy percent. In Kentucky, PRTF I's are only 9 bed facilities. There are currently no economies of scale. PRTF costs do not decrease simply because a child is not there for a few days. Recommend that if occupancy rate is kept, that how the occupancy rate is determined (i.e. last calendar year; most recent six months; most recent three months) be specified in this Section."

(d) Response: DMS is not eliminating the occupancy percent thresholds used to determine whether or not it will reimburse for a bed reserve day. DMS also uses occupancy percent thresholds with nursing facility bed reserve days.

(e) Comment: Regarding the annual bed reserve day limit, Kathy Adams stated, "Recommend this Section be amended to include how remaining bed reserve days will be calculated for youth currently receiving PRTF services when these regulatory amendments take effect."

(f) Response: DMS will insert language in an "amended after comments" regulation which clarifies that the bed reserve counts will begin at zero upon adoption of the administrative regulation and be on a calendar year basis for subsequent years.

(g) Comment: Regarding the annual bed reserve day limit of five days, Kathy Adams stated the following:

"Recommend that 'five (5) days' be changed to: 'seven (7) hospital reserve days and fourteen (14) pass days' so that (2)(a) reads: 'The annual bed reserve day limit per recipient per Level I or II PRTF shall be seven (7) hospital reserve days and fourteen (14) pass days per calendar year.'

Due to the cycling of children that can be expected with shorter hospital and PRTF stays, these hospital and pass days are critical to the successful treatment and

transition of the child back to their home. Currently, fourteen (14) hospital reserve days and 21 pass days are provided per client per year. Five (5) pass days will not be sufficient for appropriate treatment and transition of these children who have severe and intensive treatment needs.”

(h) Response: DMS is revising the policy in an “amended after comments” regulation to allow five (5) hospital bed reserve days per recipient per calendar year (acute care hospital and mental hospital/psychiatric wing in an acute care hospital combined) with additional days allowed if the department determines it’s in the best interest of the recipient and fourteen (14) therapeutic pass days per recipient per calendar year (with additional days allowed if the department determines it’s in the best interest of the recipient.) DMS is inserting a requirement that therapeutic pass days be stated in a recipient’s treatment plan as they are a component of treatment. DMS is altering the bed reserve day limit to be per recipient rather than per recipient per Level I or II PRTF because it thinks it is appropriate for the limit to be per recipient rather than to allow each recipient bed reserve days for each facility in Kentucky each year.

(i) Comment: Regarding Section 8(2)(b), Kathy Adams stated the following:

“Recommend that language be added to this Section to specify how exceptions to the bed reserve day limit are requested and the criteria used to grant exceptions.”

(j) Response: DMS is revising the language in an “amended after comments” regulation to clarify that an exception must be authorized by a review agency (for a child who is not enrolled in a managed care organization) or by a managed care organization or entity under contract with a managed care organization to perform authorization reviews. DMS prefers flexibility in determining what is in the best interest of a recipient as there are many possible scenarios which could be in the best interest of a recipient. It would be very difficult to establish all possible circumstances and inserting some circumstances would restrict DMS’s flexibility in being able to grant exceptions as it would be confined to only the stated circumstances.

DMS does not want to limit flexibility in granting additional days by inserting criteria.

(k) Comment: Peggy Roark, Parent Representative and Chair of the State Interagency Council (SIAC), stated the following:

“On behalf of the Kentucky State Interagency Council for Services to Children with an Emotional Disability (SIAC), we are writing to express support for the concerns noted by the Jefferson County Regional Interagency Council (RIAC.)

This RIAC attended the 10/24/2012 SIAC meeting to inform the SIAC that proposed changes to the 907 KAR 9:005 Level I and Level II psychiatric residential treatment facility (PRTF) service and coverage policies may include language which could be detrimental to the progress of children’s treatment and could reduce support for families involvement in their children’s care.

Specifically, prior to the proposed regulation change, there was support for up to 14 paid “Hospital Reserve Days”, and 21 “pass days” that could be used for families who were taking children offsite, for home time and overnight. It appears that these days have been reduced to a maximum of 5 days, total.

The Jefferson County RIAC and parents in Jefferson County believe a reduction in days would be very disruptive to families; and that “Recidivism” would increase significantly. Reducing the payment and ‘bed hold days’ would result in additional cycling of children back to hospitals, with no follow-up with the existing PRTF. A fear is that some families might be required to initiate a new referral to PRTF’s and find themselves waiting for openings repeatedly. In such cases, very needy children would be at home; waiting, without treatment, for an opening in placement. The parents questioned the impact on the systems as well; including the Cabinet for Health and Family Services, the School System, and Department of Juvenile Justice; which the parents believe would also be adversely affected by a reduction in days.

The Jefferson County RIAC and the parents are concerned that these changes, if their interpretation is correct, may not be in line with the Wraparound Framework or the Building Bridges Model and therefore, would not support healing for families. Currently, physical health convalescent units hold beds 30 days. The RIAC is also worried about ensuring parity in our Behavioral Health System.

On behalf of the Jefferson County RIAC, the active parent group in Jefferson County, and the SIAC, we request your assistance in clarifying the impact of the changes as they relate to serving children, youth and their families in line with the Wraparound Framework and/or the Building Bridges Model.”

(l) Response: DMS is revising the policy in an “amended after comments” regulation to allow five (5) hospital bed reserve days per recipient per calendar year (acute care hospital and mental hospital/psychiatric wing in an acute care hospital combined) with additional days allowed if the department determines it’s in the best interest of the recipient and fourteen (14) therapeutic pass days per recipient per calendar year (with additional days allowed if the department determines it’s in the best interest of the recipient.) DMS is inserting a requirement that therapeutic pass days be stated in a recipient’s treatment plan as they are a component of treatment. DMS is altering the bed reserve day limit to be per recipient rather than per recipient per Level I or II PRTF because it thinks it is appropriate for the limit to be per recipient rather than to allow each recipient bed reserve days for each facility in Kentucky each year.

(m) Comment: Kathy Adams stated the following:

“3. **Page 28, lines 5 through 18 – Section 8** – Suggest ‘bed reserve days’ be defined or clarified to indicate if bed reserve days include or exclude what is currently understood to be:

- a. 'hospital reserve days' (days when a child is temporarily absent from the PRTF to receive treatment in a psychiatric hospital) or
- b. 'therapeutic pass days' (days when a child is temporarily absent from the PRTF for therapeutic reasons approved by the treatment team, like overnight stays at the child's home to assist in transitioning the child back to their home).

Consistent with our comments submitted on 10/22/12, the Children's Alliance recommends that this regulation authorize bed reserve days for both hospital reserve days and therapeutic pass days as this has been the most recent practice. This will allow the child's bed to be held while the child is temporarily admitted to a psychiatric hospital and so the child can transition safely and successfully back home.

The Children's Alliance comments submitted on 10/22/12 states:

Recommend that 'five (5) days' be changed to:
'seven (7) hospital reserve days and fourteen (14) pass days' so that (2)(a) reads:
'The annual bed reserve day limit per recipient per Level I or II PRTF shall be seven (7) hospital reserve days and fourteen (14) pass days per calendar year.'

Due to the cycling of children that can be expected with shorter hospital and PRTF stays, these hospital and pass days are critical to the successful treatment and transition of the child back to their home. Currently, fourteen (14) hospital reserve days and 21 pass days are provided per client per year. Five (5) pass days will not be sufficient for appropriate treatment and transition of these children who have severe and intensive treatment needs."

(n) Response: DMS is revising the policy in an "amended after comments" regulation to allow five (5) hospital bed reserve days per recipient per calendar year (acute care hospital and mental hospital/psychiatric wing in an acute care hospital combined) with additional days allowed if the department determines it's in the best interest of the recipient and fourteen (14) therapeutic pass days per recipient per calendar year (with additional days allowed if the department determines it's in the best interest of the recipient.) DMS is inserting a requirement that therapeutic pass days be stated in a recipient's treatment plan as they are a component of treatment. DMS is altering the bed reserve day limit to be per recipient rather than per recipient per Level I or II PRTF because it thinks it is appropriate for the limit to be per recipient rather than to allow each recipient bed reserve days for each facility in Kentucky each year.

DMS is also adding the following language, in an "amended after comments" regulation:

"(5)(a) An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital.
(b) A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving

psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively.

(c) A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

1. Stated in the recipient's treatment plan; and
2. Approved by the recipient's treatment team."

(25) Subject: Regulatory Impact Analysis and Tiering Statement

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, stated the following:

"Recommend the Regulatory Impact Analysis and Tiering Statement be corrected. (3) Incorrectly states that 303 Level I beds and 132 Level II beds are filled. These numbers represent the number of beds allocated under the CON process, but in no way indicates how many beds are filled. Some issued PRTF I CON's have not been used, nor are there 33 operational facilities. Currently there are no PRTF II facilities licensed or operating in the state."

(b) Response: DMS is amending subsection (3) of the Regulatory Impact Analysis and Tiering Statement in an "amended after comments" regulation to read as follows:

"Level I and Level II psychiatric residential treatment facilities will be affected by the amendment. Level I and II PRTF beds are awarded through a certificate of need process. The Office of Certificate of Need has limited the number of Level I PRTF beds statewide to 315 and the number of Level II PRTF beds to 145 statewide. Not all Level I PRTF certificates of need have been used and currently there are no licensed or operational Level II PRTFs."

(c) Comment: Kathy Adams stated the following:

"Recommend (3)(a) be changed to accurately reflect the additional actions each of the regulated entities will have to take to comply with this administrative regulation or amendment, which includes firing current staff and hiring QMHPs if that new requirement is implemented. Potentially, the PRTF would be required to provide all financial reports/documents to all of the MCOs, which could be a huge administrative burden. A PRTF will only have 3 days to complete an initial review. A PRTF will not be paid for holding a recipient's bed if they are below a 50% occupancy rate, which means they will have to absorb the costs of necessary hospitalizations or pass days when working to successfully transition the recipient home. In some instances, PRTFs will get paid a partial per diem for 5 reserve days, but this is a significant decrease from the 14 hospital and 21 pass days currently allowed at the full per diem rate. The outcome for children will ultimately result in more hospitalizations and re-admits, as well as increased costs for PRTFs. Cutting a recipient's pass days so significantly will interfere with the continuity of a recipient's treatment, negatively affecting both the PRTF and the recipient."

(d) Response: DMS is revising the language in the Regulatory Impact Analysis and Tiering Statement in an “amended after comments” regulation to read as follows:

“(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. Kathy Adams on behalf of the Children’s Alliance stated that additional actions each of the regulated entities will have to take to comply with this administrative regulation or amendment includes the following:

“. . . firing current staff and hiring QMHPs if that new requirement is implemented. Potentially, the PRTF would be required to provide all financial reports/documents to all of the MCOs, which could be a huge administrative burden. A PRTF will only have 3 days to complete an initial review. A PRTF will not be paid for holding a recipient’s bed if they are below a 50% occupancy rate , which means they will have to absorb the costs of necessary hospitalizations or pass days when working to successfully transition the recipient home. In some instances, PRTFs will get paid a partial per diem for 5 reserve days, but this is a significant decrease from the 14 hospital and 21 pass days currently allowed at the full per diem rate. The outcome for children will ultimately result in more hospitalizations and re-admits, as well as increased costs for PRTFs. Cutting a recipient’s pass days so significantly will interfere with the continuity of a recipient’s treatment, negatively affecting both the PRTF and the recipient.”

(e) Comment: Kathy Adams stated the following:

“Recommend (3)(b) be changed to accurately reflect the additional costs these regulatory amendments will have on the regulated entities. Additional costs will be incurred for terminating current staff and having to hire QMHPs. Potentially, the PRTF would be required to provide all financial reports/documents to all of the MCOs, which could be a huge administrative and financial burden. A PRTF will not be paid for holding a recipient’s bed if they are below a 50% occupancy rate, which means they will have to absorb the costs of necessary hospitalizations or pass days when working to successfully transition the recipient home. In some instances, PRTFs will get paid a partial per diem for 5 reserve days, but this is a significant decrease from the 14 hospital and 21 pass days currently allowed and paid at the full per diem rate. Cutting pass days is the same as a rate cut. The outcome for children will ultimately result in more hospitalizations and re-admits, as well as increased costs for PRTFs.”

(f) Response: DMS is revising the language in the Regulatory Impact Analysis and Tiering Statement in an “amended after comments” regulation to read as follows:

“(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). The amendment imposes no cost on the regulated entities. Kathy Adams on behalf of the Children’s Alliance stated the following:

“Additional costs will be incurred for terminating current staff and having to hire QMHPs. Potentially, the PRTF would be required to provide all financial reports/documents to all

of the MCOs, which could be a huge administrative and financial burden. A PRTF will not be paid for holding a recipient's bed if they are below a 50% occupancy rate, which means they will have to absorb the costs of necessary hospitalizations or pass days when working to successfully transition the recipient home. In some instances, PRTFs will get paid a partial per diem for 5 reserve days, but this is a significant decrease from the 14 hospital and 21 pass days currently allowed and paid at the full per diem rate. Cutting pass days is the same as a rate cut. The outcome for children will ultimately result in more hospitalizations and re-admits, as well as increased costs for PRTFs.”

(27) Subject: Typos

(a) Comment: Kathy Adams, Direct of Public Policy of the Children's Alliance, recommended that an “and” be inserted after subparagraph 3. as follows as there is no “and” linking the subparagraphs in the series.

“(16) “Psychiatric services” means:

(a) An initial psychiatric evaluation of a recipient which shall include:

1. A review of the recipient's:

a. Personal history;

b. Family history;

c. Physical health;

d. Prior treatment; and

e. Current treatment;

2. A mental status examination appropriate to the age of the recipient;

3. A meeting with the family or any designated significant person in the recipient's life; and

4. Ordering and reviewing.”

(b) Response: DMS is amending the regulation as recommended.

(c) Comment: Kathy Adams recommended a hyphen be inserted between “MAP 570” in Section 2(4)(a) and Section 2(5) as follows:

“(4) A utilization review plan for an emergency admission to a Level II PRTF shall contain:

(a) A completed MAP 570, Medicaid Certification of Need for Inpatient Psychiatric Services for Individuals Under Age Twenty-One (21):”

“For an individual who becomes Medicaid eligible after admission, a Level I or II PRTF's interdisciplinary team shall complete a MAP 570, Medicaid Certification of Need for Inpatient Psychiatric Services for Individuals Under Age Twenty-One (21),”.

(d) Response: DMS is amending the regulation as recommended.

(e) Comment: Kathy Adams recommended that “an” be added to Section 3(2)(b)2. as follows:

“2. With a severe emotional disability in addition to severe and persistent aggressive

behaviors, an intellectual disability, sexually acting out behaviors, or a developmental.”

(f) Response: DMS is amending the regulation as recommended.

(g) Comment: Kathy Adams recommended that Section 6(3)(a) be renumbered as Section 6(4)(a) as Section 6(3) already exists.

(h) Response: DMS is amending the regulation as recommended.

(i) Comment: Kathy Adams recommended that the quotation in Section 8(1)(b) be changed to an apostrophe.

(j) Response: DMS is amending the regulation as recommended.

(k) Comment: Kathy Adams recommended that the second “(3)” in the Regulatory Impact Analysis and Tiering Statement be renumbered to “(4).”

(l) Response: DMS is amending the regulation as recommended.

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 9:005 and is amending the administrative regulation as follows:

Page 2

Section 1(3)

Line 12

After “(3)”, insert the following:

“Behavioral health professional” means:

(a) A psychiatrist;

(b) A physician licensed in Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the practice of official duties;

(c) A psychologist licensed and practicing in accordance with KRS 319.050;

(d) A certified psychologist with autonomous functioning or licensed psychological practitioner certified and practicing in accordance with KRS 319.056;

(e) A clinical social worker licensed and practicing in accordance with KRS 335.100;

(f) An advanced registered nurse practitioner licensed and practicing in accordance with KRS 314.042;

(g) A marriage and family therapist licensed and practicing in accordance with KRS 335.300;

(h) A professional clinical counselor licensed and practicing in accordance with KRS 335.500;

(i) A professional art therapist certified and practicing in accordance with KRS 309.130; or

(j) An alcohol and drug counselor certified and practicing in accordance with KRS 309.080 to 309.089.

(4) "Behavioral health professional under clinical supervision" means:

(a) A psychologist certified and practicing in accordance with KRS 319.056;

(b) A licensed psychological associate licensed and practicing in accordance with KRS 319.064;

(c) A marriage and family therapist associate permitted and practicing in accordance with KRS 335.300;

(d) A social worker certified and practicing in accordance with KRS 335.080; or

(e) A professional counselor associate licensed and practicing in accordance with KRS 335.500.

(5)

Page 2

Section 1(4)

Line 13

Renumber this subsection by inserting "(6)" and deleting "(4)".

Page 2

Section 1(5)

Line 17

Renumber this subsection by inserting "(7)" and deleting "(5)".

Line 18

After "evaluation", insert the following:

or specialty evaluation performed via telemedicine

Page 2

Section 1(5)

Line 20

After "Include", insert a colon and the following:

1. Interviewing and evaluating; or

2.

Delete "and interviewing".

Page 3

Section 1(6) to (8)

Lines 3, 4, and 16

Renumber these three (3) subsections by inserting "(8)", "(9)", and "(10)", respectively, and by deleting "(6)", "(7)", and "(8)" respectively.

Page 3

Section 1(7)(a)1.a.

Line 7

After "a.", insert "An".

Delete the following:

A severe and persistent aggressive behavior

After "disability", insert the following:

a severe and persistent aggressive behavior.

Page 4

Section 1(9) to (16)

Lines 5, 7, 9, 15, 17, 18, 19, and 20

Renumber these eight (8) subsections by inserting "(11)", "(12)", "(13)", "(14)", "(15)", "(16)", "(17)", and "(18)", respectively, and by deleting "(9)", "(10)", "(11)", "(12)", "(13)", "(14)", "(15)", and "(16)" respectively.

Page 5

Section 1(16)(a)3.

Line 7

After "life;", insert "and".

Page 5

Section 1(16)(d)

Line 18

After "status;", delete "and".

Page 5

Section 1(16)(e)

Line 19

After "Consulting", insert the following:

, if determined to be necessary by the psychiatrist responsible for providing or overseeing the recipient's psychiatric services.

After "police.", delete "a".

After "school", insert "staff".

Line 20

After "program", insert "staff".

After "other", insert "organization's staff".

Delete "organization".

After "treatment", insert the following:

; and

(f) Ensuring that the psychiatrist responsible for providing or overseeing the recipient's psychiatric services has access to the information referenced in paragraph (e) of this subsection.

(19)

Delete the period

Page 5

Section 1(17)

Line 21

Delete "(17)".

Page 6

Section 1(18) and (19)

Lines 18 and 19

Renumber these two (2) subsections by inserting "(20)" and "(21)", respectively, and deleting "(18)" and "(19)" respectively.

Page 6

Section 1(19)

Line 19

After "KRS 216B.450(7)", insert a return and the following:

(22) "Review agency" means the:

(a) Department if the Medicaid recipient is not enrolled in a managed care organization; or

(b) Entity under contract with a managed care organization if the Medicaid recipient is not enrolled in a managed care organization.

(23)

Page 6

Section 1(20)

Line 20

Delete "(20)".

After "KRS 205.639(3)", insert a return and the following:

(24) "Telemedicine" means the use of electronic information and telecommunication technologies to support long-distance clinical health care.

(25)

Page 6

Section 1(21)

Line 21

Delete "(21)".

Page 7

Section 1(21)(c)5.

Line 13

After “criteria”, delete the following:
for each of the requested services

Page 12
Section 2(4)(a)
Line 17

After “MAP”, insert a hyphen.

Page 14
Section 2(5)
Line 13

After “MAP”, insert a hyphen.

Page 16
Section 2(6)(e)7.
Line 4

After “contracted”, insert the following:
if the recipient is enrolled with the managed care organization

Page 16
Section 3(1)(a)
Line 7

After “be”, delete the following:
“1.”, and lowercase the “P” in “Prior authorized”.

Page 16
Section 3(1)(a)1.
Line 8

After “authorized”, insert the following:
by:
1. A review agency if the admission is for a recipient who is not enrolled with a managed care organization; or
2. A managed care organization or an entity under contract with a managed care organization to perform prior authorization reviews if the admission is for a recipient who is enrolled with a managed care organization

Page 16
Section 3(1)(a)2.
Line 9

Delete subparagraph 2. in its entirety

Page 17
Section 3(2)(b)2.
Line 2

After “behaviors”, insert “an”.

Page 17
Section 4
Title
Line 9

After “Services”, insert the following:

(1)(a) There shall be a treatment plan developed for each recipient.

(b) A treatment plan shall specify:

1. The amount and frequency of services needed; and

2. The number of therapeutic pass days for a recipient, if the treatment plan includes any therapeutic pass days.

(2)

Delete “and Coverage Criteria. (1)”.

Page 17
Section 4(1)(a)
Line 11

After “be”, insert the following:

available to a recipient covered under Section 3 of this administrative regulation

Delete “prior authorized”.

Page 17
Section 4(1)(a)2.
Line 14

After “development”, insert “review or revision”.

Page 17
Section 4(1)(a)8.
Line 20

After “therapy”, insert the following
or attempted contact with family

Page 18
Section 4(1)(a)11.
Line 1

After “education”, delete the following:

which shall comply with 902 KAR 20:320

Page 18
Section 4(1)(b)2.
Line 15

After “2.”, insert the following:

If included in the recipient’s treatment plan,

Page 18
Section 4(1)(b)3. and 4.
Lines 16-18

After “3.”, delete the following:
Provided at least once per week, except for diagnostic and assessment services which shall have no weekly minimum requirement;
4.

Page 18
Section 4(1)(c)
Line 21

After “professional”, insert the following:
, behavioral health professional, or behavioral health professional under clinical supervision

Page 19
Section 4(1)(d)2.
Line 1

After “2.”, insert the following:
If included in the recipient’s treatment plan,

Page 19
Section 4(2)
Line 10

After “professional”, insert the following:
, behavioral health professional, or behavioral health professional under clinical supervision

Page 20
Section 6(2)(a)
Line 15

After criteria, insert the following:
established in Section 5(2) of this administrative regulation

Page 20
Section 6(2)(b)
Line 16

After “plan”, delete “of care shall”.

Page 20
Section 6(2)(c)1.
Line 19

After “of”, insert the following:
“.”
a.”, and lowercase the “A” in “Appropriate”.

After “staff”, insert the following:

; and

b. If present for the treatment plan meeting, a dated signature of a

Delete the comma.

Page 21

Section 6(2)(d)

Line 5

After “stay.”, insert a return and the following:

(e) The re-evaluation referenced in paragraph (a) of this subsection shall be Performed by:

1. A review agency if the recipient is not enrolled with a managed care organization; or

2. A managed care organization or entity under contract with a managed care organization in which the recipient is enrolled if the recipient is enrolled in a managed care organization.

Page 25

Section 8

Title

Line 15

After “Bed”, insert “and Therapeutic Pass”.

Page 25

Section 8(1)

Line 5

After “(1)”, insert “(a)”.

After “reserve day”, insert the following:

for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital

Page 25

Section 8(1)(a)

Line 7

Re-number by inserting “1.” and deleting “(a)”

Page 25

Section 8(1)(a)1.

Line 8

Re-number by inserting “a.” and deleting “1.”.

Page 25

Section 8(1)(a)2.

Line 9

Re-number by inserting “b.” and deleting “2.”.

Page 25
Section 8(1)(a)3.
Line 10

Re-number by inserting "c." and deleting "3.".

Page 25
Section 8(1)(a)4.
Line 11

Re-number by inserting "d." and deleting "4.".

After "established in", insert the following:
paragraph (b) of this subsection

Delete the following:
subsection (2) of this section

Page 25
Section 8(1)(b)
Line 13

Re-number by inserting "2." and deleting "(b)".

After "or II", insert "PRTF's".
Delete "PRTF's".

Page 25
Section 8(2)(a)
Line 14

After "recipient", delete the following:
per Level I or II PRTF

Line 15 and 16

After "year" insert the following:
in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital.

(c)
Delete the period.

Page 25
Section 8(2)(b)
Line 16

Delete "(b)".

Lines 16 and 17

After "paragraph", insert "(b)".

Delete “(a)”.

Page 25

Section 8(2)(b)

Line 18

After the period, insert a return and the following:

(2)(a) The department may cover a therapeutic pass day for a recipient’s absence from a Level I or II PRTF if:

1. The recipient:

a. Is in Medicaid payment status in a Level I or II PRTF;

b. Has been in the Level I or II PRTF overnight for at least one (1) night;

c. Is reasonably expected to return requiring Level I or II PRTF care; and

d. Has not exceeded the therapeutic pass day limit established in paragraph (b) of this subsection; and

2. The Level I or II PRTF’s occupancy percent is at least fifty (50) percent.

(b) The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.

(c) The department may allow a recipient to exceed the limit established in paragraph (b) of this subsection, if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

(3)(a) The bed reserve day and therapeutic pass day count for each recipient shall be zero (0) upon adoption of this administrative regulation.

(b) For subsequent calendar years, the bed reserve day and therapeutic pass day count for each recipient shall begin at zero (0) on January 1 of the calendar year.

(4) An authorization decision regarding a bed reserve day or therapeutic pass day in excess of the limits established in this section shall be performed by:

(a) A review agency if the decision is regarding a recipient who is not enrolled with a managed care organization; or

(b) A managed care organization or an entity under contract with a managed care organization to perform authorization reviews if the decision is regarding a recipient who is enrolled with a managed care organization.

(5)(a) An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital.

(b) A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively.

(c) A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

1. Stated in the recipient’s treatment plan; and

2. Approved by the recipient’s treatment team.