

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (New Administrative Regulation)

5 907 KAR 10:025. Reimbursement provisions and requirements regarding outpatient
6 psychiatric hospital services.

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

8 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

9 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
10 Services, Department for Medicaid Services, has a responsibility to administer the Med-
11 icaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to
12 comply with any requirement that may be imposed or opportunity presented by federal
13 law to qualify for federal Medicaid funds. This administrative regulation establishes the
14 reimbursement provisions and requirements regarding Medicaid Program outpatient
15 behavioral health services provided by psychiatric hospitals to Medicaid recipients who
16 are not enrolled with a managed care organization.

17 Section 1. (1) "Billing provider" means the individual who, group of individual provid-
18 ers that, or organization that:

19 (a) Is authorized to bill the department or a managed care organization for a service;
20 and

1 (b) Is eligible to be reimbursed by the department or a managed care organization for
2 a service.

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

4 (3) "Federal financial participation" is defined by 42 C.F.R. 400.203.

5 (4) "Managed care organization" means an entity for which the Department for Medi-
6 caid Services has contracted to serve as a managed care organization as defined in 42
7 C.F.R. 438.2.

8 (5) "Provider" is defined by KRS 205.8451(7).

9 Section 2. General Requirements. For the department to reimburse for a service cov-
10 ered under this administrative regulation, the service shall:

11 (1) Meet the requirements established in 907 KAR 10:020; and

12 (2) Be covered in accordance with 907 KAR 10:020.

13 Section 3. Reimbursement. (1)(a) Except as established in Section 4 of this adminis-
14 trative regulation, the department shall reimburse a psychiatric hospital on an interim
15 basis for outpatient behavioral health services at a facility specific outpatient cost-to-
16 charge ratio based on the facility's most recently filed cost report that has been re-
17 viewed and approved by the department.

18 (b) An outpatient behavioral health service cost-to-charge ratio shall be expressed as
19 a percent of the psychiatric hospital's outpatient behavioral health service charges.

20 (2) Except as established in subsection (4) of this section, a facility specific outpatient
21 behavioral health service cost-to-charge ratio paid during the course of a psychiatric
22 hospital's fiscal year shall be designed to result in reimbursement, at the psychiatric
23 hospital's fiscal year end, equaling ninety-five (95) percent of the psychiatric hospital's

1 total outpatient behavioral health services costs, excluding diagnostic laboratory ser-
2 vices costs, incurred during the psychiatric hospital's fiscal year.

3 (3) Except as established in subsection (4) of this section:

4 (a) Upon reviewing a psychiatric hospital's as submitted cost report for the hospital's
5 fiscal year, the department shall preliminarily settle reimbursement to the psychiatric
6 hospital equal to ninety-five (95) percent of the psychiatric hospital's total outpatient be-
7 havioral health services costs, excluding diagnostic laboratory services costs, incurred
8 in the corresponding fiscal year; and

9 (b) Upon receiving and reviewing a psychiatric hospital's finalized outpatient behav-
10 ioral health services cost report for the hospital's fiscal year, the department shall settle
11 final reimbursement to the facility equal to ninety-five (95) percent of the psychiatric
12 hospital's total outpatient behavioral health services costs, excluding diagnostic labora-
13 tory services costs, incurred in the corresponding fiscal year.

14 (4)(a) The department's total reimbursement for psychiatric hospital outpatient behav-
15 ioral health services shall not exceed the aggregate limit established in 42 C.F.R.
16 447.321.

17 (b) If projections indicate for a given state fiscal year that reimbursing for a psychiatric
18 hospital's outpatient behavioral health services at ninety-five (95) percent of costs would
19 result in the department's total psychiatric hospital outpatient behavioral health service
20 reimbursement exceeding the aggregate limit established in 42 C.F.R. 447.321, the de-
21 partment shall proportionately reduce the final psychiatric hospital outpatient behavioral
22 health service reimbursement for each psychiatric hospital to equal a percent of costs
23 which shall result in the total psychiatric hospital outpatient behavioral health service re-

1 reimbursement equaling the aggregate limit established in 42 C.F.R. 447.321.

2 (5) The department shall not reimburse for a service billed by or on behalf of an entity
3 or individual that is not a billing provider.

4 **Section 4. Initial Interim Reimbursement and New Hospital Reimbursement. (1)(a)**

5 Except as established in subsection (2) of this section, until a psychiatric hospital has
6 submitted to the department a cost report containing twelve (12) months of outpatient
7 behavioral health services cost information that has been reviewed and approved by the
8 department, the department shall reimburse the psychiatric hospital on an interim basis
9 for outpatient behavioral health services using the most recently available statewide av-
10 erage cost-to-charge ratio for in-state acute care hospitals.

11 (b) The department shall update the statewide average in-state acute care hospital
12 cost-to-charge ratio effective July 1 of each year.

13 (2)(a) After the department has established a cost-to-charge ratio for at least two (2)
14 psychiatric hospital pursuant to Section 3 of this administrative regulation, the depart-
15 ment shall reimburse on an interim basis a newly participating psychiatric hospital for
16 which a cost report containing twelve (12) months of outpatient behavioral health ser-
17 vices information has not been reviewed and approved by the department, the
18 statewide average cost-to-charge ratio of in-state psychiatric hospitals.

19 (b) The department shall update the statewide average in-state psychiatric hospital
20 cost-to-charge ratio effective July 1 of each year.

21 **Section 5. Cost Reporting Requirements. (1)** A psychiatric hospital participating in the
22 Medicaid Program shall submit to the department a copy of the Medicare cost report it
23 submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid

1 Schedule KMAP-1, the Supplemental Medicaid Schedule KMAP-4, and the Supple-
2 mental Medicaid Schedule KMAP-6.

3 (a) A cost report shall be submitted:

- 4 1. For the fiscal year used by the psychiatric hospital; and
- 5 2. Within five (5) months after the close of the psychiatric hospital's fiscal year.

6 (b) Except as provided in subparagraphs 1, 2, or 3 of this paragraph, the department
7 shall not grant a cost report submittal extension.

8 1. The department shall grant an extension if an extension has been granted by Med-
9 icare. If an extension has been granted by Medicare, when the facility submits its cost
10 report to Medicare it shall simultaneously submit a copy of the cost report to the de-
11 partment.

12 2. If a catastrophic circumstance exists, as determined by the department (for exam-
13 ple flood, fire, or other equivalent occurrence), the department shall grant a thirty (30)
14 day extension.

15 3. The department shall extend the deadline for a psychiatric hospital to submit a cost
16 report if:

17 a. The psychiatric hospital:

- 18 (i) Requests the extension in writing; and
- 19 (ii) Describes the circumstances necessitating the extension; and

20 b. The department approves the extension.

21 (c) A psychiatric hospital shall include all Medicaid outpatient behavioral health ser-
22 vices costs on the cost report that it submits to:

- 23 1. Medicare; and

1 2. The department.

2 (2)(a) If a cost report submittal date lapses and no extension has been granted, the
3 department shall immediately suspend all payment to the psychiatric hospital for outpa-
4 tient behavioral health services until a complete cost report is received.

5 (3) If a cost report indicates that payment is due by a psychiatric hospital to the de-
6 partment, the psychiatric hospital shall submit the amount due or submit a payment plan
7 request with the cost report.

8 (4) If a cost report indicates a payment is due by a psychiatric hospital to the depart-
9 ment and the psychiatric hospital fails to remit the amount due or request a payment
10 plan, the department shall suspend future payment to the psychiatric hospital for outpa-
11 tient behavioral health services until the psychiatric hospital remits the payment or sub-
12 mits a request for a payment plan.

13 (5) An estimated payment shall not be considered payment-in-full until a final deter-
14 mination of cost has been made by the department.

15 (6) A cost report submitted by a psychiatric hospital to the department shall be sub-
16 ject to departmental audit and review.

17 (7) Within seventy (70) days of receipt from the Medicare intermediary, a hospital
18 shall submit to the department a printed copy of the final Medicare-audited cost report
19 including adjustments.

20 (8)(a) If it is determined that an additional payment is due by a psychiatric hospital af-
21 ter a final determination of cost has been made by the department, the additional pay-
22 ment shall be due by a hospital to the department within sixty (60) days after notifica-
23 tion.

1 (b) If a psychiatric hospital does not submit the additional payment within sixty (60)
2 days, the department shall withhold future payment to the psychiatric hospital until the
3 department has collected in full the amount owed by the psychiatric hospital to the de-
4 partment.

5 **Section 6. Outpatient Psychiatric Hospital Laboratory Services Reimbursement.**

6 (1) The department shall reimburse for an in-state or out-of-state outpatient psychiat-
7 ric hospital diagnostic laboratory service:

8 (a) At the Medicare-established technical component rate for the service in accord-
9 ance with 907 KAR 1:028 if a Medicare-established component rate exists for the ser-
10 vice; or

11 (b) By multiplying the facility's current outpatient cost-to-charge ratio by its billed la-
12 boratory charges if no Medicare rate exists for the service.

13 (2) Laboratory service reimbursement, in accordance with subsection (1) of this sec-
14 tion, shall be:

15 (a) Final; and

16 (b) Not settled to cost.

17 **Section 7. Out-of-State Outpatient Psychiatric Hospital Services Reimbursement.**

18 (1)(a) Except as established in paragraph (b) of this subsection, excluding laboratory
19 services, reimbursement for psychiatric hospital outpatient behavioral health services
20 provided by an out-of-state hospital shall equal ninety-five (95) percent of the statewide
21 average in-state psychiatric hospital cost-to-charge ratio multiplied by the applicable
22 covered Medicaid charges for the service.

23 (b) The department shall update the statewide average in-state psychiatric hospital

1 cost-to-charge ratio effective July 1 of each year.

2 (2) Out-of-state hospital reimbursement, in accordance with subsection (1) of this
3 section, shall be:

4 (a) Final; and

5 (b) Not settled to cost.

6 Section 8. Not Applicable to Managed Care Organizations. A managed care organi-
7 zation shall not be required to reimburse in accordance with this administrative regula-
8 tion for a service covered pursuant to:

9 (1) 907 KAR 15:020; and

10 (2) This administrative regulation.

11 Section 9. Federal Approval and Federal Financial Participation. The department's
12 reimbursement for services pursuant to this administrative regulation shall be contingent
13 upon:

14 (1) Receipt of federal financial participation for the reimbursement; and

15 (2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

16 Section 10. Appeals. A psychiatric hospital may appeal a decision by the department
17 regarding the application of this administrative regulation in accordance with 907 KAR
18 1:671.

19 Section 11. Incorporation by Reference. (1) The following material is incorporated by
20 reference:

21 (a) "Supplemental Worksheet E-3, Part III", May 2004;

22 (b) "Supplemental Medicaid Schedule KMAP-1", January 2007;

23 (c) "Supplemental Medicaid Schedule KMAP-4", January 2007;

1 (d) The "Supplemental Medicaid Schedule KMAP-5", November 2011; and

2 (e) "Supplemental Medicaid Schedule KMAP-6", January 2007.

3 (2) This material may be inspected, copied, or obtained, subject to applicable copy-
4 right law:

5 (a) At the Department for Medicaid Services, 275 East Main Street, Frankfort, Ken-
6 tucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.; or

7 (b) Online at the department's Web site at
8 <http://www.chfs.kv.gov/dms/incorporated.htm>.

907 KAR 10:025

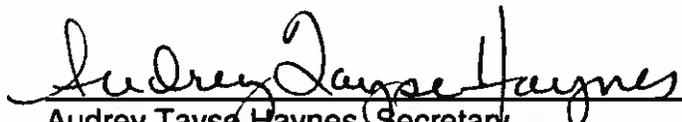
REVIEWED:

3-9-15
Date


Lisa Lee, Commissioner
Department for Medicaid Services

APPROVED:

4/10/15
Date


Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

907 KAR 10:025

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on May 22, 2015 at 9:00 a.m. in the Health Services Auditorium, Suite B, 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 May 15, 2015 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 June 1, 2015. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, Phone: (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 10:025
Contact person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes the reimbursement provisions and requirements regarding Medicaid Program outpatient behavioral health services provided by psychiatric hospitals. This administrative regulation is being promulgated in conjunction with 907 KAR 10:020 (Coverage provisions and requirements regarding psychiatric hospital outpatient behavioral health services). Psychiatric hospitals are authorized to provide, to Medicaid recipients, outpatient behavioral health services related to a mental health disorder, substance use disorder, or co-occurring disorders. The array of services includes a screening; an assessment; psychological testing; crisis intervention; mobile crisis services; day treatment; peer support; parent or family peer support; intensive outpatient program services; individual outpatient therapy; group outpatient therapy; family outpatient therapy; collateral outpatient therapy; service planning; a screening, brief intervention, and referral to treatment for a substance use disorder; assertive community treatment; comprehensive community support services; and therapeutic rehabilitation program services. The Department for Medicaid Services (DMS) will ultimately reimburse a psychiatric hospital ninety-five (95) percent of the hospital's costs for outpatient behavioral health services. To achieve this each psychiatric hospital will annually submit a cost report identifying all of the hospital's outpatient behavioral health services' costs incurred for the given fiscal year. DMS will review and audit the report and compare the reimbursement paid to the hospital on an interim basis (during the course of the given fiscal year) to the psychiatric hospital's incurred costs. If DMS's interim reimbursement exceeded the psychiatric hospital's incurred costs for the fiscal year, the psychiatric hospital will remit the amount due back to DMS. If DMS's interim reimbursement was less than the psychiatric hospital's costs, DMS will send the amount owed to the psychiatric hospital to equate to the incurred costs. DMS will use the most recent cost report to establish an interim reimbursement (cost-to-charge ratio) to pay the psychiatric hospital during the course of the fiscal year. For the initial year, as no cost report yet exists, DMS will pay on an interim basis a reimbursement equal to the statewide average cost-to-charge ratio for acute care hospitals.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal mandates. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment" for all recipients. 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that ser-

vices are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base (to include psychiatric hospitals) will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

(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 complying with federal mandates and enhancing and ensuring Medicaid recipients' access to behavioral health services.

(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 complying with federal mandates and enhancing and ensuring Medicaid recipients' access to behavioral health services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

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

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

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

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Psychiatric hospitals, behavioral health professionals authorized to provide outpatient behavioral health services in psychiatric hospitals, and Medicaid recipients in need of outpatient behavioral health services will be affected by the administrative regulation. Currently, there are twelve (12) psychiatric hospitals enrolled in the Medicaid Program. The following behavioral health professionals are authorized to provide outpatient behavioral health services in a psychiatric hospital: licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychological practitioners, licensed psychological associates, certified social workers, licensed professional counselor associates, marriage and family therapy associates, licensed behavior analysts, licensed assistant behavior analysts, licensed professional art therapists, licensed professional art therapist associates, certified alcohol and drug counselors, peer support specialists, and community support associates.

(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. Psychiatric hospitals who wish to provide outpatient behavioral health services will need to comply

with the service requirements.

(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 projected.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Psychiatric hospitals will benefit by receiving Medicaid Program reimbursement for outpatient behavioral health services. Behavioral health professionals authorized to provide outpatient behavioral health services will benefit by having more employment opportunities in Kentucky. Medicaid recipients in need of outpatient behavioral health services will benefit from an expanded base of providers from which to receive these services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the outpatient behavioral health services provider base due to the variables involved as DMS cannot estimate the utilization of these services in psychiatric hospitals compared to utilization in other authorized provider settings (independent behavioral health providers, community mental health centers, federally-qualified health centers, rural health clinics, and primary care centers.) However, an actuary with whom DMS contracted has estimated an average per recipient per month increase (to DMS) of \$27.00 associated with DMS's expansion of behavioral health services (including substance use disorder services) as well as behavioral health providers this year.

(b) On a continuing basis: The response in paragraph (a) also applies here.

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

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

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

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

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 907 KAR 10:025
Contact person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), and 42 U.S.C. 1396a(a)(30)(A).

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. Substance use disorder services are federally mandated for Medicaid programs. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid.) Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. Similarly, 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

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

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

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 907 KAR 10:025
Contact person: Stuart Owen (502) 564-4321

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

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3).

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

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

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

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the outpatient behavioral health services provider base due to the variables involved as DMS cannot estimate the utilization of these services in psychiatric hospitals compared to utilization in other authorized provider settings (independent behavioral health providers, community mental health centers, federally-qualified health centers, rural health clinics, and primary care centers.) However, an actuary with whom DMS contracted has estimated an average per recipient per month increase (to DMS) of \$27.00 associated with DMS's expansion of behavioral health services (including substance use disorder services) as well as behavioral health providers this year.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) also applies here.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 10:025

Summary of Material Incorporated by Reference

(1) "Supplemental Worksheet E-3, Part III", May 2004 is incorporated by reference and used to document cost reported on covered services on the supplemental worksheet. This is a one (1) page form.

(2) The "Supplemental Medicaid Schedule KMAP-1"; November 2011 is incorporated by reference and used to document hospital costs, legal fees, political contributions and out-of-state travel. This is a one (1) page form.

(3) The "Supplemental Medicaid Schedule KMAP-4", November 2011 is incorporated by reference and is a disproportionate share hospital (DSH) questionnaire used to document miscellaneous care or related including whether non-emergency obstetric services are offered, age threshold (under or over eighteen (18)) of predominant number of individuals served, Medicaid revenues, total revenues, state and local government revenues, charges attributable to charity care, and total inpatient charges. This is a one (1) page form.

(4) The "Supplemental Medicaid Schedule KMAP-5", November 2011 is incorporated by reference and used to document capital costs and depreciation. This is a one (1) page form.

(5) The "Supplemental Medicaid Schedule KMAP-6", January 2007 is incorporated by reference and used to document miscellaneous care or related including whether non-emergency obstetric services are offered, age threshold (under or over eighteen (18)) of predominant number of individuals served, Medicaid revenues, total revenues, state and local government revenues, charges attributable to charity care, and total inpatient charges. This is a one (1) page form.

A total of five (5) pages are incorporated by reference into this administrative regulation.