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Donna Little
REGULATIONS COMPILER

STATEMENT OF EMERGENCY

907 KAR 15:050E

(1) This emergency administrative regulation is being promulgated in conjunction with 907 KAR 15:055E, Reimbursement provisions and requirements regarding targeted case management for individuals with co-occurring mental health or substance use disorders and chronic or complex physical health issues - to comply with a federal mandate. The Affordable Care Act mandates coverage of behavioral health services (including substance use disorder services) and federal law requires Medicaid Programs to ensure that recipients have access to services. These two (2) administrative regulations will help ensure that Medicaid recipients are able to access mandated behavioral health services.

(2) Targeted case management ensures that Medicaid recipients with a co-occurring mental health diagnosis and substance use disorder and chronic or complex physical health issues are monitored to ensure that they receive the services most beneficial to their particular illnesses. As mental illness and substance use disorders are often life-threatening and require long-term treatment, targeted case management gives continuity of care to a Medicaid recipient whose illness needs long-term monitoring. This action must be taken on an emergency basis to prevent a loss of Medicaid federal funds, to meet a deadline for the promulgation of an administrative regulation necessary under federal law and regulation, and so as not to delay providing this service to Medicaid recipients at risk.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

Steven L. Beshear
Governor

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (New Emergency Administrative Regulation)

5 907 KAR 15:050E. Coverage provisions and requirements regarding targeted case

6 management for individuals with co-occurring mental health or substance use disorders

7 and chronic or complex physical health issues.

8 RELATES TO: KRS 205.520, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23)

9 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C.

10 1396n(g).

11 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family

12 Services, Department for Medicaid Services, has a responsibility to administer the Med-

13 icaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to

14 comply with any requirement that may be imposed or opportunity presented by federal

15 law to qualify for federal Medicaid funds. This administrative regulation establishes the

16 coverage provisions and requirements regarding Medicaid Program targeted case man-

17 agement services for Medicaid recipients with co-occurring mental health or substance

18 use disorders and chronic or complex physical health issues.

19 Section 1. General Coverage Requirements. For the department to reimburse for a

20 service covered under this administrative regulation, the service shall be:

21 (1) Medically necessary; and

1 (2) Provided:

2 (a) To a recipient; and

3 (b) By a provider that meets the provider participation requirements established in

4 Section 3 of this administrative regulation.

5 Section 2. Eligibility Criteria. (1) To be eligible for targeted case management ser-

6 vices under this administrative regulation a recipient shall:

7 (a) Have a primary moderate or severe substance use disorder diagnosis;

8 (b) Have a severe mental illness:

9 (c) Be a child with a severe emotional disability as defined in KRS 200.503(2);

10 (d) Have a chronic or complex physical health issue;

11 (e) Not be:

12 1. Over the age of twenty-one (21) years and under the age of sixty-four (64) years

13 while receiving services in an institution for mental diseases; or

14 2. An inmate of a public institution; and

15 (f)1. Need assistance with access to:

16 a. Housing; or

17 b. Vocational, medical, social, educational, or other community services or supports;

18 2. Have been involved with at least one (1) child welfare agency or criminal justice

19 agency; or

20 3. Be:

21 a. In the custody of the Department for Community Based Services;

22 b. At risk of an out-of-home placement; or

23 c. At risk of inpatient mental health treatment.

1 (2)(a) A severe mental illness shall be a diagnosis of a major mental disorder as in-
2 cluded in the current edition of the American Psychiatric Association Diagnostic and
3 Statistical Manual of Mental Disorders™ under:
4 1. Schizophrenia spectrum and other psychiatric disorders;
5 2. Bipolar and related disorders;
6 3. Depressive disorders;
7 4. Post-traumatic stress disorders (under trauma and stressor related disorders); and
8 5. Personality disorders.
9 (b) A recipient's information and history, for the purpose of determining if the recipient
10 has a severe mental illness, shall indicate that the recipient exhibits persistent disability
11 and significant impairment in major areas of community living.
12 (c) In addition to the requirements established in paragraph (a) and (b), to qualify as
13 having a severe mental illness a recipient shall:
14 1. Have clinically significant symptoms which have persisted for a continuous period
15 of at least two (2) years; or
16 2.a. Been hospitalized for mental illness more than once within the past two (2)
17 years; and
18 b. Be significantly impaired in the ability to function socially or occupationally or both.
19 Section 3. Provider Requirements. (1) To be eligible to provide services under this
20 administrative regulation, an individual, entity, or organization shall:
21 (a) Be currently enrolled in the Kentucky Medicaid Program in accordance with 907
22 KAR 1:672;
23 (b) Except as established in subsection (2) of this section, be currently participating in

1 the Kentucky Medicaid Program in accordance with 907 KAR 1:671;

2 (c) Be:

3 1. A community mental health center authorized to provide services pursuant to 907

4 KAR 1:044;

5 2. An individual or provider group authorized to provide behavioral health services

6 pursuant to 907 KAR 15:010; or

7 3. A behavioral health services organization authorized to provide behavioral health

8 services pursuant to 907 KAR 15:020;

9 (d) Have:

10 1. For each service it provides, the capacity to provide the full range of the service as

11 established in this administrative regulation;

12 2. Demonstrated experience in serving the population of individuals with behavioral

13 health disorders relevant to the particular services provided;

14 3. The administrative capacity to ensure quality of services;

15 4. A financial management system that provides documentation of services and

16 costs;

17 5. The capacity to document and maintain individual case records;

18 6. Demonstrated programmatic and administrative experience in providing compre-

19 hensive case management services; and

20 7. Demonstrated referral systems and linkages and referral ability with essential so-

21 cial and health services' agencies.

22 (2)(a) In accordance with 907 KAR 17:015, Section 3(3), a targeted case manage-

23 ment services provider which provides a service to an enrollee shall not be required to

1 be currently participating in the fee-for-service Medicaid Program.

2 (3) A targeted case management services provider shall:

3 (a) Agree to provide services in compliance with federal and state laws regardless of

4 age, sex, race, creed, religion, national origin, handicap, or disability; and

5 (b) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and

6 any amendments to the Act.

7 Section 4. Case Manager Requirements. (1)(a) A case manager shall:

8 1. Have at least a bachelor of arts or sciences degree in a behavioral science includ-

9 ing:

10 a. Psychology;

11 b. Sociology;

12 c. Social work;

13 d. Family studies;

14 e. Human services;

15 f. Counseling;

16 g. Nursing; or

17 h. Another human service degree program approved by the department;

18 2. Have successfully completed case management training approved by the Depart-

19 ment for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) within

20 six (6) months of employment; and

21 3. Successfully completed recertification requirements approved by DBHDID every

22 three (3) years.

1 (b)1. Supervision by a behavioral health professional who has completed case man-
2 agement training approved by DBHDID shall occur at least twice per month.
3 2. At least one (1) of these supervisory contacts shall be on an individual basis and
4 face-to-face.
5 (c)1. Except as established in subparagraph 2 of this paragraph, a case manager
6 shall have at least one (1) year of full-time employment working directly with individuals
7 in a human service setting after completing the educational requirements.
8 2. A master's degree in one (1) or more of the following behavioral science disci-
9 plines may substitute for the one (1) year of experience:
10 a. Psychology;
11 b. Sociology;
12 c. Social work;
13 d. Family studies;
14 e. Human services;
15 f. Counseling;
16 g. Nursing; or
17 h. Another human service degree program approved by the department may substi-
18 tute for the one (1) year of experience.
19 (d) A behavioral health professional shall be:
20 1. An advanced practice registered nurse;
21 2. A licensed clinical social worker;
22 3. A licensed marriage and family therapist;
23 4. A licensed professional clinical counselor;

1 5. A licensed psychological practitioner;

2 6. A licensed psychologist;

3 7. A licensed professional art therapist;

4 8. A physician;

5 9. A psychiatrist;

6 10. A behavioral health practitioner under supervision except that a certified alcohol

7 and drug counselor shall not be considered a behavioral health professional for the pur-

8 pose of providing targeted case management to an individual with a complex or chronic

9 physical health issue;

10 11. A registered nurse working under the supervision of a physician or advanced

11 practice registered nurse; or

12 12. An individual with a bachelor's degree in a behavioral science program or other

13 human service degree program approved by the department who:

14 a. Is working under the supervision of a billing supervisor; and

15 b. Has at least five (5) years of documented full-time experience providing special-

16 ized case management services for the target population.

17 Section 5. Freedom of Choice of Provider. (1) A recipient shall have the freedom to

18 choose from which:

19 (a) Case manager to receive services within the recipient's geographic area identified

20 in the recipient's care plan; and

21 (b) Provider of non-targeted case management Medicaid covered services to receive

22 services.

23 (2) A case manager shall not have the authority to authorize or deny the provision of

1 non-targeted case management Medicaid covered services to a recipient.

2 (3) A recipient shall not be required to receive targeted case management services

3 as a condition of receiving non-targeted case management Medicaid-covered services.

4 Section 6. Covered Services. (1) Targeted case management services covered under

5 this administrative regulation shall:

6 (a) Be services furnished to assist a recipient in gaining access to needed medical,

7 social, educational, or other services;

8 (b) Include:

9 1. A comprehensive assessment and periodic reassessments of the recipient's needs

10 to determine the need for any medical, educational, social, or other services;

11 2. The development and periodic revision of a specific care plan for the recipient;

12 3. A referral or related activities to help the recipient obtain needed services;

13 4. Monitoring or follow-up activities; or

14 5. Contacts with non-recipients who are directly related to identifying the recipient's

15 needs and care for the purpose of:

16 a. Helping the recipient access services;

17 b. Identifying supports necessary to enable the recipient to obtain services;

18 c. Providing a case manager with useful input regarding the recipient's past or current

19 functioning, symptoms, adherence to treatment, or other information relevant to the re-

20 cipient's behavioral health condition; or

21 d. Alerting a case manager to a change in the recipient's needs.

22 (2)(a) An assessment or reassessment shall include:

23 1. Taking the recipient's history;

1 2. Identifying the recipient's strengths and needs and completing related documenta-
2 tion; and
3 3. Gathering information from other sources including family members, medical pro-
4 viders, social workers, or educators, to form a complete assessment of the recipient.
5 (b) A face-to-face assessment or reassessment shall be completed:
6 1. At least annually; or
7 2. More often if needed based on changes in the recipient's condition.
8 (3) The development and periodic revision of the recipient's care plan shall:
9 (a) Specify the goals and actions to address the medical, social, educational, or other
10 services needed by the recipient;
11 (b) Include ensuring the active participation of the recipient and working with the re-
12 cipient, the recipient's authorized health care decision maker, or others to develop the
13 goals; or
14 (c) Identifying a course of action to respond to the assessed needs of the recipient.
15 (4) A referral or related activities shall include activities that help link the recipient with
16 medical providers, social providers, educational providers, or other programs and ser-
17 vices that are capable of providing needed services to:
18 (a) Address the identified needs; and
19 (b) Achieve goals specified in the care plan.
20 (5)(a) Monitoring and follow-up activities shall:
21 1. Be activities and contacts that:
22 a. Are necessary to ensure that the recipient's care plan is implemented;
23 b. Adequately addresses the recipient's strengths and needs; and

1 c. May be with the recipient, the recipient's family members, the recipient's service
2 providers, or other entities or individuals;
3 2. Be conducted as frequently as necessary;
4 3. Include making necessary adjustments in the recipient's care plan and service ar-
5 rangements with providers.
6 (b) Monitoring shall:
7 1. Occur at least once every three (3) months;
8 2. Be face-to-face; and
9 3. Determine if:
10 a. The services are being furnished in accordance with the recipient's care plan;
11 b. The services in the recipient's care plan are adequate to meet the recipient's
12 needs; and
13 c. Changes in the needs or status of the recipient are reflected in the care plan.
14 Section 7. No Duplication of Service. (1) The department shall not pay for targeted
15 case management services which duplicate services provided by another public agency
16 or a private entity.
17 (2)(a) The department shall not reimburse for a service provided to a recipient by
18 more than one (1) provider of any program in which the service is covered during the
19 same time period.
20 (b) For example, if a recipient is receiving targeted case managements service from
21 an independent behavioral health provider, the department shall not reimburse for tar-
22 geted case management services provided to the same recipient during the same time
23 period by a behavioral health services organization.

1 Section 8. Exclusions and Limits. (1) Targeted case management services shall not
2 include services defined in 42 C.F.R. 440.169 if the:
3 (a) Activities are an integral and inseparable component of another covered Medicaid
4 service;
5 (b) Constitute the the direct delivery of underlying medical, educational, social, or
6 other services to which an eligible recipient has been referred, including:
7 1. Foster care programs;
8 2. Research gathering and completing documentation required by the foster care
9 program;
10 3. Assessing adoption placements;
11 4. Recruiting or interviewing potential foster care parents;
12 5. Serving legal papers;
13 6. Home investigations;
14 7. Providing transportation;
15 8. Administering foster care subsidies; or
16 9. Making placement arrangements.
17 (2) A recipient who is receiving case management services under a 1915(c) home
18 and community based waiver program shall not be eligible to receive targeted case
19 management services under this administrative regulation.
20 (3) An individual who provides targeted case management to a recipient shall not
21 provide any Medicaid covered service other than targeted case management to any re-
22 cipient.
23 Section 9. Records Maintenance, Documentation, Protection, and Security. (1) A tar-

1 geted case management service provider shall maintain a current case record for each
2 recipient.
3 (2)(a) A case record shall document each service provided to the recipient including
4 the date of the service and the signature of the individual who provided the service.
5 (b) The individual who provided the service shall date and sign the case record on
6 the date that the individual provided the service.
7 (3) A case record shall:
8 (a) Include:
9 1. The recipient's name;
10 2. The time and date corresponding to each occasion in which a service was provid-
11 ed to the recipient;
12 3. The name of the targeted case management services:
13 a. Provider agency, if an agency; and
14 b. Name of the practitioner who provided the targeted case management services;
15 4. The nature, content, and units of the targeted case management services provid-
16 ed;
17 5. Whether goals in the recipient's care plan have been achieved;
18 6. Whether the recipient has declined to receive any services in the recipient's care
19 plan;
20 7. A timeline for obtaining needed services; and
21 8. A timeline for reevaluating the recipient's care plan; and
22 (b) Be:
23 1. Maintained in an organized and secure central file;

1 2. Furnished to the:

2 a. Cabinet for Health and Family Services upon request; or

3 b. For an enrollee, managed care organization in which the recipient is enrolled upon

4 request;

5 3. Made available for inspection and copying by:

6 a. Cabinet for Health and Family Services' personnel; or

7 b. Personnel of the managed care organization in which the recipient is enrolled if

8 applicable;

9 4. Readily accessible; and

10 5. Adequate for the purpose of establishing the current treatment modality and pro-

11 gress of the recipient.

12 (4)(a) A discharge summary shall:

13 1. Be required, upon termination of services, for each recipient who received at least

14 three (3) service visits; and

15 2. Contain a summary of the significant findings and events during the course of

16 treatment including the:

17 a. Final assessment regarding the progress of the recipient toward reaching goals

18 and objectives established in the recipient's care plan; and

19 b. Recipient's condition upon termination and disposition.

20 (b) A case record relating to a recipient who was terminated from receiving services

21 shall be fully completed within ten (10) business days following termination.

22 (5) If a recipient's case is reopened within ninety (90) calendar days of terminating

23 services for the same or related issue, a reference to the prior case history with a note

1 regarding the interval period shall be acceptable.

2 (6) If a recipient is transferred or referred to a health care facility or other provider for
3 care or treatment, the transferring targeted case management services provider shall,
4 within ten (10) business days of the transfer or referral, transfer the recipient's records
5 in a manner that complies with the records' use and disclosure requirements as estab-
6 lished in or required by:

7 (a)1. The Health Insurance Portability and Accountability Act;

8 2. 42 U.S.C. 1320d-2 to 1320d-8; and

9 3. 45 C.F.R. Parts 160 and 164; or

10 (b)1. 42 U.S.C. 290 ee-3; and

11 2. 42 C.F.R Part 2.

12 (7)(a) If a targeted case management service's Medicaid Program participation status
13 changes as a result of voluntarily terminating from the Medicaid Program, involuntarily
14 terminating from the Medicaid Program, a licensure suspension, or death of an owner or
15 deaths of owners, the case records of the targeted case management service shall:

16 1. Remain the property of the targeted case management service; and

17 2. Be subject to the retention requirements established in subsection (13) of this sec-
18 tion.

19 (b) A targeted case management service shall have a written plan addressing how to
20 maintain case records in the event of an owner's death or owners' deaths.

21 (8)(a) Except as established in paragraph (b) or (c) of this subsection, a targeted
22 case management service shall maintain a case record regarding a recipient for at least
23 six (6) years from the date of the service or until any audit dispute or issue is resolved

1 beyond six (6) years.

2 (b) After a recipient's death or discharge from services, a provider shall maintain the

3 recipient's record for the longest of the following periods:

4 1. Six (6) years unless the recipient is a minor; or

5 2. If the recipient is a minor, three (3) years after the recipient reaches the age of ma-

6 jority under state law.

7 (c) If the Secretary of the United States Department of Health and Human Services

8 requires a longer document retention period than the period referenced in paragraph (a)

9 of this section, pursuant to 42 C.F.R. 431.17 the period established by the secretary

10 shall be the required period.

11 (9)(a) A targeted case management service shall comply with 45 C.F.R. Chapter 164.

12 (b) All information contained in a case record shall:

13 1. Be treated as confidential;

14 2. Not be disclosed to an unauthorized individual; and

15 3. Be disclosed to an authorized representative of the:

16 a. Department; or

17 b. Federal government.

18 (c)1. Upon request, a targeted case management service shall provide to an author-

19 ized representative of the department or federal government information requested to

20 substantiate:

21 a. Staff notes detailing a service that was rendered;

22 b. The professional who rendered a service; and

23 c. The type of service rendered and any other requested information necessary to de-

1 termine, on an individual basis, whether the service is reimbursable by the department.

2 2. Failure to provide information referenced in subparagraph 1 of this paragraph shall

3 result in denial of payment for any service associated with the requested information.

4 Section 10. Medicaid Program Participation Compliance. (1) A targeted case man-

5 agement services provider shall comply with:

6 (a) 907 KAR 1:671;

7 (b) 907 KAR 1:672; and

8 (c) All applicable state and federal laws.

9 (2)(a) If a targeted case management services provider receives any duplicate pay-

10 ment or overpayment from the department, regardless of reason, the targeted case

11 management services provider shall return the payment to the department.

12 (b) Failure to return a payment to the department in accordance with paragraph (a) of

13 this section may be:

14 1. Interpreted to be fraud or abuse; and

15 2. Prosecuted in accordance with applicable federal or state law.

16 (3)(a) When the department makes payment for a covered service and the targeted

17 case management services provider accepts the payment:

18 1. The payment shall be considered payment in full;

19 2. No bill for the same service shall be given to the recipient; and

20 3. No payment from the recipient for the same service shall be accepted by the pro-

21 vider.

22 (b)1. A targeted case management services provider may bill a recipient for a service

23 that is not covered by the Kentucky Medicaid Program if the:

1 a. Recipient requests the service; and

2 b. Targeted case management services provider makes the recipient aware in ad-

3 vance of providing the service that the:

4 (i) Recipient is liable for the payment; and

5 (ii) Department is not covering the service.

6 2. If a recipient makes payment for a service in accordance with subparagraph 1 of

7 this paragraph, the:

8 a. Targeted case management services provider shall not bill the department for the

9 service; and

10 b. Department shall not:

11 (i) Be liable for any part of the payment associated with the service; and

12 (ii) Make any payment to the targeted case management services provider regarding

13 the service.

14 (4)(a) A targeted case management services provider attests by the targeted case

15 management services provider signature that any claim associated with a service is val-

16 id and submitted in good faith.

17 (b) Any claim and substantiating record associated with a service shall be subject to

18 audit by the:

19 1. Department or its designee;

20 2. Cabinet for Health and Family Services, Office of Inspector General or its design-

21 ee;

22 3. Kentucky Office of Attorney General or its designee;

23 4. Kentucky Office of the Auditor for Public Accounts or its designee; or

1 5. United States General Accounting Office or its designee.

2 (c) If a targeted case management services provider receives a request from the de-
3 partment to provide a claim, related information, related documentation, or record for
4 auditing purposes, the targeted case management services provider shall provide the
5 requested information to the department within the timeframe requested by the depart-
6 ment.

7 (d)1. All services provided shall be subject to review for recipient or provider abuse.

8 2. Willful abuse by a targeted case management services provider shall result in the
9 suspension or termination of the targeted case management services provider from
10 Medicaid Program participation.

11 Section 11. Third Party Liability. (1) A targeted case management service provider
12 shall comply with KRS 205.622.

13 (2) If a third party is liable to pay for targeted case management services, the de-
14 partment shall not pay for the services.

15 Section 12. Use of Electronic Signatures. (1) The creation, transmission, storage, and
16 other use of electronic signatures and documents shall comply with the requirements
17 established in KRS 369.101 to 369.120.

18 (2) A targeted case management services provider that chooses to use electronic
19 signatures shall:

20 (a) Develop and implement a written security policy that shall:

21 1. Be adhered to by each of the targeted case management services' provider's em-
22 ployees, officers, agents, or contractors;

23 2. Identify each electronic signature for which an individual has access; and

1 3. Ensure that each electronic signature is created, transmitted, and stored in a se-
2 cure fashion;
3 (b) Develop a consent form that shall:
4 1. Be completed and executed by each individual using an electronic signature;
5 2. Attest to the signature's authenticity; and
6 3. Include a statement indicating that the recipient has been notified of his or her re-
7 sponsibility in allowing the use of the electronic signature; and
8 (c) Provide the department, immediately upon request, with:
9 1. A copy of the targeted case management services' provider's electronic signature
10 policy;
11 2. The signed consent form; and
12 3. The original filed signature.
13 Section 13. Auditing Authority. The department shall have the authority to audit any:
14 (1) Claim;
15 (2) Medical record; or
16 (3) Documentation associated with any claim or medical record.
17 Section 14. Federal Approval and Federal Financial Participation. The department's
18 coverage of services pursuant to this administrative regulation shall be contingent upon:
19 (1) Receipt of federal financial participation for the coverage; and
20 (2) Centers for Medicare and Medicaid Services' approval for the coverage.
21 Section 15. Appeals. (1) An appeal of an adverse action by the department regarding
22 a service and a recipient who is not enrolled with a managed care organization shall be
23 in accordance with 907 KAR 1:563.

1 (2) An appeal of an adverse action by a managed care organization regarding a ser-

2 vice and an enrollee shall be in accordance with 907 KAR 17:010.

907 KAR 15:050E

REVIEWED:

8/19/14
Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

9/9/14
Date

Audrey Tayse Haynes
Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 15:050E
Contact person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program targeted case management services for Medicaid recipients with co-occurring mental health or substance use disorders and chronic or complex physical health issues. This administrative regulation is being promulgated in conjunction with 907 KAR 15:055E (Reimbursement provisions and requirements regarding targeted case management for individuals with co-occurring mental health or substance use disorders and chronic or complex physical health issues.) Targeted case management services are services that assist Medicaid recipients in accessing needed medical, social, educational, and other services. The components of targeted case management include assessing the recipient's need for services by taking the recipient's history, identifying the recipient's needs, and gathering information from other sources (family members, medical providers, social workers, and educators) to form a complete assessment; developing a customized care plan for the recipient; referring the recipient or related activities to help the recipient obtain needed services; and monitoring activities to ensure that the recipient's care plan is implemented effectively and adequately addresses the recipient's needs.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to help ensure that recipients (who have co-occurring mental health or substance use disorders and chronic or complex physical health issues) receive necessary services and care. The targeted case manager provider is the individual or entity responding for coordinating the individual's services/care, facilitating access to services/care, and monitoring individual's progress or difficulties while receiving services/care. Targeted case management helps ensure that the recipient receives the appropriate and necessary services and care they need rather than randomly receive services/care or fail to receive any services/care at all.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by helping ensure that recipients with co-occurring mental health or substance use disorders and chronic or complex physical health issues receive necessary services and care.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by helping ensure that recipients with co-occurring mental health or substance use disorders and chronic or complex physical health issues receive necessary services and care.

(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: This is a new administrative regulation rather than an amendment.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than an amendment.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Entities eligible to provide targeted case management services (such as community mental health centers, individual behavioral health service providers or behavioral health provider groups, behavioral health services organizations, federally-qualified health centers (FQHCs), FQHC look-alikes, rural health clinics, primary care centers) will be affected by this administrative regulation as well as the various professionals who are authorized to provide services either independently or via the aforementioned providers. Medicaid recipients who qualify for targeted case management services will also be affected by this administrative regulation.

(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. Entities that qualify and wish to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the individual wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). The entities referenced in paragraph (a) could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The entities referenced in paragraph (a) will benefit by receiving Medicaid Program reimbursement. The professionals authorized to provide services will benefit by having more employment opportunities in Kentucky. Medicaid recipients in need of targeted case management will benefit from having the option to receive these services.

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

(a) Initially: DMS estimates that implementing the administrative regulation will cost approximately $1.33 million state funds/$5.47 million federal funds initially.

(b) On a continuing basis: DMS estimates that implementing the administrative regulation will cost approximately $2.28 million state funds/$9.38 million federal funds for the second year of implementation. The federal matching percent will decrease somewhat when the federal matching percent for recipients eligible under "Medicaid expansion"

recedes from its current 100% to 90%.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund 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 is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 907 KAR 15:050E
Contact person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), and 42 U.S.C. 1396a(a)(23).

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. Targeted case management services are not federally mandated; however, Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the targeted case management service provider base to include targeted case management for recipients with co-occurring mental health or substance use disorders and chronic or complex physical health issues will help ensure Medicaid recipient access to these services.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 907 KAR 15:050E
Contact person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate revenue for state or local government.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment is not expected to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS estimates that implementing the administrative regulation will cost approximately $1.33 million state funds/$5.47 million federal funds initially.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing the administrative regulation will cost approximately $2.28 million state funds/$9.38 million federal funds for the second year of implementation. The federal matching percent will decrease somewhat when the federal matching percent for recipients eligible under "Medicaid expansion" recedes from its current 100% to 90%.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation: