1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Commissioner's Office

4 (New Administrative Regulation)

5 907 KAR 17:005. Managed care organization requirements and policies.

6 RELATES TO: 194A.025(3)

7 STATUTORY AUTHORITY: KRS 194A.010(1), 194A.025(3), 194A.030 (2), 194A.050(1),

8 205.520(3), 205.560, 42 USC 1396n(b), and 42 CFR Part 438

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

10 Services, Department for Medicaid Services, has responsibility to administer the Medicaid

11 Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply

12 with a requirement that may be imposed or opportunity presented by federal law to qualify

13 for federal Medicaid funds. This administrative regulation establishes the policies and

14 procedures relating to the provision of Medicaid services through contracted managed

15 care organizations pursuant to, and in accordance with, 42 USC 1396n(b) and 42 CFR

16 Part 438.

17 Section 1. Definitions. (1) "1915(c) home and community based waiver program" means a

18 Kentucky Medicaid program established pursuant to, and in accordance with, 42 USC

19 1396n(c).

20 (2) "Adverse action" means:

21 (a) The denial or limited authorization of a requested service, including the type or

1 level of service;

2 (b) The reduction, suspension, or termination of a previously authorized service;

3 (c) The denial, in whole or in part, of payment for a service;

4 (d) The failure to provide services in a timely manner; or

5 (e) The failure of a managed care organization to act within the timeframes provided

6 in 42 CFR 438.408(b).

7 (3) “Advanced practice registered nurse” is defined by KRS 314.011(7).

8 (4) “Aged” means at least sixty-five (65) years of age.

9 (5) “Appeal” means a request for review of an adverse action or a decision by an MCO

10 related to a covered service.

11 (6) “Behavioral health service” means a clinical, rehabilitative, or support service

12 in an inpatient or outpatient setting to treat a mental illness, emotional disability, or

13 substance abuse disorder.

14 (7) “Blind” is defined by 42 USC 1382c(a)(2).

15 (8) "Capitation payment" means the total per enrollee, per month payment amount the

16 department pays an MCO.

17 (9) “Capitation rate” means the negotiated amount to be paid on a monthly basis by the

18 department to an MCO:

19 (a) Per enrollee; and

20 (b) Based on the enrollee’s aid category, age, and gender.

21 (10) “Care coordination” means the integration of all processes in response to an

22 enrollee’s needs and strengths to ensure the:

23 (a) Achievement of desired outcomes; and

24 (b) Effectiveness of services.

1 (11) “Case management” means a collaborative process that:
2 (a) Assesses, plans, implements, coordinates, monitors, and evaluates the options and
3 services required to meet an enrollee’s health and human service needs;
4 (b) Is characterized by advocacy, communication, and resource management; and
5 (c) Promotes quality and cost-effective interventions and outcomes.
6 (12) “CHFS OIG” means the Cabinet for Health and Family Services, Office of
7 Inspector General.
8 (13) “Child” means a person who:
9 (a)1. Is under the age of eighteen (18) years;
10 2.a. Is a full-time student in a secondary school or the equivalent level of vocational
11 or technical training; and
12 b. Is expected to complete the program before the age of nineteen (19) years;
13 3. Is not self supporting;
14 4. Is not a participant in any of the United States Armed Forces; and
15 5. If previously emancipated by marriage, has returned to the home of his or her
16 parents or to the home of another relative;
17 (b) Has not attained the age of nineteen (19) years in accordance with 42 USC
18 1396a(l)(1)(D); or
19 (c) Is under the age of nineteen (19) years if the person is a KCHIP recipient.
20 (14) “Chronic Illness and Disability Payment System” is a diagnostic classification
21 system that Medicaid programs can use to make health-based, capitated payments for
22 TANF and disabled Medicaid beneficiaries.
23 (15) “Commission for Children with Special Health Care Needs” or “CCSHCN” means
24 the Title V agency which provides specialty medical services for children with specific

1 diagnoses and health care needs that make them eligible to participate in programs
2 sponsored by the CCSHCN, including the provision of medical care.
3 (16) “Community mental health center” means a facility which meets the community
4 mental health center requirements established in 902 KAR 20:091.
5 (17) “Consumer Assessment of Healthcare Providers and Systems” or “CAHPS”
6 means a program that develops standardized surveys that ask consumers and patients
7 to report on and evaluate their experiences with health care.
8 (18) “Court-ordered commitment” means an involuntary commitment by an order of a
9 court to a psychiatric facility for treatment pursuant to KRS Chapter 202A.
10 (19) “DAIL” means the Department for Aging and Independent Living.
11 (20) “DCBS” means the Department for Community Based Services.
12 (21) "Department" means the Department for Medicaid Services or its designee.
13 (22) “Disabled” is defined by 42 USC 1382c(a)(3).
14 (23) “DSM-IV” means a manual published by the American Psychiatric Association
15 that covers all mental health disorders for both children and adults.
16 (24) “Dual eligible” means an individual eligible for Medicare and Medicaid benefits.
17 (25) “Early and periodic screening, diagnosis and treatment” or “EPSDT” is defined
18 by 42 CFR 440.40(b).
19 (26) “Emergency services” is defined by 42 USC 1396u-2(b)(2)(B).
20 (27) "Encounter" means a health care visit of any type by an enrollee to a provider of
21 care, drugs, items, or services.
22 (28) “Enrollee” means a recipient who is enrolled with a managed care organization for
23 the purpose of receiving Medicaid or KCHIP covered services.
24 (29) “External quality review organization” or “EQRO”:

1 (a) Is defined by 42 CFR 438.320; and

2 (b) Includes any affiliate or designee of the EQRO.

3 (30) “Family planning service” means a counseling service, medical service, or

4 a pharmaceutical supply or device to prevent or delay pregnancy.

5 (31) “Federally-qualified health center” or “FQHC” is defined by 42 CFR 405.2401(b).

6 (32) “Fee-for-service” means a reimbursement model in which a health insurer

7 reimburses a provider for each service provided to a recipient.

8 (33) “Foster care” means the DCBS program which provides temporary care for a

9 child:

10 (a) Placed in the custody of the Commonwealth of Kentucky; and

11 (b) Who is waiting for a permanent home.

12 (34) “Fraud” means any act that constitutes fraud under applicable federal law or KRS

13 205.8451 – KRS 205.8483.

14 (35) “Grievance” is defined by 42 CFR 438.400.

15 (36) “Grievance system” means a system that includes a grievance process, an appeal

16 process, and access to the Commonwealth of Kentucky’s fair hearing system.

17 (37) “Healthcare Effectiveness Data and Information Set” or “HEDIS” means a tool

18 used to measure performance regarding important dimensions of health care or services.

19 (38) “Health maintenance organization” is defined by KRS 304.38-030(5).

20 (39) “Health risk assessment” or “HRA” is a health questionnaire used to provide

21 individuals with an evaluation of their health risks and quality of life.

22 (40) “Homeless individual” means an individual who:

23 (a) Lacks a fixed, regular, or nighttime residence;

1 (b) Is at risk of becoming homeless in a rural or urban area because the residence is
2 not safe, decent, sanitary, or secure;
3 (c) Has a primary nighttime residence at a:
4 1. Publicly or privately operated shelter designed to provide temporary living
5 accommodations; or
6 2. Public or private place not designed as regular sleeping accommodations; or
7 (d) Is an individual who lacks access to normal accommodations due to violence or
8 the threat of violence from a cohabitant.
9 (43) "Individual with a special health care need" or "ISHCN" means an individual who:
10 (a) Has, or is at a high risk of having, a chronic physical, developmental, behavioral,
11 neurological, or emotional condition; and
12 (b) May require a broad range of primary, specialized, medical, behavioral health, or
13 related services.
14 (41) "Initial implementation" means the process of transitioning a current Medicaid or
15 KCHIP recipient from fee-for-service into managed care.
16 (42) "KCHIP" means the Kentucky Children's Health Insurance Program administered
17 in accordance with 42 U.S.C. 1397aa to jj.
18 (43) "Kentucky Health Information Exchange" or "KHIE" means the name given to the
19 system that will support the statewide exchange of health information among healthcare
20 providers and organizations according to nationally-recognized standards.
21 (44) "Knowingly" is defined by KRS 205.8451(5).
22 (45) "Managed care organization" or "MCO" means an entity for which the Department
23 for Medicaid Services has contracted to serve as managed care organization as defined
24 in 42 CFR 438.2.

(46) "Maternity care" means prenatal, delivery and postpartum care and includes care related to complications from delivery.

(47) "Mandatory enrollment" means the requirement that a recipient enroll in managed care.

(48) “Marketing” means any activity conducted by or on behalf of an MCO in which information regarding the services offered by the MCO is disseminated in order to educate enrollees or potential enrollees about the MCO’s services.

(49) “Medicaid works individual” means an individual who:

(a) But for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be receiving SSI benefits;

(b) Is at least sixteen (16), but less than sixty-five (65), years of age;

(c) Is engaged in active employment verifiable with:

1. Paycheck stubs;

2. Tax returns;

3. 1099 forms; or

4. Proof of quarterly estimated tax;

(d) Meets the income standards established in 907 KAR 1:640; and

(e) Meets the resource standards established in 907 KAR 1:645.

(50) “Medically necessary” means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(51) “Medical record” means a single, complete record that documents all of the treatment plans developed for, and medical services received by, an individual.

(52) “Medicare qualified individual group 1 (QI-1)” means an eligibility category, in

1 in which pursuant to 42 USC 1396a(a)(10)(E)(iv), an individual who would be a
2 Qualified Medicaid beneficiary but for the fact that the individual's income:
3 (a) Exceeds the income level established in accordance with 42 USC 1396d(p)(2);
4 and
5 (b) Is at least 120 percent, but less than 135 percent, of the federal poverty level for a
6 family of the size involved and who are not otherwise eligible for Medicaid under the
7 state plan.
8 (53) "National Practitioner Data Bank" is an electronic repository that collects:
9 (a) Information on adverse licensure activities, certain actions restricting clinical
10 privileges, and professional society membership actions taken against physicians,
11 dentists and other practitioners; and
12 (b) Data on payments made on behalf of physicians in connection with liability
13 settlements and judgments.
14 (54) "Nonqualified alien" means a resident of the United States of America who does
15 not meet the qualified alien requirements.
16 (55) "Nursing facility" means
17 (a) A facility:
18 1. To which the state survey agency has granted a nursing facility license;
19 2. For which the state survey agency has recommended to the department
20 certification as a Medicaid provider; and
21 3. To which the department has granted certification for Medicaid participation; or
22 (b) A hospital swing bed that provides services in accordance with 42 U.S.C. 1395tt
23 and 1396l, if the swing bed is certified to the department as meeting requirements for

1 the provision of swing bed services in accordance with 42 U.S.C. 1396r(b), (c), and (d)
2 and 42 C.F.R. 447.280 and 482.66.
3 (56) "*Olmstead* decision" means the court decision of *Olmstead v. L.C. and E.W.*,
4 U.S. Supreme Court, No. 98–536, June 26, 1999 in which the U.S. Supreme Court
5 ruled, "For the reasons stated, we conclude that, under Title II of the ADA, States are
6 required to provide community-based treatment for persons with mental disabilities
7 when the State's treatment professionals determine that such placement is appropriate,
8 the affected persons do not oppose such treatment, and the placement can be
9 reasonably accommodated, taking into account the resources available to the State and
10 the needs of others with mental disabilities."
11 (57) "Open enrollment" means an annual period during which an enrollee can choose
12 a different MCO.
13 (58) "Out-of- network provider" means a person or entity that has not entered into a
14 participating provider agreement with an MCO or any of the MCO's subcontractors.
15 (59) "Physician" is defined by KRS 311.550(12).
16 (60) "Post stabilization services" means covered services related to an emergency
17 medical condition that are provided to an enrollee:
18 (a) After an enrollee is stabilized in order to maintain the stabilized condition; or
19 (b) Under the circumstances described in 42 CFR 438.114(e) to improve or resolve
20 the enrollee's condition.
21 (61) "Primary care center" means an entity that meets the primary care center
22 requirements established in 902 KAR 20:058.
23 (62) "Primary care provider" means a licensed or certified health care practitioner
24 who meets the description as established in Section 7(6) of this administrative regulation.

1 (63) "Prior authorization" means the advance approval by an MCO of a service or item
2 provided to an enrollee.
3 (64) "Provider" means any person or entity under contract with an MCO or its
4 contractual agent that provides covered services to enrollees.
5 (64) "Provider network" means the group of physicians, hospitals, and other medical
6 care professionals that a managed care organization has contracted with to deliver
7 medical services to its enrollees.
8 (65) "Quality improvement" or "QI" means the process of assuring that covered
9 services provided to enrollees are appropriate, timely, accessible, available, and
10 medically necessary and the level of performance of key processes and outcomes of
11 the healthcare delivery system are improved through the MCO's policies and
12 procedures.
13 (66) "Qualified alien" means an individual who is lawfully admitted into the United
14 States of America for permanent residence under Title 8 of the United States Code (The
15 Immigrant and Nationality Act) including:
16 (a) An asylee;
17 (b) A refugee;
18 (c) An individual who:
19 1. Has been paroled into the United States of America for a period of one (1) year;
20 2. Has had his or her deportation withheld;
21 3. Has been granted conditional entry into the United States of America; or
22 4. Is a Cuban or Haitian entrant who was receiving Medicaid benefits on August 22,
23 1996; or
24 (d) A battered immigrant.

1 (67) “Qualified disabled and working individual” is defined by 42 USC 1396d(s).
2 (68) “Qualified Medicare beneficiary” or “QMB” is defined by 42 U.S.C. 1396d(p)(1).
3 (69) “Recipient” is defined in KRS 205.8451(9),
4 (70) “Risk adjustment” means a corrective tool to reduce both the negative financial
5 consequences for a managed care organization that enrolls high-risk users and the
6 positive financial consequences for a managed care organization that enrolls low-risk
7 users.
8 (71) “Rural area” means an area not in an urban area.
9 (72) “Rural health clinic” is defined by 42 CFR 405.2401(b).
10 (73) “Specified low-income Medicare beneficiary” means an individual who meets the
11 requirements established in 42 U.S.C. 1396a(a)(10)(E)(iii).
12 (74) “State fair hearing” means an administrative hearing provided by the Cabinet for
13 Health and Family Services pursuant to KRS Chapter 13B and 907 KAR 1:560.
14 (75) "State-funded adoption assistance" is defined by KRS 199.555(2).
15 (76) “State plan” is defined by 42 CFR 400.203.
16 (77) “Subcontract” means an agreement entered into, directly or indirectly, by an MCO
17 to arrange for the provision of covered services, or any administrative, support or other
18 health service, but does not include an agreement with a provider.
19 (78) “Supplemental security income benefits” or “SSI benefits” is defined by 20 CFR
20 416.2101.
21 (79) “Teaching hospital” means a hospital which has a teaching program approved as
22 specified in 42 U.S.C. 1395x (b)(6).
23 (80) “Temporary Assistance for Needy Families” or “TANF” means a block grant
24 program which:

(a) Succeeded AFDC; and

(b) Is designed to:

1. Assist needy families so that children can be cared for in their own homes;

2. Reduce the dependency of needy parents by promoting job preparation, work, and marriage;

3. Prevent out-of-wedlock pregnancies; and

4. Encourage the formation and maintenance of two-parent families.

(81) “Third party liability resource” means a resource available to an enrollee for the payment of expenses:

(a) Associated with the provision of covered services; and

(b) That does not include amounts exempt under Title XIX of the Social Security Act.

(82) “Transport time” means travel time:

(a) Under normal driving conditions; and

(b) With no extenuating circumstances.

(84)"Urban area" is defined by 42 CFR 412.62(f)(1)(ii).

(85) "Urgent care" means care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment.

(86) “Ward” is defined in KRS 387.510(15).

(87) “Women, Infants and Children program” means a federally-funded health and nutrition program for women, infants, and children.

Section 2. Enrollment of Medicaid or KCHIP Recipients into Managed Care.

(1) Enrollment into a managed care organization shall be mandatory for a Medicaid or a KCHIP recipient except as established in subsection (3) of this section.

(2) The provisions in this administrative regulation shall be applicable to a:

1 (a) Medicaid recipient; or

2 (b) KCHIP recipient.

3 (3) The following shall not be required to enroll into a managed care organization:

4 (a) A recipient who resides in:

5 1. A nursing facility for more than thirty (30) days; or

6 2. An intermediate care facility for individuals with mental retardation or a

7 developmental disability;

8 (b) A recipient who is:

9 1. Determined to be eligible for Medicaid benefits due to a nursing facility admission;

10 2. Enrolled in another managed care program in accordance with 907 KAR 1:705;

11 3. Receiving:

12 a. Services through the breast and cervical cancer program pursuant to 907 KAR

13 1:805;

14 b. Medicaid benefits in accordance with the spend-down policies established in 907

15 KAR 1:640;

16 c. Services through a 1915(c) home and community based services waiver program;

17 d. Hospice services in a nursing facility or intermediate care facility for individuals with

18 mental retardation or a developmental disability; or

19 e. Medicaid benefits as a Medicaid Works individual;

20 4. A Qualified Medicare beneficiary;

21 5. A specified low income Medicare beneficiary;

22 6. A Medicare qualified individual group 1 (QI-1) individual;

23 7. A qualified disabled and working individual;

24 8. A qualified alien eligible for Medicaid benefits for a limited period of time; or

1 9. A nonqualified alien eligible for Medicaid benefits for a limited period of time.
2 (4)(a) Except for a child in foster care, a recipient who is eligible for enrollment into
3 managed care shall be enrolled with an MCO that provides services to an enrollee whose
4 primary residence is within the MCO's service area.
5 (b) A child in foster care shall be enrolled with an MCO in the county where the child's
6 DCBS case is located.
7 (5) During the department's initial implementation of managed care in accordance with
8 this administrative regulation, the department shall assign a recipient to an MCO based
9 upon an algorithm that considers:
10 1. Continuity of care;
11 2. Enrollee preference of MCO or of an MCO provider; and
12 3. Cost.
13 (b) An assignment shall focus on a need of a child or an individual with a special
14 health care need.
15 (6) A recipient shall have fourteen (14) calendar days from the date of the written
16 notification of the MCO assignment referenced in subsection (5) of this section to choose
17 a different MCO.
18 (7)(a) A newly eligible recipient or a recipient who has had a break in eligibility of
19 greater than two months, shall have an opportunity to choose an MCO during the
20 eligibility application process.
21 (b) If a recipient does not choose an MCO during the eligibility application process, the
22 department shall assign the recipient to an MCO.
23 (8) Each member of a household shall be assigned to the same MCO.

1 (9) The effective date of enrollment for a recipient described in subsection (7) of this
2 section shall be:
3 (a) The date of Medicaid eligibility; and
4 (b) No earlier than November 1, 2011.
5 (10) A recipient shall be given a choice of MCOs, but not less than two (2).
6 (11) A recipient enrolled with an MCO who loses Medicaid eligibility for less than two
7 (2) months shall be automatically reenrolled with the same MCO upon redetermination of
8 Medicaid eligibility unless the recipient moves to a county in region three (3) as
9 established in Section 28 of this administrative regulation.
10 (12) A newborn who has been deemed eligible for Medicaid shall be automatically
11 enrolled with the newborn's mother's MCO as an individual enrollee for up to sixty (60)
12 days.
13 (13) An enrollee may change an MCO for any reason, regardless of whether the
14 MCO was selected by the enrollee or assigned by the department:
15 (a) Within ninety (90) days of the effective date of enrollment; and
16 (b)1. Annually during an open enrollment period that shall be at the time of an
17 enrollee's recertification for Medicaid eligibility; or
18 2. Annually during the month of birth for an enrollee who receives SSI benefits;
19 (c) Upon automatic enrollment under subsection (11) of this section, if a temporary
20 loss of Medicaid eligibility caused the recipient to miss the annual opportunity in
21 paragraph (b) of this subsection; and
22 (d) When the Commonwealth of Kentucky imposes an intermediate sanction
23 specified in 42 CFR 438.702(a)(3).

(14) Only the department shall have the authority to enroll a Medicaid recipient with a MCO in accordance with this section.

(15) Upon enrollment with an MCO, an enrollee shall receive two (2) identification cards:

(a) A card shall be issued from the department that shall verify Medicaid eligibility; and

(b) A card shall be issued by the MCO that shall verify enrollment with the MCO.

(16)(a) Within five (5) business days after receipt of notification of a new enrollee, an MCO shall send, by a method that shall not take more than three (3) days to reach the enrollee, a confirmation letter to an enrollee.

(b) The confirmation letter shall include at least the following information:

1. The effective date of enrollment;

2. Name, location and contact information of PCP;

3. How to obtain a referral;

4. Care coordination;

5. The benefits of preventive health care;

6. Enrollee identification card;

7. A member handbook; and

8. A list of covered services.

(17) Enrollment with an MCO shall be without restriction.

(18) An MCO shall:

(a) Have continuous open enrollment for new enrollees; and

(b) Accept enrollees regardless of overall enrollment.

1 (19)(a) A recipient eligible to enroll with an MCO shall be enrolled beginning with the
2 first day of the month that the enrollee applied for Medicaid with the exception of:
3 1. A newborn who shall be enrolled beginning with their date of birth;
4 2. An unemployed parent who shall be enrolled beginning with the date unemployed
5 parent meets the definition of unemployment in accordance with 45 CFR 233.100; or
6 3. An enrollee who shall be retro-actively determined eligible for Medicaid.
7 (b) Retro-active eligibility shall be for a period up to three (3) months prior to the
8 month that the enrollee applied for Medicaid.
9 (20) For an enrollee whose eligibility resulted from a successful appeal of a denial of
10 eligibility, the enrollment period shall begin:
11 (a)1. On the first day of the month of the original application for eligibility; or
12 2. On the first day of the month of retroactive eligibility as referenced in subsection
13 (19) of this section, if applicable; and
14 (b) No earlier than November 1, 2011.
15 (21) A provider shall be responsible for verifying an individual's eligibility for Medicaid
16 and enrollment in a managed care organization when providing a service.
17 Section 3. Disenrollment. (1) The policies established in 42 CFR 438.56 shall apply to
18 an MCO.
19 (2) Only the department shall have the authority to disenroll a recipient from an MCO.
20 (3) A disenrollment of a recipient from an MCO shall:
21 (a) Become effective on the first day of the month following disenrollment; and
22 (b) Occur:
23 1. If the enrollee:
24 a. No longer resides in an area served by the MCO;

1 b. Becomes incarcerated or deceased; or

2 c. Is exempt from managed care enrollment in accordance with Section 2(3) of this

3 administrative regulation; or

4 2. In accordance with 42 CFR 438.56.

5 (4) An MCO may recommend to the department that an enrollee be disenrolled if the

6 enrollee:

7 (a) Is found guilty of fraud in a court of law or administratively determined to have

8 committed fraud related to the Medicaid program;

9 (b) Is abusive or threatening;

10 (c) Becomes deceased; or

11 (d) No longer resides in an area served by the MCO.

12 (5) An enrollee shall not be disenrolled by the department, nor shall the managed care

13 organization recommend disenrollment of an enrollee, due to an adverse change in an

14 enrollee’s health.

15 (6)(a) An approved disenrollment shall be effective no later than the first day of the

16 second month following the month the enrollee or the MCO files a request in

17 accordance with 42 CFR 438.56(e)(1).

18 (b) If the department fails to make a determination within the timeframe specified in

19 subsection (6)(a), the disenrollment shall be considered approved in accordance with 42

20 CFR 438.56(e)(2).

21 (7) If an enrollee is disenrolled from an MCO, the MCO shall

22 (a) Assist in the selection of a new primary care provider, if requested;

23 (b) Cooperate with the new primary care provider in transitioning the enrollee’s care;

24 and

1 (c) Make the enrollee's medical record available to the new primary care provider, in
2 accordance with state and federal law.
3 (8) An MCO shall notify the department or Social Security Administration in an
4 enrollee's county of residence within five (5) working days of receiving notice of the
5 death of an enrollee.
6 Section 4. Enrollee Rights and Responsibilities. (1) An MCO shall have written policies
7 and procedures:
8 (a) To protect the rights of an enrollee that includes the:
9 1. Protection against liability for payment in accordance with 42 USC 1396u-2(b)(6);
10 2. Rights specified in 42 CFR 438.100;
11 3. Right to prepare an advance medical directive pursuant to KRS 311.621 through
12 KRS 311.643;
13 4. Right to choose and change a primary care provider;
14 5. Right to file a grievance or appeal;
15 6. Right to receive assistance in filing a grievance or appeal;
16 7. Right to a state fair hearing;
17 8. Right to a timely referral and access to medically indicated specialty care; and
18 9. Right to access the enrollee's medical records in accordance with federal and state
19 law.
20 (b) Regarding the responsibilities of enrollees that include the responsibility to:
21 1. Become informed about:
22 a. Enrollee rights specified in subsection (1) of this section; and
23 b. Service and treatment options;
24 2. Abide by the MCO's and department's policies and procedures;

3. Actively participate in personal health and care decisions;

4. Report suspected fraud or abuse; and

5. Keep appointments or call to cancel if unavailable to keep an appointment.

(2) The information specified in subsection (1) of this section, shall meet the information requirements established in 42 CFR 438.10.

Section 5. Enrollee Grievance System. (1) An MCO shall have an internal grievance system in place that allows an enrollee or a provider on behalf of an enrollee to challenge a denial of coverage of, or payment for, a service in accordance with 42 CFR 438.400 through 424 and 42 USC 1396u-2(b)(4).

(2) An enrollee shall have a right to a state fair hearing in accordance with KRS Chapter 13 B without exhausting an MCO's internal appeal process.

(3) An MCO shall have written policies and procedures describing how an enrollee shall submit a request for a:

(a) Grievance or an appeal with the MCO; or

(b) State fair hearing in accordance with KRS Chapter 13B.

(4) A legal guardian of an enrollee who is a minor or an incapacitated adult, a representative of an enrollee as designated in writing to an MCO, or a provider acting on behalf of an enrollee and with the enrollee's written consent, has the right to file a grievance on behalf of the enrollee.

(5) An enrollee shall have thirty (30) calendar days from the date of an event causing dissatisfaction to file a grievance orally or in writing with the MCO.

(6) Within five (5) working days of receipt of a grievance, an MCO shall provide the enrollee with written notice that the grievance has been received and the expected date of its resolution.

1 (7) An investigation and final resolution of a grievance shall:

2 (a) Be completed within thirty (30) calendar days of the date the grievance is received
3 by the MCO; and

4 (b) Include a resolution letter to the enrollee that shall include:

5 1. All information considered in investigating the grievance;

6 2. Findings and conclusions based on the investigation; and

7 3. The disposition of the grievance.

8 (8) An enrollee shall have thirty (30) calendar days from the date of receiving a notice
9 of adverse action from an MCO to file an appeal either orally or in writing with the MCO.

10 (9) A legal guardian of an enrollee who is a minor or an incapacitated adult, a
11 representative of the enrollee as designated in writing to an MCO, or a provider acting
12 on behalf of an enrollee with the enrollee’s written consent, shall have the right to file an
13 appeal of an adverse action on behalf of the enrollee.

14 (10) An MCO shall resolve an appeal within thirty (30) calendar days from the date
15 the initial oral or written appeal is received by the MCO.

16 (11) An MCO shall have a process in place that ensures that an oral or written inquiry
17 from an enrollee seeking to appeal an adverse action is treated as an appeal to
18 establish the earliest possible filing date for the appeal.

19 (12) An oral appeal shall be followed by a written appeal that is signed by the
20 enrollee within ten (10) calendar days.

21 (13) Within five (5) working days of receipt of an appeal, an MCO shall provide the
22 enrollee with written notice that the appeal has been received and the expected date of
23 its resolution, unless an expedited resolution has been requested.

1 (14) An MCO shall extend the thirty (30) day timeframe for resolution of an appeal in
2 subsection (11) of this section by fourteen (14) calendar days if:
3 (a) An enrollee requests the extension; or
4 (b)1. An MCO demonstrates to the department that there is need for additional
5 information; and
6 2. The extension is in the enrollee's interest.
7 (15) For an extension requested by an MCO, the MCO shall give the enrollee written
8 notice of the extension and the reason for the extension within two (2) working days of
9 the decision to extend.
10 (16) For an appeal, an MCO shall provide written notice of its decision within thirty
11 (30) calendar days to an enrollee or a provider, if the provider filed the appeal.
12 (17) An MCO shall:
13 (a) Continue to provide benefits to an enrollee until one of the following occurs:
14 1. The enrollee withdraws the appeal;
15 2. Fourteen (14) days have passed since the date of the resolution letter, provided
16 the resolution of the appeal was against the enrollee and the enrollee has not requested
17 a state fair hearing or taken any further action; or
18 3. A state fair hearing decision adverse to the enrollee has been issued;
19 (b) Have an expedited review process for appeals when the MCO determines that
20 allowing the time for a standard resolution could seriously jeopardize an enrollee's life or
21 health or ability to attain, maintain, or regain maximum function;
22 (c) Resolve an expedited appeal within three (3) working days of receipt of the
23 request; and

(d) Extend the timeframe for an expedited appeal in paragraph (b) of this subsection by up to fourteen (14) calendar days if the enrollee requests the extension or the MCO demonstrates to the department that there is need for additional information and the extension is in the enrollee's interest.

(18) For an extension requested by an MCO, the MCO shall give the enrollee written notice of the reason for the extension.

(19) If an MCO denies a request for an expedited resolution of an appeal, it shall:

(a) Transfer the appeal to the thirty (30) day timeframe for a standard resolution, in which the thirty (30) day period begins on the date the MCO received the original request for appeal;

(b) Give prompt oral notice of the denial; and

(c) Follow up with a written notice within two (2) calendar days of the denial.

(20) An MCO shall document in writing an oral request for an expedited resolution and shall maintain the documentation in the enrollee case file.

(21) The department shall provide an enrollee with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.

(22) An enrollee shall be able to request a state fair hearing if dissatisfied with an adverse action that has been taken by an MCO:

(a) Within thirty (30) days of receiving notice of an adverse action; or

(b) Within thirty (30) days of the final decision of an MCO to an appeal filed by an enrollee.

(23) A document supporting an MCO's adverse action shall be:

(a) Received by the department no later than five (5) days from the date the MCO

1 receives a notice from the department that a request for a state fair hearing has been
2 filed by an enrollee; and
3 (b) Made available to an enrollee upon request by either the enrollee or the enrollee's
4 legal counsel.
5 (24) An automatic ruling shall be made by the department in favor of an enrollee if an
6 MCO fails to:
7 (a) Comply with the state fair hearing requirements established by the state and
8 federal Medicaid law; or
9 (b) Appear in person and present evidence at the state fair hearing.
10 (25) An MCO shall:
11 (a) Provide information specified in 42 CFR 438.10(g)(1) about the grievance system
12 to a service provider and a subcontractor at the time they enter into a contract;
13 (b) Maintain a grievance or an appeal file in a secure and designated area;
14 (c) Make a grievance or an appeal file accessible to the department or its designee
15 upon request;
16 (d) Retain a grievance or an appeal file for ten (10) years following a final decision by
17 the MCO, the department, an administrative law judge, judicial appeal, or closure of a
18 file, whichever occurs later;
19 (e) Have procedures for assuring that a grievance or an appeal file contains:
20 1. Information to identify the grievance or appeal;
21 2. The date a grievance or appeal was received;
22 3. The nature of the grievance or appeal;
23 4. A notice to the enrollee of receipt of the grievance or appeal;
24 5. Correspondence between the MCO and the enrollee;

1 6. The date the grievance or appeal is resolved;
2 7. The decision made by the MCO of the grievance or appeal;
3 8. The notice of a final decision to the enrollee; and
4 9. Information pertaining to the grievance or appeal; and
5 (f) Make available to an enrollee documentation regarding a grievance or an appeal.
6 (26) An MCO shall designate an individual to:
7 (a) Execute the policies and procedures for resolution of a grievance or appeal;
8 (b) Review patterns or trends in grievances or appeals; and
9 (c) Initiate a corrective action, if needed.
10 Section 6. Member Services. (1) An MCO shall have a member services function that
11 includes a member call center and a behavioral health call center that shall:
12 (a) Be staffed Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern
13 Standard Time; and
14 (b) Meet the current American Accreditation Health Care Commission or Utilization
15 Review Accreditation Committee (URAC)-designed Health Call Center Standard (HCC)
16 for call center abandonment rate, blockage rate and average speed of answer.
17 (2)(a) An MCO shall provide access to medical advice to an enrollee through a toll-
18 free call-in system, available twenty-four (24) hours a day, seven (7) days a week.
19 (b) The call-in system shall be staffed by medical professionals to include:
20 1. Physicians;
21 2. Physician assistants;
22 3. Licensed practical nurses; or
23 4. Registered nurses.
24 (3) An MCO shall:

1 (a)1. Provide foreign language interpreter services for an enrollee.

2 2. Interpreter services shall be available free of charge.

3 (b) Respond to the special communication needs of the disabled, blind, deaf, or

4 aged.

5 (c) Facilitate direct access to a specialty physician for an enrollee:

6 1. With a chronic or complex health condition;

7 2. Who is aged, blind, deaf, or disabled; or

8 3. Identified as having a special healthcare need and requires a course of treatment

9 or regular healthcare monitoring;

10 (d) Arrange for and assist with scheduling an EPSDT service in conformance with

11 federal law governing EPSDT;

12 (e) Provide an enrollee with information or refer to a support service;

13 (f) Facilitate direct access to a covered service in accordance with Section 29(4)

14 (g) Facilitate access to a:

15 1. Behavioral health service;

16 2. Pharmaceutical service; or

17 3. Service provided by a public health department, community mental health center,

18 rural health clinic, federally qualified health center, the Commission for Children with

19 Special Health Care Needs or a charitable care provider;

20 (h) Assist an enrollee in:

21 1. Scheduling an appointment with a provider;

22 2. Obtaining transportation for an emergency or non-emergency service;

23 3. Completing a health risk assessment; or

24 4. Accessing an MCO health education program;

(i) Process, record, and track an enrollee grievance and appeal; or

(j) Refer an enrollee to case management or disease management.

Section 7. Enrollee Selection of Primary Care Provider. (1) Except for an enrollee described in subsection (2) of this section, an MCO shall have a process for enrollee selection and assignment of a primary care provider.

(2) The following shall not be required to have a primary care provider:

(a) A dual eligible;

(b) A child in foster care;

(c) A child under the age of eighteen (18) years who is disabled; or

(d) A pregnant woman who is presumptively eligible pursuant to 907 KAR 1:810.

(3)(a) For an enrollee who is not receiving supplemental security income benefits:

1. An MCO shall notify the enrollee within ten (10) days of notification of enrollment by the department of the procedure for choosing a primary care provider; and

2. If the enrollee does not choose a primary care provider, an MCO shall assign to the enrollee a primary care provider who:

a. Has historically provided services to the enrollee; and

b. Meets the requirements of subsection (5) of this section.

(b) If no primary care provider meets the requirements of paragraph (a)2, an MCO shall assign the enrollee to a primary care provider who is within:

1. Thirty (30) miles or thirty (30) minutes from the enrollee's residence or place of employment if the enrollee is in an urban area; or

2. Forty-five (45) miles or forty-five (45) minutes from the enrollee's residence or place of employment if the enrollee is in a rural area.

(4)(a) For an enrollee who is receiving supplemental security income benefits and

1 is not a dual eligible, an MCO shall notify the enrollee of the procedure for choosing a
2 primary care provider.
3 (b) If an enrollee has not chosen a primary care provider within thirty (30) days, an
4 MCO shall send a second notice to the enrollee.
5 (c) If an enrollee has not chosen a primary care provider within thirty (30) days of a
6 second notice, the MCO shall send a third notice to the enrollee.
7 (d) If an enrollee and has chosen a primary care provider after the third notice, the
8 MCO shall assign a primary care provider.
9 (e) Except for an enrollee who was previously enrolled with the MCO, an MCO shall
10 not automatically assign a primary care provider within ninety (90) days of the enrollee's
11 initial enrollment.
12 (5)(a) An enrollee shall be allowed to select from at least two (2) primary care providers
13 within an MCO's provider network.
14 (b) At least one (1) of the two primary care providers referenced in paragraph (a) of this
15 subsection shall be a physician.
16 (6) A primary care provider shall:
17 (a) Be a licensed or certified health care practitioner who functions within their scope of
18 licensure or certification, including:
19 1. A physician;
20 2. An advanced practice registered nurse;
21 3. A physician assistant; or
22 4. A clinic, including a primary care center, federally qualified health center, or rural
23 health clinic;

1 (b) Have admitting privileges at a hospital or a formal referral agreement with a
2 provider possessing admitting privileges;
3 (c) Agree to provide twenty-four (24) hours a day, seven (7) days a week primary
4 health care services to enrollees; and
5 (d) For an enrollee who has a gynecological or obstetrical health care need, a disability
6 or chronic illness, be a specialist who agrees to provide or arrange for primary and
7 preventive care directly or through linkage with a primary care provider.
8 (7) Upon enrollment in an MCO, an enrollee shall have the right to change primary
9 care providers:
10 (a) Within the first ninety (90) days of assignment;
11 (b) Once a year regardless of reason;
12 (c) At any time for a reason approved by the MCO;
13 (d) If during a temporary loss of eligibility, an enrollee loses the opportunity in
14 paragraph (b) of this subsection;
15 (e) If Medicare or Medicaid imposes a sanction on the PCP;
16 (f) If the PCP is no longer in the MCO provider network; or
17 (g) At any time with cause which shall include and enrollee:
18 1. Receiving poor quality of care; or
19 3. Lacking access to providers qualified to treat the enrollee's medical condition.
20 (8) A PCP shall not be able to request the reassignment of an enrollee to a different
21 PCP for the following:
22 (a) A change in the enrollee's health status or treatment needs;
23 (b) An enrollee's utilization of health services;
24 (c) An enrollee's diminished mental capacity; or

(d) Disruptive behavior of an enrollee due to the enrollee's special health care needs unless the behavior impairs the PCP's ability to provide services to the enrollee or others.

(9) A PCP change request shall not be based on race, color, national origin, disability, age, or gender.

(10) An MCO shall have the authority to approve or deny a primary care provider change.

(11) An enrollee shall be able to obtain the following services outside of an MCO's provider network:

(a) A family planning service in accordance with 42 CFR 431.51;

(b) An emergency service in accordance with 42 CFR 438.114;

(c) A post-stabilization service in accordance with 42 CFR 438.114 and 42 CFR 422.113(c);

(d) An out-of-network service that an MCO is unable to provide within its network to meet the medical need of the enrollee in accordance with 42 CFR 438.206(b)(4).

(12) An MCO shall:

(a) Notify an enrollee within:

1. Thirty (30) days of the effective date of a voluntary termination of the enrollee's primary care provider; or

2. Fifteen (15) days of an involuntary termination of the enrollee's primary care provider; and

(b) Assist the enrollee in selecting a new primary care provider.

Section 8. Primary Care Provider Responsibilities. (1) A PCP shall:

(a) Maintain:

1. Continuity of an enrollee's health care;

1 2. A current medical record for an enrollee in accordance with Section 24 of this
2 administrative regulation; and
3 3. Formalized relationships with other PCPs to refer enrollees for after hours care,
4 during certain days, for certain services, or other reasons to extend their practice.
5 (b) Refer an enrollee for specialty care and other medically necessary services, both
6 in and out of network, if the services are not available within the MCO's network;
7 (c) Discuss advance medical directives with an enrollee;
8 (d) Provide primary and preventive care, including EPSDT services;
9 (e) Refer an enrollee for a behavioral health service if clinically indicated; and
10 (f) Have an after-hours phone arrangement that ensures that a PCP or a designated
11 medical practitioner returns the call within thirty (30) minutes;
12 (2) An MCO shall monitor a PCP to ensure compliance with the policies in this
13 section.
14 Section 9. Member Handbook. (1) An MCO shall:
15 (a) Send a member handbook to an enrollee, by a method that shall not take more
16 than three (3) days to reach the enrollee, within five (5) business days of enrollment;
17 (b) Review a member handbook at least annually;
18 (c) Communicate a change to a member handbook to an enrollee in writing; and
19 (d) Add a revision date to a member handbook after revising.
20 (2) A member handbook shall:
21 (a) Be available:
22 1. In English, Spanish, and any other language spoken by at least five (5) percent of
23 the potential enrollee or enrollee population;
24 2. In hardcopy; and

1 3. On the MCO's website;
2 (b) Be written at no higher than a sixth grade reading comprehensive level; and
3 (c) Include at a minimum the following information:
4 1. The MCO's network of primary care providers, including the names, telephone
5 numbers, and service site addresses of available primary care providers;
6 2. The procedures for:
7 a. Selecting a PCP and scheduling an initial health appointment;
8 b. Obtaining:
9 (i) Emergency or non-emergency care after hours;
10 (ii) Transportation for emergency or non-emergency care;
11 (iii) An EPSDT service;
12 (iv) A covered service from an out-of-network provider; or
13 (v) A long term care service;
14 c. Notifying DCBS of a change in family size or address, a birth, or a death of an
15 enrollee;
16 d.(i) Selecting or requesting to change a PCP;
17 (ii) A reason a request for a change may be denied by the MCO;
18 (iii) A reason a provider may request to transfer an enrollee to a different PCP;
19 e. Filing a grievance or appeal, including the title, address and telephone number of
20 the person responsible for processing and resolving a grievance or appeal;
21 3. The name of the MCO, address, and telephone number from which it conducts its
22 business;
23 4. The MCO's:
24 a. Business hours; and

b. Member service and toll-free medical call-in telephone numbers;

5. Covered services, an explanation of any service limitation or exclusion from coverage, and a notice stating that the MCO will be liable only for those services authorized by the MCO, except for the services excluded in Section 7(11) of this administrative regulation.

6. Member rights and responsibilities;

7. For a life-threatening situation, instructions to use the emergency medical services available or to activate emergency medical services by dialing 911;

8. Information on:

a. The availability of maternity and family planning services, and for the prevention and treatment of sexually transmitted diseases;

b. Accessing the services referenced in clause a. of this paragraph;

c. Accessing care before a primary care provider is assigned or chosen;

d. The Cabinet for Health and Family Services' independent ombudsman program; and

e. The availability of, and procedures for, obtaining:

(i) A behavioral health or substance abuse service;

(ii) A health education service; and

(iii) Care coordination, case management, and disease management services;

9. Direct access services that may be accessed without a referral; and

10. An enrollee's right to obtain a second opinion and information on obtaining a second opinion; and

(c) Meet the information requirements established in Section 12 of this administrative regulation.

1 (3) Changes to a member handbook shall be approved by the department prior to the
2 publication of the handbook.
3 Section 10. Member Education and Outreach. (1) An MCO shall:
4 (a) Have an enrollee and community education and outreach program throughout the
5 MCO's service area;
6 (b) Submit an annual outreach plan to the department for approval;
7 (c) Assess the homeless population within its service area by implementing and
8 maintaining an outreach plan for homeless individuals, including victims of domestic
9 violence; and
10 (d) Not differentiate between a service provided to an enrollee who is homeless and
11 an enrollee who is not homeless.
12 (2) An MCO's outreach plan shall include:
13 (a) Utilizing existing community resources including shelters and clinics; and
14 (b) Face-to-face encounters.
15 Section 11. Enrollee Non-Liability for Payment. (1) Except as specified in Section 58
16 or Section 7(11) of this administrative regulation, an enrollee shall not be required to
17 pay for a medically necessary covered service provided by the enrollee's MCO.
18 (2) An MCO shall not impose cost sharing on an enrollee greater than the limits
19 established by the department in 907 KAR 1:604.
20 (3) If an enrollee agrees in advance in writing to pay for a non-Medicaid covered
21 service, the enrollee's MCO shall be authorized to bill the enrollee for the service.
22 Section 12. Provision of Information Requirements. (1) An MCO shall:
23 (a) Comply with the requirements established in 42 USC 1396u-2(a)(5) and 42 CFR
24 438.10; and

1 (b) Provide translation services to an enrollee on site or via telephone.
2 (2) Written material provided by an MCO to an enrollee or potential enrollee shall:
3 (a) Be written at a sixth grade reading comprehension level;
4 (b) Be published in at least a twelve (12) point font;
5 (c) Comply with the requirements established in 42 USC Chapter 126 and 47 USC
6 Chapter 5 (the Americans with Disabilities Act);
7 (d) Be updated as necessary to maintain accuracy; and
8 (e) Be available in Braille or in an audio format for an individual who is partially blind or
9 blind.
10 (3) All written material intended for an enrollee, unless unique to an individual enrollee
11 or exempted by the department, shall be submitted to the department for review and
12 approval prior to publication or distribution to the enrollee.
13 Section 13. Provider Services. (1) An MCO shall have a provider services function
14 responsible for:
15 (a) Enrolling, credentialing, recredentialing, and evaluating a provider;
16 (b) Assisting a provider with an inquiry regarding enrollee status, prior authorization,
17 referral, claim submission, or payment;
18 (c) Informing a provider of their rights and responsibilities;
19 (d) Handling, recording, and tracking a provider grievance and appeal;
20 (e) Developing, distributing, and maintaining a provider manual;
21 (f) Provider orientation and training, including:
22 1. Medicaid covered services;
23 2. EPSDT coverage;
24 3. Medicaid policies and procedures;

4. MCO policies and procedures; and

5. Fraud, waste, and abuse;

(g) Assisting in coordinating care for a child or adult with a complex or chronic condition;

(h) Assisting a provider with enrolling in the Vaccines for Children Program in accordance with 907 KAR 1:680; and

(i) Providing technical support to a provider regarding the provision of a service.

(2) An MCO's provider services staff shall:

(a) Be available Monday through Friday from 8:00 a.m. to 6:00 p.m Eastern Standard Time; and

(b) Operate a provider call center.

Section 14. Provider Network. (1) An MCO shall:

(a) Enroll providers of sufficient types, numbers, and specialties in its network to satisfy the:

1. Access and capacity requirements established in Section 15 of this administrative regulation; and

2. Quality requirements established in Section 48 of this administrative regulation;

(b) Attempt to enroll the following providers in its network:

1. A teaching hospital;

2. A rural health clinic;

3. The Kentucky Commission for Children with Special Health Care Needs;

4. A local health department; and

5. A community mental health center;

1 (c) Demonstrate to the department the extent to which it has enrolled providers in its
2 network who have traditionally provided services to Medicaid recipients;
3 (d) Have at least one (1) FQHC in a region where the MCO operates in accordance
4 with Section 28, if there is an FQHC that is appropriately licensed to provide services in
5 the region; and
6 (e) Exclude, terminate, or suspend from its network a provider or subcontractor who
7 engages in an activity that results in suspension, termination, or exclusion from the
8 Medicare or a Medicaid program.
9 (2) The length of an exclusion, termination, or suspension referenced in subsection
10 (1)(e) of this subsection shall equal the length of the exclusion, termination, or
11 suspension imposed by the Medicare or a Medicaid program.
12 (3) If an MCO is unable to enroll a provider specified in subsection (1)(b) or (1)(c) of
13 this section, the MCO shall submit to the department for approval, documentation which
14 supports the MCO's conclusion that adequate services and service sites as required in
15 Section 15 of this administrative regulation shall be provided without enrolling the
16 specified provider.
17 (4) If an MCO determines that its provider network is inadequate to comply with the
18 access standards established in Section 15 of this administrative regulation, the MCO
19 shall:
20 (a) Notify the department; and
21 (b) Submit a corrective action plan to the department.
22 (5) A corrective action plan referenced in subsection (4)(b) of this section shall:
23 (a) Describe the deficiency in detail; and

1 (b) Identify a specific action to be taken by the MCO to correct the deficiency, including
2 a time frame.
3 Section 15. Provider Access Requirements. (1) The access standards requirements
4 established in 42 CFR 438.206 through 210 shall apply to an MCO.
5 (2) An MCO shall make available and accessible to an enrollee:
6 (a) Facilities, service locations, and personnel sufficient to provide covered services
7 consistent with the requirements specified in this section;
8 (b) Emergency medical services twenty-four (24) hours a day, seven (7) days a
9 week; and
10 (c) Urgent care services within 48 hours of request.
11 (3)(a) An MCO's primary care provider delivery site shall be no more than:
12 1. Thirty (30) miles or thirty (30) minutes from an enrollee's residence or place of
13 employment in an urban area; or
14 2. Forty-five (45) miles or forty-five (45) minutes from an enrollee's residence or place
15 of employment in a non-urban area.
16 (b) An MCO's primary care provider shall not have an enrollee to primary care provider
17 ratio greater than 1,500:1.
18 (c) An appointment wait time at an MCO's primary care delivery site shall not exceed:
19 1. Thirty (30) days from the date of an enrollee's request for a routine or preventive
20 service; or
21 2. Forty-eight (48) hours from an enrollee's request for urgent care.
22 (4)(a) An appointment wait time for a specialist, except for a specialist providing a
23 behavioral health service, shall not exceed thirty (30) days from the referral for routine
24 care or forty-eight (48) hours from the referral for urgent care.

1 (b)1. A behavioral health service requiring crisis stabilization shall be provided within
2 twenty-four (24) hours of the referral.
3 2. Behavioral health urgent care shall be provided within forty-eight (48) hours of the
4 referral.
5 3. A behavioral health service appointment following a discharge from an acute
6 psychiatric hospital shall occur within fourteen (14) days of discharge.
7 4. A behavioral health service appointment not included in subparagraph 1, 2, or 3 of
8 this paragraph shall occur within sixty (60) days of the referral.
9 (5) An MCO shall have:
10 1. Specialists available for the subpopulations designated in Section 30 of this
11 administrative regulation; and
12 2. Sufficient pediatric specialists to meet the needs of enrollees who are less than
13 twenty-one (21) years of age.
14 (6) An emergency service shall be provided at a health care facility most suitable for
15 the type of injury, illness, or condition, whether or not the facility is in the MCO network.
16 (7)(a) Except as provided in paragraph (b) of this subsection, an enrollee's transport
17 time to a hospital shall not exceed thirty (30) minutes from an enrollee's residence.
18 (b) Transport time to a hospital shall not exceed sixty (60) minutes from an enrollee's
19 residence:
20 1. In a rural area; or
21 2. For a behavioral or physical rehabilitation service.
22 (8)(a) Transport time for a dental service shall not exceed one (1) hour from an
23 enrollee's residence.
24 (b) A dental appointment wait time shall not exceed:

1 1. Three (3) weeks for a regular appointment; or
2 2. Forty-eight (48) hours for urgent care.
3 (9)(a) Transport time to a general vision, laboratory, or radiological service shall not
4 exceed one (1) hour from an enrollee's residence.
5 (b) A general vision, laboratory, or radiological appointment wait time shall not exceed:
6 1. Three (3) weeks for a regular appointment; or
7 2. Forty-eight (48) hours for urgent care.
8 (10)(a) Transport time to a pharmacy service shall not exceed one (1) hour from an
9 enrollee's residence.
10 (b) A pharmacy delivery site shall not be further than fifty (50) miles from an enrollee's
11 residence.
12 Section 16. Provider Manual. (1) An MCO shall provide a provider manual to a
13 provider within five (5) working days of enrollment with the MCO.
14 (2) Prior to distributing a provider manual or update to a provider manual, an MCO
15 shall procure the department's approval of the provider manual or provider manual
16 update
17 (3) A provider manual shall be available in hard copy and on the MCO's website.
18 Section 17. Provider Orientation and Education. An MCO shall:
19 (1) Conduct an initial orientation for a provider within thirty (30) days of enrollment
20 with the MCO to include:
21 (a) Medicaid coverage policies and procedures;
22 (b) Reporting fraud and abuse;
23 (c) Medicaid eligibility groups;
24 (d) The standards for preventive health services;

(e) The special needs of enrollees;

(f) Advance medical directives;

(g) EPSDT services;

(h) Claims submission;

(i) Care management or disease management programs available to enrollees;

(j) Cultural sensitivity;

(k) The needs of enrollees with mental, developmental, or physical disabilities;

(l) The reporting of communicable diseases;

(m) The MCO's QAPI program as referenced in Section 48;

(n) Medical records;

(o) The external quality review organization; and

(p) The rights and responsibilities of enrollees and providers; and

(2) Ensure that a provider:

(a) Is informed of an update on a federal, state, or contractual requirement;

(b) Receives education on a finding from its QAPI program when deemed necessary by the MCO or department; and

(c) Makes available to the department training attendance rosters that shall be dated and signed by the attendees.

Section 18. Provider Credentialing and Recredentialing. (1) An MCO shall:

(a) Have policies and procedures that comply with 907 KAR 1:672, KRS 205.560, and 42 CFR 455 subpart E regarding the credentialing and recredentialing of a provider;

(b) Have a process for verifying a provider's credentials and malpractice insurance that shall include:

1. Written policies and procedures for credentialing and re-credentialing of a provider;

1 2. A governing body, or a group or individual to whom the governing body has
2 formally delegated the credentialing function; and
3 3. A review of the credentialing policies and procedures by a governing body;
4 (c) Have a credentialing committee that makes recommendations regarding
5 credentialing;
6 (d) If a provider requires a review by the credentialing committee, notify the
7 department of the facts and outcomes of the review;
8 (e) Have written policies and procedures for:
9 1. Terminating and suspending a provider; and
10 2. Reporting a quality deficiency that results in a suspension or termination of a
11 provider;
12 (f) Document its monitoring of a provider;
13 (g) Verify a provider's qualifications through a primary source that includes:
14 1. A current valid license or certificate to practice in the commonwealth of Kentucky;
15 2. A Drug Enforcement Administration certificate and number, if applicable;
16 3. If a provider is not board certified, graduation from a medical school and
17 completion of a residency program;
18 4. Completion of an accredited nursing, dental, physician assistant, or vision
19 program, if applicable;
20 5. If a provider states on an application that the provider is board certified in a
21 specialty, a professional board certification;
22 6. A previous five (5) year work history;
23 7. A professional liability claims history;
24 8. If a provider requires access to a hospital to practice, proof that the provider

1 has clinical privileges and is in good standing at a hospital designated by the provider
2 as the primary admitting hospital;
3 9. Malpractice insurance;
4 10. Documentation of a:
5 a. Revocation, suspension, or probation of a state license or Drug Enforcement
6 Agency certificate and number;
7 b. Curtailment or suspension of a medical staff privilege;
8 c. Sanction or penalty imposed by the United States Department of Health and
9 Human Services or a state Medicaid agency; and
10 d. Censure by a state or county professional association; or
11 11. The most recent provider information available from the National Practitioner
12 Data Bank;
13 (h)Obtain access to the National Practitioner Data Bank as part of its credentialing
14 process;
15 (i) Have:
16 1. A process to recredential a provider at least once every three (3) years that shall
17 be in accordance with subsection (3) of this section; and
18 2. Procedures for monitoring a provider sanction, a complaint , or a quality issue
19 between a recredentialing cycle; and
20 (j) Have NCQA certification for credentialing by April 1, 2012.
21 (2) If an MCO subcontracts a credentialing and re-credentialing function, the MCO
22 and the subcontractor shall have written policies and procedures for credentialing and
23 recredentialing.

(3) A provider shall complete a credentialing application that includes a statement by the provider regarding:

(a) The provider's ability to perform an essential function of a position, with or without accommodation;

(b) The provider's lack of current illegal drug use;

(c) The provider's history of a:

1. Loss of license or a felony conviction;

2. Loss or limitation of a privilege; or

3. Disciplinary action;

(d) A sanction, suspension, or termination by the United States Department of Health and Human Services or a state Medicaid agency;

(e) Clinical privileges and standing at a hospital designated as the primary admitting hospital of the provider;

(f) Malpractice insurance maintained by the provider; and

(g) The correctness and completeness of the application.

(4) The department shall be responsible for credentialing and recredentialing a:

(a) Hospital-based provider; and

(b) Provider enrolled with an MCO for a six (6) month period that begins on November 1, 2011 and ends on April 30, 2012.

Section 19. MCO Provider Enrollment. (1) A provider enrolled with an MCO shall:

(a) Be credentialed by the MCO in accordance with the standards established in Section 18 of this administrative regulation; and

(b) Be eligible to enroll with the Kentucky Medicaid Program in accordance with 907 KAR 1:672.

1 (2) An MCO shall:

2 (a) Not enroll a provider in its network if:

3 1. The provider has an active sanction imposed by the Centers for Medicare and

4 Medicaid Services or a state Medicaid agency;

5 2. A required provider license and a certification are not current;

6 3. A provider owes money to the Kentucky Medicaid program;

7 4. The Kentucky Office of the Attorney General has an active fraud investigation of

8 the provider; or

9 5. The provider is not credentialed;

10 (b) Have and maintain documentation regarding a provider's qualifications; and

11 (c) Make the documentation referenced in paragraph (b) of this subsection available

12 for review by the department.

13 (3)(a) A provider shall not be required to participate in Kentucky Medicaid fee-for-

14 service to enroll with an MCO.

15 (b) If a provider is not a participant in Kentucky Medicaid fee-for-service, the provider

16 shall obtain a Medicaid provider number from the department.

17 Section 20. Provider Discrimination. An MCO shall:

18 (1) Comply with the antidiscrimination requirements established in:

19 (a) 42 USC 1396u-2(b)(7);

20 (b) 42 CFR 438.12; and

21 (c) KRS 304.17A-270; and

22 (2) Provide written notice to a provider denied participation in the MCO's network

23 stating the reason for the denial.

24 Section 21. Release for Ethical Reasons. An MCO shall:

(1) Not:

(a) Require a provider to perform a treatment or procedure that is contrary to the provider's conscience, religious beliefs, or ethical principles in accordance with 42 CFR 438.102; or

(b) Prohibit or restrict a provider from advising an enrollee about health status, medical care or a treatment:

1. Whether or not coverage is provided by the MCO; and

2. If the provider is acting within the lawful scope of practice; and

(2) Have a referral process in place for a situation where a provider declines to perform a service because of an ethical reason.

Section 22. Provider Grievances and Appeals. (1) An MCO shall have written policies and procedures for the filing of a provider grievance or appeal.

(2) A provider shall have the right to file a grievance or an appeal with an MCO.

(3)(a) A provider grievance or appeal shall be resolved within thirty (30) calendar days.

(b) If a grievance or appeal is not resolved within thirty (30) days, an MCO shall request a fourteen (14) day extension from the provider.

(c) If a provider requests an extension, the MCO shall approve the extension.

Section 23. Cost Reporting Information. The department shall provide to the MCO the calculation of Medicaid allowable costs as used in the Medicaid program.

Section 24. Medical Records. (1) An MCO shall:

(a) Require a provider to maintain an enrollee medical record on paper or in an electronic format; and

1 (b) Have a process to systematically review provider medical records to ensure
2 compliance with the medical records standards established in this section.
3 (2) An enrollee medical record shall:
4 (a) Be legible, current, detailed, organized, and signed by the service provider;
5 (b)1. Be kept for at least five (5) years from the date of service unless federal law or
6 regulation requires a longer retention period; and
7 2. If federal law or regulation requires a retention period longer than five (5) years, an
8 enrollee medical record shall be kept for at least as long as the federally-required
9 retention period;
10 (c) Include the following minimal detail for an individual clinical encounter:
11 1. The history and physical examination for the presenting complaint;
12 2. A psychological or social factor affecting the patient's physical or behavioral health;
13 3. An unresolved problem, referral, or result from a diagnostic test; and
14 4. The plan of treatment including:
15 a. Medication history, medications prescribed, including the strength, amount, and
16 directions for use and refills;
17 b. Therapy or other prescribed regimen; and
18 c. Follow-up plans, including consultation, referrals, and return appointment.
19 (3) A medical chart organization and documentation shall, at a minimum, contain the
20 following:
21 (a) Enrollee identification information on each page;
22 (b) Enrollee date of birth, age, gender, marital status, race, or ethnicity, mailing
23 address, home and work addresses, and telephone numbers (if applicable), employer

(if applicable), school (if applicable), name and telephone number of an emergency contact, consent form, language spoken and guardianship information (if applicable);

(c) Date of data entry and of encounter;

(d) Provider's name;

(e) Any known allergies or adverse reactions of the enrollee;

(f) Enrollee's past medical history;

(g) Identification of any current problem;

(h) A consultation, laboratory, or radiology report filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;

(i) Documentation of immunizations;

(j) Identification and history of nicotine, alcohol use, or substance abuse;

(k) Documentation of notification of reportable diseases and conditions to the local health department serving the jurisdiction in which the enrollee resides or to the Department for Public Health pursuant to 902 KAR 2:020;

(l) Follow-up visits provided secondary to reports of emergency room care;

(m) Hospital discharge summaries;

(n) Advance medical directives for adults; and

(o) All written denials of service and the reason for the denial.

Section 25. Confidentiality of Medical Information. (1) An MCO shall:

(a) Maintain confidentiality of all enrollee eligibility information and medical records;

(b) Prevent unauthorized disclosure of the information referenced in subsection (1) of this section in accordance with KRS 194A.060, KRS 214.185, KRS 434.840 to 434.860, and 42 CFR 431, Subpart F;

1 (c) Have written policies and procedures for maintaining the confidentiality of enrollee
2 records;
3 (d) Comply with 42 USC 1320d (Health Insurance Portability and Accountability Act)
4 and 45 CFR Parts 160 and 164;
5 (e) An MCO on behalf of its employees and agents shall sign a confidentiality
6 agreement;
7 (f) Limit access to medical information to a person or agency which requires the
8 information in order to perform a duty related to the department's administration of the
9 Medicaid program, including the department, the United States Department of Health
10 and Human Services, the United States Attorney General, the CHFS OIG, the Kentucky
11 Attorney General, or other agency required by the department; and
12 (g) Submit a request for disclosure of information to the department within twenty-four
13 (24) hours.
14 (2) No information referenced in subsection (1)(g) of this section shall be disclosed by
15 an MCO pursuant to the request without prior written authorization from the department.
16 Section 26. Americans with Disabilities Act and Cabinet Ombudsman. (1) An MCO
17 shall:
18 (a) Require by contract with its network providers and subcontractors that a service
19 location meets:
20 1. The requirements established in 42 USC Chapter 126 and 47 USC Chapter 5 (the
21 Americans with Disabilities Act); and
22 2. All local requirements which apply to health facilities pertaining to adequate space,
23 supplies, sanitation, and fire and safety procedures;

1 (b) Fully cooperate with the Cabinet for Health and Family Services independent
2 ombudsman; and
3 (c) Provide immediate access, to the Cabinet for Health and Family Services
4 independent ombudsman, to an enrollee's records if the enrollee has given consent.
5 (2) An MCO's member handbook shall contain information regarding the Cabinet for
6 Health and Family Services independent ombudsman program.
7 Section 27. Marketing. (1) An MCO shall:
8 (a) Comply with the requirements in 42 CFR 438.104 regarding marketing activities;
9 (b) Have a system of control over the content, form, and method of dissemination of
10 its marketing and information materials;
11 (c) Submit a marketing plan and marketing materials to the department for written
12 approval prior to implementation or distribution.
13 (d) If conducting mass media marketing, direct the marketing activities to enrollees in
14 the entire service area pursuant to the marketing plan; and
15 (e) Not:
16 1. Conduct face-to-face marketing;
17 2. Use fraudulent, misleading, or misrepresentative information in its marketing
18 materials;
19 3. Offer material or financial gain to a:
20 a. Potential enrollee as an inducement to select a particular provider or use a
21 product; or
22 b. Person for the purpose of soliciting, referring, or otherwise facilitating the
23 enrollment of an enrollee;
24 4. Conduct:

a. Direct telephone marketing to enrollees and potential enrollees who do not reside in the MCO service area; or

b. Direct or indirect door-to-door, telephone, or other cold-call marketing activity; or

5. Include in its marketing materials an assertion or statement that CMS, the federal government, the commonwealth, or other entity endorses the MCO.

(2) An MCO's marketing material shall meet the information requirements established in Section 12 of this administrative regulation.

Section 28. MCO Service Areas. (1)(a) An MCO's service areas shall include regions one (1), two (2), four (4), five (5), six (6), seven (7), and eight (8).

(b) An MCO's service areas shall not include region three (3).

(2) A recipient who is eligible for enrollment with a managed care organization and who resides in region three (3) shall receive services in accordance with 907 KAR 1:705.

(3) Region one (1) shall include the following counties:

(a) Ballard;

(b) Caldwell;

(c) Calloway;

(d) Carlisle;

(e) Crittenden;

(f) Fulton;

(g) Graves;

(h) Hickman;

(i) Livingston;

(j). Lyon;

(k) Marshall; and

1 (l) McCracken;
2 (4) Region two (2) shall include the following counties:
3 (a) Christian;
4 (b) Daviess;
5 (c) Hancock;
6 (d) Henderson;
7 (e) Hopkins;
8 (f) McLean;
9 (g) Muhlenberg;
10 (h) Ohio;
11 (i) Trigg;
12 (j). Todd;
13 (k) Union; and
14 (l) Webster;
15 (5) Region three (3) shall include the following counties:
16 (a) Breckenridge;
17 (b) Bullitt;
18 (c) Carroll;
19 (d) Grayson;
20 (e) Hardin;
21 (f) Henry;
22 (g) Jefferson;
23 (h) Larue;
24 (i) Marion;

1 (j) Meade;

2 (k) Nelson;

3 (l) Oldham;

4 (m) Shelby;

5 (n) Spencer;

6 (o) Trimble; and

7 (p) Washington;

8 (6) Region four (4) shall include the following counties:

9 (a) Adair;

10 (b) Allen;

11 (c) Barren;

12 (d) Butler;

13 (e) Casey;

14 (f) Clinton;

15 (g) Cumberland;

16 (h) Edmonson;

17 (i) Green;

18 (j) Hart;

19 (k) Logan;

20 (l) McCreary;

21 (m) Metcalfe;

22 (n) Monroe;

23 (o)Pulaski;

24 (p) Russell;

1 (q) Simpson;

2 (r) Taylor;

3 (s) Warren; and

4 (t) Wayne;

5 (7) Region five (5) shall include the following counties:

6 (a) Anderson;

7 (b) Bourbon;

8 (c) Boyle;

9 (d) Clark;

10 (e) Estill;

11 (f) Fayette;

12 (g) Franklin;

13 (h) Garrard;

14 (i) Harrison;

15 (j) Jackson;

16 (k) Jessamine;

17 (l) Lincoln;

18 (m) Madison;

19 (n) Mercer;

20 (o) Montgomery;

21 (p) Nicholas;

22 (q) Owen;

23 (r) Powell;

24 (s) Rockcastle;

1 (t) Scott; and
2 (u) Woodford;
3 (8) Region six (6) shall include the following counties:
4 (a) Boone;
5 (b) Campbell;
6 (c) Gallatin;
7 (d) Grant;
8 (e) Kenton; and
9 (f) Pendleton;
10 (9) Region seven (7) shall include the following counties:
11 (a) Bath;
12 (b) Boyd;
13 (c) Bracken;
14 (d) Carter;
15 (e) Elliott;
16 (f) Fleming;
17 (g) Greenup;
18 (h) Lawrence;
19 (i) Lewis;
20 (j) Mason;
21 (k) Menifee;
22 (l) Morgan;
23 (m) Rowan;
24 (n) Robertson;

(10) Region eight (8) shall include the following counties:

(a) Bell;

(b) Breathitt;

(c) Clay;

(d) Floyd;

(e) Harlan;

(f) Johnson;

(g) Knott;

(h) Knox;

(i) Laurel;

(j) Lee;

(k) Leslie;

(l) Letcher;

(m) Magoffin;

(n) Martin;

(o) Owsley;

(p) Perry;

(q) Pike;

(r) Wolfe; and

(s) Whitley.

Section 29. Covered Services. (1) Except as established in subsection (2) of this section, an MCO shall be responsible for the provision and costs of a covered health service:

(a) Established in Title 907 of the Kentucky Administrative Regulations;

1 (b) In the amount, duration, and scope that the services are covered for recipients
2 pursuant to the department's administrative regulations located in Title 907 of the
3 Kentucky Administrative Regulations; and
4 (c) Beginning on the date of enrollment of a recipient into the MCO.
5 (2) Other than a nursing facility cost referenced in subsection (3)(g) of this section, an
6 MCO shall be responsible for the cost of a non-nursing facility covered service provided to
7 an enrollee during the first thirty (30) days of a nursing facility admission in accordance
8 with this administrative regulation.
9 (3) An MCO shall not be responsible for the provision or costs of the following:
10 (a) A service provided to a recipient in an intermediate care facility for individuals with
11 mental retardation or a developmental disability;
12 (b) A service provided to a recipient in a 1915(c) home and community based waiver
13 program;
14 (c) A hospice service provided to a recipient in an institution;
15 (d) A nonemergency transportation service provided in accordance with 907 KAR
16 3:066;
17 (e) Except as established in Section 35 of this administration regulation, a school-
18 based health service;
19 (f) A service not covered by the Kentucky Medicaid program;
20 (g) A health access nurturing developing service pursuant to 907 KAR 3:140;
21 (h) An early intervention program service pursuant to 907 KAR 1:720; or
22 (i) A nursing facility service for an enrollee during the first thirty (30) days of a nursing
23 facility admission.

(4) The following covered services provided by an MCO shall be accessible to an enrollee without a referral from the enrollee’s primary care provider:

(a) A primary care vision service;

(b) A primary dental or oral surgery service;

(c) An evaluation by an orthodontist or a prosthodontist;

(d) A service provided by a women’s health specialist;

(e) A family planning service;

(f) An emergency service;

(g) Maternity care for an enrollee under age eighteen (18);

(h) An immunization for an enrollee under twenty-one (21);

(i) A screening, evaluation, or treatment service for a sexually transmitted disease or tuberculosis;

(j) Testing for HIV, HIV-related condition, or other communicable disease; and

(k) A chiropractic service.

(5) An MCO shall:

(a) Not require the use of a network provider for a family planning service;

(b) In accordance with 42 CFR 431.51(b), reimburse for a family planning service provided within or outside of the MCO’s provider network;

(c) Cover an emergency service:

1. In accordance with 42 USC 1396u-2(b)(2)(A)(i);

2. Provided within or outside of the MCO’s provider network; or

3. Out-of-state in accordance with 42 CFR 431.52;

(d) Comply with 42 USC 1396u-2(b)(A)(ii); and

(e) Be responsible for the provision and costs of a covered service as described in

this section beginning on or after the beginning date of enrollment of a recipient with an MCO as described in Section 2 of this administrative regulation.

(6)(a) If an enrollee is receiving a medically necessary covered service the day before enrollment with an MCO, the MCO shall be responsible for the costs of continuation of the medically necessary covered service without prior approval and without regard to whether services are provided within or outside the MCO's network until the MCO can reasonably transfer the enrollee to a network provider.

(b)An MCO shall comply with paragraph (a) of this subsection without impeding service delivery or jeopardizing the enrollee's health.

Section 30. Enrollees with Special Health Care Needs. (1) In accordance with 42 CFR 438.208:

(a) The following shall be considered an individual with a special health care need:

1. A child in or receiving foster care or adoption assistance;

2. A homeless individual;

3. An individual with a chronic physical or behavioral illness;

4. A blind or disabled child under the age of nineteen (19) years;

5. An individual who is eligible for SSI benefits; or

6. An adult who is a ward of the commonwealth in accordance with 910 KAR Chapter 2; and

(b) An MCO shall:

1. Have a process to target enrollees for the purpose of screening and identifying those with special health care needs;

2. Assess each enrollee identified by the department as having a special health care need to determine if the enrollee needs case management or regular care monitoring;

3. Include the use of appropriate health care professionals to perform an assessment; and

4. Have a treatment plan for an enrollee with a special health care need who has been determined, through an assessment, to need a course of treatment or regular care monitoring.

(2) A treatment plan referenced in subsection (1)(b)4 of this section shall be developed by an enrollee's primary care provider with participation from the enrollee or the enrollee's legal guardian as referenced in Section 43 of this administrative regulation.

(3) An MCO shall:

(a)1. Develop materials specific to the needs of an enrollee with a special health care need; and

2. Provide the materials referenced in paragraph (a) of this subsection to the enrollee, caregiver, parent, or legal guardian;

(b) Have a mechanism to allow an enrollee identified as having a special health care need to directly access a specialist, as appropriate, for the enrollee's condition and identified need;

(c) Distribute to an enrollee with a special health care need or a caregiver, parent, or legal guardian of an enrollee with a special health care need, information and materials specific to the need of the enrollee; and

(d) Be responsible for the ongoing care coordination for an enrollee with a special health care need.

(4) The information referenced in subsection (3)(c) of this section shall include health educational material to assist the enrollee with a special health care need or the

enrollee's caregiver, parent, or legal guardian in understanding the enrollee's special need.

(5)(a) An enrollee who is a child in foster care or receiving adoption assistance shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DCBS prior to being enrolled with the MCO.

(b) The service plan referenced in paragraph (a) of this subsection shall be used by DCBS and the MCO to determine the enrollee's medical needs and identify the need for case management.

(c) At least once a month, the MCO shall meet with DCBS to discuss the health care needs of the child as identified in the service plan.

(d) If a service plan identifies the need for case management or DCBS requests case management for an enrollee, the foster parent of the child or DCBS shall work with MCO to develop a plan of care.

(e) The MCO shall consult with DCBS prior to developing or modifying a plan of care.

(6)(a) An enrollee who is a ward of the commonwealth shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DAIL prior to being enrolled with the MCO.

(b) If the service plan referenced in paragraph (a) of this subsection identifies the need for case management, the MCO shall work with DAIL or the enrollee to develop a plan of care.

Section 31. Second Opinion. An enrollee shall have the right to a second opinion within the MCO's provider network for a surgical procedure or diagnosis and treatment of a complex or chronic condition.

Section 32. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. (1) An MCO shall provide an enrollee under the age of twenty-one (21) years EPSDT services in compliance with:

(a) 907 KAR 11:034;

(b) 42 USC 1396d; and

(c) The Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule.

(2) A provider of an EPSDT service shall meet the requirements established in 907 KAR 11:034.

Section 33. Emergency Care, Urgent Care, and Post-Stabilization Care. (1) An MCO shall provide to an enrollee:

(a) Emergency care twenty-four (24) hours a day, seven (7) days a week; and

(b) Urgent care within forty-eight (48) hours.

(2) Post-stabilization services shall be provided and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(e).

Section 34. Maternity Care. An MCO shall:

(1) Have procedures to assure:

(a) Prompt initiation of prenatal care; or

(b) Continuation of prenatal care without interruption for a woman who is pregnant at the time of enrollment;

(2) Provide maternity care that includes:

(a) Prenatal;

(b) Delivery;

(c) Postpartum care; and

(d) Care for a condition that complicates a pregnancy; and

(3) Perform all the newborn screenings referenced in 902 KAR 4:030.

Section 35. Pediatric Interface. (1) An MCO shall:

(a) Have procedures to coordinate care for a child receiving a school-based health service or an early intervention service; and

(b) Monitor the continuity and coordination of care for the child receiving a service referenced in paragraph (a) of this subsection as part of its quality assessment and performance improvement (QAPI) program referenced in Section 48.

(2) Except when a child's course of treatment is interrupted by a school break, after-school hours, or summer break, an MCO shall not be responsible for a service referenced in subsection (1)(a) of this section.

(3) A school-based health service provided by a school district shall not be covered by an MCO.

(4) A school-based health service provided by a local health department shall be covered by an MCO.

Section 36. Pediatric Sexual Abuse Examination. (1) An MCO shall enroll a provider in its network that has the capacity to perform a forensic pediatric sexual abuse examination.

(2) A forensic pediatric sexual abuse examination shall be conducted for an enrollee at the request of the DCBS.

Section 37. Lock-in Program. (1) An MCO shall have a program to control utilization of:

(a) Drugs and other pharmacy benefits; and

(b) Non-emergency care provided in an emergency setting.

(2) The program referenced in subsection (1) of this subsection shall be approved by the department.

Section 38. Pharmacy Benefit Program. (1) An MCO shall:

(a) Have a pharmacy benefit program that shall have:

1. A point-of-sale claims processing service;

2. Prospective drug utilization review;

3. An accounts receivable process;

4. Retrospective utilization review services;

5. Formulary and non-formulary drugs;

6. Prior authorization process for drugs;

7. Pharmacy provider relations;

8. A toll-free call center that shall respond to a pharmacy or a physician prescriber twenty-four (24) hours a day, seven (7) days a week; and

9. A seamless interface with the department's management information system;

(b) Maintain a preferred drug list (PDL);

(c) Provide the following to an enrollee or a provider:

1. PDL information; and

2. Pharmacy cost sharing information; and

(d) Have a Pharmacy and Therapeutics Committee (P&T Committee).

(2)(a) The department shall comply with the drug rebate collection requirement established in 42 USC 1396b(m)(2)(A)(xiii).

(b) An MCO shall:

1. Cooperate with the department in complying with 42 USC 1396b(m)(2)(A)(xiii);

2. Assist the department in resolving a drug rebate dispute with a manufacturer; and

3. Be responsible for drug rebate administration in a non-pharmacy setting.

(3) An MCO's P&T committee shall meet and make recommendations to the MCO for changes to the drug formulary.

(4) If a prescription for an enrollee is for a non-preferred drug and the pharmacist cannot reach the enrollee's primary care provider or the MCO for approval and the pharmacist determines it necessary to provide the prescribed drug, the pharmacist shall:

(a) Provide a seventy-two (72) hour supply of the prescribed drug; or

(b) Provide less than a seventy-two (72) hour supply of the prescribed drug if request is for less than a seventy-two (72) hour supply.

(5) Cost sharing imposed by an MCO shall not exceed the cost sharing limits established in 907 KAR 1:604.

Section 39. MCO Interface with State Mental Health Agency. An MCO shall:

(1) Meet with the department monthly to discuss:

(a) Serious mental illness and serious emotional disturbance operating definitions;

(b) Priority populations;

(c) Targeted case management and peer support provider certification training and process;

(d) IMPACT Plus program operations;

(e) Satisfaction survey requirements;

(f) Priority training topics;

(g) Behavioral health services hotline; or

(h) Behavioral health crisis services;

(2) Coordinate:

(a) An IMPACT Plus covered service provided to an enrollee in accordance with 907 KAR 3:030;

(b) With the department:

1. An enrollee education process for:

a. Individuals with a serious mental illness; and

b. Children or youth with a serious emotional disturbance; and

2. On establishing a collaborative agreement with a:

a. State-operated or stated-contracted psychiatric hospital; and

b. Facility that provides a service to an individual with a co-occurring behavioral health and developmental and intellectual disabilities; and

(c) With the department and community mental health centers a process for integrating a behavioral health service hotline; and

(3) Provide the department with proposed materials and protocols for the enrollee education referenced in subsection 2(b) of this section.

Section 40. Behavioral Health Services. (1) An MCO shall:

(a) Provide a medically necessary behavioral health service to an enrollee in accordance with the access standards described in Section 15 of this administrative regulation;

(b) Use the DSM-IV multi-axial classification system to assess an enrollee for a behavioral service;

(c) Have an emergency or crisis behavioral health toll-free hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week; and

(d) Not:

1 1. Operate one (1) hotline to handle an emergency or crisis call and a routine
2 enrollee call; or
3 2. Impose a maximum call duration limit.
4 (2) Staff of a hotline referenced in subsection (1)(c) of this section shall:
5 (a) Communicate in a culturally competent and linguistically accessible manner to an
6 enrollee; and
7 (b) Include or have access to a qualified behavioral health professional to assess and
8 triage a behavioral health emergency.
9 (3) A face-to-face emergency service shall be available:
10 (a) Twenty-four (24) hours a day; and
11 (b) Seven (7) days a week.
12 Section 41. Coordination Between a Behavioral Health Provider and a Primary Care
13 Provider. (1) An MCO shall:
14 (a) Require a PCP to have a screening and evaluation procedure for the detection
15 and treatment of, or referral for, a known or suspected behavioral health problem or
16 disorder.
17 (b) Provide training to a PCP in its network on:
18 1. Screening and evaluate a behavioral health disorder;
19 2. The MCO's referral process for a behavioral health service;
20 3. Coordination requirements for a behavioral health service; and
21 4. Quality of care standards;
22 (c) Have policies and procedures that shall be approved by the department regarding
23 clinical coordination between a behavioral health service provider and a PCP;
24 (d) Establish guidelines and procedures to ensure accessibility, availability, referral,

1 and triage to physical and behavioral health care;

2 (e) Facilitate the exchange of information among providers to reduce inappropriate or

3 excessive use of psychopharmacological medications and adverse drug reactions;

4 (f) Identify a method to evaluate continuity and coordination of care; and

5 (g) Include the monitoring and evaluation of the MCO's compliance with the

6 requirements established in paragraphs (a), (b), (c), and (d) of this subsection in the

7 MCO's quality improvement plan.

8 (2) With consent from an enrollee or the enrollee's legal guardian, an MCO shall

9 require a behavioral health service provider to:

10 (a) Refer an enrollee with a known or suspected and untreated physical health

11 problem or disorder to their PCP for examination and treatment; and

12 (b) Send an initial and quarterly summary report of an enrollee's behavioral health

13 status to the enrollee's PCP.

14 Section 42. Court-Ordered Psychiatric Services. (1) An MCO shall:

15 (a) Provide an inpatient psychiatric service to an enrollee under the age of twenty-

16 one (21) and over the age of sixty-five (65), up to the annual limit, who has been

17 ordered to receive the service by a court of competent jurisdiction under the provisions

18 of KRS Chapter 202A and 645;

19 (b) Not deny, reduce, or negate the medical necessity of an inpatient psychiatric

20 service provided pursuant to a court-ordered commitment for an enrollee under the age

21 of twenty-one (21) or over the age of sixty-five (65);

22 (c) Coordinate with a provider of a behavioral health service the treatment objectives

23 and projected length of stay for an enrollee committed by a court of law to a state

24 psychiatric hospital; and

1 (d) Enter into a collaborative agreement with the state-operated or state-contracted
2 psychiatric hospital assigned to the enrollee's region in accordance with 908 KAR
3 3:040 and in accordance with the *Olmstead* decision.
4 (2) An MCO shall present a modification or termination of a service referenced in
5 subsection (1)(b) of this section to the court with jurisdiction over the matter for
6 determination.
7 (3)(a) An MCO behavioral health service provider shall:
8 1. Participate in a quarterly continuity of care meeting with a state-operated or state-
9 contracted psychiatric hospital;
10 2. Assign a case manager prior to or on the date of discharge of an enrollee from a
11 facility referenced in subsection (3)(a)1 of this section; and
12 3. Provide case management services to an enrollee with a severe mental illness and
13 co-occurring developmental disability who is discharged from a:
14 a. Facility referenced in subsection (3)(a)1 of this section; or
15 b. State-operated nursing facility for individuals with severe mental illness.
16 (b) A case manager and a behavioral health service provider shall participate in
17 discharge planning to ensure compliance with the *Olmstead* decision.
18 Section 43. Legal Guardians. (1) A parent, custodial parent, person exercising
19 custodial control or supervision, or an agency with a legal responsibility for a child by
20 virtue of a voluntary commitment or of an emergency or temporary custody order shall
21 be authorized to act on behalf of an enrollee who is under the age of eighteen (18)
22 years, a potential enrollee, or a former enrollee for the purpose of:
23 (a) Selecting a primary care provider;
24 (b) Filing a grievance or appeal; or

1 (c) Taking an action on behalf of a child regarding an interaction with an MCO.
2 (2)(a) A legal guardian who has been appointed pursuant to KRS 387.500 to 387.800
3 shall be allowed to act on behalf of an enrollee who is a ward of the commonwealth.
4 (b) A person authorized to make a health care decision pursuant to KRS 311.621 to
5 311. 643 shall be allowed to act on behalf of an enrollee, potential enrollee, or former
6 enrollee.
7 (c) An enrollee shall have the right to:
8 1. Represent the enrollee; or
9 2. Use legal counsel, a relative, a friend, or other spokesperson.
10 Section 44. Utilization Management or UM. (1) An MCO shall:
11 (a) Have a utilization management program that:
12 1. Meets the requirements established in 42 CFR 456, 42 CFR 431, 42 CFR 438, and
13 the private review agent requirements of KRS 304.17A, as applicable; and
14 2. Shall:
15 a. Identify, define, and specify the amount, duration, and scope of each service that
16 the MCO is required to offer;
17 b. Review, monitor, and evaluate the appropriateness and medical necessity of care
18 and services;
19 c. Identify and describe the UM mechanisms used to:
20 (i) Detect the under or over utilization of services; and
21 (ii) Act after identifying under utilization or over utilization of services;
22 d. Have a written UM program description; and
23 e. Be evaluated annually by the:
24 (i) MCO, including an evaluation of clinical and service outcomes; and

1 (ii) Department.

2 (b) Adopt nationally-recognized standards of care and written criteria that shall be:

3 1. Based upon sound clinical evidence, if available, for making utilization decisions;

4 and

5 2. Approved by the department;

6 (c) Include physicians and other health care professionals in the MCO network in

7 reviewing and adopting medical necessity criteria;

8 (d) Have:

9 1. A process to review, evaluate, and ensure the consistency with which physicians

10 and other health care professionals involved in UM apply review criteria for

11 authorization decisions;

12 2. A medical director who:

13 a. Is a licensed physician and responsible for treatment policies, protocols, and

14 decisions; and

15 b. Supervises the UM program; and

16 3. Written policies and procedures that explain how prior authorization data will be

17 incorporated into the MCO's Quality Improvement Plan;

18 (e) Submit a request for a change in review criteria for authorization decisions to the

19 department for approval prior to implementation;

20 (f) Administer or use a CAHPS survey to evaluate and report enrollee and provider

21 satisfaction with the quality of, and access to, care and services in accordance with

22 Section 55 of this administrative regulation;

23 (g) Provide written confirmation of an approval of a request for a service within two

24 (2) business days of providing notification of a decision if:

1 1. The initial decision was not in writing; and

2 2. Requested by an enrollee or provider;

3 (h) If the MCO uses a subcontractor to perform UM, require the subcontractor to have
4 written policies, procedures, and a process to review, evaluate, and ensure consistency
5 with which physicians and other health care professionals involved in UM apply review
6 criteria for authorization decisions; and

7 (i) Not provide a financial or other type of incentive to an individual or entity that
8 conducts UM activities to deny, limit, or discontinue a medically necessary service to an
9 enrollee pursuant to 42 CFR 422.208, 42 CFR 438.6(h), and 42 CFR 438.210(e).

10 (2) A UM program description referenced in subsection (1)(a)2.d. of this section shall:

11 (a) Outline the UM program's structure;

12 (b) Define the authority and accountability for UM activities, including activities
13 delegated to another party; and

14 (c) Include the:

15 1. Scope of the program;

16 2. Processes and information sources used to determine service coverage, clinical
17 necessity, and appropriateness and effectiveness;

18 3. Policies and procedures to evaluate:

19 a. Care coordination;

20 b. Discharge criteria;

21 c. Site of services;

22 d. Levels of care;

23 e. Triage decisions; and

24 f. Cultural competence of care delivery; and

1 4. Processes to review, approve, and deny services as needed.

2 (3) Only a physician with clinical expertise in treating an enrollee's medical condition
3 or disease shall be authorized to make a decision to deny a service authorization
4 request or authorize a service in an amount, duration, or scope that is less than
5 requested by the enrollee.

6 (4) A medical necessity review process shall be in accordance with Section 45 of this
7 administrative regulation.

8 Section 45. Service Authorization and Notice. (1) For the processing of a request for
9 initial and continuing authorization of a service, an MCO shall identify what constitutes
10 medical necessity and establish a written policy and procedure, which includes a
11 timeframe for:

12 (a) Making an authorization decision; and

13 (b) If the service is denied or authorized in an amount, duration, or scope which is
14 less than requested, providing a notice to an enrollee and provider acting on behalf of
15 and with the consent of an enrollee.

16 (2) For an authorization of a service, an MCO shall make a decision:

17 (a) As expeditiously as the enrollee's health condition requires; and

18 (b) Within two (2) business days following receipt of a request for service.

19 (3) The timeframe for making an authorization decision referenced in subsection (2)
20 of this section may be extended:

21 (a) By the:

22 1. Enrollee, or the provider acting on behalf of and with content of an enrollee, if the
23 enrollee requests an extension; or

24 2. MCO, if the MCO:

1 a. Justifies to the department, upon request, a need for additional information and
2 how the extension is in the enrollee's interest;
3 b. Gives the enrollee written notice of the extension, including the reason for
4 extending the authorization decision timeframe and the right of the enrollee to file a
5 grievance if the enrollee disagrees with that decision; and
6 c. Makes and carries out the authorization decision as expeditiously as the enrollee's
7 health condition requires and no later than the date the extension expires; and
8 (b) Up to fourteen (14) additional calendar days.
9 (4) If an MCO denies a service authorization or authorizes a service in an amount,
10 duration, or scope which is less than requested, the MCO shall provide:
11 (a) A notice to the:
12 1. Enrollee, in writing, as expeditiously as the enrollee's condition requires and within
13 two (2) business days of receipt of the request for service; and
14 2. Requesting provider, if applicable;
15 (b) For an adverse action relating to medical necessity and a coverage denial, a
16 notice to the enrollee, which shall:
17 1. Meet the language and formatting requirements established in 42 CFR 438:404;
18 2. Include the:
19 a. Action the MCO or its subcontractor, if applicable, has taken or intends to take;
20 b. Reason for the action;
21 c. Right of the enrollee or provider who is acting on behalf of the enrollee to file an
22 MCO appeal;
23 d. Right of the enrollee to request a state fair hearing;
24 e. Procedure for filing an appeal and requesting a state fair hearing;

f. Circumstance under which an expedited resolution is available and how to request it; and

g. Right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstance under which the enrollee may be required to pay the costs of these services; and

3. Be provided:

a. At least ten (10) days before the date of action if the action is a termination, suspension, or reduction of a covered service authorized by the department, department designee, or enrollee's MCO, except the department may shorten the period of advance notice to five (5) days before the date of action because of probable fraud by the enrollee;

b. By the date of action for the following:

(i) The death of a member;

(ii) A signed written enrollee statement requesting service termination or giving information requiring termination or reduction of services in which the enrollee understands this must be the result of supplying the information;

(iii) The enrollee's address is unknown and mail directed to the enrollee has no forwarding address;

(iv) The enrollee has been accepted for Medicaid services by another local jurisdiction;

(v) The enrollee's admission to an institution results in the enrollee's ineligibility for more services;

(vi) The enrollee's physician prescribes a change in the level of medical care;

1 (vii) An adverse decision has been made regarding the preadmission screening
2 requirements for a nursing facility admission, pursuant to 907 KAR 1:755, on or after
3 January 1, 1989; and
4 (viii) The safety or health of individuals in a facility would be endangered, if the
5 enrollee's health improves sufficiently to allow a more immediate transfer or discharge,
6 an immediate transfer or discharge is required by the enrollee's urgent medical needs,
7 or an enrollee has not resided in the nursing facility for thirty (30) days;
8 c. On the date of action, if the action is a denial of payment;
9 d. As expeditiously as the enrollee's health condition requires and within two (2)
10 business days following receipt of a request;
11 e. When the MCO carries out its authorization decision, as expeditiously as the
12 enrollee's health condition requires and no later than the date the extension as identified
13 in subsection (3) of this section expires;
14 f. If a provider indicates or the MCO determines that following the standard timeframe
15 could seriously jeopardize the enrollee's life or health, or ability to attain, maintain or
16 regain maximum function, as expeditiously as the enrollee's health condition requires
17 and no later than two (2) business days after receipt of the request for service; and
18 g. For an authorization decision not made within the timeframe identified in
19 subsection (2) of this section, on the date the timeframe expires as this shall constitute
20 a denial.
21 Section 46. Health Risk Assessment. An MCO shall:
22 (1) Conduct an initial health risk assessment of an enrollee at the implementation of
23 the MCO program within 180 days from enrolling the individual;
24 (2) After the initial implementation of the MCO program, conduct an initial health risk

1 assessment of an enrollee wjthin ninety (90) days of enrolling the individual if the
2 individual has not been enrolled with the MCO in a prior twelve (12) month period;
3 (3) Use health care professionals in the health risk assessment process;
4 (4) Screen an enrollee who it believes to be pregnant within thirty (30) days of
5 enrollment;
6 (5) If an enrollee is pregnant, refer the enrollee for prenatal care;
7 (6) Use a health risk assessment to determine an enrollee's need for:
8 (a) Care management;
9 (b) Disease management;
10 (c) A behavioral health service;
11 (d) A physical health service or procedure; or
12 (e) A community service.
13 Section 47. Care Coordination and Management. An MCO shall:
14 (1) Have a care coordinator and a case manager to arrange, assure delivery of,
15 monitor, and evaluate care, treatment, and services for an enrollee;
16 (2) Have guidelines for care coordination that shall be approved by the department
17 prior to implementation;
18 (3) Develop a plan of care for an enrollee in accordance with 42 CFR 438.208;
19 (4) Have policies and procedures to ensure access to care coordination for a DCBS
20 client or a DAIL client;
21 (5) Provide information on and coordinate services with the Women, Infants and
22 Children program; and
23 (6) Provide information to an enrollee and a provider regarding:
24 (a) An available care management service; and

1 (b) How to obtain a care management service.

2 Section 48. Quality Assessment and Performance Improvement (QAPI) Program. An

3 MCO shall:

4 (1) Have a quality assessment and performance improvement (QAPI) program that

5 shall:

6 (a) Conform to the requirements of 42 CFR 438, subpart D;

7 (b) Assess, monitor, evaluate, and improve the quality of care provided to an

8 enrollee;

9 (c) Provide for the evaluation of:

10 1. Access to care;

11 2. Continuity of care;

12 3. Health care outcomes; and

13 4. Services provided or arranged for by the MCO;

14 (d) Demonstrate the linkage of Quality Improvement (QI) activities to findings from a

15 quality evaluation; and

16 (e) Be developed in collaboration with input from enrollees;

17 (2) Submit annually to the department a description of its QAPI program;

18 (3) Conduct and submit to the department an annual review of the program;

19 (4) Maintain documentation of:

20 (a) Enrollee input;

21 (b) Response;

22 (c) A performance improvement activity; and

23 (d) MCO feedback to an enrollee;

(5)(a) Have or obtain within four (4) years of initial implementation National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line; and;

(b) After obtaining NCQA accreditation, maintain the accreditation;

(6) If the MCO has NCQA accreditation:

(a) Submit to the department a copy of its current certificate of accreditation with a copy of the complete accreditation survey report; and

(b) Maintain the accreditation;

(7) Integrate behavioral health service indicators into its QAPI program;

(8) Include a systematic, on-going process for monitoring, evaluating, and improving the quality and appropriateness of a behavioral health service provided to an enrollee;

(9) Collect data, monitor, and evaluate for evidence of improvement to a physical health outcome resulting from integration of behavioral health into an enrollee's care; and

(10) Annually review and evaluate the effectiveness of the QAPI program.

Section 49. Quality Assessment and Performance Improvement Plan. (1) An MCO shall:

(a) Have a written QAPI work plan that:

1. Outlines the scope of activities;

2. Is submitted quarterly to the department; and

3. Sets goals, objectives, and timelines for the QAPI program;

(b) Set new goals and objectives:

1. At least annually; and

2. Based on a finding from:

a. A quality improvement activity or study;

b. A survey result;

c. A grievance or appeal;

d. A performance measure; or

e. The External Quality Review Organization;

(c) Be accountable to the department for the quality of care provided to an enrollee;

(d) Obtain approval from the department for its QAPI program and annual QAPI work plan;

(e) Have an accountable entity within the MCO:

1. To provide direct oversight of its QAPI program; and

2. That shall review reports from the quality improvement committee referenced in paragraph (h) of this subsection;

(f) Review its QAPI program annually;

(g) Modify its QAPI program to accommodate a review finding or concern of the MCO if a review finding or concern occurs;

(h) Have a quality improvement committee that shall:

1. Be responsible for the QAPI program;

2. Be interdisciplinary;

3. Include:

a. Providers and administrative staff; and

b. Health professionals with knowledge of and experience with individuals with special health care needs;

4. Meet on a regular basis;

5. Document activities of the committee;

1 6. Make committee minutes and a committee report available to the department upon
2 request; and
3 7. Submit a report to the accountable entity referenced in paragraph (c) of this
4 subsection that shall include:
5 a. A description of the QAPI activities;
6 b. Progress on objectives; and
7 c. Improvements made;
8 (i) Require a provider to participate in QAPI activities in the provider agreement or
9 subcontract; and
10 (j) Provide feedback to a provider or a subcontractor regarding integration of or
11 operation of a corrective action necessary in a QAPI activity if a corrective action is
12 necessary.
13 (2) If a QAPI activity of a provider or a subcontractor is separate from an MCO's
14 QAPI program, the activity shall be integrated into the MCO's QAPI program.
15 Section 50. QAPI Monitoring and Evaluation. (1) Through its QAPI program an MCO
16 shall:
17 (a) Monitor and evaluate the quality of health care provided to an enrollee;
18 (b) Study and prioritize health care needs for performance measurement,
19 performance improvement, and development of practice guidelines;
20 (c) Use a standardized quality indicator:
21 1. To assess improvement, assure achievement of at least a minimum performance
22 level, monitor adherence to a guideline, and identify a pattern of over and under
23 utilization of a service; and
24 2. Which shall be:

1 a. Supported by a valid data collection and analysis method; and
2 b. Used to improve clinical care and services;
3 (d) Measure a provider performance against a practice guideline and a standard
4 adopted by the quality improvement committee;
5 (e) Use a multidisciplinary team to analyze and address data and systems issues;
6 and
7 (f) Have practice guidelines that shall:
8 1. Be:
9 a. Disseminated to a provider, or upon request, to an enrollee;
10 b. Based on valid and reliable medical evidence or consensus of health
11 professionals;
12 c. Reviewed and updated; and
13 d. Used by the MCO in making a decision regarding utilization management, a
14 covered service and enrollee education;
15 2. Consider the needs of enrollees; and
16 3. Include consultation with network providers.
17 (2) If an area needing improvement is identified by the QAPI program, the MCO shall
18 take a corrective action and monitor the corrective action for improvement.
19 Section 51. Quality and Member Access Committee. (1) An MCO shall:
20 (a) Have a Quality and Member Access Committee (QMAC) composed of:
21 1. Enrollees who shall be representative of the enrollee population; and
22 2. Individuals from consumer advocacy groups or the community who represent the
23 interests of enrollees in the MCO; and

(b) Submit to the department annually a list of enrollee representatives participating in the QMAC.

(2) A QMAC committee shall be responsible for reviewing:

(a) Quality and access standards;

(b) The grievance and appeals process;

(c) Policy modifications needed based on reviewing aggregate grievance and appeals data;

(d) The member handbook;

(e) Enrollee education materials;

(f) Community outreach activities; and

(g) MCO and department policies that affect enrollees.

Section 52. External Quality Review. (1) In accordance with 42 USC 1396a(a)(30), the department shall have an independent external quality review organization (EQRO) annually review the quality of services provided by an MCO.

(2) An MCO shall:

(a) Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438; and

(b) Cooperate and participate in external quality review activities in accordance with the protocol established in 42 CFR 438 subpart E.

(3) The department shall have the option of using information from a Medicare or private accreditation review of an MCO in accordance with 42 CFR 438.360.

(4) If an adverse finding or deficiency is identified by an EQRO conducting an external quality review, an MCO shall correct the finding or deficiency.

Section 53. Health Care Outcomes. An MCO shall:

1 (1) Comply with the requirements established in 42 CFR 438.240 relating to quality
2 assessment and performance improvement;
3 (2) Collaborate with the department to establish a set of unique Kentucky Medicaid
4 managed care performance measures which shall:
5 (a) Be aligned with national and state preventive initiatives; and
6 (b) Focus on improving health;
7 (3) In collaboration with the department and the EQRO, develop a performance
8 measure specific to individuals with special health care needs;
9 (4) Report activities on performance measures in the QAPI work plan referenced in
10 Section 49 of this regulation;
11 (5) Submit an annual report to the department after collecting performance data
12 which shall be stratified by:
13 (a) Medicaid eligibility category;
14 (b) Race;
15 (c) Ethnicity;
16 (d) Gender; and
17 (e) Age;
18 (6) Collect and report HEDIS data annually; and
19 (7) Submit to the department:
20 (a) The final auditor's report issued by the NCQA certified audit organization;
21 (b) A copy of the interactive data submission system tool used by the MCO; and
22 (c) The reports specified in MCO Reporting Requirements.
23 Section 54. Performance Improvement Projects (PIPs). (1) An MCO shall:
24 (a) Implement PIPs to address aspects of clinical care and non-clinical services;

(b) Collaborate with local health departments, behavioral health agencies, and other community- based health or social service agencies to achieve improvements in priority areas;

(c) Initiate a minimum of two (2) PIPs each year with at least one (1) PIP relating to physical health and at least one (1) PIP relating to behavioral health;

(d) Report on a PIP using standardized indicators;

(e) Specify a minimum performance level for a PIP; and

(f) Include the following for a PIP:

1. The topic and its importance to enrolled members;

2. Methodology for topic selection;

3. Goals of the PIP;

4. Data sources and collection methods;

5. An intervention; and

6. Results and interpretations.

(2) A clinical PIP shall address preventive and chronic healthcare needs of enrollees including:

(a) The enrollee population;

(b) A subpopulation of the enrollee population; and

(c) Specific clinical need of enrollees with conditions and illnesses that have a higher prevalence in the enrolled population.

(3) A non-clinical PIP shall address improving the quality, availability, and accessibility of services provided by an MCO to enrollees and providers.

(4) The department may require an MCO to implement a PIP specific to the MCO if:

1 (a) A finding from an EQRO review referenced in Section 52 or an audit indicates a
2 need for a PIP; or
3 (b) Directed by CMS.
4 (5) The department shall be authorized to require an MCO to assist in a statewide
5 PIP which shall be limited to providing the department with data from the MCO's service
6 area.
7 Section 55. Enrollee and Provider Surveys. (1) An MCO shall:
8 (a) Conduct an annual survey of enrollee and provider satisfaction of the quality and
9 accessibility to a service provided by an MCO;
10 (b) Satisfy a member satisfaction survey requirement by participating in the Agency
11 for Health Research and Quality's current Consumer Assessment of Healthcare
12 Providers and Systems Survey (CAHPS) for Medicaid Adults and Children, which shall
13 be administered by an NCQA-certified survey vendor;
14 (c) Provide a copy of the current CAHPS survey referenced in paragraph (b) of this
15 subsection to the department;
16 (d) Annually assess the need for conducting other surveys to support quality and
17 performance improvement initiatives;
18 (e) Submit to the department for approval the survey tool used to conduct the survey
19 referenced in paragraph (a) of this subsection; and
20 (f) Provide to the department:
21 1. A copy of the results of the enrollee and provider surveys referenced in paragraph
22 (a) of this subsection;
23 2. A description of a methodology to be used to conduct surveys;
24 3. The number and percentage of enrollees and providers surveyed;

4. Enrollee and provider survey response rates;

5. Enrollee and provider survey findings; and

6. Interventions conducted or planned by the MCO related to activities in this section.

(2) The department shall:

(a) Approve enrollee and provider survey instruments prior to implementation; and

(b) Approve or disapprove an MCO's provider survey tool within fifteen (15) days of receipt of the survey tool.

(3) If an MCO conducts a survey that targets a subpopulation's perspective or experience with access, treatment, and services, the MCO shall comply with the requirements established in subsection (1)(e) and (f) of this section.

Section 56. Prompt Payment of Claims (1) In accordance with 42 USC 1396a(a)(37), an MCO shall:

(a) Implement claims payment procedures that ensure that:

1. Ninety (90) percent of all provider claims for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of the claims; and

2. Ninety nine (99) percent of all claims are processed within ninety (90) days of the date of receipt of the claims; and

(b) Have prepayment and postpayment claims review procedures that ensure the proper and efficient payment of claims and management of the program.

(2) An MCO shall:

(a) Comply with the prompt payment provisions established in:

1. 42 CFR 447.45; and

2. KRS 205.593, KRS 304.14-135, and KRS 304.17A-700-730; and

(b) Notify a requesting provider of a decision to:

1. Deny a claim; or

2. Authorize a service in an amount, duration, or scope that is less than requested.

(3) The payment provisions in this section shall apply to a payment to:

(a) A provider within the MCO network; and

(b) An out-of-network provider.

Section 57. Payments to an MCO. (1) The department shall provide an MCO a per enrollee, per month capitation payment whether or not the enrollee receives a service during the period covered by the payment except for an enrollee whose eligibility is determined due to being unemployed in accordance with 45 CFR 233.100.

(2) The monthly capitation payment for an enrollee whose eligibility is determined due to being unemployed, shall be prorated from the date of eligibility.

(3) A capitation rate referenced in subsection (1) of this section shall:

(a) Meet the requirements of 42 CFR 438.6(c); and

(b) Be approved by the Centers for Medicare and Medicaid Services; and

(4)(a) The department shall apply a risk adjustment to a capitation rate referenced in subsection (4) of this section in an amount that shall be budget neutral to the department.

(b) The department shall use the latest version of the Chronic Illness and Disability Payment System to determine the risk adjustment referenced in paragraph (a) of this subsection.

Section 58. Recoupment of Payment from an Enrollee for Fraud, Waste and Abuse.

(1) If an enrollee is determined to be ineligible for Medicaid through an administrative

hearing or adjudication of fraud by the CHFS OIG, the department shall recoup a capitation payment it has made to an MCO on behalf of the enrollee.

(2) An MCO shall request a refund from the enrollee referenced in subsection (1) of this section of a payment the MCO has made to a provider for the service provided to the enrollee.

(3) If an MCO has been unable to collect a refund referenced in subsection (2) of this section within six (6) months, the commonwealth shall have the right to recover the refund.

Section 59. MCO Administration. An MCO shall have executive management responsible for operations and functions of the MCO that shall include:

(1) An executive director who shall:

(a) Act as a liaison to the department regarding a contract between the MCO and the department;

(b) Be authorized to represent the MCO regarding an inquiry pertaining to a contract between the MCO and the department;

(c) Have decision making authority; and

(d) Be responsible for following up regarding a contract inquiry or issue;

(2) A medical director who shall be:

(a) A physician licensed to practice medicine in Kentucky;

(b) Actively involved in all major clinical programs and quality improvement components of the MCO; and

(c) Available for after-hours consultation;

(3) A dental director who shall be:

(a) Licensed by a dental board of licensure in any state;

(b) Actively involved in all oral health programs of the MCO; and

(c) Available for after-hours consultation;

(4)(a) A finance officer who shall oversee the MCO’s budget and accounting systems; and

(b) An internal auditor who shall ensure compliance with adopted standards and review expenditures for reasonableness and necessity;

(5) A quality improvement director who shall be responsible for the operation of:

(a) The MCO’s quality improvement program; and

(b) A subcontractor’s quality improvement program;

(6) A behavioral health director who shall be:

(a) A behavioral health practitioner;

(b) Actively involved in all of the MCO’s programs or initiatives relating to behavioral health; and

(c) Responsible for the coordination of behavioral health services provided by the MCO or any of its behavioral health subcontractors;

(7) A case management coordinator who shall be responsible for coordinating and overseeing case management services and continuity of care for MCO enrollees;

(8) An early and periodic screening, diagnosis, and treatment (EPSDT) coordinator who shall coordinate and arrange for the provision of EPSDT services and EPSDT special services for MCO enrollees;

(9) A foster care and subsidized adoption care liaison who shall serve as the MCO’s primary liaison for meeting the needs of an enrollee who is:

(a) A child in foster care; or

(b) A child receiving state-funded adoption assistance;

1 (10) A guardianship liaison who shall serve as the MCO's primary liaison for meeting
2 the needs of an enrollee who is a ward of the commonwealth;
3 (11) A management information systems director who shall oversee, manage, and
4 maintain the MCO's management information system;
5 (12) A program integrity coordinator who shall coordinate, manage, and oversee the
6 MCO's program integrity functions;
7 (13) A pharmacy director who shall coordinate, manage, and oversee the MCO's
8 pharmacy program;
9 (14) A compliance director who shall be responsible for the MCO's:
10 (a) Financial and programmatic accountability, transparency, and integrity; and
11 (b) Compliance with:
12 1. All applicable federal and state law;
13 2. Any administrative regulation promulgated by the department relating to the MCO;
14 and
15 3. The requirements established in the contract between the MCO and the
16 department;
17 (15) A member services director who shall:
18 (a) Coordinate communication with MCO enrollees; and
19 (b) Respond in a timely manner to an enrollee seeking a resolution of a problem or
20 inquiry;
21 (16) A provider services director who shall:
22 (a) Coordinate communication with MCO providers and subcontractors; and
23 (b) Respond in a timely manner to a provider seeking a resolution of a problem or
24 inquiry; and

1 (17) A claims processing director who shall ensure the timely and accurate
2 processing of claims.
3 Section 60. MCO Reporting Requirements. An MCO shall:
4 (1) Submit to the department a report as required by MCO Reporting Requirements;
5 (2) Verify the accuracy of data and information on a report submitted to the
6 department;
7 (3) Analyze a required report to identify an early pattern of change, a trend, or an
8 outlier before submitting the report to the department; and
9 (4) Submit the analysis required in subsection (3) of this section with a required
10 report.
11 Section 61. Health Care Data Submission and Penalties. (1)(a) An MCO shall
12 submit an original encounter record and denial encounter record, if any, to the
13 department weekly.
14 (b) An original encounter record or a denial encounter record shall be considered late
15 if not received by the department within four (4) calendar days from the weekly due
16 date.
17 (c) Beginning on the fifth calendar day late, the department shall withhold $500 per
18 day for each day late from an MCO's total capitation payments for the month following
19 non-submission of an original encounter record and denial encounter record.
20 (2)(a) If an MCO fails to submit health care data derived from processed claims or
21 encounter data in a form or format established in the MCO Reporting Requirements for
22 one (1) calendar month, the department shall withhold an amount equal to five (5)
23 percent of the MCO's capitation payment for the month following non-submission.

1 (b) The department shall retain the amount referenced in paragraph (a) of this
2 subsection until the data is received and accepted by the department, less $500 per day
3 for each day late.
4 (3)(a) The department shall transmit to an MCO an encounter record with an error for
5 correction by the MCO.
6 (b) An MCO shall have ten (10) days to submit a corrected encounter record to the
7 department.
8 (c) If an MCO fails to submit a corrected encounter record within the time frame
9 specified in paragraph (b) of this subsection, the department shall be able to assess and
10 withhold for the month following the non-submission, an amount equal to one-tenth of a
11 percent of the MCO's total capitation payments per day until the corrected encounter
12 record is received and accepted by the department.
13 Section 62. Program Integrity. An MCO shall comply with:
14 (1) 42 CFR 438.608;
15 (2) 42 USC 1396a(a)(68); and
16 (3) The requirements established in the MCO Program Integrity Requirements.
17 Section 63. Third Party Liability and Coordination of Benefits. (1) Medicaid shall be the
18 payer of last resort for a service provided to an enrollee.
19 (2) An MCO shall:
20 (a) Exhaust a payment by a third party prior to payment for a service provided to an
21 enrollee;
22 (b) Be responsible for determining a legal liability of a third party to pay for a service
23 provided to an enrollee;

1 (c) Actively seek and identify a third party liability resource to pay for a service provided
2 to an enrollee in accordance with 42 CFR 433.138; and
3 (d) Assure that Medicaid shall be the payer of last resort for a service provided to an
4 enrollee.
5 (3) In accordance with 907 KAR 1:011 and KRS 205.624, an enrollee shall:
6 (a) Assign, in writing, the enrollee's rights to an MCO for a medical support or payment
7 from a third party for a medical service provided by the MCO; and
8 (b) Cooperate with an MCO in identifying and providing information to assist the MCO
9 in pursuing a third party that shall be liable to pay for a service provided by the MCO.
10 (4) If an MCO becomes aware of a third party liability resource after payment for a
11 service provided to an enrollee, the MCO shall seek recovery from the third party
12 resource.
13 (5) An MCO shall have a process for third party liability and coordination of benefits in
14 accordance with Third Party Liability and Coordination of Benefits.
15 Section 64. Management Information System. (1) An MCO shall:
16 (a) Have a management information system that shall:
17 1. Provide support to the MCO operations; and
18 2. Include a:
19 a. Member subsystem;
20 b. Third party liability subsystem;
21 c. Provider subsystem;
22 d. Reference subsystem;
23 e. Claim processing subsystem;
24 f. Financial subsystem;

1 g. Utilization and quality improvement subsystem; and
2 h. Surveillance utilization review subsystem; and
3 (b) Transmit data to the department:
4 1. In accordance with 42 CFR 438; and
5 2. The Management Information System Requirements.
6 (2) If an MCO subcontracts for services, the MCO shall provide guidelines for its
7 subcontractor to the department for approval.
8 Section 65. Kentucky Health Information Exchange (KHIE). (1) An MCO shall:
9 (a) Submit to the KHIE:
10 1. An adjudicated claim within twenty-four (24) hours of the final claim adjudication;
11 and
12 2. Clinical data as soon as it is available;
13 (b) Make an attempt to have a PCP in the MCO's network connect to KHIE within:
14 1. One (1) year of enrollment in the MCO's network; or
15 2. A timeframe approved by the department if greater than one (1) year; and
16 (c) Encourage a provider in its network to establish connectivity with the KHIE.
17 (2) The department shall:
18 (a) Administer an electronic health record incentive payment program; and
19 (b) Inform an MCO of a provider that has received an electronic health record
20 incentive payment.
21 Section 66. MCO Qualifications and Maintenance of Records. (1) An MCO shall:
22 (a) Be licensed by the Department of Insurance as a health maintenance organization
23 or an insurer;
24 (b) Have a governing body;

1 (c) Have protection against insolvency in accordance with:

2 1. 806 KAR 3:190; and

3 2. 42 CFR 438.116;

4 (d) Maintain all books, records, and information related to MCO providers, recipients,

5 or recipient services, and financial transactions for:

6 1. A minimum of five (5) years in accordance with 907 KAR 1:672; and

7 2. Any additional time period as required by federal or state law; and

8 (e) Submit a request for disclosure of information from the public to the department

9 within twenty-four (24) hours.

10 (2) No information shall be disclosed by an MCO pursuant to a request it received

11 without prior written authorization from the department.

12 (3) The books, records, and information referenced in subsection (1)(d) of this section,

13 shall be available upon request of a reviewer or auditor during routine business hours at

14 the MCO's place of operations.

15 (4) MCO staff shall be available upon request of a reviewer or auditor during routine

16 business hours at the MCO's place of operations.

17 Section 67. Prohibited Affiliations. The policies or requirements:

18 (1) Imposed on a managed care entity in 42 USC 1396u-2(d)(1) shall apply to an

19 MCO; and

20 (2) Established in 42 CFR 438.610 shall apply to an MCO.

21 Section 68. Termination of MCO Participation in the Medicaid Program. The

22 department shall terminate an MCO Participation in accordance with KRS Chapter 45A.

23 Section 69. Incorporation by Reference. (1) The following is incorporated by reference

24 into this administrative regulation:

1 (a) The "MCO Reporting Requirements", July 2011 edition;

2 (b) The "MCO Program Integrity Requirements", July 2011 edition;

3 (c) The "Early and Periodic Screening, Diagnosis and Treatment Program Periodicity

4 Schedule", July 2011 edition;

5 (d) The "Third Party Liability and Coordination of Benefits", July 2011 edition; and

6 (e) The "Management Information Systems Requirements", July 2011 edition.

7 (2) The material referenced in subsection (1) of this section shall be available at:

8 (a) http://www.chfs.ky.gov/dms/incorporated.htm; or

9 (b)The Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky

10 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 17:005

REVIEWED:

__________________ ____

Date

Neville Wise, Acting Commissioner
Department for Medicaid Services

APPROVED:

Date

Janie Miller, Secretary
Cabinet for Health and Family Services

A public hearing on this administrative regulation shall, if requested, be held on December 21, 2011 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by December 14, 2011, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business January 3, 2012. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 17:005
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321 or Wanda Fowler (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the Kentucky Medicaid Program managed care policies and requirements for every region in Kentucky except for region three (3.) Region three (3) is comprised of Jefferson County and fifteen (15) other counties neighboring or nearby Jefferson County. Under managed care, each Medicaid recipient (except for those excluded from managed care participation) residing outside of region three (3) will be given a choice of enrolling with one (1) of three (3) managed care organizations (MCOs) for the purpose of receiving Medicaid services and benefits. The three (3) MCOs are CoventryCares, Kentucky Spirit Health Plan and WellCare. Recipients residing in region three (3) will remain under the responsibility of the managed care organization, Passport Health Plan, that currently serves that region. Individuals who fail to choose an MCO will be assigned to one by the Department for Medicaid Services. Some individuals, including recipients residing in a nursing facility or in an intermediate care facility for individuals with mental retardation or a developmental disability, individuals receiving services through a home and community based waiver (or “1915c waiver”), individuals eligible for Medicare and certain categories of children under age nineteen (19), to name a few, will be excluded from managed care enrollment. The excluded individuals will remain under the umbrella of the Kentucky Medicaid “fee-for-service” reimbursement/delivery model. The proposed changes under the waiver and any necessary plan revisions will be contingent upon the approval of the Centers for Medicare and Medicaid Services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Kentucky Medicaid Program managed care policies and requirements for every region in Kentucky except for region three (3.) Transforming the majority of the Medicaid program from a fee-for-service model into a managed care model is necessary to improve quality of care, facilitate access to care, and to effectively manage costs.

(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 establishing the Kentucky Medicaid Program managed care policies and requirements for every region in Kentucky except for region three (3.) DMS anticipates that this action will effectively manage costs while enhancing service quality and facilitating access to 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 establishing the Kentucky Medicaid Program managed care policies and requirements for every region in Kentucky except for region three (3.) DMS anticipates that this action will effectively manage costs while enhancing service quality and facilitating access to 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.
(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers, Medicaid recipients (except those excluded from managed care) and the three (3) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the 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: Medicaid recipients who participate in managed care must either choose a managed care organization or be assigned to one (1) if they fail to choose one (1) within the time period required. Managed care organizations will be responsible for providing Medicaid covered services to recipients enrolled with them. In order to be reimbursed for providing care (covered under managed care) to Medicaid recipients, providers must enroll 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). No cost is imposed.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients should benefit from the following components of managed care: coordinated care, a medical home focused on improving health outcomes, a plan of care which coordinates physical and behavioral health, and the MCO emphasis on wellness and prevention. Managed care organizations will benefit by receiving payments from DMS pursuant to their contract with the Commonwealth.

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

regulation:

(a) Initially: Rather than increase expenditures, DMS estimates that implementing the administrative regulation will reduce Medicaid benefit expenditures by approximately $281.6 million (state and federal combined) in state fiscal year (SFY) 2012 with a November 1, 2011 implementation. The impact on the Medicaid budget for SFY 2012 takes into consideration the one-time incurred claims cost for Medicaid recipients enrolled in managed care for services received by them prior to November 1, 2011 as well as other factors.

(b) On a continuing basis: DMS projects that implementing the administrative regulation will reduce Medicaid benefit expenditures by approximately $464.1 million (state and federal combined) in SFY 2013 and $552.5 million (federal and state combined) in SFY 2014. These estimates may vary from the actual enrollment and are subject to change.

(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 Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted 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 are necessary.

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

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is applied in that certain individuals are excluded from managed care enrollment. Federal regulation or law excludes the individuals from being enrolled into managed care.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 17:005E
Agency Contact Person: Stuart Owen (502) 564-4321 or Wanda Fowler (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs.

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. A managed care program is not federally mandated for Medicaid programs.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care but does not impose additional or stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. A managed care method of administering the program is being implemented but stricter requirements are not imposed. A managed care program is not federally mandated for Medicaid programs.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 17:005E
Agency Contact Person: Stuart Owen (502) 564-4321 or Wanda Fowler (502) 564-4321

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

   Yes _X__ No ____
   If yes, complete 2-4.

2. 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 this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 CFR 438 and this administrative regulation authorizes the action taken by this administrative regulation.

4. 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? None.
   (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? None.
   (c) How much will it cost to administer this program for the first year? Rather than increase expenditures, DMS estimates that implementing the administrative regulation will reduce Medicaid benefit expenditures by approximately $281.6 million (state and federal combined) in state fiscal year (SFY) 2012 with a November 1, 2011 implementation. The impact on the Medicaid budget for SFY 2012 takes into consideration the one-time incurred claims cost for Medicaid recipients enrolled in managed care for services received by them prior to November 1, 2011 as well as other factors.
   (d) How much will it cost to administer this program for subsequent years? DMS projects that implementing the administrative regulation will reduce Medicaid benefit expenditures by approximately $464.1 million (state and federal combined) in SFY 2013 and $552.5 million (federal and state combined) in SFY

2014. These estimates may vary from the actual enrollment and are subject to change.