

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Commissioner's Office

4 (Amendment)

5 907 KAR 17:005. Definitions for administrative regulations located in Chapter 17 of  
6 Title 907 of the Kentucky Administrative Regulations~~[Managed care organization re-~~  
7 ~~quirements and policies].~~

8 RELATES TO: 194A.025(3), 42 U.S.C. 1396n(c), 42 C.F.R. 438

9 STATUTORY AUTHORITY: KRS 194A.010(1), 194A.025(3), 194A.030 (2),  
10 194A.050(1), 205.520(3), 205.560, 42 U.S.C. 1396n(b), 42 C.F.R. Part 438

11 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family  
12 Services, Department for Medicaid Services, has responsibility to administer the Medi-  
13 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to  
14 comply with a requirement that may be imposed or opportunity presented by federal law  
15 to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 estab-  
16 lish requirements relating to managed care. This administrative regulation establishes  
17 the definitions for administrative regulations in Chapter 17 of Title 907. The definitions  
18 established in this administrative regulation apply to the policies and procedures relating  
19 to the provision of Medicaid services through contracted managed care organizations  
20 pursuant to, and in accordance with, 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438.

21 Section 1. Definitions. (1) "1915(c) home and community based waiver program"

1 means a Kentucky Medicaid program established pursuant to, and in accordance with,  
2 42 U.S.C. 1396n(c).

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

4 (3) "Adverse action" means:

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

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

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

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

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

12 (4) "Aged" means at least sixty-five (65) years of age.

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

15 (6) "Authorized representative" means an individual or entity acting on behalf of, and  
16 with written consent from, an enrollee.

17 (7) "Behavioral health service" means a clinical, rehabilitative, or support service in  
18 an inpatient or outpatient setting to treat a mental illness, emotional disability, or sub-  
19 stance abuse disorder.

20 (8)~~(7)~~ "Blind" is defined by 42 U.S.C. 1382c(a)(2).

21 (9)~~(8)~~ "Capitation payment" means the total per enrollee, per month payment  
22 amount the department pays an MCO.

23 (10)~~(9)~~ "Capitation rate" means the negotiated amount to be paid on a monthly ba-

1 sis by the department to an MCO:

2 (a) Per enrollee; and

3 (b) Based on the enrollee's aid category, age, and gender.

4 (11)~~(10)~~ "Care coordination" means the integration of all processes in response to  
5 an enrollee's needs and strengths to ensure the:

6 (a) Achievement of desired outcomes; and

7 (b) Effectiveness of services.

8 (12)~~(11)~~ "Case management" means a collaborative process that:

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

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

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

13 (d) Is in addition to and not in lieu of targeted case management for:

14 1. Adults with a chronic mental illness pursuant to 907 KAR 1:515; or

15 2. Children with a severe emotional disability pursuant to 907 KAR 1:525.

16 (13)~~(12)~~ "CHFS OIG" means the Cabinet for Health and Family Services, Office of  
17 Inspector General.

18 (14)~~(13)~~ "Child" means a person who:

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

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

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

23 3. Is not self supporting;

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

2 5. If previously emancipated by marriage, has returned to the home of his or her par-  
3 ents or to the home of another relative;

4 (b) Has not attained the age of nineteen (19) years in accordance with 42 U.S.C.  
5 1396a(l)(1)(D); or

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

7 (15)~~[(14)]~~ "Chronic Illness and Disability Payment System" means a diagnostic classi-  
8 fication system that Medicaid programs use to make health-based, capitated payments  
9 for TANF and Medicaid beneficiaries with a disability.

10 (16)~~[(15)]~~ "Commission for Children with Special Health Care Needs" or "CCSHCN"  
11 means the Title V agency which provides specialty medical services for children with  
12 specific diagnoses and health care needs that make them eligible to participate in pro-  
13 grams sponsored by the CCSHCN, including the provision of medical care.

14 (17)~~[(16)]~~ "Community mental health center" means a facility which meets the com-  
15 munity mental health center requirements established in 902 KAR 20:091.

16 (18)~~[(17)]~~ "Complex or chronic condition" means a physical, behavioral, or develop-  
17 mental condition which:

18 (a) May have no known cure;

19 (b) Is progressive; or

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

21 (19)~~[(18)]~~ "Consumer Assessment of Healthcare Providers and Systems" or "CA-  
22 HPS" means a program that develops standardized surveys that ask consumers and  
23 patients to report on and evaluate their experiences with health care.

1        ~~(20)~~~~(19)~~ "Court-ordered commitment" means an involuntary commitment by an or-  
2 der of a court to a psychiatric facility for treatment pursuant to KRS Chapter 202A.

3        ~~(21)~~~~(20)~~ "DAIL" means the Department for Aging and Independent Living.

4        ~~(22)~~~~(21)~~ "DCBS" means the Department for Community Based Services.

5        ~~(23)~~~~(22)~~ "Department" means the Department for Medicaid Services or its designee.

6        ~~(24)~~~~(23)~~ "Disabled" is defined by 42 U.S.C. 1382c(a)(3).

7        ~~(25)~~~~(24)~~ "DSM-IV" means a manual published by the American Psychiatric Associa-  
8 tion that covers all mental health disorders for both children and adults.

9        ~~(26)~~~~(25)~~ "Dual eligible" means an individual eligible for Medicare and Medicaid ben-  
10 efits.

11       ~~(27)~~~~(26)~~ "Early and periodic screening, diagnosis and treatment" or "EPSDT" is de-  
12 fined by 42 C.F.R. 440.40(b).

13       ~~(28)~~~~(27)~~ "Emergency service" means "emergency services" as defined by 42 U.S.C.  
14 1396u-2(b)(2)(B).

15       ~~(29)~~~~(28)~~ "Encounter" means a health care visit of any type by an enrollee to a pro-  
16 vider of care, drugs, items, or services.

17       ~~(30)~~~~(29)~~ "Enrollee" means a recipient who is enrolled with a managed care organi-  
18 zation for the purpose of receiving Medicaid or KCHIP covered services.

19       ~~(31)~~~~(30)~~ "External quality review organization" or "EQRO":  
20       (a) Is defined by 42 C.F.R. 438.320; and  
21       (b) Includes any affiliate or designee of the EQRO.

22       ~~(32)~~~~(31)~~ "Family planning service" means a counseling service, medical service, or  
23 a pharmaceutical supply or device to prevent or delay pregnancy.

1        ~~(33)~~~~(32)~~ "Federally qualified health center" or "FQHC" is defined by 42 C.F.R.  
2 405.2401(b).

3        ~~(34)~~~~(33)~~ "Fee-for-service" means a reimbursement model in which a health insurer  
4 reimburses a provider for each service provided to a recipient.

5        ~~(35)~~~~(34)~~ "Foster care" is defined by KRS 620.020(5).

6        ~~(36)~~~~(35)~~ "Fraud" means any act that constitutes fraud under applicable federal law  
7 or KRS 205.8451 to KRS 205.8483.

8        ~~(37)~~~~(36)~~ "Grievance" is defined by 42 C.F.R. 438.400.

9        ~~(38)~~~~(37)~~ "Grievance system" means a system that includes a grievance process, an  
10 appeal process, and access to the Commonwealth of Kentucky's fair hearing system.

11        ~~(39)~~~~(38)~~ "Health maintenance organization" is defined by KRS 304.38-030(5).

12        ~~(40)~~~~(39)~~ "Health risk assessment" or "HRA" means a health questionnaire used to  
13 provide individuals with an evaluation of their health risks and quality of life.

14        ~~(41)~~~~(40)~~ "Healthcare Effectiveness Data and Information Set" or "HEDIS" means a  
15 tool used to measure performance regarding important dimensions of health care or  
16 services.

17        ~~(42)~~~~(41)~~ "Homeless individual" means an individual who:

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

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

21        (c) Has a primary nighttime residence at a:

22        1. Publicly or privately operated shelter designed to provide temporary living accom-  
23 modations; or

1 2. Public or private place not designed as regular sleeping accommodations; or  
2 (d) Lacks access to normal accommodations due to violence or the threat of violence  
3 from a cohabitant.

4 ~~(43)~~~~(42)~~ "Individual with a special health care need" or "ISHCN" means an individual  
5 who:

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

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

10 ~~(44)~~~~(43)~~ "Initial implementation" means the process of transitioning a current Medi-  
11 caid or KCHIP recipient from fee-for-service into managed care.

12 ~~(45)~~~~(44)~~ "KCHIP" means the Kentucky Children's Health Insurance Program admin-  
13 istered in accordance with 42 U.S.C. 1397aa to jj.

14 ~~(46)~~~~(45)~~ "Kentucky Health Information Exchange" or "KHIE" means the name given  
15 to the system that will support the statewide exchange of health information among  
16 healthcare providers and organizations according to nationally-recognized standards.

17 ~~(47)~~~~(46)~~ "Managed care organization" or "MCO" means an entity for which the De-  
18 partment for Medicaid Services has contracted to serve as a managed care organiza-  
19 tion as defined in 42 C.F.R. 438.2.

20 ~~(48)~~~~(47)~~ "Marketing" means any activity conducted by or on behalf of an MCO in  
21 which information regarding the services offered by the MCO is disseminated in order to  
22 educate enrollees or potential enrollees about the MCO's services.

23 ~~(49)~~~~(48)~~ "Maternity care" means prenatal, delivery, and postpartum care and in-

1 cludes care related to complications from delivery.

2 (50)~~(49)~~ "Medicaid works individual" means an individual who:

3 (a) But for earning in excess of the income limit established under 42 U.S.C.

4 1396d(q)(2)(B), would be considered to be receiving SSI benefits;

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

6 (c) Is engaged in active employment verifiable with:

7 1. Paycheck stubs;

8 2. Tax returns;

9 3. 1099 forms; or

10 4. Proof of quarterly estimated tax;

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

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

13 (51)~~(50)~~ "Medical record" means a single, complete record that documents all of the  
14 treatment plans developed for, and medical services received by, an individual.

15 (52)~~(51)~~ "Medically necessary" means that a covered benefit is determined to be  
16 needed in accordance with 907 KAR 3:130.

17 (53)~~(52)~~ "Medicare qualified individual group 1 (QI-1)" means an eligibility category,  
18 in which pursuant to 42 U.S.C. 1396a(a)(10)(E)(iv), an individual who would be a Quali-  
19 fied Medicaid beneficiary but for the fact that the individual's income:

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

21 and

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

1 state plan.

2 (54)~~(53)~~ "National Practitioner Data Bank" means an electronic repository that col-  
3 lects:

4 (a) Information on adverse licensure activities, certain actions restricting clinical privi-  
5 leges, and professional society membership actions taken against physicians, dentists,  
6 and other practitioners; and

7 (b) Data on payments made on behalf of physicians in connection with liability set-  
8 tlements and judgments.

9 (55)~~(54)~~ "Nonqualified alien" means a resident of the United States of America who  
10 does not meet the qualified alien requirements established in 907 KAR 1:011, Section  
11 5(12).

12 (56)~~(55)~~ "Nursing facility" means:

13 (a) A facility:

- 14 1. To which the state survey agency has granted a nursing facility license;
- 15 2. For which the state survey agency has recommended to the department certifica-  
16 tion as a Medicaid provider; and
- 17 3. To which the department has granted certification for Medicaid participation; or

18 (b) A hospital swing bed that provides services in accordance with 42 U.S.C. 1395tt  
19 and 1396l, if the swing bed is certified to the department as meeting requirements for  
20 the provision of swing bed services in accordance with 42 U.S.C. 1396r(b), (c), and (d)  
21 and 42 C.F.R. 447.280 and 482.66.

22 (57)~~(56)~~ "Olmstead decision" means the court decision of Olmstead v. L.C. and  
23 E.W., U.S. Supreme Court, No. 98–536, June 26, 1999 in which the U.S. Supreme

1 Court ruled, "For the reasons stated, we conclude that, under Title II of the ADA, States  
2 are required to provide community-based treatment for persons with mental disabilities  
3 when the State's treatment professionals determine that such placement is appropriate,  
4 the affected persons do not oppose such treatment, and the placement can be reason-  
5 ably accommodated, taking into account the resources available to the State and the  
6 needs of others with mental disabilities."

7 (58)~~[(57)]~~ "Open enrollment" means an annual period during which an enrollee can  
8 choose a different MCO.

9 (59)~~[(58)]~~ "Out-of-network provider" means a person or entity that has not entered in-  
10 to a participating provider agreement with an MCO or any of the MCO's subcontractors.

11 (60)~~[(59)]~~ "Physician" is defined by KRS 311.550(12).

12 (61)~~[(60)]~~ "Post-stabilization services" means covered services related to an emer-  
13 gency medical condition that are provided to an enrollee:

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

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

17 (62)~~[(61)]~~ "Primary care center" means an entity that meets the primary care center  
18 requirements established in 902 KAR 20:058.

19 (63)~~[(62)]~~ "Primary care provider" or "PCP" means a licensed or certified health care  
20 practitioner who meets the description as established in Section 6(6) of 907 KAR  
21 17:010~~[7(6) of this administrative regulation]~~.

22 (64)~~[(63)]~~ "Prior authorization" means the advance approval by an MCO of a service  
23 or item provided to an enrollee.

1       (65)[(64)] "Provider" means any person or entity under contract with an MCO or its  
2 contractual agent that provides covered services to enrollees.

3       (66)[(65)] "Provider network" means the group of physicians, hospitals, and other  
4 medical care professionals that a managed care organization has contracted with to de-  
5 liver medical services to its enrollees.

6       (67)[(66)] "QAPI" means the Quality Assessment and Performance Improvement  
7 Program established in accordance with 907 KAR 17:025, Section 5~~[Section 48 of this~~  
8 ~~administrative regulation]~~.

9       (68)[(67)] "Qualified alien" means an alien who, at the time of applying for or receiv-  
10 ing Medicaid benefits, meets the requirements established in 907 KAR 1:011, Section  
11 5(12).

12       (69)[(68)] "Qualified disabled and working individual" is defined by 42 U.S.C.  
13 1396d(s).

14       (70)[(69)] "Qualified Medicare beneficiary" or "QMB" is defined by 42 U.S.C.  
15 1396d(p)(1).

16       (71)[(70)] "Quality improvement" or "QI" means the process of assuring that covered  
17 services provided to enrollees are appropriate, timely, accessible, available, and medi-  
18 cally necessary and the level of performance of key processes and outcomes of the  
19 healthcare delivery system is improved through the MCO's policies and procedures.

20       (72)[(71)] "Recipient" is defined in KRS 205.8451(9).

21       (73) "Region eight (8)" means the region containing Bell, Breathitt, Clay, Floyd, Har-  
22 lan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry,  
23 Pike, Wolfe, and Whitley Counties.

1 (74) "Region five (5)" means the region containing Anderson, Bourbon, Boyle, Clark,  
2 Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer,  
3 Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, and Woodford Counties.

4 (75) "Region four (4)" means the region containing Adair, Allen, Barren, Butler, Ca-  
5 sey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Mon-  
6 roe, Pulaski, Russell, Simpson, Taylor, Warren, and Wayne Counties.

7 (76) "Region one (1)" means the region containing Ballard, Caldwell, Calloway, Car-  
8 lisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, and McCracken  
9 Counties.

10 (77) "Region seven (7)" means the region containing Bath, Boyd, Bracken, Carter, El-  
11 liott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Rowan, and Rob-  
12 ertson Counties.

13 (78) "Region six (6)" means the region containing Boone, Campbell, Gallatin, Grant,  
14 Kenton, and Pendleton Counties.

15 (79) "Region three (3)" means the region containing Breckenridge, Bullitt, Carroll,  
16 Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby,  
17 Spencer, Trimble, and Washington Counties.

18 (80) "Region two (2)" means the region containing Christian, Daviess, Hancock, Hen-  
19 derson, Hopkins, McLean, Muhlenberg, Ohio, Trigg, Todd, Union, and Webster Coun-  
20 ties.

21 (81)[(72)] "Risk adjustment" means a corrective tool to reduce both the negative fi-  
22 nancial consequences for a managed care organization that enrolls high-risk users and  
23 the positive financial consequences for a managed care organization that enrolls low-

1 risk users.

2 (82)~~[(73)]~~ "Rural area" means an area not in an urban area.

3 (83)~~[(74)]~~ "Rural health clinic" is defined by 42 C.F.R. 405.2401(b).

4 (84)~~[(75)]~~ "Specialist" means a provider who provides specialty care.

5 (85)~~[(76)]~~ "Specialty care" means care or a service that is provided by a provider who  
6 is not:

7 (a) A primary care provider; or

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

9 (86)~~[(77)]~~ "Specified low-income Medicare beneficiary" means an individual who  
10 meets the requirements established in 42 U.S.C. 1396a(a)(10)(E)(iii).

11 (87)~~[(78)]~~ "State fair hearing" means an administrative hearing provided by the Cabi-  
12 net for Health and Family Services pursuant to KRS Chapter 13B and 907 KAR 1:563.

13 (88)~~[(79)]~~ "State plan" is defined by 42 C.F.R. 400.203.

14 (89)~~[(80)]~~ "State survey agency" means the Cabinet for Health and Family Services,  
15 Office of Inspector General, Division of Health Care Facilities and Services.

16 (90)~~[(81)]~~ "State-funded adoption assistance" is defined by KRS 199.555(2).

17 (91)~~[(82)]~~ "Subcontract" means an agreement entered into, directly or indirectly, by  
18 an MCO to arrange for the provision of covered services, or any administrative, support  
19 or other health service, but does not include an agreement with a provider.

20 (92)~~[(83)]~~ "Supplemental security income benefits" or "SSI benefits" is defined by 20  
21 C.F.R. 416.2101.

22 (93)~~[(84)]~~ "Teaching hospital" means a hospital which has a teaching program ap-  
23 proved as specified in 42 U.S.C. 1395x(b)(6).

1        ~~(94)~~~~(85)~~ "Temporary Assistance for Needy Families" or "TANF" means a block grant  
2 program which is designed to:

3        (a) Assist needy families so that children can be cared for in their own homes;

4        (b) Reduce the dependency of needy parents by promoting job preparation, work,  
5 and marriage;

6        (c) Prevent out-of-wedlock pregnancies; and

7        (d) Encourage the formation and maintenance of two-parent families.

8        ~~(95)~~~~(86)~~ "Third party liability resource" means a resource available to an enrollee for  
9 the payment of expenses:

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

11       (b) That does not include amounts exempt under Title XIX of the Social Security Act,  
12 42 U.S.C. 1396 to 1396v.

13       ~~(96)~~~~(87)~~ "Transport time" means travel time:

14       (a) Under normal driving conditions; and

15       (b) With no extenuating circumstances.

16       ~~(97)~~~~(88)~~ "Urban area" is defined by 42 C.F.R. 412.62(f)(1)(ii).

17       ~~(98)~~~~(89)~~ "Urgent care" means care for a condition not likely to cause death or lasting  
18 harm but for which treatment should not wait for a normally scheduled appointment.

19       ~~(99)~~~~(90)~~ "Ward" is defined in KRS 387.510(15).

20       ~~(100)~~~~(91)~~ "Women, Infants and Children program" means a federally-funded health  
21 and nutrition program for women, infants, and children.

22       ~~[Section 2. Enrollment of Medicaid or KCHIP Recipients into Managed Care. (1) Ex-~~  
23 ~~cept as provided in subsection (3) of this section, enrollment into a managed care or-~~

1 ~~ganization shall be mandatory for a Medicaid or KCHIP recipient.~~

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

3 ~~(a) Medicaid recipient; or~~

4 ~~(b) KCHIP recipient.~~

5 ~~(3) The following recipients shall not be required to enroll, and shall not enroll, into a~~  
6 ~~managed care organization:~~

7 ~~(a) A recipient who resides in:~~

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

9 ~~2. An intermediate care facility for individuals with mental retardation or a develop-~~  
10 ~~mental disability; or~~

11 ~~(b) A recipient who is:~~

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

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

14 ~~3. Receiving:~~

15 ~~a. Services through the breast and cervical cancer program pursuant to 907 KAR~~  
16 ~~1:805;~~

17 ~~b. Medicaid benefits in accordance with the spend-down policies established in 907~~  
18 ~~KAR 1:640;~~

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

20 ~~d. Hospice services in a nursing facility or intermediate care facility for individuals~~  
21 ~~with mental retardation or a developmental disability; or~~

22 ~~e. Medicaid benefits as a Medicaid Works individual;~~

23 ~~4. A Qualified Medicare beneficiary who is not otherwise eligible for Medicaid bene-~~

1 fits;

2 ~~5. A specified low-income Medicare beneficiary who is not otherwise eligible for Med-~~  
3 ~~icaid benefits;~~

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

5 ~~7. A qualified disabled and working individual;~~

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

7 ~~9. A nonqualified alien eligible for Medicaid benefits for a limited period of time.~~

8 ~~(4)(a) Except for a child in foster care, a recipient who is eligible for enrollment into~~  
9 ~~managed care shall be enrolled with an MCO that provides services to an enrollee~~  
10 ~~whose primary residence is within the MCO's service area.~~

11 ~~(b) A child in foster care shall be enrolled with an MCO in the county where the~~  
12 ~~child's DCBS case is located.~~

13 ~~—(5)(a) During the department's initial implementation of managed care in accordance~~  
14 ~~with this administrative regulation, the department shall assign a recipient to an MCO~~  
15 ~~based upon an algorithm that considers:~~

16 ~~—1. Continuity of care;~~

17 ~~—2. Enrollee preference of MCO or of an MCO provider; and~~

18 ~~—3. Cost.~~

19 ~~—(b) An assignment shall focus on a need of a child or an individual with a special~~  
20 ~~health care need.~~

21 ~~—(6)(a) A newly eligible recipient or a recipient who has had a break in eligibility of~~  
22 ~~greater than two (2) months shall have an opportunity to choose an MCO during the eli-~~  
23 ~~gibility application process.~~

1 ~~—(b) If a recipient does not choose an MCO during the eligibility application process,~~  
2 ~~the department shall assign the recipient to an MCO.~~

3 ~~—(7) Each member of a household shall be assigned to the same MCO.~~

4 ~~—(8) The effective date of enrollment for a recipient described in subsection (6) of this~~  
5 ~~section shall be:~~

6 ~~—(a) The date of Medicaid eligibility; and~~

7 ~~—(b) No earlier than November 1, 2011.~~

8 ~~—(9) A recipient shall be given a choice of MCOs.~~

9 ~~—(10) A recipient enrolled with an MCO who loses Medicaid eligibility for less than two~~  
10 ~~(2) months shall be automatically reenrolled with the same MCO upon redetermination~~  
11 ~~of Medicaid eligibility unless the recipient moves to a county in region three (3) as es-~~  
12 ~~tablished in Section 28 of this administrative regulation.~~

13 ~~—(11) A newborn who has been deemed eligible for Medicaid shall be automatically~~  
14 ~~enrolled with the newborn's mother's MCO as an individual enrollee for up to sixty (60)~~  
15 ~~days.~~

16 ~~—(12)(a) An enrollee may change an MCO for any reason, regardless of whether the~~  
17 ~~MCO was selected by the enrollee or assigned by the department:~~

18 ~~—1. Within ninety (90) days of the effective date of enrollment;~~

19 ~~—2.a. Annually during an open enrollment period that shall be at the time of an enrol-~~  
20 ~~lee's recertification for Medicaid eligibility; or~~

21 ~~—b. Annually during the month of birth for an enrollee who receives SSI benefits;~~

22 ~~—3. Upon automatic enrollment under subsection (10) of this section, if a temporary~~  
23 ~~loss of Medicaid eligibility caused the recipient to miss the annual opportunity in sub-~~

1 ~~paragraph 2. of this paragraph; or~~

2 ~~—4. When the Commonwealth of Kentucky imposes an intermediate sanction specified~~

3 ~~in 42 C.F.R. 438.702(a)(3).~~

4 ~~—(b) An MCO shall accept an enrollee who changes MCOs under this section.~~

5 ~~—(13) Only the department shall have the authority to enroll a Medicaid recipient with~~

6 ~~an MCO in accordance with this section.~~

7 ~~—(14) Upon enrollment with an MCO, an enrollee shall receive two (2) identification~~

8 ~~cards.~~

9 ~~—(a) A card shall be issued from the department that shall verify Medicaid eligibility.~~

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

11 ~~—(15)(a) Within five (5) business days after receipt of notification of a new enrollee, an~~

12 ~~MCO shall send, by a method that shall not take more than three (3) days to reach the~~

13 ~~enrollee, a confirmation letter to an enrollee.~~

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

15 ~~—1. The effective date of enrollment;~~

16 ~~—2. The name, location and contact information of the PCP;~~

17 ~~—3. How to obtain a referral;~~

18 ~~—4. Care coordination;~~

19 ~~—5. The benefits of preventive health care;~~

20 ~~—6. The enrollee identification card;~~

21 ~~—7. A member handbook; and~~

22 ~~—8. A list of covered services.~~

23 ~~—(16) Enrollment with an MCO shall be without restriction.~~

1 —(17) An MCO shall:

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

3 —(b) Accept enrollees regardless of overall enrollment.

4 —(18)(a) Except as provided in paragraph (b) of this subsection, a recipient eligible to

5 enroll with an MCO shall be enrolled beginning with the first day of the month that the

6 enrollee applied for Medicaid.

7 —(b)1. A newborn shall be enrolled beginning with the newborn's date of birth.

8 —2. An unemployed parent shall be enrolled beginning with the date the unemployed

9 parent met the definition of unemployment in accordance with 45 C.F.R. 233.100.

10 —3. If an enrollee is retro-actively determined eligible for Medicaid, the retro-active eli-

11 gibility shall be for a period up to three (3) months prior to the month that the enrollee

12 applied for Medicaid.

13 —a. The department shall be responsible for reimbursing for services provided to an

14 individual determined to be retroactively eligible for any portion of the retroactive eligibil-

15 ity period which occurred prior to November 1, 2011, if the individual has a retroactive

16 eligibility period prior to November 1, 2011.

17 —b. A retroactive eligible individual's MCO shall be responsible for reimbursing for ser-

18 vices provided to an individual determined to be retroactively eligible for any portion of

19 the retroactive eligibility period which occurred beginning on or after November 1, 2011.

20 —(19) For an enrollee whose eligibility resulted from a successful appeal of a denial of

21 eligibility, the enrollment period shall begin:

22 —(a)1. On the first day of the month of the original application for eligibility; or

23 —2. On the first day of the month of retroactive eligibility as referenced in subsection

1 ~~(18)(b)3. of this section, if applicable; and~~  
2 ~~—(b) No earlier than November 1, 2011.~~  
3 ~~—(20) A provider shall be responsible for verifying an individual's eligibility for Medicaid~~  
4 ~~and enrollment in a managed care organization when providing a service.~~  
5 ~~—Section 3. Disenrollment. (1) The policies established in 42 C.F.R. 438.56 shall apply~~  
6 ~~to an MCO.~~  
7 ~~—(2) Only the department shall have the authority to disenroll a recipient from an MCO.~~  
8 ~~—(3) A disenrollment of a recipient from an MCO shall:~~  
9 ~~—(a) Become effective on the first day of the month following disenrollment; and~~  
10 ~~—(b) Occur:~~  
11 ~~—1. If the enrollee:~~  
12 ~~—a. No longer resides in an area served by the MCO;~~  
13 ~~—b. Becomes incarcerated or deceased; or~~  
14 ~~—c. Is exempt from managed care enrollment in accordance with Section 2(3) of this~~  
15 ~~administrative regulation; or~~  
16 ~~—2. In accordance with 42 C.F.R. 438.56.~~  
17 ~~—(4) An MCO may recommend to the department that an enrollee be disenrolled if the~~  
18 ~~enrollee:~~  
19 ~~—(a) Is found guilty of fraud in a court of law or administratively determined to have~~  
20 ~~committed fraud related to the Medicaid Program;~~  
21 ~~—(b) Is abusive or threatening but not for uncooperative or disruptive behavior resulting~~  
22 ~~from his or her special needs (except if his or her continued enrollment in the MCO seri-~~  
23 ~~ously impairs the entity's ability to furnish services to either this particular enrollee or~~

1 other enrollees) pursuant to ~~42 C.F.R. 438.56(b)(2);~~

2 ~~—(c) Becomes deceased; or~~

3 ~~—(d) No longer resides in an area served by the MCO.~~

4 ~~—(5) An enrollee shall not be disenrolled by the department, nor shall the managed~~

5 ~~care organization recommend disenrollment of an enrollee, due to an adverse change in~~

6 ~~the enrollee's health.~~

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

8 ~~second month following the month the enrollee or the MCO files a request in accord-~~

9 ~~ance with 42 C.F.R. 438.56(e)(1).~~

10 ~~—(b) If the department fails to make a determination within the timeframe specified in~~

11 ~~paragraph (a) of this subsection, the disenrollment shall be considered approved in ac-~~

12 ~~cordance with 42 C.F.R. 438.56(e)(2).~~

13 ~~—(7) If an enrollee is disenrolled from an MCO, the:~~

14 ~~—(a) Enrollee shall be enrolled with a new MCO if the enrollee is:~~

15 ~~—1. Eligible for Medicaid; and~~

16 ~~—2. Not excluded from managed care participation; and~~

17 ~~—(b) MCO shall:~~

18 ~~—1. Assist in the selection of a new primary care provider, if requested;~~

19 ~~—2. Cooperate with the new primary care provider in transitioning the enrollee's care;~~

20 ~~and~~

21 ~~—3. Make the enrollee's medical record available to the new primary care provider, in~~

22 ~~accordance with state and federal law.~~

23 ~~—(8) An MCO shall notify the department or Social Security Administration in an enrol-~~

1 ~~lee's county of residence within five (5) working days of receiving notice of the death of~~  
2 ~~an enrollee.~~

3 ~~—Section 4. Enrollee Rights and Responsibilities. (1) An MCO shall have written poli-~~  
4 ~~cies and procedures:~~

5 ~~—(a) To protect the rights of an enrollee that includes the:~~

6 ~~—1. Protection against liability for payment in accordance with 42 U.S.C. 1396u-2(b)(6);~~

7 ~~—2. Rights specified in 42 C.F.R. 438.100;~~

8 ~~—3. Right to prepare an advance medical directive pursuant to KRS 311.621 through~~  
9 ~~KRS 311.643;~~

10 ~~—4. Right to choose and change a primary care provider;~~

11 ~~—5. Right to file a grievance or appeal;~~

12 ~~—6. Right to receive assistance in filing a grievance or appeal;~~

13 ~~—7. Right to a state fair hearing;~~

14 ~~—8. Right to a timely referral and access to medically indicated specialty care; and~~

15 ~~—9. Right to access the enrollee's medical records in accordance with federal and state~~  
16 ~~law; and~~

17 ~~—(b) Regarding the responsibilities of enrollees that include the responsibility to:~~

18 ~~—1. Become informed about:~~

19 ~~—a. Enrollee rights specified in paragraph (a) of this subsection; and~~

20 ~~—b. Service and treatment options;~~

21 ~~—2. Abide by the MCO's and department's policies and procedures;~~

22 ~~—3. Actively participate in personal health and care decisions;~~

23 ~~—4. Report suspected fraud or abuse; and~~

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

2 —~~(2) The information specified in subsection (1) of this section shall meet the infor-~~  
3 ~~mation requirements established in 42 C.F.R. 438.10.~~

4 —~~Section 5. Enrollee Grievance System. (1) An MCO shall have an internal grievance~~  
5 ~~system in place that allows an enrollee or a provider on behalf of an enrollee to chal-~~  
6 ~~lenge a denial of coverage of, or payment for, a service in accordance with 42 C.F.R.~~  
7 ~~438.400 through 438.424 and 42 U.S.C. 1396u-2(b)(4).~~

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

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

12 —~~(a) Grievance or an appeal with the MCO; or~~

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

14 —~~(4) A legal guardian of an enrollee who is a minor or an incapacitated adult, a repre-~~  
15 ~~sentative of an enrollee as designated in writing to an MCO, or a provider acting on be-~~  
16 ~~half of an enrollee and with the enrollee's written consent shall have the right to file a~~  
17 ~~grievance on behalf of the enrollee.~~

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

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

23 —~~(7) An investigation and final resolution of a grievance shall:~~

- 1 ~~—(a) Be completed within thirty (30) calendar days of the date the grievance is received~~  
2 ~~by the MCO; and~~
- 3 ~~—(b) Include a resolution letter to the enrollee that shall include:~~
- 4 ~~—1. All information considered in investigating the grievance;~~  
5 ~~—2. Findings and conclusions based on the investigation; and~~  
6 ~~—3. The disposition of the grievance.~~
- 7 ~~—(8) An enrollee shall have thirty (30) calendar days from the date of receiving a notice~~  
8 ~~of adverse action from an MCO to file an appeal either orally or in writing with the MCO.~~
- 9 ~~—(9) A legal guardian of an enrollee who is a minor or an incapacitated adult, a repre-~~  
10 ~~sentative of the enrollee as designated in writing to an MCO, or a provider acting on be-~~  
11 ~~half of an enrollee with the enrollee's written consent shall have the right to file an ap-~~  
12 ~~peal of an adverse action on behalf of the enrollee.~~
- 13 ~~—(10) An MCO shall resolve an appeal within thirty (30) calendar days from the date~~  
14 ~~the initial oral or written appeal is received by the MCO.~~
- 15 ~~—(11) An MCO shall have a process in place that ensures that an oral or written inquiry~~  
16 ~~from an enrollee seeking to appeal an adverse action is treated as an appeal to estab-~~  
17 ~~lish the earliest possible filing date for the appeal.~~
- 18 ~~—(12) An oral appeal shall be followed by a written appeal that is signed by the enrol-~~  
19 ~~lee within ten (10) calendar days.~~
- 20 ~~—(13) Within five (5) working days of receipt of an appeal, an MCO shall provide the~~  
21 ~~enrollee with written notice that the appeal has been received and the expected date of~~  
22 ~~its resolution, unless an expedited resolution has been requested.~~
- 23 ~~—(14) An MCO shall extend the thirty (30) day timeframe for resolution of an appeal es-~~

1 ~~established in subsection (10) of this section by fourteen (14) calendar days if:~~

2 ~~—(a) The enrollee requests the extension; or~~

3 ~~—(b)1. The MCO demonstrates to the department that there is need for additional in-~~

4 ~~formation; and~~

5 ~~—2. The extension is in the enrollee's interest.~~

6 ~~—(15) For an extension requested by an MCO, the MCO shall give the enrollee written~~

7 ~~notice of the extension and the reason for the extension within two (2) working days of~~

8 ~~the decision to extend.~~

9 ~~—(16) For an appeal, an MCO shall provide written notice of its decision within thirty~~

10 ~~(30) calendar days to an enrollee or a provider, if the provider filed the appeal. The pro-~~

11 ~~vider shall:~~

12 ~~—(a) Give a copy of the notice to the enrollee; or~~

13 ~~—(b) Inform the enrollee of the provisions of the notice.~~

14 ~~—(17) An MCO shall:~~

15 ~~—(a) Continue to provide benefits to an enrollee, if the enrollee requested a continua-~~

16 ~~tion of benefits, until one of the following occurs:~~

17 ~~—1. The enrollee withdraws the appeal;~~

18 ~~—2. Fourteen (14) days have passed since the date of the resolution letter, if the reso-~~

19 ~~lution of the appeal was against the enrollee and the enrollee has not requested a state~~

20 ~~fair hearing or taken any further action; or~~

21 ~~—3. A state fair hearing decision adverse to the enrollee has been issued;~~

22 ~~—(b) Have an expedited review process for appeals if the MCO determines that allow-~~

23 ~~ing the time for a standard resolution could seriously jeopardize an enrollee's life or~~

1 health or ability to attain, maintain, or regain maximum function;

2 ~~—(c) Resolve an expedited appeal within three (3) working days of receipt of the re-~~

3 ~~quest; and~~

4 ~~—(d) Extend the timeframe for an expedited appeal established in paragraph (c) of this~~

5 ~~subsection by up to fourteen (14) calendar days if:~~

6 ~~—1. The enrollee requests the extension; or~~

7 ~~—2.a. The MCO demonstrates to the department that there is need for additional infor-~~

8 ~~mation; and~~

9 ~~—b. The extension is in the enrollee's interest.~~

10 ~~—(18) For an extension requested by an MCO, the MCO shall give the enrollee written~~

11 ~~notice of the reason for the extension.~~

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

13 ~~—(a) Transfer the appeal to the thirty (30) day timeframe for a standard resolution, in~~

14 ~~which the thirty (30) day period shall begin on the date the MCO received the original~~

15 ~~request for appeal;~~

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

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

18 ~~—(20) An MCO shall document in writing an oral request for an expedited resolution~~

19 ~~and shall maintain the documentation in the enrollee case file.~~

20 ~~—(21) The department shall provide an enrollee with a hearing process that shall ad-~~

21 ~~here to 907 KAR 1:563, 42 C.F.R. 438 Subpart F and 42 C.F.R. 431 Subpart E.~~

22 ~~—(22) An enrollee shall be able to request a state fair hearing if dissatisfied with an ad-~~

23 ~~verse action that has been taken by an MCO:~~

- 1 ~~—(a) Within thirty (30) days of receiving notice of an adverse action; or~~
- 2 ~~—(b) Within thirty (30) days of the final decision of an MCO to an appeal filed by the en-~~
- 3 ~~rollee.~~
- 4 ~~—(23) A document supporting an MCO's adverse action shall be:~~
- 5 ~~—(a) Received by the department no later than five (5) days from the date the MCO~~
- 6 ~~receives a notice from the department that a request for a state fair hearing has been~~
- 7 ~~filed by an enrollee; and~~
- 8 ~~—(b) Made available to an enrollee upon request by either the enrollee or the enrollee's~~
- 9 ~~legal counsel.~~
- 10 ~~—(24) An automatic ruling shall be made by the department in favor of an enrollee if an~~
- 11 ~~MCO fails to:~~
- 12 ~~—(a) Comply with the state fair hearing requirements established by the state and fed-~~
- 13 ~~eral Medicaid law; or~~
- 14 ~~—(b) Appear in person and present evidence at the state fair hearing.~~
- 15 ~~—(25) An MCO shall:~~
- 16 ~~—(a) Provide information specified in 42 C.F.R. 438.10(g)(1) about the grievance sys-~~
- 17 ~~tem to a service provider and a subcontractor at the time they enter into a contract;~~
- 18 ~~—(b) Maintain a grievance or an appeal file in a secure and designated area;~~
- 19 ~~—(c) Make a grievance or an appeal file accessible to the department or its designee~~
- 20 ~~upon request;~~
- 21 ~~—(d) Retain a grievance or an appeal file for ten (10) years following a final decision by~~
- 22 ~~the MCO, the department, an administrative law judge, judicial appeal, or closure of a~~
- 23 ~~file, whichever occurs later;~~

- 1 — ~~(e) Have procedures for assuring that a grievance or an appeal file contains:~~
- 2 — ~~1. Information to identify the grievance or appeal;~~
- 3 — ~~2. The date a grievance or appeal was received;~~
- 4 — ~~3. The nature of the grievance or appeal;~~
- 5 — ~~4. A notice to the enrollee of receipt of the grievance or appeal;~~
- 6 — ~~5. Correspondence between the MCO and the enrollee;~~
- 7 — ~~6. The date the grievance or appeal is resolved;~~
- 8 — ~~7. The decision made by the MCO of the grievance or appeal;~~
- 9 — ~~8. The notice of a final decision to the enrollee; and~~
- 10 — ~~9. Information pertaining to the grievance or appeal; and~~
- 11 — ~~(f) Make available to an enrollee documentation regarding a grievance or an appeal.~~
- 12 — ~~(26) An MCO shall designate an individual to:~~
- 13 — ~~(a) Execute the policies and procedures for resolution of a grievance or appeal;~~
- 14 — ~~(b) Review patterns or trends in grievances or appeals; and~~
- 15 — ~~(c) Initiate a corrective action, if needed.~~
- 16 — ~~Section 6. Member Services. (1) An MCO shall have a member services function that~~
- 17 ~~includes a member call center and a behavioral health call center that shall:~~
- 18 — ~~(a) Be staffed Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern Time; and~~
- 19 — ~~(b) Meet the call center standards, which shall:~~
- 20 — ~~1. Be approved by the American Accreditation Health Care Commission or Utilization~~
- 21 ~~Review Accreditation Committee (URAC); and~~
- 22 — ~~2. Include provisions addressing the call center abandonment rate, blockage rate and~~
- 23 ~~average speed of answer.~~

- 1 —(2)(a) An MCO shall provide access to medical advice to an enrollee through a toll-  
2 free call-in system, available twenty-four (24) hours a day, seven (7) days a week.
- 3 —(b) The call-in system shall be staffed by medical professionals to include:
- 4 —1. Physicians;
- 5 —2. Physician assistants;
- 6 —3. Licensed practical nurses; or
- 7 —4. Registered nurses.
- 8 —(3) An MCO shall:
- 9 —(a) Provide foreign language interpreter services, free of charge, for an enrollee;
- 10 —(b) Respond to the special communication needs of the disabled, blind, deaf, or  
11 aged;
- 12 —(c) Facilitate direct access to a specialty physician for an enrollee:
- 13 —1. With a chronic or complex health condition;
- 14 —2. Who is aged, blind, deaf, or disabled; or
- 15 —3. Identified as having a special healthcare need and requiring a course of treatment  
16 or regular healthcare monitoring;
- 17 —(d) Arrange for and assist with scheduling an EPSDT service in conformance with  
18 federal law governing EPSDT;
- 19 —(e) Provide an enrollee with information or refer the enrollee to a support service;
- 20 —(f) Facilitate direct access to a covered service in accordance with Section 29(4) of  
21 this administrative regulation.
- 22 —(g) Facilitate access to a:
- 23 —1. Behavioral health service;

1    ~~—2. Pharmaceutical service; or~~

2    ~~—3. Service provided by a public health department, community mental health center,~~

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

4    ~~Special Health Care Needs, or a charitable care provider;~~

5    ~~—(h) Assist an enrollee in:~~

6    ~~—1. Scheduling an appointment with a provider;~~

7    ~~—2. Obtaining transportation for an emergency or non-emergency service;~~

8    ~~—3. Completing a health risk assessment; or~~

9    ~~—4. Accessing an MCO health education program;~~

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

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

12   ~~—Section 7. Enrollee Selection of Primary Care Provider. (1) Except for an enrollee de-~~

13   ~~scribed in subsection (2) of this section, an MCO shall have a process for enrollee se-~~

14   ~~lection and assignment of a primary care provider.~~

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

16   ~~—(a) A dual eligible;~~

17   ~~—(b) A child in foster care;~~

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

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

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

21   ~~—1. An MCO shall notify the enrollee within ten (10) days of notification of enrollment~~

22   ~~by the department of the procedure for choosing a primary care provider; and~~

23   ~~—2. If the enrollee does not choose a primary care provider, an MCO shall assign to~~

1 ~~the enrollee a primary care provider who:~~

2 ~~—a. Has historically provided services to the enrollee; and~~

3 ~~—b. Meets the requirements of subsection (6) of this section.~~

4 ~~—(b) If no primary care provider meets the requirements of paragraph (a)2 of this sub-~~

5 ~~section, an MCO shall assign the enrollee to a primary care provider who is within:~~

6 ~~—1. Thirty (30) miles or thirty (30) minutes from the enrollee’s residence or place of~~

7 ~~employment if the enrollee is in an urban area; or~~

8 ~~—2. Forty five (45) miles or forty five (45) minutes from the enrollee’s residence or~~

9 ~~place of employment if the enrollee is in a rural area.~~

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

11 ~~is not a dual eligible, an MCO shall notify the enrollee of the procedure for choosing a~~

12 ~~primary care provider.~~

13 ~~—(b) If an enrollee has not chosen a primary care provider within thirty (30) days, an~~

14 ~~MCO shall send a second notice to the enrollee.~~

15 ~~—(c) If an enrollee has not chosen a primary care provider within thirty (30) days of the~~

16 ~~second notice, the MCO shall send a third notice to the enrollee.~~

17 ~~—(d) If an enrollee has not chosen a primary care provider after the third notice, the~~

18 ~~MCO shall assign a primary care provider.~~

19 ~~—(e) Except for an enrollee who was previously enrolled with the MCO, an MCO shall~~

20 ~~not automatically assign a primary care provider within ninety (90) days of the enrollee’s~~

21 ~~initial enrollment.~~

22 ~~—(5)(a) An enrollee shall be allowed to select from at least two (2) primary care provid-~~

23 ~~ers within an MCO’s provider network.~~

1 ~~—(b) At least one (1) of the two (2) primary care providers referenced in paragraph (a)~~  
2 ~~of this subsection shall be a physician.~~

3 ~~—(6) A primary care provider shall:~~

4 ~~—(a) Be a licensed or certified health care practitioner who functions within the provid-~~  
5 ~~er's scope of licensure or certification, including:~~

6 ~~—1. A physician;~~

7 ~~—2. An advanced practice registered nurse;~~

8 ~~—3. A physician assistant; or~~

9 ~~—4. A clinic, including a primary care center, federally qualified health center, or rural~~  
10 ~~health clinic;~~

11 ~~—(b) Have admitting privileges at a hospital or a formal referral agreement with a pro-~~  
12 ~~vider possessing admitting privileges;~~

13 ~~—(c) Agree to provide twenty-four (24) hours a day, seven (7) days a week primary~~  
14 ~~health care services to enrollees; and~~

15 ~~—(d) For an enrollee who has a gynecological or obstetrical health care need, a disabil-~~  
16 ~~ity, or chronic illness, be a specialist who agrees to provide or arrange for primary and~~  
17 ~~preventive care directly or through linkage with a primary care provider.~~

18 ~~—(7) Upon enrollment in an MCO, an enrollee shall have the right to change primary~~  
19 ~~care providers:~~

20 ~~—(a) Within the first ninety (90) days of assignment;~~

21 ~~—(b) Once a year regardless of reason;~~

22 ~~—(c) At any time for a reason approved by the MCO;~~

23 ~~—(d) If during a temporary loss of eligibility, an enrollee loses the opportunity provided~~

1 by paragraph (b) of this subsection;

2 —(e) If Medicare or Medicaid imposes a sanction on the PCP;

3 —(f) If the PCP is no longer in the MCO provider network; or

4 —(g) At any time with cause which shall include the enrollee:

5 —1. Receiving poor quality of care;

6 —2. Lacking access to providers qualified to treat the enrollee’s medical condition; or

7 —3. Being denied access to needed medical services.

8 —(8) A PCP shall not be able to request the reassignment of an enrollee to a different

9 PCP for the following reasons:

10 —(a) A change in the enrollee’s health status or treatment needs;

11 —(b) An enrollee’s utilization of health services;

12 —(c) An enrollee’s diminished mental capacity; or

13 —(d) Disruptive behavior of an enrollee due to the enrollee’s special health care needs

14 unless the behavior impairs the PCP’s ability to provide services to the enrollee or oth-

15 ers.

16 —(9) A PCP change request shall not be based on race, color, national origin, disabil-

17 ity, age, or gender.

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

19 change.

20 —(11) An enrollee shall be able to obtain the following services outside of an MCO’s

21 provider network:

22 —(a) A family planning service in accordance with 42 C.F.R. 431.51;

23 —(b) An emergency service in accordance with 42 C.F.R. 438.114;

1 ~~—(c) A poststabilization service in accordance with 42 C.F.R. 438.114 and 42 C.F.R.~~  
2 ~~422.113(c); or~~

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

5 ~~—(12) An MCO shall:~~

6 ~~—(a) Notify an enrollee within:~~

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

9 ~~—2. Fifteen (15) days of an involuntary termination of the enrollee's primary care pro-~~  
10 ~~vider; and~~

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

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

13 ~~—(a) Maintain:~~

14 ~~—1. Continuity of an enrollee's health care;~~

15 ~~—2. A current medical record for an enrollee in accordance with Section 24 of this ad-~~  
16 ~~ministrative regulation; and~~

17 ~~—3. Formalized relationships with other PCPs to refer enrollees for after hours care,~~  
18 ~~during certain days, for certain services, or other reasons to extend their practice;~~

19 ~~—(b) Refer an enrollee for specialty care or other medically necessary services, both in~~  
20 ~~and out of network, if the services are not available within the MCO's network;~~

21 ~~—(c) Discuss advance medical directives with an enrollee;~~

22 ~~—(d) Provide primary and preventive care, including EPSDT services;~~

23 ~~—(e) Refer an enrollee for a behavioral health service if clinically indicated; and~~

1 ~~—(f) Have an after-hours phone arrangement that ensures that a PCP or a designated~~  
2 ~~medical practitioner returns the call within thirty (30) minutes.~~

3 ~~—(2) An MCO shall monitor a PCP to ensure compliance with the requirements estab-~~  
4 ~~lished in this section.~~

5 ~~—Section 9. Member Handbook. (1) An MCO shall:~~

6 ~~—(a) Send a member handbook to an enrollee, by a method that shall not take more~~  
7 ~~than three (3) days to reach the enrollee, within five (5) business days of enrollment;~~

8 ~~—(b) Review the member handbook at least annually;~~

9 ~~—(c) Communicate a change to the member handbook to an enrollee in writing; and~~

10 ~~—(d) Add a revision date to the member handbook after revising the member hand-~~  
11 ~~book.~~

12 ~~—(2) A member handbook shall:~~

13 ~~—(a) Be available:~~

14 ~~—1. In hardcopy in English, Spanish, and any other language spoken by at least five~~  
15 ~~(5) percent of the potential enrollee or enrollee population; and~~

16 ~~—2. On the MCO's Web site;~~

17 ~~—(b) Be written at no higher than a sixth grade reading comprehension level; and~~

18 ~~—(c) Include at a minimum the following information:~~

19 ~~—1. The MCO's network of primary care providers, including the names, telephone~~  
20 ~~numbers, and service site addresses of available primary care providers, and, if desired~~  
21 ~~by the MCO, the names and contact information for other providers included in the~~  
22 ~~MCO's network;~~

23 ~~—2. The procedures for:~~

- 1 —a. ~~Selecting a PCP and scheduling an initial health appointment;~~
- 2 —b. ~~Obtaining:~~
  - 3 —(i) ~~Emergency or non-emergency care after hours;~~
  - 4 —(ii) ~~Transportation for emergency or non-emergency care;~~
  - 5 —(iii) ~~An EPSDT service;~~
  - 6 —(iv) ~~A covered service from an out-of-network provider; or~~
  - 7 —(v) ~~A long term care service;~~
- 8 —c. ~~Notifying DCBS of a change in family size or address, a birth, or a death of an en-~~  
9 ~~rollee;~~
- 10 —d. (i) ~~Selecting or requesting to change a PCP;~~
  - 11 —(ii) ~~A reason a request for a change may be denied by the MCO;~~
  - 12 —(iii) ~~A reason a provider may request to transfer an enrollee to a different PCP; and~~
- 13 —e. ~~Filing a grievance or appeal, including the title, address and telephone number of~~  
14 ~~the person responsible for processing and resolving a grievance or appeal;~~
- 15 —3. ~~The name of the MCO, address, and telephone number from which it conducts its~~  
16 ~~business;~~
- 17 —4. ~~The MCO's:~~
  - 18 —a. ~~Business hours; and~~
  - 19 —b. ~~Member service and toll-free medical call-in telephone numbers;~~
- 20 —5. ~~Covered services, an explanation of any service limitation or exclusion from cover-~~  
21 ~~age, and a notice stating that the MCO shall be liable only for those services authorized~~  
22 ~~by the MCO, except for the services excluded in Section 7(11) of this administrative~~  
23 ~~regulation;~~

- 1 ~~—6. Member rights and responsibilities;~~
- 2 ~~—7. For a life-threatening situation, instructions to use the emergency medical services~~
- 3 ~~available or to activate emergency medical services by dialing 911;~~
- 4 ~~—8. Information on:~~
- 5 ~~—a. The availability of maternity and family planning services, and for the prevention~~
- 6 ~~and treatment of sexually transmitted diseases;~~
- 7 ~~—b. Accessing the services referenced in clause a. of this paragraph;~~
- 8 ~~—c. Accessing care before a primary care provider is assigned or chosen;~~
- 9 ~~—d. The Cabinet for Health and Family Services' independent ombudsman program;~~
- 10 ~~and~~
- 11 ~~—e. The availability of, and procedures for, obtaining:~~
- 12 ~~—(i) A behavioral health or substance abuse service;~~
- 13 ~~—(ii) A health education service; and~~
- 14 ~~—(iii) Care coordination, case management, and disease management services;~~
- 15 ~~—9. Direct access services that may be accessed without a referral; and~~
- 16 ~~—10. An enrollee's right to obtain a second opinion and information on obtaining a se-~~
- 17 ~~cond opinion; and~~
- 18 ~~—(c) Meet the information requirements established in Section 12 of this administrative~~
- 19 ~~regulation.~~
- 20 ~~—(3) Changes to the member handbook shall be approved by the department prior to~~
- 21 ~~the publication of the handbook.~~
- 22 ~~—Section 10. Member Education and Outreach. (1) An MCO shall:~~
- 23 ~~—(a) Have an enrollee and community education and outreach program throughout the~~

1 MCO's service area;

2 —(b) Submit an annual outreach plan to the department for approval;

3 —(c) Assess the homeless population within its service area by implementing and  
4 maintaining an outreach plan for homeless individuals, including victims of domestic vio-  
5 lence; and

6 —(d) Not differentiate between a service provided to an enrollee who is homeless and  
7 an enrollee who is not homeless.

8 —(2) An MCO's outreach plan shall include:

9 —(a) Utilizing existing community resources including shelters and clinics; and  
10 —(b) Face-to-face encounters.

11 —Section 11. Enrollee Non-Liability for Payment. (1) Except as specified in Section 58  
12 of this administrative regulation, an enrollee shall not be required to pay for a medically  
13 necessary covered service provided by the enrollee's MCO.

14 —(2) An MCO shall not impose cost sharing on an enrollee greater than the limits es-  
15 tablished by the department in 907 KAR 1:604.

16 —(3) If an enrollee agrees, in advance and in writing, to pay for a non-Medicaid cov-  
17 ered service, the provider of the service shall be authorized to bill the enrollee for the  
18 service.

19 —Section 12. Provision of Information Requirements. (1) An MCO shall:

20 —(a) Comply with the requirements established in 42 U.S.C. 1396u-2(a)(5) and 42  
21 C.F.R. 438.10; and

22 —(b) Provide translation services to an enrollee on site or via telephone.

23 —(2) Written material provided by an MCO to an enrollee or potential enrollee shall:

- 1 —(a) ~~Be written at a sixth grade reading comprehension level;~~
- 2 —(b) ~~Be published in at least a twelve (12) point font;~~
- 3 —(c) ~~Comply with the requirements established in 42 U.S.C. Chapter 126, the Ameri-~~  
4 ~~cans with Disabilities Act;~~
- 5 —(d) ~~Be updated as necessary to maintain accuracy;~~
- 6 —(e) ~~Be available in Braille or in an audio format for an individual who is partially blind~~  
7 ~~or blind; and~~
- 8 —(f) ~~Be provided and printed in each language spoken by five (5) percent or more of~~  
9 ~~the enrollees in each county.~~
- 10 —(3) ~~All written material intended for an enrollee, unless unique to an individual enrol-~~  
11 ~~lee 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 the provider's 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;~~

- 1 —~~3. Medicaid policies and procedures;~~
- 2 —~~4. MCO policies and procedures; and~~
- 3 —~~5. Fraud, waste, and abuse;~~
- 4 —~~(g) Assisting in coordinating care for a child or adult with a complex or chronic condi-~~
- 5 ~~tion;~~
- 6 —~~(h) Assisting a provider with enrolling in the Vaccines for Children Program in ac-~~
- 7 ~~cordance with 907 KAR 1:680; and~~
- 8 —~~(i) Providing technical support to a provider regarding the provision of a service.~~
- 9 —~~(2) An MCO's provider services staff shall:~~
- 10 —~~(a) Be available at a minimum Monday through Friday from 8:00 a.m. to 6:00 p.m.~~
- 11 ~~Eastern Time; and~~
- 12 —~~(b) Operate a provider call center.~~
- 13 —~~Section 14. Provider Network. (1) An MCO shall:~~
- 14 —~~(a) Enroll providers of sufficient types, numbers, and specialties in its network to sat-~~
- 15 ~~isfy the:~~
- 16 —~~1. Access and capacity requirements established in Section 15 of this administrative~~
- 17 ~~regulation; and~~
- 18 —~~2. Quality requirements established in Section 48 of this administrative regulation;~~
- 19 —~~(b) Attempt to enroll the following providers in its network:~~
- 20 —~~1. A teaching hospital;~~
- 21 —~~2. A rural health clinic;~~
- 22 —~~3. The Kentucky Commission for Children with Special Health Care Needs;~~
- 23 —~~4. A local health department; and~~

1 —5. A community mental health center;

2 —(c) Demonstrate to the department the extent to which it has enrolled providers in its  
3 network who have traditionally provided services to Medicaid recipients;

4 —(d) Have at least one (1) FQHC in a region where the MCO operates in accordance  
5 with Section 28 of this administrative regulation, if there is an FQHC that is licensed to  
6 provide services in the region; and

7 —(e) Exclude, terminate, or suspend from its network a provider or subcontractor who  
8 engages in an activity that results in suspension, termination, or exclusion from the  
9 Medicare or a Medicaid program.

10 —(2) The length of an exclusion, termination, or suspension referenced in subsection  
11 (1)(e) of this section shall equal the length of the exclusion, termination, or suspension  
12 imposed by the Medicare or a Medicaid program.

13 —(3) If an MCO is unable to enroll a provider specified in subsection (1)(b) or (c) of this  
14 section, the MCO shall submit to the department for approval, documentation which  
15 supports the MCO's conclusion that adequate services and service sites as required in  
16 Section 15 of this administrative regulation shall be provided without enrolling the speci-  
17 fied provider.

18 —(4) If an MCO determines that its provider network is inadequate to comply with the  
19 access standards established in Section 15 of this administrative regulation, the MCO  
20 shall:

21 —(a) Notify the department; and

22 —(b) Submit a corrective action plan to the department.

23 —(5) A corrective action plan referenced in subsection (4)(b) of this section shall:

1 ~~—(a) Describe the deficiency in detail; and~~  
2 ~~—(b) Identify a specific action to be taken by the MCO to correct the deficiency, includ-~~  
3 ~~ing a time frame.~~  
4 ~~—Section 15. Provider Access Requirements. (1) The access standards requirements~~  
5 ~~established in 42 C.F.R. 438.206 through 438.210 shall apply to an MCO.~~  
6 ~~—(2) An MCO shall make available and accessible to an enrollee:~~  
7 ~~—(a) Facilities, service locations, and personnel sufficient to provide covered services~~  
8 ~~consistent with the requirements specified in this section;~~  
9 ~~—(b) Emergency medical services twenty-four (24) hours a day, seven (7) days a~~  
10 ~~week; and~~  
11 ~~—(c) Urgent care services within 48 hours of request.~~  
12 ~~—(3)(a) An MCO's primary care provider delivery site shall be no more than:~~  
13 ~~—1. Thirty (30) miles or thirty (30) minutes from an enrollee's residence or place of em-~~  
14 ~~ployment in an urban area; or~~  
15 ~~—2. Forty-five (45) miles or forty-five (45) minutes from an enrollee's residence or place~~  
16 ~~of employment in a non-urban area.~~  
17 ~~—(b) An MCO's primary care provider shall not have an enrollee to primary care pro-~~  
18 ~~vider ratio greater than 1,500:1.~~  
19 ~~—(c) An appointment wait time at an MCO's primary care delivery site shall not exceed:~~  
20 ~~—1. Thirty (30) days from the date of an enrollee's request for a routine or preventive~~  
21 ~~service; or~~  
22 ~~—2. Forty-eight (48) hours from an enrollee's request for urgent care.~~  
23 ~~—(4)(a) An appointment wait time for a specialist, except for a specialist providing a~~

1 ~~behavioral health service as provided in paragraph (b) of this subsection, shall not ex-~~  
2 ~~ceed:~~

3 ~~—1. Thirty (30) days from the referral for routine care; or~~  
4 ~~—2. Forty-eight (48) hours from the referral for urgent care.~~

5 ~~—(b)1. A behavioral health service requiring crisis stabilization shall be provided within~~  
6 ~~twenty-four (24) hours of the referral.~~

7 ~~—2. Behavioral health urgent care shall be provided within forty-eight (48) hours of the~~  
8 ~~referral.~~

9 ~~—3. A behavioral health service appointment following a discharge from an acute psy-~~  
10 ~~chiatric hospital shall occur within fourteen (14) days of discharge.~~

11 ~~—4. A behavioral health service appointment not included in subparagraph 1, 2, or 3 of~~  
12 ~~this paragraph shall occur within sixty (60) days of the referral.~~

13 ~~—(5) An MCO shall have:~~

14 ~~—1. Specialists available for the subpopulations designated in Section 30 of this admin-~~  
15 ~~istrative regulation; and~~

16 ~~—2. Sufficient pediatric specialists to meet the needs of enrollees who are less than~~  
17 ~~twenty-one (21) years of age.~~

18 ~~—(6) An emergency service shall be provided at a health care facility most suitable for~~  
19 ~~the type of injury, illness, or condition, whether or not the facility is in the MCO network.~~

20 ~~—(7)(a) Except as provided in paragraph (b) of this subsection, an enrollee's transport~~  
21 ~~time to a hospital shall not exceed thirty (30) minutes from an enrollee's residence.~~

22 ~~—(b) Transport time to a hospital shall not exceed sixty (60) minutes from an enrollee's~~  
23 ~~residence:~~

1 —1. In a rural area; or  
2 —2. For a behavioral or physical rehabilitation service.  
3 —(8)(a) Transport time for a dental service shall not exceed one (1) hour from an enrol-  
4 lee's residence.  
5 —(b) A dental 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 —(9)(a) Transport time to a general vision, laboratory, or radiological service shall not  
9 exceed one (1) hour from an enrollee's residence.  
10 —(b) A general vision, laboratory, or radiological appointment wait time shall not ex-  
11 ceed:  
12 —1. Three (3) weeks for a regular appointment; or  
13 —2. Forty-eight (48) hours for urgent care.  
14 —(10)(a) Transport time to a pharmacy service shall not exceed one (1) hour from an  
15 enrollee's residence.  
16 —(b) A pharmacy delivery site, except for a mail-order pharmacy, shall not be further  
17 than fifty (50) miles from an enrollee's residence.  
18 —(c) Transport time or distance threshold shall not apply to a mail-order pharmacy ex-  
19 cept that it shall:  
20 —1. Be physically located within the United States of America; and  
21 —2. Provide delivery to the enrollee's residence.  
22 —(11)(a) Prior authorization shall not be required for a physical emergency service or a  
23 behavioral health emergency service.

- 1 —(b) In order to be covered, an emergency service shall be:
- 2 —1. Medically necessary;
- 3 —2. Authorized after being provided if the service was not prior authorized; and
- 4 —3. Covered in accordance with Section 29(1) of this administrative regulation.
- 5 —Section 16. Provider Manual. (1) An MCO shall provide a provider manual to a pro-
- 6 vider within five (5) working days of enrollment with the MCO.
- 7 —(2) Prior to distributing a provider manual or update to a provider manual, an MCO
- 8 shall procure the department's approval of the provider manual or provider manual up-
- 9 date.
- 10 —(3) The provider manual shall be available in hard copy and on the MCO's website.
- 11 —Section 17. Provider Orientation and Education. An MCO shall:
- 12 —(1) Conduct an initial orientation for a provider within thirty (30) days of enrollment
- 13 with the MCO to include:
- 14 —(a) Medicaid coverage policies and procedures;
- 15 —(b) Reporting fraud and abuse;
- 16 —(c) Medicaid eligibility groups;
- 17 —(d) The standards for preventive health services;
- 18 —(e) The special needs of enrollees;
- 19 —(f) Advance medical directives;
- 20 —(g) EPSDT services;
- 21 —(h) Claims submission;
- 22 —(i) Care management or disease management programs available to enrollees;
- 23 —(j) Cultural sensitivity;

- 1 ~~—(k) The needs of enrollees with mental, developmental, or physical disabilities;~~
- 2 ~~—(l) The reporting of communicable diseases;~~
- 3 ~~—(m) The MCO's QAPI program as referenced in Section 48 of this administrative reg-~~
- 4 ~~ulation;~~
- 5 ~~—(n) Medical records;~~
- 6 ~~—(o) The external quality review organization; and~~
- 7 ~~—(p) The rights and responsibilities of enrollees and providers; and~~
- 8 ~~—(2) Ensure that a provider:~~
  - 9 ~~—(a) Is informed of an update on a federal, state, or contractual requirement;~~
  - 10 ~~—(b) Receives education on a finding from its QAPI program if deemed necessary by~~
  - 11 ~~the MCO or department; and~~
  - 12 ~~—(c) Makes available to the department training attendance rosters that shall be dated~~
  - 13 ~~and signed by the attendees.~~
- 14 ~~—Section 18. Provider Credentialing and Recredentialing. (1) An MCO shall:~~
  - 15 ~~—(a) Have policies and procedures that comply with 907 KAR 1:672, KRS 205.560,~~
  - 16 ~~and 42 C.F.R. 455 Subpart E, 455.400 to 455.470, regarding the credentialing and~~
  - 17 ~~credentialing of a provider;~~
  - 18 ~~—(b) Have a process for verifying a provider's credentials and malpractice insurance~~
  - 19 ~~that shall include:~~
    - 20 ~~—1. Written policies and procedures for credentialing and recredentialing of a provider;~~
    - 21 ~~—2. A governing body, or a group or individual to whom the governing body has formal-~~
    - 22 ~~ly delegated the credentialing function; and~~
    - 23 ~~—3. A review of the credentialing policies and procedures by the governing body or its~~

- 1 delegate;
- 2 ~~—(c) Have a credentialing committee that makes recommendations regarding creden-~~  
3 ~~tialing;~~
- 4 ~~—(d) If a provider requires a review by the credentialing committee, based on the~~  
5 ~~MCO's quality criteria, notify the department of the facts and outcomes of the review;~~
- 6 ~~—(e) Have written policies and procedures for:~~
- 7 ~~—1. Excluding, terminating, or suspending a provider; and~~
- 8 ~~—2. Reporting a quality deficiency that results in an exclusion, suspension, or termina-~~  
9 ~~tion of a provider;~~
- 10 ~~—(f) Document its monitoring of a provider;~~
- 11 ~~—(g) Verify a provider's qualifications through a primary source that includes:~~
- 12 ~~—1. A current valid license or certificate to practice in the Commonwealth of Kentucky;~~
- 13 ~~—2. A Drug Enforcement Administration certificate and number, if applicable;~~
- 14 ~~—3. If a provider is not board certified, proof of graduation from a medical school and~~  
15 ~~completion of a residency program;~~
- 16 ~~—4. Proof of completion of an accredited nursing, dental, physician assistant, or vision~~  
17 ~~program, if applicable;~~
- 18 ~~—5. If a provider states on an application that the provider is board certified in a spe-~~  
19 ~~cialty, a professional board certification;~~
- 20 ~~—6. A previous five (5) year work history;~~
- 21 ~~—7. A professional liability claims history;~~
- 22 ~~—8. If a provider requires access to a hospital to practice, proof that the provider has~~  
23 ~~clinical privileges and is in good standing at the hospital designated by the provider as~~

1 the primary admitting hospital;

2 —9. Malpractice insurance;

3 —10. Documentation, if applicable, of a:

4 —a. Revocation, suspension, or probation of a state license or Drug Enforcement

5 Agency certificate and number;

6 —b. Curtailment or suspension of a medical staff privilege;

7 —c. Sanction or penalty imposed by the United States Department of Health and Hu-

8 man Services or a state Medicaid agency; or

9 —d. Censure by a state or county professional association; and

10 —11. The most recent provider information available from the National Practitioner Da-

11 ta Bank;

12 —(h) Obtain access to the National Practitioner Data Bank as part of its credentialing

13 process;

14 —(i) Have:

15 —1. A process to recredential a provider at least once every three (3) years that shall

16 be in accordance with subsection (3) of this section; and

17 —2. Procedures for monitoring a provider sanction, a complaint, or a quality issue be-

18 tween a recredentialing cycle;

19 —(j) Have or obtain National Committee for Quality Assurance (NCQA) accreditation for

20 its Medicaid product line within four (4) years of implementation of this administrative

21 regulation; and

22 —(k) Continuously maintain NCQA accreditation for its Medicaid product line after ob-

23 taining the accreditation.

1 ~~—(2) If an MCO subcontracts a credentialing or recredentialing function, the MCO and~~  
2 ~~the subcontractor shall have written policies and procedures for credentialing and~~  
3 ~~recredentialing.~~

4 ~~—(3) A provider shall complete a credentialing application, in accordance with 907 KAR~~  
5 ~~1:672, that includes a statement by the provider regarding:~~

6 ~~—(a) The provider's ability to perform essential functions of a position, with or without~~  
7 ~~accommodation;~~

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

9 ~~—(c) The provider's history of a:~~

10 ~~—1. Loss of license or a felony conviction;~~

11 ~~—2. Loss or limitation of a privilege; or~~

12 ~~—3. Disciplinary action;~~

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

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

17 ~~—(f) Malpractice insurance maintained by the provider; and~~

18 ~~—(g) The correctness and completeness of the application.~~

19 ~~—(4) The department shall be responsible for credentialing and recredentialing a hospi-~~  
20 ~~tal-based provider.~~

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

22 ~~—(a) Be credentialed by the MCO in accordance with the standards established in Sec-~~  
23 ~~tion 18 of this administrative regulation; and~~

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

3 ~~—(2) An MCO shall:~~

4 ~~—(a) Not enroll a provider in its network if:~~

5 ~~—1. The provider has an active sanction imposed by the Centers for Medicare and~~  
6 ~~Medicaid Services or a state Medicaid agency;~~

7 ~~—2. A required provider license or a certification is not current;~~

8 ~~—3. Based on information or records available to the MCO:~~

9 ~~—a. The provider owes money to the Kentucky Medicaid program; or~~  
10 ~~—b. The Kentucky Office of the Attorney General has an active fraud investigation of~~  
11 ~~the provider; or~~

12 ~~—4. The provider is not credentialed;~~

13 ~~—(b) Have and maintain documentation regarding a provider's qualifications; and~~

14 ~~—(c) Make the documentation referenced in paragraph (b) of this subsection available~~  
15 ~~for review by the department.~~

16 ~~—(3)(a) A provider shall not be required to participate in Kentucky Medicaid fee-for-~~  
17 ~~service to enroll with an MCO.~~

18 ~~—(b) If a provider is not a participant in Kentucky Medicaid fee for service, the provider~~  
19 ~~shall obtain a Medicaid provider number from the department in accordance with 907~~  
20 ~~KAR 1:672.~~

21 ~~—Section 20. Provider Discrimination. An MCO shall:~~

22 ~~—(1) Comply with the antidiscrimination requirements established in:~~

23 ~~—(a) 42 U.S.C. 1396u-2(b)(7);~~

1 ~~—(b) 42 C.F.R. 438.12; and~~  
2 ~~—(c) KRS 304.17A-270; and~~  
3 ~~—(2) Provide written notice to a provider denied participation in the MCO's network~~  
4 ~~stating the reason for the denial.~~  
5 ~~—Section 21. Release for Ethical Reasons. An MCO shall:~~  
6 ~~—(1) Not require a provider to perform a treatment or procedure that is contrary to the~~  
7 ~~provider's conscience, religious beliefs, or ethical principles in accordance with 42~~  
8 ~~C.F.R. 438.102;~~  
9 ~~—(2) Not prohibit or restrict a provider from advising an enrollee about health status,~~  
10 ~~medical care, or a treatment:~~  
11 ~~—(a) Whether or not coverage is provided by the MCO; and~~  
12 ~~—(b) If the provider is acting within the lawful scope of practice; and~~  
13 ~~—(3) Have a referral process in place if a provider declines to perform a service be-~~  
14 ~~cause of an ethical reason.~~  
15 ~~—Section 22. Provider Grievances and Appeals. (1) An MCO shall have written policies~~  
16 ~~and procedures for the filing of a provider grievance or appeal.~~  
17 ~~—(2) A provider shall have the right to file:~~  
18 ~~—(a) A grievance with an MCO; or~~  
19 ~~—(b) An appeal with an MCO regarding:~~  
20 ~~—1. A provider payment issue; or~~  
21 ~~—2. A contractual issue.~~  
22 ~~—(3)(a) A provider grievance or appeal shall be resolved within thirty (30) calendar~~  
23 ~~days.~~

1 ~~—(b) If a grievance or appeal is not resolved within thirty (30) days, an MCO shall re-~~  
2 ~~quest a fourteen (14) day extension from the provider. The provider shall approve the~~  
3 ~~extension request from the MCO.~~

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

5 ~~—Section 23. Cost Reporting Information. The department shall provide to the MCO the~~  
6 ~~calculation of Medicaid allowable costs as used in the Medicaid Program.~~

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

8 ~~—(a) Require a provider to maintain an enrollee medical record on paper or in an elec-~~  
9 ~~tronic format; and~~

10 ~~—(b) Have a process to systematically review provider medical records to ensure com-~~  
11 ~~pliance with the medical records standards established in this section.~~

12 ~~—(2) An enrollee medical record shall:~~

13 ~~—(a) Be legible, current, detailed, organized, and signed by the service provider;~~

14 ~~—(b)1. Be kept for at least five (5) years from the date of service unless a federal stat-~~  
15 ~~ute or regulation requires a longer retention period; and~~

16 ~~—2. If a federal statute or regulation requires a retention period longer than five (5)~~  
17 ~~years, be kept for at least as long as the federally required retention period;~~

18 ~~—(c) Include the following minimal detail for an individual clinical encounter:~~

19 ~~—1. The history and physical examination for the presenting complaint;~~

20 ~~—2. A psychological or social factor affecting the patient's physical or behavioral health;~~

21 ~~—3. An unresolved problem, referral, or result from a diagnostic test; and~~

22 ~~—4. The plan of treatment including:~~

23 ~~—a. Medication history, medications prescribed, including the strength, amount, and di-~~

- 1 ~~rections for use and refills;~~
- 2 ~~—b. Therapy or other prescribed regimen; and~~
- 3 ~~—c. Follow-up plans, including consultation, referrals, and return appointment.~~
- 4 ~~—(3) A medical chart organization and documentation shall, at a minimum, contain the~~
- 5 ~~following:~~
- 6 ~~—(a) Enrollee identification information on each page;~~
- 7 ~~—(b) Enrollee date of birth, age, gender, marital status, race or ethnicity, mailing ad-~~
- 8 ~~dress, home and work addresses, and telephone numbers (if applicable), employer (if~~
- 9 ~~applicable), school (if applicable), name and telephone number of an emergency con-~~
- 10 ~~tact, consent form, language spoken and guardianship information (if applicable);~~
- 11 ~~—(c) Date of data entry and of the encounter;~~
- 12 ~~—(d) Provider's name;~~
- 13 ~~—(e) Any known allergies or adverse reactions of the enrollee;~~
- 14 ~~—(f) Enrollee's past medical history;~~
- 15 ~~—(g) Identification of any current problem;~~
- 16 ~~—(h) If a consultation, laboratory, or radiology report is filed in the medical record, the~~
- 17 ~~ordering provider's initials or other documentation indicating review;~~
- 18 ~~—(i) Documentation of immunizations;~~
- 19 ~~—(j) Identification and history of nicotine, alcohol use, or substance abuse;~~
- 20 ~~—(k) Documentation of notification of reportable diseases and conditions to the local~~
- 21 ~~health department serving the jurisdiction in which the enrollee resides or to the De-~~
- 22 ~~partment for Public Health pursuant to 902 KAR 2:020;~~
- 23 ~~—(l) Follow-up visits provided secondary to reports of emergency room care;~~

- 1 ~~—(m) Hospital discharge summaries;~~
- 2 ~~—(n) Advance medical directives for adults; and~~
- 3 ~~—(o) All written denials of service and the reason for each denial.~~
- 4 ~~—Section 25. Confidentiality of Medical Information. (1) An MCO shall:~~
- 5 ~~—(a) Maintain confidentiality of all enrollee eligibility information and medical records;~~
- 6 ~~—(b) Prevent unauthorized disclosure of the information referenced in this subsection~~
- 7 ~~in accordance with KRS 194A.060, KRS 214.185, KRS 434.840 to 434.860, and 42~~
- 8 ~~C.F.R. 431 Subpart F, 431.300 to 431.307;~~
- 9 ~~—(c) Have written policies and procedures for maintaining the confidentiality of enrollee~~
- 10 ~~records;~~
- 11 ~~—(d) Comply with 42 U.S.C. 1320d-2, the Health Insurance Portability and Accountabil-~~
- 12 ~~ity Act, and 45 C.F.R. Parts 160 and 164;~~
- 13 ~~—(e) On behalf of its employees and agents:~~
- 14 ~~—1. Sign a confidentiality agreement attesting that it will comply with the confidentiality~~
- 15 ~~requirements established in this section; and~~
- 16 ~~—2. Submit the confidentiality agreement referenced in subparagraph 1. of this para-~~
- 17 ~~graph to the department;~~
- 18 ~~—(f) Limit access to medical information to a person or agency which requires the in-~~
- 19 ~~formation in order to perform a duty related to the department's administration of the~~
- 20 ~~Medicaid program, including the department, the United States Department of Health~~
- 21 ~~and Human Services, the United States Attorney General, the CHFS OIG, the Kentucky~~
- 22 ~~Attorney General, or other agency required by the department; and~~
- 23 ~~—(g) Submit a request for disclosure of information referenced in this subsection which~~

1 ~~has been received by the MCO to the department within twenty-four (24) hours.~~

2 ~~—(2) Information referenced in subsection (1)(g) of this section shall not be disclosed~~  
3 ~~by an MCO pursuant to the request without prior written authorization from the depart-~~  
4 ~~ment.~~

5 ~~—Section 26. Americans with Disabilities Act and Cabinet Ombudsman. (1) An MCO~~  
6 ~~shall:~~

7 ~~—(a) Require by contract with its network providers and subcontractors that a service~~  
8 ~~location meets:~~

9 ~~—1. The requirements established in 42 U.S.C. Chapter 126, the Americans with Disa-~~  
10 ~~bilities Act; and~~

11 ~~—2. All local requirements which apply to health facilities pertaining to adequate space,~~  
12 ~~supplies, sanitation, and fire and safety procedures;~~

13 ~~—(b) Fully cooperate with the Cabinet for Health and Family Services independent om-~~  
14 ~~budsman; and~~

15 ~~—(c) Provide immediate access, to the Cabinet for Health and Family Services inde-~~  
16 ~~pendent ombudsman, to an enrollee's records if the enrollee has given consent.~~

17 ~~—(2) An MCO's member handbook shall contain information regarding the Cabinet for~~  
18 ~~Health and Family Services independent ombudsman program.~~

19 ~~—Section 27. Marketing. (1) An MCO shall:~~

20 ~~—(a) Comply with the requirements established in 42 C.F.R. 438.104 regarding market-~~  
21 ~~ing activities;~~

22 ~~—(b) Have a system of control over the content, form, and method of dissemination of~~  
23 ~~its marketing and information materials;~~

- 1 ~~—(c) Submit a marketing plan and marketing materials to the department for written~~  
2 ~~approval prior to implementation or distribution;~~
- 3 ~~—(d) If conducting mass media marketing, direct the marketing activities to enrollees in~~  
4 ~~the entire service area pursuant to the marketing plan;~~
- 5 ~~—(e) Not conduct face-to-face marketing;~~
- 6 ~~—(f) Not use fraudulent, misleading, or misrepresentative information in its marketing~~  
7 ~~materials;~~
- 8 ~~—(g) Not offer material or financial gain to a:~~
- 9 ~~—1. Potential enrollee as an inducement to select a particular provider or use a prod-~~  
10 ~~uct; or~~
- 11 ~~—2. Person for the purpose of soliciting, referring, or otherwise facilitating the enroll-~~  
12 ~~ment of an enrollee;~~
- 13 ~~—(h) Not conduct:~~
- 14 ~~—1. Direct telephone marketing to enrollees or potential enrollees who do not reside in~~  
15 ~~the MCO service area; or~~
- 16 ~~—2. Direct or indirect door-to-door, telephone, or other cold-call marketing activity; and~~
- 17 ~~—(i) Not include in its marketing materials an assertion or statement that CMS, the fed-~~  
18 ~~eral government, the Commonwealth, or another entity endorses the MCO.~~
- 19 ~~—(2) An MCO's marketing material shall meet the information requirements established~~  
20 ~~in Section 12 of this administrative regulation.~~
- 21 ~~—Section 28. MCO Service Areas. (1)(a) An MCO's service areas shall include regions~~  
22 ~~one (1), two (2), four (4), five (5), six (6), seven (7), and eight (8).~~
- 23 ~~—(b) An MCO's service areas shall not include region three (3).~~

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

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

5 —(a) Ballard;

6 —(b) Caldwell;

7 —(c) Calloway;

8 —(d) Carlisle;

9 —(e) Crittenden;

10 —(f) Fulton;

11 —(g) Graves;

12 —(h) Hickman;

13 —(i) Livingston;

14 —(j) Lyon;

15 —(k) Marshall; and

16 —(l) McCracken.

17 —(4) Region two (2) shall include the following counties:

18 —(a) Christian;

19 —(b) Daviess;

20 —(c) Hancock;

21 —(d) Henderson;

22 —(e) Hopkins;

23 —(f) McLean;

- 1    ~~—(g) Muhlenberg;~~
- 2    ~~—(h) Ohio;~~
- 3    ~~—(i) Trigg;~~
- 4    ~~—(j) Todd;~~
- 5    ~~—(k) Union; and~~
- 6    ~~—(l) Webster.~~
- 7    ~~—(5) Region three (3) shall include the following counties:~~
- 8    ~~—(a) Breckenridge;~~
- 9    ~~—(b) Bullitt;~~
- 10   ~~—(c) Carroll;~~
- 11   ~~—(d) Grayson;~~
- 12   ~~—(e) Hardin;~~
- 13   ~~—(f) Henry;~~
- 14   ~~—(g) Jefferson;~~
- 15   ~~—(h) Larue;~~
- 16   ~~—(i) Marion;~~
- 17   ~~—(j) Meade;~~
- 18   ~~—(k) Nelson;~~
- 19   ~~—(l) Oldham;~~
- 20   ~~—(m) Shelby;~~
- 21   ~~—(n) Spencer;~~
- 22   ~~—(o) Trimble; and~~
- 23   ~~—(p) Washington.~~

1 —~~(6) Region four (4) shall include the following counties:~~

2 —~~(a) Adair;~~

3 —~~(b) Allen;~~

4 —~~(c) Barren;~~

5 —~~(d) Butler;~~

6 —~~(e) Casey;~~

7 —~~(f) Clinton;~~

8 —~~(g) Cumberland;~~

9 —~~(h) Edmonson;~~

10 —~~(i) Green;~~

11 —~~(j) Hart;~~

12 —~~(k) Logan;~~

13 —~~(l) McCreary;~~

14 —~~(m) Metcalfe;~~

15 —~~(n) Monroe;~~

16 —~~(o) Pulaski;~~

17 —~~(p) Russell;~~

18 —~~(q) Simpson;~~

19 —~~(r) Taylor;~~

20 —~~(s) Warren; and~~

21 —~~(t) Wayne.~~

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

23 —~~(a) Anderson;~~

- 1    ~~—(b) Bourbon;~~
- 2    ~~—(c) Boyle;~~
- 3    ~~—(d) Clark;~~
- 4    ~~—(e) Estill;~~
- 5    ~~—(f) Fayette;~~
- 6    ~~—(g) Franklin;~~
- 7    ~~—(h) Garrard;~~
- 8    ~~—(i) Harrison;~~
- 9    ~~—(j) Jackson;~~
- 10   ~~—(k) Jessamine;~~
- 11   ~~—(l) Lincoln;~~
- 12   ~~—(m) Madison;~~
- 13   ~~—(n) Mercer;~~
- 14   ~~—(o) Montgomery;~~
- 15   ~~—(p) Nicholas;~~
- 16   ~~—(q) Owen;~~
- 17   ~~—(r) Powell;~~
- 18   ~~—(s) Rockcastle;~~
- 19   ~~—(t) Scott; and~~
- 20   ~~—(u) Woodford.~~
- 21   ~~—(8) Region six (6) shall include the following counties:~~
- 22   ~~—(a) Boone;~~
- 23   ~~—(b) Campbell;~~

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

- 1    ~~—(d) Floyd;~~
- 2    ~~—(e) Harlan;~~
- 3    ~~—(f) Johnson;~~
- 4    ~~—(g) Knott;~~
- 5    ~~—(h) Knox;~~
- 6    ~~—(i) Laurel;~~
- 7    ~~—(j) Lee;~~
- 8    ~~—(k) Leslie;~~
- 9    ~~—(l) Letcher;~~
- 10   ~~—(m) Magoffin;~~
- 11   ~~—(n) Martin;~~
- 12   ~~—(o) Owsley;~~
- 13   ~~—(p) Perry;~~
- 14   ~~—(q) Pike;~~
- 15   ~~—(r) Wolfe; and~~
- 16   ~~—(s) Whitley.~~

17   ~~—Section 29. Covered Services. (1) Except as established in subsection (2) of this sec-~~  
18   ~~tion, an MCO shall be responsible for the provision and costs of a covered health ser-~~  
19   ~~vice:~~

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

21   ~~—(b) In the amount, duration, and scope that the services are covered for recipients~~  
22   ~~pursuant to the department's administrative regulations located in Title 907 of the Ken-~~  
23   ~~tucky Administrative Regulations; and~~

- 1 ~~—(c) Beginning on the date of enrollment of a recipient into the MCO.~~
- 2 ~~—(2) Other than a nursing facility cost referenced in subsection (3)(i) of this section, an~~  
3 ~~MCO shall be responsible for the cost of a non-nursing facility covered service provided~~  
4 ~~to an enrollee during the first thirty (30) days of a nursing facility admission in accord-~~  
5 ~~ance with this administrative regulation.~~
- 6 ~~—(3) An MCO shall not be responsible for the provision or costs of the following:~~
- 7 ~~—(a) A service provided to a recipient in an intermediate care facility for individuals with~~  
8 ~~mental retardation or a developmental disability;~~
- 9 ~~—(b) A service provided to a recipient in a 1915(c) home and community based waiver~~  
10 ~~program;~~
- 11 ~~—(c) A hospice service provided to a recipient in an institution;~~
- 12 ~~—(d) A nonemergency transportation service provided in accordance with 907 KAR~~  
13 ~~3:066;~~
- 14 ~~—(e) Except as established in Section 35 of this administration regulation, a school-~~  
15 ~~based health service;~~
- 16 ~~—(f) A service not covered by the Kentucky Medicaid program;~~
- 17 ~~—(g) A health access nurturing developing service pursuant to 907 KAR 3:140;~~
- 18 ~~—(h) An early intervention program service pursuant to 907 KAR 1:720; or~~
- 19 ~~—(i) A nursing facility service for an enrollee during the first thirty (30) days of a nursing~~  
20 ~~facility admission.~~
- 21 ~~—(4) The following covered services provided by an MCO shall be accessible to an en-~~  
22 ~~rollee without a referral from the enrollee's primary care provider:~~
- 23 ~~—(a) A primary care vision service;~~

- 1 ~~—(b) A primary dental or oral surgery service;~~
- 2 ~~—(c) An evaluation by an orthodontist or a prosthodontist;~~
- 3 ~~—(d) A service provided by a women’s health specialist;~~
- 4 ~~—(e) A family planning service;~~
- 5 ~~—(f) An emergency service;~~
- 6 ~~—(g) Maternity care for an enrollee under age eighteen (18);~~
- 7 ~~—(h) An immunization for an enrollee under twenty-one (21);~~
- 8 ~~—(i) A screening, evaluation, or treatment service for a sexually transmitted disease or~~
- 9 ~~tuberculosis;~~
- 10 ~~—(j) Testing for HIV, HIV-related condition, or other communicable disease; and~~
- 11 ~~—(k) A chiropractic service.~~
- 12 ~~—(5) An MCO shall:~~
- 13 ~~—(a) Not require the use of a network provider for a family planning service;~~
- 14 ~~—(b) In accordance with 42 C.F.R. 431.51(b), reimburse for a family planning service~~
- 15 ~~provided within or outside of the MCO’s provider network;~~
- 16 ~~—(c) Cover an emergency service:~~
- 17 ~~—1. In accordance with 42 U.S.C. 1396u-2(b)(2)(A)(i);~~
- 18 ~~—2. Provided within or outside of the MCO’s provider network; or~~
- 19 ~~—3. Out-of-state in accordance with 42 C.F.R. 431.52;~~
- 20 ~~—(d) Comply with 42 U.S.C. 1396u-2(b)(A)(ii); and~~
- 21 ~~—(e) Be responsible for the provision and costs of a covered service as described in~~
- 22 ~~this section beginning on or after the beginning date of enrollment of a recipient with an~~
- 23 ~~MCO as established in Section 2 of this administrative regulation.~~

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

6 —(b) An MCO shall comply with paragraph (a) of this subsection without impeding ser-  
7 vice delivery or jeopardizing the enrollee's health.

8 —Section 30. Enrollees with Special Health Care Needs. (1) In accordance with 42  
9 C.F.R. 438.208:

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

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

12 —2. A homeless individual;

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

14 —4. A blind or disabled child;

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

16 —6. An adult who is a ward of the Commonwealth in accordance with 910 KAR Chap-  
17 ter 2; and

18 —(b) An MCO shall:

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

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

23 —3. Include the use of appropriate health care professionals to perform an assess-

1 ment; and

2 ~~—4. Have a treatment plan for an enrollee with a special health care need who has~~

3 ~~been determined, through an assessment, to need a course of treatment or regular care~~

4 ~~monitoring.~~

5 ~~—(2) A treatment plan referenced in subsection (1)(b)4 of this section shall be devel-~~

6 ~~oped:~~

7 ~~—(a) With participation from the enrollee or the enrollee's legal guardian as referenced~~

8 ~~in Section 43 of this administrative regulation; and~~

9 ~~—(b) By the enrollee's primary care provider, if the enrollee has a primary care provid-~~

10 ~~er.~~

11 ~~—(3) An MCO shall:~~

12 ~~—(a)1. Develop materials specific to the needs of an enrollee with a special health care~~

13 ~~need; and~~

14 ~~—2. Provide the materials referenced in subparagraph 1. of this paragraph to the enrol-~~

15 ~~lee, caregiver, parent, or legal guardian;~~

16 ~~—(b) Have a mechanism to allow an enrollee identified as having a special health care~~

17 ~~need to directly access a specialist, as appropriate, for the enrollee's condition and~~

18 ~~identified need; and~~

19 ~~—(c) Be responsible for the ongoing care coordination for an enrollee with a special~~

20 ~~health care need.~~

21 ~~—(4) The information referenced in subsection (3)(a) of this section shall include health~~

22 ~~educational material to assist the enrollee with a special health care need or the enrol-~~

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

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

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

7 ~~—(c) The MCO shall be available to meet with DCBS at least once a month to discuss~~  
8 ~~the health care needs of the child as identified in the service plan.~~

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

12 ~~—(e) The MCO shall consult with DCBS prior to developing or modifying a case man-~~  
13 ~~agement plan of care.~~

14 ~~—(6)(a) An enrollee who is a ward of the Commonwealth shall be enrolled with an MCO~~  
15 ~~through a service plan that shall be completed for the enrollee by DAHL prior to being~~  
16 ~~enrolled with the MCO.~~

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

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

23 ~~—Section 32. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Ser-~~

1 vices. ~~(1) An MCO shall provide an enrollee under the age of twenty-one (21) years with~~  
2 ~~EPSDT services in compliance with:~~

- 3 ~~—(a) 907 KAR 11:034;~~
- 4 ~~—(b) 42 U.S.C. 1396d(r); and~~
- 5 ~~—(c) The Early and Periodic Screening, Diagnosis and Treatment Program Periodicity~~  
6 ~~Schedule.~~

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

9 ~~—Section 33. Emergency Care, Urgent Care, and Poststabilization Care. (1) An MCO~~  
10 ~~shall provide to an enrollee:~~

- 11 ~~—(a) Emergency care twenty-four (24) hours a day, seven (7) days a week; and~~
- 12 ~~—(b) Urgent care within forty-eight (48) hours.~~

13 ~~—(2) Poststabilization services shall be provided and reimbursed in accordance with 42~~  
14 ~~C.F.R. 422.113(c) and 438.114(e).~~

15 ~~—Section 34. Maternity Care. An MCO shall:~~

- 16 ~~—(1) Have procedures to assure:~~
- 17 ~~—(a) Prompt initiation of prenatal care; or~~
- 18 ~~—(b) Continuation of prenatal care without interruption for a woman who is pregnant at~~  
19 ~~the time of enrollment;~~
- 20 ~~—(2) Provide maternity care that includes:~~
- 21 ~~—(a) Prenatal;~~
- 22 ~~—(b) Delivery;~~
- 23 ~~—(c) Postpartum care; and~~

1    ~~—(d) Care for a condition that complicates a pregnancy; and~~  
2    ~~—(3) Perform all the newborn screenings referenced in 902 KAR 4:030.~~  
3    ~~—Section 35. Pediatric Interface. (1) An MCO shall:~~  
4    ~~—(a) Have procedures to coordinate care for a child receiving a school-based health~~  
5    ~~service or an early intervention service; and~~  
6    ~~—(b) Monitor the continuity and coordination of care for the child receiving a service~~  
7    ~~referenced in paragraph (a) of this subsection as part of its quality assessment and per-~~  
8    ~~formance improvement (QAPI) program established in Section 48 of this administrative~~  
9    ~~regulation.~~  
10   ~~—(2) Except when a child's course of treatment is interrupted by a school break, after~~  
11   ~~school hours, or summer break, an MCO shall not be responsible for a service refer-~~  
12   ~~enced in subsection (1)(a) of this section.~~  
13   ~~—(3) A school-based health service provided by a school district shall not be covered~~  
14   ~~by an MCO.~~  
15   ~~—(4) A school-based health service provided by a local health department shall be~~  
16   ~~covered by an MCO.~~  
17   ~~—Section 36. Pediatric Sexual Abuse Examination. (1) An MCO shall enroll at least one~~  
18   ~~(1) provider in its network who has the capacity to perform a forensic pediatric sexual~~  
19   ~~abuse examination.~~  
20   ~~—(2) A forensic pediatric sexual abuse examination shall be conducted for an enrollee~~  
21   ~~at the request of the DCBS.~~  
22   ~~—Section 37. Lock-in Program. (1) An MCO shall have a program to control utilization~~  
23   ~~of:~~

- 1 —(a) ~~Drugs and other pharmacy benefits; and~~
- 2 —(b) ~~Non-emergency care provided in an emergency setting.~~
- 3 —(2) ~~The program referenced in subsection (1) of this section shall be:~~
- 4 —(a) ~~Approved by the department; and~~
- 5 —(b) ~~In accordance with 907 KAR 1:677.~~
- 6 —~~Section 38. Pharmacy Benefit Program. (1) An MCO shall:~~
- 7 —(a) ~~Have a pharmacy benefit program that shall have:~~
- 8 —1. ~~A point-of-sale claims processing service;~~
- 9 —2. ~~Prospective drug utilization review;~~
- 10 —3. ~~An accounts receivable process;~~
- 11 —4. ~~Retrospective utilization review services;~~
- 12 —5. ~~Formulary and non-formulary drugs;~~
- 13 —6. ~~A prior authorization process for drugs;~~
- 14 —7. ~~Pharmacy provider relations;~~
- 15 —8. ~~A toll-free call center that shall respond to a pharmacy or a physician prescriber~~
- 16 ~~twenty-four (24) hours a day, seven (7) days a week; and~~
- 17 —9. ~~A seamless interface with the department's management information system;~~
- 18 —(b) ~~Maintain a preferred drug list (PDL);~~
- 19 —(c) ~~Provide the following to an enrollee or a provider:~~
- 20 —1. ~~PDL information; and~~
- 21 —2. ~~Pharmacy cost sharing information; and~~
- 22 —(d) ~~Have a Pharmacy and Therapeutics Committee (P&T Committee), which shall:~~
- 23 —1. ~~Meet periodically throughout the calendar year as necessary; and~~

- 1 —2. Make recommendations to the MCO for changes to the drug formulary.
- 2 —(2)(a) The department shall comply with the drug rebate collection requirement estab-
- 3 lished in 42 U.S.C. 1396b(m)(2)(A)(xiii).
- 4 —(b) An MCO shall:
- 5 —1. Cooperate with the department in complying with 42 U.S.C. 1396b(m)(2)(A)(xiii);
- 6 —2. Assist the department in resolving a drug rebate dispute with a manufacturer; and
- 7 —3. Be responsible for drug rebate administration in a non-pharmacy setting.
- 8 —(3) An MCO's P&T committee shall meet and make recommendations to the MCO for
- 9 changes to the drug formulary.
- 10 —(4) If a prescription for an enrollee is for a non-preferred drug and the pharmacist
- 11 cannot reach the enrollee's primary care provider or the MCO for approval and the
- 12 pharmacist determines it necessary to provide the prescribed drug, the pharmacist
- 13 shall:
- 14 —(a) Provide a seventy-two (72) hour supply of the prescribed drug; or
- 15 —(b) Provide less than a seventy-two (72) hour supply of the prescribed drug, if the re-
- 16 quest is for less than a seventy-two (72) hour supply.
- 17 —(5) Cost sharing imposed by an MCO shall not exceed the cost sharing limits estab-
- 18 lished in 907 KAR 1:604.
- 19 —Section 39. MCO Interface with the Department Regarding Behavioral Health. An
- 20 MCO shall:
- 21 —(1) Meet with the department monthly to discuss:
- 22 —(a) Serious mental illness and serious emotional disturbance operating definitions;
- 23 —(b) Priority populations;

- 1 ~~—(c) Targeted case management and peer support provider certification training and~~  
2 ~~processes;~~
- 3 ~~—(d) IMPACT Plus program operations;~~
- 4 ~~—(e) Satisfaction survey requirements;~~
- 5 ~~—(f) Priority training topics;~~
- 6 ~~—(g) Behavioral health services hotline; or~~
- 7 ~~—(h) Behavioral health crisis services;~~
- 8 ~~—(2) Coordinate:~~
- 9 ~~—(a) An IMPACT Plus covered service provided to an enrollee in accordance with 907~~  
10 ~~KAR 3:030;~~
- 11 ~~—(b) With the department:~~
- 12 ~~—1. An enrollee education process for:~~
- 13 ~~—a. Individuals with a serious mental illness; and~~
- 14 ~~—b. Children or youth with a serious emotional disturbance; and~~
- 15 ~~—2. On establishing a collaborative agreement with a:~~
- 16 ~~—a. State-operated or stated-contracted psychiatric hospital; and~~
- 17 ~~—b. Facility that provides a service to an individual with a co-occurring behavioral~~  
18 ~~health and developmental and intellectual disabilities; and~~
- 19 ~~—(c) With the department and community mental health centers a process for integrat-~~  
20 ~~ing a behavioral health service hotline; and~~
- 21 ~~—(3) Provide the department with proposed materials and protocols for the enrollee~~  
22 ~~education referenced in subsection (2)(b) of this section.~~
- 23 ~~—Section 40. Behavioral Health Services. (1) An MCO shall:~~

- 1 ~~—(a) Provide a medically necessary behavioral health service to an enrollee in accord-~~  
2 ~~ance with the access standards established in Section 15 of this administrative regula-~~  
3 ~~tion;~~
- 4 ~~—(b) Use the DSM-IV multi-axial classification system to assess an enrollee for a be-~~  
5 ~~havioral service;~~
- 6 ~~—(c) Have an emergency or crisis behavioral health toll-free hotline staffed by trained~~  
7 ~~personnel twenty-four (24) hours a day, seven (7) days a week;~~
- 8 ~~—(d) Not operate one (1) hotline to handle both an emergency or crisis call and a rou-~~  
9 ~~tine enrollee call; and~~
- 10 ~~—(e) Not impose a maximum call duration limit.~~
- 11 ~~—(2) Staff of a hotline referenced in subsection (1)(c) of this section shall:~~
- 12 ~~—(a) Communicate in a culturally competent and linguistically accessible manner to an~~  
13 ~~enrollee; and~~
- 14 ~~—(b) Include or have access to a qualified behavioral health professional to assess and~~  
15 ~~triage a behavioral health emergency.~~
- 16 ~~—(3) A face-to-face emergency service shall be available:~~
- 17 ~~—(a) Twenty-four (24) hours a day; and~~
- 18 ~~—(b) Seven (7) days a week.~~
- 19 ~~—Section 41. Coordination Between a Behavioral Health Provider and a Primary Care~~  
20 ~~Provider. (1) An MCO shall:~~
- 21 ~~—(a) Require a PCP to have a screening and evaluation procedure for the detection~~  
22 ~~and treatment of, or referral for, a known or suspected behavioral health problem or dis-~~  
23 ~~order;~~

- 1 ~~—(b) Provide training to a PCP in its network on:~~
- 2 ~~—1. Screening and evaluating a behavioral health disorder;~~
- 3 ~~—2. The MCO's referral process for a behavioral health service;~~
- 4 ~~—3. Coordination requirements for a behavioral health service; and~~
- 5 ~~—4. Quality of care standards;~~
- 6 ~~—(c) Have policies and procedures that shall be approved by the department regarding~~
- 7 ~~clinical coordination between a behavioral health service provider and a PCP;~~
- 8 ~~—(d) Establish guidelines and procedures to ensure accessibility, availability, referral,~~
- 9 ~~and triage to physical and behavioral health care;~~
- 10 ~~—(e) Facilitate the exchange of information among providers to reduce inappropriate or~~
- 11 ~~excessive use of psychopharmacological medications and adverse drug reactions;~~
- 12 ~~—(f) Identify a method to evaluate continuity and coordination of care; and~~
- 13 ~~—(g) Include the monitoring and evaluation of the MCO's compliance with the require-~~
- 14 ~~ments established in paragraphs (a) to (f) of this subsection in the MCO's quality im-~~
- 15 ~~provement plan.~~
- 16 ~~—(2) With consent from an enrollee or the enrollee's legal guardian, an MCO shall re-~~
- 17 ~~quire a behavioral health service provider to:~~
- 18 ~~—(a) Refer an enrollee with a known or suspected and untreated physical health prob-~~
- 19 ~~lem or disorder to their PCP for examination and treatment; and~~
- 20 ~~—(b) Send an initial and quarterly summary report of an enrollee's behavioral health~~
- 21 ~~status to the enrollee's PCP.~~
- 22 ~~—Section 42. Court-Ordered Psychiatric Services. (1) An MCO shall:~~
- 23 ~~—(a) Provide an inpatient psychiatric service to an enrollee under the age of twenty-~~

1 ~~one (21) and over the age of sixty-five (65) who has been ordered to receive the service~~  
2 ~~by a court of competent jurisdiction under the provisions of KRS Chapters 202A and~~  
3 ~~645;~~

4 ~~—(b) Not deny, reduce, or negate the medical necessity of an inpatient psychiatric ser-~~  
5 ~~vice provided pursuant to a court-ordered commitment for an enrollee under the age of~~  
6 ~~twenty-one (21) or over the age of sixty-five (65);~~

7 ~~—(c) Coordinate with a provider of a behavioral health service the treatment objectives~~  
8 ~~and projected length of stay for an enrollee committed by a court of law to a state psy-~~  
9 ~~chiatric hospital; and~~

10 ~~—(d) Enter into a collaborative agreement with the state-operated or state-contracted~~  
11 ~~psychiatric hospital assigned to the enrollee's region in accordance with 908 KAR 3:040~~  
12 ~~and in accordance with the Olmstead decision.~~

13 ~~—(2) An MCO shall present a modification or termination of a service referenced in~~  
14 ~~subsection (1)(b) of this section to the court with jurisdiction over the matter for determi-~~  
15 ~~nation.~~

16 ~~—(3)(a) An MCO behavioral health service provider shall:~~

17 ~~—1. Participate in a quarterly continuity of care meeting with a state-operated or state-~~  
18 ~~contracted psychiatric hospital;~~

19 ~~—2. Assign a case manager prior to or on the date of discharge of an enrollee from a~~  
20 ~~state-operated or state-contracted psychiatric hospital; and~~

21 ~~—3. Provide case management services to an enrollee with a severe mental illness and~~  
22 ~~co-occurring developmental disability who is discharged from a:~~

23 ~~—a. State-operated or state-contracted psychiatric hospital; or~~

1 ~~—b. State-operated nursing facility for individuals with severe mental illness.~~  
2 ~~—(b) A case manager and a behavioral health service provider shall participate in dis-~~  
3 ~~charge planning to ensure compliance with the Olmstead decision.~~  
4 ~~—Section 43. Legal Guardians. (1) A parent, custodial parent, person exercising custo-~~  
5 ~~dial control or supervision, or an agency with a legal responsibility for a child by virtue of~~  
6 ~~a voluntary commitment or of an emergency or temporary custody order shall be author-~~  
7 ~~ized to act on behalf of an enrollee who is under the age of eighteen (18) years, a po-~~  
8 ~~tential enrollee, or a former enrollee for the purpose of:~~  
9 ~~—(a) Selecting a primary care provider;~~  
10 ~~—(b) Filing a grievance or appeal; or~~  
11 ~~—(c) Taking an action on behalf of the child regarding an interaction with an MCO.~~  
12 ~~—(2)(a) A legal guardian who has been appointed pursuant to KRS 387.500 to 387.800~~  
13 ~~shall be allowed to act on behalf of an enrollee who is a ward of the commonwealth.~~  
14 ~~—(b) A person authorized to make a health care decision pursuant to KRS 311.621 to~~  
15 ~~311.643 shall be allowed to act on behalf of an enrollee, potential enrollee, or former en-~~  
16 ~~rollee.~~  
17 ~~—(c) An enrollee shall have the right to:~~  
18 ~~—1. Represent the enrollee; or~~  
19 ~~—2. Use legal counsel, a relative, a friend, or other spokesperson.~~  
20 ~~—Section 44. Utilization Management or UM. (1) An MCO shall:~~  
21 ~~—(a) Have a utilization management program that shall:~~  
22 ~~—1. Meet the requirements established in 42 C.F.R. Parts 431, 438, and 456, and the~~  
23 ~~private review agent requirements of KRS 304.17A, as applicable;~~

- 1 —2. Identify, define, and specify the amount, duration, and scope of each service that  
2 the MCO is required to offer;
- 3 —3. Review, monitor, and evaluate the appropriateness and medical necessity of care  
4 and services;
- 5 —4. Identify and describe the UM mechanisms used to:
  - 6 —a. Detect the under or over utilization of services; and
  - 7 —b. Act after identifying under utilization or over utilization of services;
- 8 —5. Have a written UM program description in accordance with subsection (2) of this  
9 section; and
- 10 —6. Be evaluated annually by the:
  - 11 —a MCO, including an evaluation of clinical and service outcomes; and
  - 12 —b. Department;
- 13 —(b) Adopt nationally recognized standards of care and written criteria that shall be:
  - 14 —1. Based upon sound clinical evidence, if available, for making utilization decisions;  
15 and
  - 16 —2. Approved by the department;
- 17 —(c) Include physicians and other health care professionals in the MCO network in re-  
18 viewing and adopting medical necessity criteria;
- 19 —(d) Have:
  - 20 —1. A process to review, evaluate, and ensure the consistency with which physicians  
21 and other health care professionals involved in UM apply review criteria for authoriza-  
22 tion decisions;
  - 23 —2. A medical director who:

- 1 —a. Is licensed to practice medicine or osteopathy in Kentucky;
- 2 —b. Is responsible for treatment policies, protocols, and decisions; and
- 3 —c. Supervises the UM program; and
- 4 —3. Written policies and procedures that explain how prior authorization data will be in-
- 5 corporated into the MCO's Quality Improvement Plan;
- 6 —(e) Submit a request for a change in review criteria for authorization decisions to the
- 7 department for approval prior to implementation;
- 8 —(f) Administer or use a CAHPS survey to evaluate and report enrollee and provider
- 9 satisfaction with the quality of, and access to, care and services in accordance with
- 10 Section 55 of this administrative regulation;
- 11 —(g) Provide written confirmation of an approval of a request for a service within two
- 12 (2) business days of providing notification of a decision if:
- 13 —1. The initial decision was not in writing; and
- 14 —2. Requested by an enrollee or provider;
- 15 —(h) If the MCO uses a subcontractor to perform UM, require the subcontractor to have
- 16 written policies, procedures, and a process to review, evaluate, and ensure consistency
- 17 with which physicians and other health care professionals involved in UM apply review
- 18 criteria for authorization decisions; and
- 19 —(i) Not provide a financial or other type of incentive to an individual or entity that con-
- 20 ducts UM activities to deny, limit, or discontinue a medically necessary service to an en-
- 21 rollee pursuant to 42 C.F.R. 422.208, 42 C.F.R. 438.6(h), and 42 C.F.R. 438.210(e).
- 22 —(2) A UM program description referenced in subsection (1)(a)5. of this section shall:
- 23 —(a) Outline the UM program's structure;

1 ~~—(b) Define the authority and accountability for UM activities, including activities dele-~~  
2 ~~gated to another party; and~~

3 ~~—(c) Include the:~~

4 ~~—1. Scope of the program;~~

5 ~~—2. Processes and information sources used to determine service coverage, clinical~~  
6 ~~necessity, and appropriateness and effectiveness;~~

7 ~~—3. Policies and procedures to evaluate:~~

8 ~~—a. Care coordination;~~

9 ~~—b. Discharge criteria;~~

10 ~~—c. Site of services;~~

11 ~~—d. Levels of care;~~

12 ~~—e. Triage decisions; and~~

13 ~~—f. Cultural competence of care delivery; and~~

14 ~~—4. Processes to review, approve, and deny services as needed.~~

15 ~~—(3) Only a physician with clinical expertise in treating an enrollee's medical condition~~  
16 ~~or disease shall be authorized to make a decision to deny a service authorization re-~~  
17 ~~quest or authorize a service in an amount, duration, or scope that is less than requested~~  
18 ~~by the enrollee or the enrollee's treating physician.~~

19 ~~—(4) A medical necessity review process shall be in accordance with Section 45 of this~~  
20 ~~administrative regulation.~~

21 ~~—Section 45. Service Authorization and Notice. (1) For the processing of a request for~~  
22 ~~initial or continuing authorization of a service, an MCO shall identify what constitutes~~  
23 ~~medical necessity and establish a written policy and procedure, which includes a~~

1 timeframe for:

2 —(a) Making an authorization decision; and

3 —(b) If the service is denied or authorized in an amount, duration, or scope which is

4 less than requested, providing a notice to an enrollee and provider acting on behalf of

5 and with the consent of an enrollee.

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

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

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

9 —(3) The timeframe for making an authorization decision referenced in subsection (2)

10 of this section may be extended:

11 —(a) By the:

12 —1. Enrollee, or the provider acting on behalf of and with consent of an enrollee, if the

13 enrollee requests an extension; or

14 —2. MCO, if the MCO:

15 —a. Justifies to the department, upon request, a need for additional information and

16 how the extension is in the enrollee's interest;

17 —b. Gives the enrollee written notice of the extension, including the reason for extend-

18 ing the authorization decision timeframe and the right of the enrollee to file a grievance

19 if the enrollee disagrees with that decision; and

20 —c. Makes and carries out the authorization decision as expeditiously as the enrollee's

21 health condition requires and no later than the date the extension expires; and

22 —(b) Up to fourteen (14) additional calendar days.

23 —(4) If an MCO denies a service authorization or authorizes a service in an amount,

1 duration, or scope which is less than requested, the MCO shall provide a notice:

2 —(a) To the:

3 —1. Enrollee, in writing, as expeditiously as the enrollee's condition requires and within

4 two (2) business days of receipt of the request for service; and

5 —2. Requesting provider, if applicable;

6 —(b) Which shall:

7 —1. Meet the language and formatting requirements established in 42 C.F.R. 438.404;

8 —2. Include the:

9 —a. Action the MCO or its subcontractor, if applicable, has taken or intends to take;

10 —b. Reason for the action;

11 —c. Right of the enrollee or provider who is acting on behalf of the enrollee to file an

12 MCO appeal;

13 —d. Right of the enrollee to request a state fair hearing;

14 —e. Procedure for filing an appeal and requesting a state fair hearing;

15 —f. Circumstance under which an expedited resolution is available and how to request

16 it; and

17 —g. Right to have benefits continue pending resolution of the appeal, how to request

18 that benefits be continued, and the circumstance under which the enrollee may be re-

19 quired to pay the costs of these services; and

20 —3. Be provided:

21 —a. At least ten (10) days before the date of action if the action is a termination, sus-

22 pension, or reduction of a covered service authorized by the department, department

23 designee, or enrollee's MCO, except the department may shorten the period of advance

1 ~~notice to five (5) days before the date of action because of probable fraud by the enrol-~~  
2 ~~lee;~~

3 ~~—b. By the date of action for the following:~~

4 ~~—(i) The death of a member;~~

5 ~~—(ii) A signed written enrollee statement requesting service termination or giving infor-~~  
6 ~~mation requiring termination or reduction of services in which the enrollee understands~~  
7 ~~this will be the result of supplying the information;~~

8 ~~—(iii) The enrollee's address is unknown and mail directed to the enrollee has no for-~~  
9 ~~warding address;~~

10 ~~—(iv) The enrollee has been accepted for Medicaid services by another local jurisdic-~~  
11 ~~tion;~~

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

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

15 ~~—(vii) An adverse decision has been made regarding the preadmission screening re-~~  
16 ~~quirements for a nursing facility admission, pursuant to 907 KAR 1:755 and 42 U.S.C.~~  
17 ~~1396r(b)(3)(F), on or after January 1, 1989; or~~

18 ~~—(viii) The safety or health of individuals in a facility would be endangered, if the enrol-~~  
19 ~~lee's health improves sufficiently to allow a more immediate transfer or discharge, an~~  
20 ~~immediate transfer or discharge is required by the enrollee's urgent medical needs, or~~  
21 ~~an enrollee has not resided in the nursing facility for thirty (30) days;~~

22 ~~—c. On the date of action, if the action is a denial of payment;~~

23 ~~—d. As expeditiously as the enrollee's health condition requires and within two (2)~~

1 business days following receipt of a request;

2 ~~—e. When the MCO carries out its authorization decision, as expeditiously as the enrol-~~  
3 ~~lee's health condition requires and no later than the date the extension as identified in~~  
4 ~~subsection (3) of this section expires;~~

5 ~~—f. If a provider indicates or the MCO determines that following the standard timeframe~~  
6 ~~could seriously jeopardize the enrollee's life or health, or ability to attain, maintain or re-~~  
7 ~~gain maximum function, as expeditiously as the enrollee's health condition requires and~~  
8 ~~no later than two (2) business days after receipt of the request for service; and~~

9 ~~—g. For an authorization decision not made within the timeframe identified in subsec-~~  
10 ~~tion (2) of this section, on the date the timeframe expires as this shall constitute a deni-~~  
11 ~~al.~~

12 ~~—Section 46. Health Risk Assessment. An MCO shall:~~

13 ~~—(1) After the initial implementation of the MCO program, conduct an initial health risk~~  
14 ~~assessment of each enrollee within ninety (90) days of enrolling the individual if the in-~~  
15 ~~dividual has not been enrolled with the MCO in a prior twelve (12) month period;~~

16 ~~—(2) Use health care professionals in the health risk assessment process;~~

17 ~~—(3) Screen an enrollee who it believes to be pregnant within thirty (30) days of en-~~  
18 ~~rollment;~~

19 ~~—(4) If an enrollee is pregnant, refer the enrollee for prenatal care;~~

20 ~~—(5) Use a health risk assessment to determine an enrollee's need for:~~

21 ~~—(a) Care management;~~

22 ~~—(b) Disease management;~~

23 ~~—(c) A behavioral health service;~~

1 ~~—(d) A physical health service or procedure; or~~  
2 ~~—(e) A community service.~~  
3 ~~—Section 47. Care Coordination and Management. An MCO shall:~~  
4 ~~—(1) Have a care coordinator and a case manager who shall:~~  
5 ~~—(a) Arrange, assure delivery of, monitor, and evaluate care, treatment, and services~~  
6 ~~for an enrollee; and~~  
7 ~~—(b) Not duplicate or supplant services provided by a targeted case manager to:~~  
8 ~~—1. Adults with a chronic mental illness pursuant to 907 KAR 1:515; or~~  
9 ~~—2. Children with a severe emotional disability pursuant to 907 KAR 1:525;~~  
10 ~~—(2) Have guidelines for care coordination that shall be approved by the department~~  
11 ~~prior to implementation;~~  
12 ~~—(3) Develop a plan of care for an enrollee in accordance with 42 C.F.R. 438.208;~~  
13 ~~—(4) Have policies and procedures to ensure access to care coordination for a DCBS~~  
14 ~~client or a DAIL client;~~  
15 ~~—(5) Provide information on and coordinate services with the Women, Infants and~~  
16 ~~Children program; and~~  
17 ~~—(6) Provide information to an enrollee and a provider regarding:~~  
18 ~~—(a) An available care management service; and~~  
19 ~~—(b) How to obtain a care management service.~~  
20 ~~—Section 48. Quality Assessment and Performance Improvement (QAPI) Program. An~~  
21 ~~MCO shall:~~  
22 ~~—(1) Have a quality assessment and performance improvement (QAPI) program that~~  
23 ~~shall:~~

- 1 ~~—(a) Conform to the requirements of 42 C.F.R. 438 Subpart D, 438.200 to 438.242;~~
- 2 ~~—(b) Assess, monitor, evaluate, and improve the quality of care provided to an enrol-~~
- 3 ~~lee;~~
- 4 ~~—(c) Provide for the evaluation of:~~
  - 5 ~~—1. Access to care;~~
  - 6 ~~—2. Continuity of care;~~
  - 7 ~~—3. Health care outcomes; and~~
  - 8 ~~—4. Services provided or arranged for by the MCO;~~
- 9 ~~—(d) Demonstrate the linkage of Quality Improvement (QI) activities to findings from a~~
- 10 ~~quality evaluation; and~~
- 11 ~~—(e) Be developed in collaboration with input from enrollees;~~
- 12 ~~—(2) Submit annually to the department a description of its QAPI program;~~
- 13 ~~—(3) Conduct and submit to the department an annual review of the program;~~
- 14 ~~—(4) Maintain documentation of:~~
  - 15 ~~—(a) Enrollee input;~~
  - 16 ~~—(b) The MCO's response to the enrollee input;~~
  - 17 ~~—(c) A performance improvement activity; and~~
  - 18 ~~—(d) MCO feedback to an enrollee;~~
- 19 ~~—(5) Have or obtain within four (4) years of initial implementation National Committee~~
- 20 ~~for Quality Assurance (NCQA) accreditation for its Medicaid product line;~~
- 21 ~~—(6) If the MCO has obtained NCQA accreditation:~~
  - 22 ~~—(a) Submit to the department a copy of its current certificate of accreditation with a~~
  - 23 ~~copy of the complete accreditation survey report; and~~

- 1 —(b) Maintain the accreditation;
- 2 —(7) Integrate behavioral health service indicators into its QAPI program;
- 3 —(8) Include a systematic, on-going process for monitoring, evaluating, and improving
- 4 the quality and appropriateness of a behavioral health service provided to an enrollee;
- 5 —(9) Collect data, monitor, and evaluate for evidence of improvement to a physical
- 6 health outcome resulting from integration of behavioral health into an enrollee's care;
- 7 and
- 8 —(10) Annually review and evaluate the effectiveness of the QAPI program.
- 9 —Section 49. Quality Assessment and Performance Improvement Plan. (1) An MCO
- 10 shall:
- 11 —(a) Have a written QAPI work plan that:
- 12 —1. Outlines the scope of activities;
- 13 —2. Is submitted quarterly to the department; and
- 14 —3. Sets goals, objectives, and timelines for the QAPI program;
- 15 —(b) Set new goals and objectives:
- 16 —1. At least annually; and
- 17 —2. Based on a finding from:
- 18 —a. A quality improvement activity or study;
- 19 —b. A survey result;
- 20 —c. A grievance or appeal;
- 21 —d. A performance measure; or
- 22 —e. The External Quality Review Organization;
- 23 —(c) Be accountable to the department for the quality of care provided to an enrollee;

- 1 ~~—(d) Obtain approval from the department for its QAPI program and annual QAPI work~~  
2 ~~plan;~~
- 3 ~~—(e) Have an accountable entity within the MCO:~~
- 4 ~~—1. To provide direct oversight of its QAPI program; and~~
- 5 ~~—2. To review reports from the quality improvement committee referenced in para-~~  
6 ~~graph (h) of this subsection;~~
- 7 ~~—(f) Review its QAPI program annually;~~
- 8 ~~—(g) Modify its QAPI program to accommodate a review finding or concern of the MCO~~  
9 ~~if a review finding or concern occurs;~~
- 10 ~~—(h) Have a quality improvement committee that shall:~~
- 11 ~~—1. Be responsible for the QAPI program;~~
- 12 ~~—2. Be interdisciplinary;~~
- 13 ~~—3. Include:~~
- 14 ~~—a. Providers and administrative staff; and~~
- 15 ~~—b. Health professionals with knowledge of and experience with individuals with spe-~~  
16 ~~cial health care needs;~~
- 17 ~~—4. Meet on a regular basis;~~
- 18 ~~—5. Document activities of the committee;~~
- 19 ~~—6. Make committee minutes and a committee report available to the department upon~~  
20 ~~request; and~~
- 21 ~~—7. Submit a report to the accountable entity referenced in paragraph (e) of this sub-~~  
22 ~~section that shall include:~~
- 23 ~~—a. A description of the QAPI activities;~~

1 —b. Progress on objectives; and  
2 —c. Improvements made;  
3 —(i) Require a provider to participate in QAPI activities in the provider agreement or  
4 subcontract; and  
5 —(j) Provide feedback to a provider or a subcontractor regarding integration of or oper-  
6 ation of a corrective action necessary in a QAPI activity if a corrective action is neces-  
7 sary.  
8 —(2) If a QAPI activity of a provider or a subcontractor is separate from an MCO's QA-  
9 PI program, the activity shall be integrated into the MCO's QAPI program.  
10 —Section 50. QAPI Monitoring and Evaluation. (1) Through its QAPI program, an MCO  
11 shall:  
12 —(a) Monitor and evaluate the quality of health care provided to an enrollee;  
13 —(b) Study and prioritize health care needs for performance measurement, perfor-  
14 mance improvement, and development of practice guidelines;  
15 —(c) Use a standardized quality indicator:  
16 —1. To assess improvement, assure achievement of at least a minimum performance  
17 level, monitor adherence to a guideline, and identify a pattern of over and under utiliza-  
18 tion of a service; and  
19 —2. Which shall be:  
20 —a. Supported by a valid data collection and analysis method; and  
21 —b. Used to improve clinical care and services;  
22 —(d) Measure a provider performance against a practice guideline and a standard  
23 adopted by the quality improvement committee;

1 ~~—(e) Use a multidisciplinary team to analyze and address data and systems issues;~~  
2 ~~and~~  
3 ~~—(f) Have practice guidelines that shall:~~  
4 ~~—1. Be:~~  
5 ~~—a. Disseminated to a provider, or upon request, to an enrollee;~~  
6 ~~—b. Based on valid and reliable medical evidence or consensus of health profession-~~  
7 ~~als;~~  
8 ~~—c. Reviewed and updated; and~~  
9 ~~—d. Used by the MCO in making a decision regarding utilization management, a cov-~~  
10 ~~ered service, or enrollee education;~~  
11 ~~—2. Consider the needs of enrollees; and~~  
12 ~~—3. Include consultation with network providers.~~  
13 ~~—(2) If an area needing improvement is identified by the QAPI program, the MCO shall~~  
14 ~~take a corrective action and monitor the corrective action for improvement.~~  
15 ~~—Section 51. Quality and Member Access Committee. (1) An MCO shall:~~  
16 ~~—(a) Have a Quality and Member Access Committee (QMAC) composed of:~~  
17 ~~—1. Enrollees who shall be representative of the enrollee population; and~~  
18 ~~—2. Individuals from consumer advocacy groups or the community who represent the~~  
19 ~~interests of enrollees in the MCO; and~~  
20 ~~—(b) Submit to the department annually a list of enrollee representatives participating~~  
21 ~~in the QMAC.~~  
22 ~~—(2) A QMAC shall be responsible for reviewing:~~  
23 ~~—(a) Quality and access standards;~~

1 ~~—(b) The grievance and appeals process;~~  
2 ~~—(c) Policy modifications needed based on reviewing aggregate grievance and ap-~~  
3 ~~peals data;~~  
4 ~~—(d) The member handbook;~~  
5 ~~—(e) Enrollee education materials;~~  
6 ~~—(f) Community outreach activities; and~~  
7 ~~—(g) MCO and department policies that affect enrollees.~~  
8 ~~—(3) The QMAC shall provide the results of its reviews to the MCO.~~  
9 ~~—Section 52. External Quality Review. (1) In accordance with 42 U.S.C. 1396a(a)(30),~~  
10 ~~the department shall have an independent external quality review organization (EQRO)~~  
11 ~~annually review the quality of services provided by an MCO.~~  
12 ~~—(2) An MCO shall:~~  
13 ~~—(a) Provide information to the EQRO as requested to fulfill the requirements of the~~  
14 ~~mandatory and optional activities required in 42 C.F.R. Parts 433 and 438; and~~  
15 ~~—(b) Cooperate and participate in external quality review activities in accordance with~~  
16 ~~the protocol established in 42 C.F.R. 438 Subpart E, 438.310 to 438.370.~~  
17 ~~—(3) The department shall have the option of using information from a Medicare or pri-~~  
18 ~~vate accreditation review of an MCO in accordance with 42 C.F.R. 438.360.~~  
19 ~~—(4) If an adverse finding or deficiency is identified by an EQRO conducting an exter-~~  
20 ~~nal quality review, an MCO shall correct the finding or deficiency.~~  
21 ~~—Section 53. Health Care Outcomes. An MCO shall:~~  
22 ~~—(1) Comply with the requirements established in 42 C.F.R. 438.240 relating to quality~~  
23 ~~assessment and performance improvement;~~

1 ~~—(2) Collaborate with the department to establish a set of unique Kentucky Medicaid~~  
2 ~~managed care performance measures which shall:~~

3 ~~—(a) Be aligned with national and state preventive initiatives; and~~  
4 ~~—(b) Focus on improving health;~~

5 ~~—(3) In collaboration with the department and the EQRO, develop a performance~~  
6 ~~measure specific to individuals with special health care needs;~~

7 ~~—(4) Report activities on performance measures in the QAPI work plan established in~~  
8 ~~Section 49 of this administrative regulation;~~

9 ~~—(5) Submit an annual report to the department after collecting performance data~~  
10 ~~which shall be stratified by:~~

11 ~~—(a) Medicaid eligibility category;~~  
12 ~~—(b) Race;~~  
13 ~~—(c) Ethnicity;~~  
14 ~~—(d) Gender; and~~  
15 ~~—(e) Age;~~

16 ~~—(6) Collect and report HEDIS data annually; and~~  
17 ~~—(7) Submit to the department:~~

18 ~~—(a) The final auditor's report issued by the NCQA certified audit organization;~~  
19 ~~—(b) A copy of the interactive data submission system tool used by the MCO; and~~  
20 ~~—(c) The reports specified in MCO Reporting Requirements.~~

21 ~~—Section 54. Performance Improvement Projects (PIPs). (1) An MCO shall:~~  
22 ~~—(a) Implement PIPs to address aspects of clinical care and non-clinical services;~~  
23 ~~—(b) Collaborate with local health departments, behavioral health agencies, and other~~

1 ~~community-based health or social service agencies to achieve improvements in priority~~  
2 ~~areas;~~

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

5 ~~—(d) Report on a PIP using standardized indicators;~~

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

7 ~~—(f) Include the following for a PIP:~~

8 ~~—1. The topic and its importance to enrolled members;~~

9 ~~—2. Methodology for topic selection;~~

10 ~~—3. Goals of the PIP;~~

11 ~~—4. Data sources and collection methods;~~

12 ~~—5. An intervention; and~~

13 ~~—6. Results and interpretations.~~

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

16 ~~—(a) The enrollee population;~~

17 ~~—(b) A subpopulation of the enrollee population; and~~

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

20 ~~—(3) A non-clinical PIP shall address improving the quality, availability, and accessibil-~~  
21 ~~ity of services provided by an MCO to enrollees and providers.~~

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

23 ~~—(a) A finding from an EQRO review referenced in Section 52 of this administrative~~

1 regulation or an audit indicates a need for a PIP; or

2 —(b) Directed by CMS.

3 —(5) The department shall be authorized to require an MCO to assist in a statewide

4 PIP which shall be limited to providing the department with data from the MCO's service

5 area.

6 —Section 55. Enrollee and Provider Surveys. (1) An MCO shall:

7 —(a) Conduct an annual survey of enrollee and provider satisfaction of the quality and

8 accessibility to a service provided by an MCO;

9 —(b) Satisfy a member satisfaction survey requirement by participating in the Agency

10 for Health Research and Quality's current Consumer Assessment of Healthcare Provid-

11 ers and Systems Survey (CAHPS) for Medicaid Adults and Children, which shall be

12 administered by an NCQA-certified survey vendor;

13 —(c) Provide a copy of the current CAHPS survey referenced in paragraph (b) of this

14 subsection to the department;

15 —(d) Annually assess the need for conducting other surveys to support quality and per-

16 formance improvement initiatives;

17 —(e) Submit to the department for approval the survey tool used to conduct the survey

18 referenced in paragraph (a) of this subsection; and

19 —(f) Provide to the department:

20 —1. A copy of the results of the enrollee and provider surveys referenced in paragraph

21 (a) of this subsection;

22 —2. A description of a methodology to be used to conduct surveys;

23 —3. The number and percentage of enrollees and providers surveyed;

1 —4. Enrollee and provider survey response rates;  
2 —5. Enrollee and provider survey findings; and  
3 —6. Interventions conducted or planned by the MCO related to activities in this section.  
4 —(2) The department shall:  
5 —(a) Approve enrollee and provider survey instruments prior to implementation; and  
6 —(b) Approve or disapprove an MCO's provider survey tool within fifteen (15) days of  
7 receipt of the survey tool.  
8 —(3) If an MCO conducts a survey that targets a subpopulation's perspective or expe-  
9 rience with access, treatment, or services, the MCO shall comply with the requirements  
10 established in subsection (1)(e) and (f) of this section.  
11 —Section 56. Prompt Payment of Claims. (1) In accordance with 42 U.S.C.  
12 1396a(a)(37), an MCO shall have prepayment and postpayment claims review proce-  
13 dures that ensure the proper and efficient payment of claims and management of the  
14 program.  
15 —(2) An MCO shall:  
16 —(a) Comply with the prompt payment provisions established in:  
17 —1. 42 C.F.R. 447.45; and  
18 —2. KRS 205.593, KRS 304.14-135, and KRS 304.17A-700 to 304.17A-730; and  
19 —(b) Notify a requesting provider of a decision to:  
20 —1. Deny a claim; or  
21 —2. Authorize a service in an amount, duration, or scope that is less than requested.  
22 —(3) The payment provisions in this section shall apply to a payment to:  
23 —(a) A provider within the MCO network; and

1 ~~—(b) An out-of-network provider.~~

2 ~~—Section 57. Payments to an MCO. (1) The department shall provide an MCO a per~~  
3 ~~enrollee, per month capitation payment whether or not the enrollee receives a service~~  
4 ~~during the period covered by the payment except for an enrollee whose eligibility is de-~~  
5 ~~termined due to being unemployed in accordance with 45 C.F.R. 233.100.~~

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

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

9 ~~—(a) Meet the requirements of 42 C.F.R. 438.6(c); and~~

10 ~~—(b) Be approved by the Centers for Medicare and Medicaid Services.~~

11 ~~—(4)(a) The department shall apply a risk adjustment to a capitation rate in an amount~~  
12 ~~that shall be budget neutral to the department.~~

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

16 ~~—Section 58. Recoupment of Payment from an Enrollee for Fraud, Waste, or Abuse.~~

17 ~~(1) If an enrollee is determined to be ineligible for Medicaid through an administrative~~  
18 ~~hearing or adjudication of fraud by the CHFS OIG, the department shall recoup a capita-~~  
19 ~~tion payment it has made to an MCO on behalf of the enrollee.~~

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

23 ~~—(3) If an MCO has been unable to collect a refund referenced in subsection (2) of this~~

1 ~~section within six (6) months, the Commonwealth shall have the right to recover the re-~~  
2 ~~fund from the enrollee.~~

3 ~~—Section 59. MCO Administration. An MCO shall have executive management re-~~  
4 ~~sponsible for operations and functions of the MCO that shall include:~~

5 ~~—(1) An executive director who shall:~~

6 ~~—(a) Act as a liaison to the department regarding a contract between the MCO and the~~  
7 ~~department;~~

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

10 ~~—(c) Have decision making authority; and~~

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

12 ~~—(2) A medical director who shall be:~~

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

14 ~~—(b) Actively involved in all major clinical programs and quality improvement compo-~~  
15 ~~nents of the MCO; and~~

16 ~~—(c) Available for after-hours consultation;~~

17 ~~—(3) A dental director who shall be:~~

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

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

20 ~~—(c) Available for after-hours consultation;~~

21 ~~—(4)(a) A finance officer who shall oversee the MCO's budget and accounting systems;~~

22 ~~and~~

23 ~~—(b) An internal auditor who shall ensure compliance with adopted standards and re-~~

1 ~~view expenditures for reasonableness and necessity;~~  
2 ~~—(5) A quality improvement director who shall be responsible for the operation of:~~  
3 ~~—(a) The MCO's quality improvement program; and~~  
4 ~~—(b) A subcontractor's quality improvement program;~~  
5 ~~—(6) A behavioral health director who shall be:~~  
6 ~~—(a) A behavioral health practitioner;~~  
7 ~~—(b) Actively involved in all of the MCO's programs or initiatives relating to behavioral~~  
8 ~~health; and~~  
9 ~~—(c) Responsible for the coordination of behavioral health services provided by the~~  
10 ~~MCO or any of its behavioral health subcontractors;~~  
11 ~~—(7) A case management coordinator who shall be responsible for coordinating and~~  
12 ~~overseeing case management services and continuity of care for MCO enrollees;~~  
13 ~~—(8) An early and periodic screening, diagnosis, and treatment (EPSDT) coordinator~~  
14 ~~who shall coordinate and arrange for the provision of EPSDT services and EPSDT spe-~~  
15 ~~cial services for MCO enrollees;~~  
16 ~~—(9) A foster care and subsidized adoption care liaison who shall serve as the MCO's~~  
17 ~~primary liaison for meeting the needs of an enrollee who is:~~  
18 ~~—(a) A child in foster care; or~~  
19 ~~—(b) A child receiving state-funded adoption assistance;~~  
20 ~~—(10) A guardianship liaison who shall serve as the MCO's primary liaison for meeting~~  
21 ~~the needs of an enrollee who is a ward of the Commonwealth;~~  
22 ~~—(11) A management information systems director who shall oversee, manage, and~~  
23 ~~maintain the MCO's management information system;~~

1 ~~—(12) A program integrity coordinator who shall coordinate, manage, and oversee the~~  
2 ~~MCO's program integrity functions;~~

3 ~~—(13) A pharmacy director who shall coordinate, manage, and oversee the MCO's~~  
4 ~~pharmacy program;~~

5 ~~—(14) A compliance director who shall be responsible for the MCO's:~~

6 ~~—(a) Financial and programmatic accountability, transparency, and integrity; and~~

7 ~~—(b) Compliance with:~~

8 ~~—1. All applicable federal and state law;~~

9 ~~—2. Any administrative regulation promulgated by the department relating to the MCO;~~  
10 ~~and~~

11 ~~—3. The requirements established in the contract between the MCO and the depart-~~  
12 ~~ment;~~

13 ~~—(15) A member services director who shall:~~

14 ~~—(a) Coordinate communication with MCO enrollees; and~~

15 ~~—(b) Respond in a timely manner to an enrollee seeking a resolution of a problem or~~  
16 ~~inquiry;~~

17 ~~—(16) A provider services director who shall:~~

18 ~~—(a) Coordinate communication with MCO providers and subcontractors; and~~

19 ~~—(b) Respond in a timely manner to a provider seeking a resolution of a problem or in-~~  
20 ~~quiry; and~~

21 ~~—(17) A claims processing director who shall ensure the timely and accurate pro-~~  
22 ~~cessing of claims.~~

23 ~~—Section 60. MCO Reporting Requirements. An MCO shall:~~

1 —(1) Submit to the department a report as required by MCO Reporting Requirements;

2 —(2) Verify the accuracy of data and information on a report submitted to the depart-  
3 ment;

4 —(3) Analyze a required report to identify an early pattern of change, a trend, or an out-  
5 lier before submitting the report to the department; and

6 —(4) Submit the analysis required in subsection (3) of this section with a required re-  
7 port.

8 —Section 61. Health Care Data Submission and Penalties. (1)(a) An MCO shall submit  
9 an original encounter record and denial encounter record, if any, to the department  
10 weekly.

11 —(b) An original encounter record or a denial encounter record shall be considered late  
12 if not received by the department within four (4) calendar days from the weekly due  
13 date.

14 —(c) Beginning on the fifth calendar day late, the department shall withhold \$500 per  
15 day for each day late from an MCO's total capitation payments for the month following  
16 non-submission of an original encounter record and denial encounter record.

17 —(2)(a) If an MCO fails to submit health care data derived from processed claims or  
18 encounter data in a form or format established in the MCO Reporting Requirements for  
19 one (1) calendar month, the department shall withhold an amount equal to five (5) per-  
20 cent of the MCO's capitation payment for the month following non-submission.

21 —(b) The department shall retain the amount referenced in paragraph (a) of this sub-  
22 section until the data is received and accepted by the department, less \$500 per day for  
23 each day late.

1 ~~—(3)(a) The department shall transmit to an MCO an encounter record with an error for~~  
2 ~~correction by the MCO.~~

3 ~~—(b) An MCO shall have ten (10) days to submit a corrected encounter record to the~~  
4 ~~department.~~

5 ~~—(c) If an MCO fails to submit a corrected encounter record within the time frame spec-~~  
6 ~~ified in paragraph (b) of this subsection, the department shall be able to assess and~~  
7 ~~withhold for the month following the non-submission, an amount equal to one-tenth of a~~  
8 ~~percent of the MCO's total capitation payments per day until the corrected encounter~~  
9 ~~record is received and accepted by the department.~~

10 ~~—Section 62. Program Integrity. An MCO shall comply with:~~

11 ~~—(1) 42 C.F.R. 438.608;~~

12 ~~—(2) 42 U.S.C. 1396a(a)(68); and~~

13 ~~—(3) The requirements established in the MCO Program Integrity Requirements.~~

14 ~~—Section 63. Third Party Liability and Coordination of Benefits. (1) Medicaid shall be~~  
15 ~~the payer of last resort for a service provided to an enrollee.~~

16 ~~—(2) An MCO shall:~~

17 ~~—(a) Exhaust a payment by a third party prior to payment for a service provided to an~~  
18 ~~enrollee;~~

19 ~~—(b) Be responsible for determining a legal liability of a third party to pay for a service~~  
20 ~~provided to an enrollee;~~

21 ~~—(c) Actively seek and identify a third party liability resource to pay for a service pro-~~  
22 ~~vided to an enrollee in accordance with 42 C.F.R. 433.138; and~~

23 ~~—(d) Assure that Medicaid shall be the payer of last resort for a service provided to an~~

1 enrollee.

2 —(3) In accordance with 907 KAR 1:011 and KRS 205.624, an enrollee shall:

3 —(a) Assign, in writing, the enrollee's rights to an MCO for a medical support or pay-  
4 ment from a third party for a medical service provided by the MCO; and

5 —(b) Cooperate with an MCO in identifying and providing information to assist the MCO  
6 in pursuing a third party that shall be liable to pay for a service provided by the MCO.

7 —(4) If an MCO becomes aware of a third party liability resource after payment for a  
8 service provided to an enrollee, the MCO shall seek recovery from the third party re-  
9 source.

10 —(5) An MCO shall have a process for third party liability and coordination of benefits in  
11 accordance with Third Party Liability and Coordination of Benefits.

12 —Section 64. Management Information System. (1) An MCO shall:

13 —(a) Have a management information system that shall:

14 —1. Provide support to the MCO operations; and

15 —2. Except as provided in subsection (2) of this section, include a:

16 —a. Member subsystem;

17 —b. Third party liability subsystem;

18 —c. Provider subsystem;

19 —d. Reference subsystem;

20 —e. Claim processing subsystem;

21 —f. Financial subsystem;

22 —g. Utilization and quality improvement subsystem; and

23 —h. Surveillance utilization review subsystem; and

1 ~~—(b) Transmit data to the department in accordance with 42 C.F.R. 438.242 and the~~  
2 ~~Management Information System Requirements.~~

3 ~~—(2) An MCO's management information system shall not be required to have the sub-~~  
4 ~~systems listed in subsection (1)(a)2. of this section if the MCO's management infor-~~  
5 ~~mation system:~~

6 ~~—(a) Has the capacity to:~~

7 ~~—1. Capture and provide the required data captured by the subsystems listed in sub-~~  
8 ~~section (1)(a)2. of this section; and~~

9 ~~—2. Provide the data in formats and files that shall be consistent with the subsystems~~  
10 ~~listed in subsection (1)(a)2. of this section; and~~

11 ~~—(b) Meets the requirements established in paragraph (a) of this subsection in a way~~  
12 ~~which shall be mapped to the subsystem concept established in subsection (1)(a)2. of~~  
13 ~~this section.~~

14 ~~—(3) If an MCO subcontracts for services, the MCO shall provide guidelines for its sub-~~  
15 ~~contractor to the department for approval.~~

16 ~~—Section 65. Kentucky Health Information Exchange (KHIE). (1) An MCO shall:~~

17 ~~—(a) Submit to the KHIE:~~

18 ~~—1. An adjudicated claim within twenty-four (24) hours of the final claim adjudication;~~  
19 ~~and~~

20 ~~—2. Clinical data as soon as it is available;~~

21 ~~—(b) Make an attempt to have a PCP in the MCO's network connect to KHIE within:~~

22 ~~—1. One (1) year of enrollment in the MCO's network; or~~

23 ~~—2. A timeframe approved by the department if greater than one (1) year; and~~

1 ~~—(c) Encourage a provider in its network to establish connectivity with the KHIE.~~  
2 ~~—(2) The department shall:~~  
3 ~~—(a) Administer an electronic health record incentive payment program; and~~  
4 ~~—(b) Inform an MCO of a provider that has received an electronic health record incen-~~  
5 ~~tive payment.~~  
6 ~~—Section 66. MCO Qualifications and Maintenance of Records. (1) An MCO shall:~~  
7 ~~—(a) Be licensed by the Department of Insurance as a health maintenance organiza-~~  
8 ~~tion or an insurer;~~  
9 ~~—(b) Have a governing body;~~  
10 ~~—(c) Have protection against insolvency in accordance with:~~  
11 ~~—1. 806 KAR 3:190; and~~  
12 ~~—2. 42 C.F.R. 438.116;~~  
13 ~~—(d) Maintain all books, records, and information related to MCO providers, recipients,~~  
14 ~~or recipient services, and financial transactions for:~~  
15 ~~—1. A minimum of five (5) years in accordance with 907 KAR 1:672; and~~  
16 ~~—2. Any additional time period as required by federal or state law; and~~  
17 ~~—(e) Submit a request for disclosure of information subject to open records laws, KRS~~  
18 ~~61.870 to 61.884, received from the public to the department within twenty-four (24)~~  
19 ~~hours.~~  
20 ~~—(2) Information shall not be disclosed by an MCO pursuant to a request it received~~  
21 ~~pursuant to subsection (1)(e) of this section without prior written authorization from the~~  
22 ~~department.~~  
23 ~~—(3) The books, records, and information referenced in subsection (1)(d) of this section~~

1 ~~shall be available upon request of a reviewer or auditor during routine business hours at~~  
2 ~~the MCO's place of operations.~~

3 ~~—(4) MCO staff shall be available upon request of a reviewer or auditor during routine~~  
4 ~~business hours at the MCO's place of operations.~~

5 ~~—Section 67. Prohibited Affiliations. The policies or requirements:~~

6 ~~—(1) Imposed on a managed care entity in 42 U.S.C. 1396u-2(d)(1) shall apply to an~~  
7 ~~MCO; and~~

8 ~~—(2) Established in 42 C.F.R. 438.610 shall apply to an MCO.~~

9 ~~—Section 68. Termination of MCO Participation in the Medicaid Program. If necessary,~~  
10 ~~a contract with an MCO shall be terminated and the termination shall be in accordance~~  
11 ~~with KRS Chapter 45A.~~

12 ~~—Section 69. Incorporation by Reference. (1) The following material is incorporated by~~  
13 ~~reference:~~

14 ~~—(a) "MCO Reporting Requirements", July 2011 edition;~~

15 ~~—(b) "MCO Program Integrity Requirements", July 2011 edition;~~

16 ~~—(c) "Early and Periodic Screening, Diagnosis and Treatment Program Periodicity~~  
17 ~~Schedule", July 2011 edition;~~

18 ~~—(d) "Third Party Liability and Coordination of Benefits", July 2011 edition; and~~

19 ~~—(e) "Management Information Systems Requirements", July 2011 edition.~~

20 ~~—(2) This material may be inspected, copied, or obtained, subject to applicable copy-~~  
21 ~~right law, at the Department for Medicaid Services, 275 East Main Street, Frankfort,~~  
22 ~~Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m., or from its Web site at~~  
23 ~~<http://www.chfs.ky.gov/dms/incorporated.htm>.] (38 Ky.R. 1249; 1588; 1738; eff. 5-4-12.)~~

907 KAR 17:005

REVIEWED:

---

Date

---

Lawrence Kissner, Commissioner  
Department for Medicaid Services

APPROVED:

---

Date

---

Audrey Tayse Haynes, Secretary  
Cabinet for Health and Family Services

A public hearing on this administrative regulation shall, if requested, be held on January 21, 2013 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 February 14, 2013, 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 February 28, 2013. 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, Email: [jill.brown@ky.gov](mailto:jill.brown@ky.gov), 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

- (1) Provide a brief summary of:
  - (a) What this administrative regulation does: This administrative regulation currently establishes Kentucky Medicaid program managed care policies [excluding MCO policies for region three (3) of Kentucky.] Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3).

The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than this lone administrative regulation. DMS is dividing the policies across multiple regulations in response to urging from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year.

This administrative regulation; thus, will contain the definitions for Medicaid managed care administrative regulations. The other administrative regulations are new administrative regulations (907 KAR 17:010, 907 KAR 17:015, 907 KAR 17:020, 907 KAR 17:025 and 907 KAR 17:030) which will address subjects previously addressed in this administrative regulation and are all being promulgated concurrently along with this amended administrative regulation.

- (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for chapter 17 of title 907 – which is the chapter that contains Kentucky Medicaid program managed care regulations. The definitions are not being amended from what is currently stated in this administrative regulation. DMS is establishing MCO requirements and policies in multiple administrative regulations rather than in this lone administrative regulation. DMS is doing this in response to urging from the Administrative Regulation Review Subcommittee and staff when this administrative regulation was reviewed by the committee earlier this year.
    - (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 definitions for chapter 17 of title 907 – which is

the chapter that contains Kentucky Medicaid program managed care regulations.

- (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 definitions for chapter 17 of title 907 – which is the chapter that contains Kentucky Medicaid program managed care regulations.
- (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 administrative regulation currently establishes Kentucky Medicaid program managed care policies but is being amended to establish the definitions for chapter 17 of title 907 – which is the chapter that contains Kentucky Medicaid program managed care regulations. The Department for Medicaid Services (DMS) is dividing the current regulation into four (4) regulations.
  - (b) The necessity of the amendment to this administrative regulation: DMS is dividing the administrative regulation into four (4) in response to a request by the Administrative Regulation Review Subcommittee and staff when the regulation previously was reviewed by the Subcommittee.
  - (c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by establishing the definitions for chapter 17 of title 907 – which is the chapter that contains Kentucky Medicaid program managed care regulations.
  - (d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by establishing the definitions for chapter 17 of title 907 – which is the chapter that contains Kentucky Medicaid program managed care regulations..
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently there are over 700,000 such individuals) and the four (4) 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: No action is required.
  - (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). The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
  - (a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS's projected managed care expenditures for state fiscal year (SFY 2013) are \$3,198,870,633.
  - (b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS's projected managed care expenditures for state fiscal year (SFY 2013) are \$3,303,448,347.
- (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 neither applied nor necessary as the administrative regulation establishes definitions to be used for regulations contains in chapter 17 of title 907 of the Kentucky Administrative Regulations.

## FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 17:005

Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 CFR Part 438.
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; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 CFR Part 438.
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 17:005

Agency Contact Person: Stuart Owen (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? No cost is necessary to implement this amended administrative regulation. DMS's projected managed care expenditures for SFY 2013 are \$3,198,870,633.
  - (d) How much will it cost to administer this program for subsequent years? No cost is necessary to implement this amended administrative regulation. DMS's projected managed care expenditures for SFY 2014 are \$3,303,448,347.

COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 17:005, Definitions for administrative regulations located in Chapter 17 of Title 907 of the Kentucky Administrative Regulations

Summary of Material Incorporated by Reference

The material that was previously incorporated by reference into this administrative regulation is being deleted from the incorporated material as this administrative regulation is being amended to only establish definitions for administrative regulations located in Chapter 17 of Title 907 of the Kentucky Administrative Regulations and no incorporated material is necessary to do that. Below is the material that is no longer incorporated by reference:

- (1) "MCO Reporting Requirements", July 2011 edition;
- (2) "MCO Program Integrity Requirements", July 2011 edition;
- (3) "Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule", July 2011 edition;
- (4) "Third Party Liability and Coordination of Benefits", July 2011 edition; and
- (5) "Management Information Systems Requirements", July 2011 edition.