STATEMENT OF EMERGENCY

907 KAR 17:015E

(1) This is a new emergency administrative regulation which is being promulgated concurrently with five (5) other administrative regulations which will establish the Kentucky Medicaid Program managed care organization requirements and policies. Currently, there is one administrative regulation (907 KAR 17:005) which establishes Kentucky Medicaid program managed care organization requirements and policies for every region except region three (3). Region three (3) is comprised of Jefferson County and fifteen (15) other counties neighboring or nearby Jefferson County and its requirements and policies are established in 907 KAR 1:705. One (1) managed care organization has been responsible for managed care in region three (3) since the mid-1990s; however, managed care in that region did not encompass behavioral health services and having one (1) entity does not satisfy the Centers for Medicare and Medicaid Services (CMS) requirement of providing individuals choice of managed care organizations. Consequently, DMS has contracted with four (4) entities – including the entity that has been performing managed care organization functions since the mid-1990s – to be responsible for managed care in region three (3) and the scope of managed care in region three (3) will now include behavioral health services.

As a result, DMS is repealing the existing region three (3) managed care administrative regulation (907 KAR 1:705) and establishing uniform managed care organization requirements and policies for all Medicaid managed care organizations in Kentucky. The six (6) administrative regulations which accomplish this include this administrative regulation; 907 KAR 17:005 (Definitions for administrative regulations in Chapter 17 of Title 907); 907 KAR 17:010 (managed care organization requirements and policies related to enrollees); 907 KAR 17:020 (managed care organization service and service coverage requirements and policies); 907 KAR 17:025 (managed care organization utilization management and quality requirements and policies); and 907 KAR 17:030 (managed care organization operational and related requirements and policies.) DMS is establishing managed care organization requirements across multiple administrative regulations in response to urging from the Administrative Regulation Review Subcommittee (ARRS) and ARRS staff when this administrative regulation was reviewed by the committee earlier this year. Providing a choice of managed care organizations to individuals is necessary to comply with a federal mandate and expanding the scope of managed care in region three (3) to include behavioral health services is also necessary to establish the same managed care benefit package for all Medicaid recipients enrolled in managed care in Kentucky.

(2) This action must be implemented on an emergency basis to comply with a federal mandate and to prevent a loss of federal funds as CMS has approved DMS's revised

managed care model - four (4) entities and the scope of services includes behavioral health services – for region three (3).

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

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

_____
Steven L. Beshear
Governor

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

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Commissioner's Office

(New Emergency Administrative Regulation)

907 KAR 17:015E. Managed care organization requirements and policies relating to providers.

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

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

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

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

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

1. Access and capacity requirements established in Section 2 of this administrative regulation; and

2. Quality requirements established in 907 KAR 17:025;

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

1. A teaching hospital;

2. A rural health clinic;

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

4. A local health department; and

5. A community mental health center;

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

(d) Have at least one (1) FQHC in a region where the MCO operates in accordance with 907 KAR 17:020, if there is an FQHC that is licensed to provide services in the region; and

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

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

(3) If an MCO is unable to enroll a provider specified in subsection (1)(b) or (c) of this section, the MCO shall submit to the department for approval, documentation which supports the MCO's conclusion that adequate services and service sites as required in Section 2 of this administrative regulation shall be provided without enrolling the specified provider.

(4) If an MCO or the department determines that the MCO's provider network is inadequate to comply with the access standards established in Section 2 of this administrative regulation for ninety-five (95) percent of the MCO's enrollees, the MCO shall:

(a) Notify the department; and

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

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

(a) Describe the deficiency in detail; and

(b) Identify a specific action to be taken by the MCO to correct the deficiency, including a time frame.

Section 2. Provider Access Requirements. (1) The access standards requirements established in 42 C.F.R. 438.206 through 438.210 shall apply to an MCO.

(2) An MCO shall make available and accessible to an enrollee:

(a) Facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section;

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

(c) Urgent care services within 48 hours of request.

(3)(a) An MCO's primary care provider delivery site shall be within:

1. Thirty (30) miles or thirty (30) minutes from an enrollee's residence in an urban area; or

2. Forty-five (45) miles or forty-five (45) minutes from an enrollee's residence in a non-urban area.

(b) An MCO's primary care provider shall not have an enrollee to primary care pro-

vider ratio greater than 1,500:1.

(c) An appointment wait time at an MCO's primary care delivery site shall not exceed:

1. Thirty (30) days from the date of an enrollee's request for a routine or preventive service; or

2. Forty-eight (48) hours from an enrollee's request for urgent care.

(4)(a) An appointment wait time for a specialist, except for a specialist providing a behavioral health service as provided in paragraph (b) of this subsection, shall not exceed:

1. Thirty (30) days from the referral for routine care; or

2. Forty-eight (48) hours from the referral for urgent care.

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

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

3. A behavioral health service appointment following a discharge from an acute psychiatric hospital shall occur within fourteen (14) days of discharge.

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

(5) An MCO shall have:

1. Specialists available for the subpopulations designated in Section 16 of 907 KAR 17:010; and

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

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

(7) A hospital shall be within:

(a) Thirty (30) miles or thirty (30) minutes of an enrollee's residence in an urban area; or

(b) Sixty (60) miles or sixty (60) minutes of an enrollee's residence in a non-urban area.

(8) A behavioral or physical rehabilitation service shall be within sixty (60) miles or sixty (60) minutes of an enrollee's residence.

(9)(a) A dental service shall be within sixty (60) miles or sixty (60) minutes of an enrollee's residence.

(b) A dental appointment wait time shall not exceed:

1. Three (3) weeks for a regular appointment; or

2. Forty-eight (48) hours for urgent care.

(10)(a) A general vision, laboratory, or radiological service shall be within sixty (60) miles or sixty (60) minutes of an enrollee's residence.

(b) A general vision, laboratory, or radiological appointment wait time shall not exceed:

1. Three (3) weeks for a regular appointment; or

2. Forty-eight (48) hours for urgent care.

(11)(a) A pharmacy service shall be within sixty (60) miles or sixty (60) minutes of an enrollee's residence.

(b) A pharmacy delivery site, except for a mail-order pharmacy, shall not be further

than fifty (50) miles from an enrollee's residence.

(c) Transport time or distance threshold shall not apply to a mail-order pharmacy except that it shall:

1. Be physically located within the United States of America; and

2. Provide delivery to the enrollee's residence.

(12)(a) Prior authorization shall not be required for a physical emergency service or a behavioral health emergency service.

(b) In order to be covered, an emergency service shall be:

1. Medically necessary;

2. Authorized after being provided if the service was not prior authorized; and

3. Covered in accordance with 907 KAR 17:020.

Section 3. MCO Provider Enrollment. (1) A provider enrolled with an MCO shall:

(a) Be credentialed by the MCO in accordance with the standards established in Section 4 of this administrative regulation; and

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

(2) An MCO shall:

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

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

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

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

a. The provider owes money to the Kentucky Medicaid program; or

b. The Kentucky Office of the Attorney General has an active fraud investigation of the provider; or

4. The provider is not credentialed;

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

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

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

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

Section 4. Provider Credentialing and Recredentialing. (1) An MCO shall:

(a) Have policies and procedures that comply with 907 KAR 1:672; KRS 205.560; and 42 C.F.R. 455 Subpart E, 455.400 to 455.470, regarding the credentialing and recredentialing of a provider;

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

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

2. A governing body, or a group or individual to whom the governing body has formally delegated the credentialing function; and

3. A review of the credentialing policies and procedures by the governing body or its delegate;

(c) Have a credentialing committee that makes recommendations regarding creden-

tialing;

(d) If a provider requires a review by the credentialing committee, based on the MCO's quality criteria, notify the department of the facts and outcomes of the review;

(e) Have written policies and procedures for:

1. Excluding, terminating, or suspending a provider; and

2. Reporting a quality deficiency that results in an exclusion, suspension, or termination of a provider;

(f) Document its monitoring of a provider;

(g) Verify a provider's qualifications through a primary source that includes:

1. A current valid license or certificate to practice in the Commonwealth of Kentucky;

2. A Drug Enforcement Administration certificate and number, if applicable;

3. If a provider is not board certified, proof of graduation from a medical school and completion of a residency program;

4. Proof of completion of an accredited nursing, dental, physician assistant, or vision program, if applicable;

5. If a provider states on an application that the provider is board certified in a specialty, a professional board certification;

6. A previous five (5) year work history;

7. A professional liability claims history;

8. If a provider requires access to a hospital to practice, proof that the provider has clinical privileges and is in good standing at the hospital designated by the provider as the primary admitting hospital;

9. Malpractice insurance;

10. Documentation, if applicable, of a:

a. Revocation, suspension, or probation of a state license or Drug Enforcement Agency certificate and number;

b. Curtailment or suspension of a medical staff privilege;

c. Sanction or penalty imposed by the United States Department of Health and Human Services or a state Medicaid agency; or

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

11. The most recent provider information available from the National Practitioner Data Bank;

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

(i) Have:

1. A process to recredential a provider at least once every three (3) years that shall be in accordance with subsection (3) of this section; and

2. Procedures for monitoring a provider sanction, a complaint, or a quality issue between a recredentialing cycle;

(j) Have or obtain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line within four (4) years of implementation of this administrative regulation; and

(k) Continuously maintain NCQA accreditation for its Medicaid product line after obtaining the accreditation.

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

recredentialing.

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

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

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

(c) The provider's history of a:

1. Loss of license or a felony conviction;

2. Loss or limitation of a privilege; or

3. Disciplinary action;

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

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

(f) Malpractice insurance maintained by the provider; and

(g) The correctness and completeness of the application.

(4) The department shall be responsible for credentialing and recredentialing a hospital-based provider.

Section 5. Provider Services. (1) An MCO shall have a provider services function responsible for:

(a) Enrolling, credentialing, recredentialing, and evaluating a provider;

(b) Assisting a provider with an inquiry regarding enrollee status, prior authorization, referral, claim submission, or payment;

(c) Informing a provider of the provider's rights and responsibilities;

(d) Handling, recording, and tracking a provider grievance and appeal;

(e) Developing, distributing, and maintaining a provider manual;

(f) Provider orientation and training, including:

1. Medicaid covered services;

2. EPSDT coverage;

3. Medicaid policies and procedures;

4. MCO policies and procedures; and

5. Fraud, waste, and abuse;

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

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

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

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

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

(b) Operate a provider call center.

Section 6. Provider Manual. (1) An MCO shall provide a provider manual to a provider within five (5) working days of enrollment with the MCO.

(2) Prior to distributing a provider manual or update to a provider manual, an MCO shall procure the department's approval of the provider manual or provider manual update.

(3) The provider manual shall be available in hard copy and on the MCO's website.

Section 7. Provider Orientation and Education. An MCO shall:

(1) Conduct an initial orientation for a provider within thirty (30) days of enrollment with the MCO to include:

(a) Medicaid coverage policies and procedures;

(b) Reporting fraud and abuse;

(c) Medicaid eligibility groups;

(d) The standards for preventive health services;

(e) The special needs of enrollees;

(f) Advance medical directives;

(g) EPSDT services;

(h) Claims submission;

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

(j) Cultural sensitivity;

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

(l) The reporting of communicable diseases;

(m) The MCO's QAPI program as referenced in 907 KAR 17:025;

(n) Medical records;

(o) The external quality review organization; and

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

(2) Ensure that a provider:

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

(b) Receives education on a finding from its QAPI program if deemed necessary by

the MCO or department; and

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

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

(a) Maintain:

1. Continuity of an enrollee's health care;

2. A current medical record for an enrollee in accordance with 907 KAR 17:010; and

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

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

(c) Discuss advance medical directives with an enrollee;

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

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

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

(2) An MCO shall monitor a PCP to ensure compliance with the requirements established in this section.

Section 9. Provider Discrimination. An MCO shall:

(1) Comply with the anti-discrimination requirements established in:

(a) 42 U.S.C. 1396u-2(b)(7);

(b) 42 C.F.R. 438.12; and

(c) KRS 304.17A-270; and

(2) Provide written notice to a provider denied participation in the MCO's network stating the reason for the denial.

Section 10. Release for Ethical Reasons. An MCO shall:

(1) Not require a provider to perform a treatment or procedure that is contrary to the provider's conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. 438.102;

(2) Not prohibit or restrict a provider from advising an enrollee about health status, medical care, or a treatment:

(a) Whether or not coverage is provided by the MCO; and

(b) If the provider is acting within the lawful scope of practice; and

(3) Have a referral process in place if a provider declines to perform a service because of an ethical reason.

Section 11. Provider Grievances and Appeals. (1) An MCO shall have written policies and procedures for the filing of a provider grievance or appeal.

(2) A provider shall have the right to file:

(a) A grievance with an MCO; or

(b) An appeal with an MCO regarding:

1. A provider payment issue; or

2. A contractual issue.

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

(b)1. If a grievance or appeal is not resolved within thirty (30) days, an MCO shall request a fourteen (14) day extension from the provider.

2. The provider shall approve the extension request from the MCO.

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

Section 12. Medical Records. (1) An MCO shall:

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

(b) Have a process to systematically review provider medical records to ensure compliance with the medical records standards established in this section.

(2) An enrollee medical record shall:

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

(b)1. Be kept for at least five (5) years from the date of service unless a federal statute or regulation requires a longer retention period; and

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

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

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

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

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

4. The plan of treatment including:

a. Medication history, medications prescribed, including the strength, amount, and directions for use and refills;

b. Therapy or other prescribed regimen; and

c. Follow-up plans, including consultation, referrals, and return appointment.

(3) A medical chart organization and documentation shall, at a minimum, contain the

following:

(a) Enrollee identification information on each page;

(b) Enrollee date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses, and telephone numbers (if applicable), employer (if applicable), school (if applicable), name and telephone number of an emergency contact, consent form, language spoken and guardianship information (if applicable);

(c) Date of data entry and of the encounter;

(d) Provider's name;

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

(f) Enrollee's past medical history;

(g) Identification of any current problem;

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

(i) Documentation of immunizations;

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

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

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

(m) Hospital discharge summaries;

(n) Advance medical directives for adults; and

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

Section 13. Provider Surveys. (1) An MCO shall:

(a) Conduct an annual survey of provider satisfaction of the quality and accessibility to a service provided by an MCO;

(b) Annually assess the need for conducting other surveys to support quality and performance improvement initiatives;

(c) Submit to the department for approval the survey tool used to conduct the survey referenced in paragraph (a) of this subsection; and

(d) Provide to the department:

1. A copy of the results of the provider surveys referenced in paragraph (a) of this subsection;

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

3. The number and percentage of providers surveyed;

4. Provider survey response rates;

5. Provider survey findings; and

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

(2) The department shall:

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

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

Section 14. Cost Reporting Information. The department shall provide to the MCO the calculation of Medicaid allowable costs as used in the Medicaid Program.

Section 15. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies or does not provide federal financial participation for the policy; or

(2) Disapproves the policy.

907 KAR 17:015E

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

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

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 17:015E
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 is a new administrative regulation which establishes Kentucky Medicaid program managed care organization (MCO) requirements and policies relating to providers. Previously, those policies were contained in one (1) administrative regulation - (907 KAR 17:005) – which contained all MCO policies and requirements (excluding policies related to the MCO operating in region three (3). 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 the aforementioned 907 KAR 17:005. 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. Thus, this is a new administrative regulation but it contains policies that were previously stated in 907 KAR 17:005. Though this is a new administrative regulation, it does contain a couple of amended policies. The amendments include clarifying that the Department for Medicaid Services (DMS) has authority to determine if an MCO's provider network is inadequate; and adding a proximity requirement (mileage and time) for enrollee's access to providers which previously had no proximity requirement (pharmacies, dentists, general vision, laboratory and radiological services); and eliminating an enrollee's place of employment as a measuring point in determining the enrollee's access to providers.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization requirements and policies relating to providers. The amendments are necessary to clarify DMS's authority in assessing the adequacy of an MCO's provider network; to establish provider access requirements (enrollee proximity to providers) for provider types for which no proximity (distance/time) requirements existed in order to ensure recipients have reasonable access to those provider types; and to elim-

inate an enrollee's place of employment as a proximity (to providers) measuring point as this was impractical as DMS lacks place of employment information for enrollees (whereas DMS does possess longitudinal and latitudinal information for enrollee residences and providers.)

(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 Medicaid managed care organization requirements and policies relating to providers. The amended policies conform to the content of the authorizing statutes by clarifying or improving policies based on a year of experience and analysis.

(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 Medicaid managed care organization requirements and policies relating to providers. The amended policies conform to the content of the authorizing statutes by clarifying or improving policies based on a year of experience and analysis.

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

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

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

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

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

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers 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 applies equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 17:015E
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. This administrative regulation established MCO provider requirements. Those requirements are established in 42 CFR 438.12, 42 CFR 438.52, and 42 CFR 438.206 through 42 CFR 438.208.

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, Medicaid managed care organizations must meet certain federal requirements established in 42 CFR Part 438. This administrative regulation establishes MCO provider requirements. Those requirements include the following: MCOs must not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification (if an MCO, PIHP, or PAHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision; MCOs must give allow enrollees to receive services from out-of-network providers in appropriate circumstances including (1) when the network cannot provide the necessary services; (2) the only network provider refuses to perform the service on moral or religious grounds; (3) the recipient's primary care provider or other provider determines that the recipient needs related services that would present unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network; MCOs must give enrollees a free choice of family planning providers; MCOs must demonstrate that it has the capacity to serve the expected enrollment in the service area, including assurances that the organization offers an appropriate range of services and access to preventive and primary care services and maintains a sufficient number, mix, and geographic distribution of service providers; MCOs must met access standards including:
   1. Timely access to care and services, taking into account the urgency of the need for services;
   2. Hours of operation for network providers that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees;

3. Services available 24 hours a day, 7 days a week, when medically necessary;
4. Direct access for female enrollees to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services - this is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist;
5. Second opinion from a qualified health care professional within the network, or arrangements for the enrollee to obtain one outside the network, at no cost to the enrollee; and
6. Participation in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

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 17:015E
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.