CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Program Quality and Outcomes

(Amendment)

907 KAR 17:005. Definitions for 907 KAR Chapter 17.

RELATES TO: KRS Chapter 13B, 194A.025(3), 199.555(2), Chapter 202A, 205.8451-205.8483, 311.550(12), 314.011(7), 387.510(15), 620.020(5), 42 U.S.C. 1382c, 1395tt, 1396-1396w-5, 20 C.F.R. 416.2101, 42 C.F.R. 400.203, 405.2401(b), 412.62, Part 438, 440.40(b), 447.280, 482.58

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), 205.560, 42 U.S.C. 1396n(b), 42 C.F.R. Part 438

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the definitions for 907 KAR Chapter 17.

Section 1. Definitions. (1) "1915(c) home and community based waiver program" means a Kentucky Medicaid program established pursuant to, and in accordance with, 42 U.S.C. 1396n(c).

(2) "Advanced practice registered nurse" is defined by KRS 314.011(7).

(3) "Adverse action" means:

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

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

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

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

(e) The failure of a managed care organization to act within the timeframes provided in 42 C.F.R. 438.408(b).

(4) "Appeal" means a request for review of an adverse action or a decision by an MCO related to a covered service.

(5) "Authorized representative" means:

(a) For an enrollee who is authorized by Kentucky law to provide written consent, an individual or entity acting on behalf of, and with written consent from, the enrollee; or

(b) A legal guardian.

(6) "Behavioral health service" means a clinical, rehabilitative, or support service in an inpatient or outpatient setting to treat a mental illness, emotional disability, or substance use disorder.

(7) "Blind" is defined by 42 U.S.C. 1382c(a)(2).

(8) "Capitation payment" means the total per enrollee, per month payment amount the department pays an MCO.

(9) "Care coordination" means the integration of all processes in response to an enrollee's needs and strengths to ensure the:

(a) Achievement of desired outcomes; and

(b) Effectiveness of services.

(10) "Case management" means a collaborative process that:

(a) Assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an enrollee's health and human service needs;

(b) Is characterized by advocacy, communication, and resource management;

(c) Promotes quality and cost-effective interventions and outcomes; and

(d) Is in addition to and not in lieu of targeted case management for individuals pursuant to 907 KAR Chapter 15.

(11) "CHFS OIG" means the Cabinet for Health and Family Services, Office of Inspector General.

(12) "Child" means a person who:

(a)1. Is under the age of eighteen (18) years;

2.a. Is a full-time student in a secondary school or the equivalent level of vocational or technical training; and

b. Is expected to complete the program before the age of nineteen (19) years;

3. Is not self supporting;

4. Is not a participant in any of the United States Armed Forces; and

5. If previously emancipated by marriage, has returned to the home of his or her parents or to the home of another relative;

(b) Has not attained the age of nineteen (19) years in accordance with 42 U.S.C. 1396a(l)(1)(D);

(c) Is under the age of nineteen (19) years if the person is a KCHIP recipient; or

(d) Is under the age of twenty-one (21) years for EPSDT.

(13) "Complex or chronic condition" means a physical, behavioral, or developmental condi-

tion that:

(a) May have no known cure;

(b) Is progressive; or

(c) Can be debilitating or fatal if left untreated or under-treated.

(14) "Court-ordered commitment" means an involuntary commitment by an order of a court to a psychiatric facility for treatment pursuant to KRS Chapter 202A.

(15) "DAIL" means the Department for Aging and Independent Living.

(16) "DCBS" means the Department for Community Based Services.

(17) "Department" means the Department for Medicaid Services or its designee.

(18) "Disabled" is defined by 42 U.S.C. 1382c(a)(3).

(19) "DSM-IV" means a manual published by the American Psychiatric Association that covers all mental health disorders for both children and adults.

(20) "Dual eligible" means an individual eligible for Medicare and Medicaid benefits.

(21) "Early and periodic screening, diagnosis, and treatment" or "EPSDT" is defined by 42 C.F.R. 440.40(b).

(22) "Emergency service" means "emergency services" as defined by 42 U.S.C. 1396u-2(b)(2)(B).

(23) "Enrollee" means a recipient who is enrolled with a managed care organization for the purpose of receiving Medicaid or KCHIP covered services.

(24) "Family planning service" means a counseling service, a medical service, or a pharmaceutical supply or device to prevent or delay pregnancy.

(25) "Federally qualified health center" or "FQHC" is defined by 42 C.F.R. 405.2401(b).

(26) "Federally qualified health center look-alike" or "FQHC look-alike" means an entity that

is currently approved by the United States Department of Health and Human Services, Health Resources and Services Administration, and the Centers for Medicare and Medicaid Services to be a federally qualified health center look-alike.

(27) "Fee-for-service" means a reimbursement model in which a health insurer reimburses a provider for each service provided to a recipient.

(28) "Foster care" is defined by KRS 620.020(5).

(29) "Fraud" means any act that constitutes fraud under applicable federal law or KRS 205.8451 to KRS 205.8483.

(30) "Grievance" is defined by 42 C.F.R. 438.400(b).

(31) "Homeless individual" means an individual who:

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

(b) Is at risk of becoming homeless in a rural or urban area because the residence is not safe, decent, sanitary, or secure;

(c) Has a primary nighttime residence at a:

1. Publicly or privately operated shelter designed to provide temporary living accommodations; or

2. Public or private place not designed as regular sleeping accommodations; or

(d) Lacks access to normal accommodations due to violence or the threat of violence from a cohabitant.

(32) "Individual with a special health care need" or "ISHCN" means an individual who:

(a) Has, or is at a high risk of having, a chronic physical, developmental, behavioral, neurological, or emotional condition; and

(b) May require a broad range of primary, specialized, medical, behavioral health, or related

services.

(33) "KCHIP" means the Kentucky Children's Health Insurance Program administered in accordance with 42 U.S.C. 1397aa to jj.

(34) "Managed care organization" or "MCO" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

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

(36) [~~"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 20:020; and~~

~~(e) Meets the resource standards established in 907 KAR 20:025.~~

~~(37)~~] "Medical record" means a single, complete record that documents all of the treatment plans developed for, and medical services received by, an individual.

(37)[~~(38)~~] "Medicare qualified individual group 1 (QI-1)" means an eligibility category that includes, pursuant to 42 U.S.C. 1396a(a)(10)(E)(iv), an individual who would be a Qualified

Medicaid beneficiary but for the fact that the individual's income:

(a) Exceeds the income level established in accordance with 42 U.S.C. 1396d(p)(2); and

(b) Is at least 120 percent, but less than 135 percent, of the federal poverty level for a family of the size involved and who is not otherwise eligible for Medicaid under the state plan.

(38)[~~(39)~~] "Nonqualified alien" means a resident of the United States of America who does not meet the qualified alien requirements established in 907 KAR 20:005, Section 2(2)(a)2. or 3.

(39)[~~(40)~~] "Nursing facility" means:

(a) A facility:

1. To which the state survey agency has granted a nursing facility license;

2. For which the state survey agency has recommended to the department certification as a Medicaid provider; and

3. To which the department has granted certification for Medicaid participation; or

(b) A hospital swing bed that provides services in accordance with 42 U.S.C. 1395tt and 1396l, if the swing bed is certified to the department as meeting requirements for the provision of swing bed services in accordance with 42 U.S.C. 1396r(b), (c), and (d) and 42 C.F.R. 447.280 and 482.58.

(40)[~~(41)~~] "Olmstead decision" means the court decision of Olmstead v. L.C. and E.W., U.S. Supreme Court, No. 98–536, June 26, 1999 in which the U.S. Supreme Court ruled, "For the reasons stated, we conclude that, under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

(41)[~~(42)~~] "Open enrollment" means an annual period during which an enrollee can choose a different MCO.

(42)[~~(43)~~] "Out-of-network provider" means a person or entity that has not entered into a participating provider agreement with an MCO or any of the MCO's subcontractors.

(43)[~~(44)~~] "Physician" is defined by KRS 311.550(12).

(44)[~~(45)~~] "Post-stabilization services" means covered services related to an emergency medical condition that are provided to an enrollee:

(a) After an enrollee is stabilized in order to maintain the stabilized condition; or

(b) Under the circumstances described in 42 C.F.R. 438.114(e) to improve or resolve the enrollee's condition.

[~~(46) "Primary care center" means an entity that meets the primary care center requirements established in 902 KAR 20:058.~~]

(45)[~~(47)~~] "Primary care provider" or "PCP" means a licensed or certified health care practitioner who meets the description as established in 907 KAR 17:010, Section 6(6).

(46)[~~(48)~~] "Prior authorization" means the advance approval by an MCO of a service or item provided to an enrollee.

(47)[~~(49)~~] "Provider" means any person or entity under contract with an MCO or its contractual agent that provides covered services to enrollees.

(48)[~~(50)~~] "Provider network" means the group of physicians, hospitals, and other medical care professionals that a managed care organization has contracted with to deliver medical services to its enrollees.

(49)[~~(51)~~] "QAPI" means the Quality Assessment and Performance Improvement Program established in accordance with 42 C.F.R. 438 Subpart D, 438.206 to 438.242.

(50)[~~(52)~~] "Qualified alien" means an alien who, at the time of applying for or receiving Medicaid benefits, meets the requirements established in 907 KAR 20:005, Section 2(2)(a)2. or 3.

(51)[~~(53)~~] "Qualified disabled and working individual" is defined by 42 U.S.C. 1396d(s).

(52)[~~(54)~~] "Qualified Medicare beneficiary" or "QMB" is defined by 42 U.S.C. 1396d(p)(1).

(53)[~~(55)~~] "Recipient" is defined by KRS 205.8451(9).

(54)[~~(56)~~] "Rural area" means an area not in an urban area.

(55)[~~(57)~~] "Rural health clinic" is defined by 42 C.F.R. 405.2401(b).

(56)[~~(58)~~] "Specialist" means a provider who provides specialty care.

(57)[~~(59)~~] "Specialty care" means care or a service that is provided by a provider who is not:

(a) A primary care provider; or

(b) Acting in the capacity of a primary care provider while providing the service.

(58)[~~(60)~~] "Specified low-income Medicare beneficiary" means an individual who meets the requirements established in 42 U.S.C. 1396a(a)(10)(E)(iii).

(59)[~~(61)~~] "State fair hearing" means an administrative hearing provided by the Cabinet for Health and Family Services pursuant to KRS Chapter 13B.

(60)[~~(62)~~] "State plan" is defined by 42 C.F.R. 400.203.

(61)[~~(63)~~] "State survey agency" means the Cabinet for Health and Family Services, Office of Inspector General, Division of Health Care Facilities and Services.

(62)[~~(64)~~] "State-funded adoption assistance" is defined by KRS 199.555(2).

(63)[~~(65)~~] "Supplemental security income benefits" or "SSI benefits" is defined by 20 C.F.R. 416.2101(c).

(64)[~~(66)~~]"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, 42 U.S.C. 1396 to 1396w-5.

(65)[~~(67)~~] "Transport time" means travel time:

(a) Under normal driving conditions; and

(b) With no extenuating circumstances.

(66)[~~(68)~~]"Urban area" is defined by 42 C.F.R. 412.62(f)(1)(ii).

(67)[~~(69)~~] "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.

(68)[~~(70)~~] "Ward" is defined by KRS 387.510(15).

907 KAR 17:005

REVIEWED:

10/26/2021
Date

DocuSigned by:
Lisa Lee
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Lisa Lee, Commissioner
Department for Medicaid Services

APPROVED:

10/26/2021
Date

DocuSigned by:
Eric Friedlander
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Eric Friedlander, Secretary
Cabinet for Health and Family Services

PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall, if requested, be held on January 24, 2022, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by January 14, 2022, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends virtually will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until January 31, 2022. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, KY 40621; Phone: 502-564-6746; Fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 17:005
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2565, jonathant.scott@ky.gov; and Krista Quarles, (502) 564-6746, CHFSRegs@ky.gov

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the definitions for 907 KAR Chapter 17, which relates to managed care
(b) The necessity of this administrative regulation: This definitions administrative regulation is necessary to define the terms used in 907 KAR Chapter 17, in accordance with KRS 13A.222(4)(d) and (e).
(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. KRS 13A.222(4)(d) and (e) authorize the use of definitions for terms used within a chapter of the Kentucky Administrative Regulations Service.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by providing the definitions for terms used throughout 907 KAR Chapter 17. Defining the terms will lead to less confusion as the regulated community will know the meanings of common terms.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment to 907 KAR 17:005 removes the phrase "Medicaid Works individual" to reflect the ending of that program, and "primary care center" is removed to reflect the removal of licensure for that facility type.

(b) The necessity of the amendment to this administrative regulation: The amendments to this definitions administrative regulation are necessary to reflect the ending of the Medicaid Works program, and to reflect a statutory change to eligible facility licensure types.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by reflecting the ending of the Medicaid Works program, and a statutory modification to eligible facility licensure types.

(d) How the amendment will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by providing the definitions for terms used throughout 907 KAR Chapter 17, while complying with KRS 13A.222 and providing correct cross-references. Additionally, defining the terms will lead to less confusion as the regulated community will know the meanings of

common terms. Finally, this amendment will assist in the effective administration of the statues by reflecting current state law as it relates to facility licensure and the Medicaid Works program.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All Medicaid providers and all six managed care organizations will be affected by this administrative regulation. Since the creation of the Medicaid Works program in 2007, only 15 different people have ever used it. Currently, there are only 5 beneficiaries using the program, and DMS intends to otherwise accommodate this population within the existing healthcare system.

(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: There are not any actions that regulated entities will have to take to comply with this amendment as it simply updates the definitions.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There are not any costs to complying with the changes to this definitions administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The Medicaid providers and six managed care organizations will receive the benefit of updated (and corrected) cross-references.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:
(a) Initially: There are no costs to implementing the definitions administrative regulation either initially or on a continuing basis.

(b) On a continuing basis: There are no costs to implementing the definitions administrative regulation either initially or on a continuing basis.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of funding to be used for the implementation and enforcement of 907 KAR Chapter 17 are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: An increase in fees or funding is not necessary to implement this amendment.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish any fees or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applied because this administrative regulation applies equally to all those individuals or entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 907 KAR 17:005
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2565, jonathant.scott@ky.gov; and Krista Quarles, (502) 564-6746, CHFSRegs@ky.gov

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438

2. State compliance standards. KRS 194A.010(1), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), and 205.560

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes definitions for terms used in 907 KAR Chapter 17.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this administrative regulation does not impose stricter, additional, or different requirements or responsibilities than those required by the federal mandate. It merely establishes definitions, not requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This administrative regulation does not impose stricter, additional, or different requirements or responsibilities than those required by the federal mandate. It merely establishes definitions, not requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 907 KAR 17:005
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2565, jonathant.scott@ky.gov; and Krista Quarles, (502) 564-6746, CHFSRegs@ky.gov

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Cabinet for Health and Family Services, Department for Medicaid Services

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.010(1), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), 205.560, 42 U.S.C. 1396n(b), 42 C.F.R. Part 438.

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

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

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

(c) How much will it cost to administer this program for the first year? The department anticipates no additional costs in the implementation of this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? The department anticipates no additional costs in the continuing operation of this administrative regulation.

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