

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Medical Management

4 (Amendment)

5 907 KAR 1:677. Medicaid recipient lock-in program.

6 RELATES TO: KRS 205.8453, 21 CFR 1308.12, 1308.13, 1308.14, 42 CFR 431.54,
7 42 CFR 433.111(b), 42 USC 1396(a), 1396 (a)(2)

8 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6318,
9 205.6310, 205.8453, 42 CFR 431.54, Part I.G.3.b.(26) of HB 1 of the 2010
10 Extraordinary Session of the General Assembly[, ~~EO 2004-726~~]

11 NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-716, effective July 9,~~
12 ~~2004, reorganized the Cabinet for Health Services and placed the Department for~~
13 ~~Medicaid Services and the Medicaid Program under the Cabinet for Health and Family~~
14 ~~Services.~~] The Cabinet for Health and Family Services, Department for Medicaid
15 Services, has responsibility to administer the Medicaid program. KRS 205.520(3)
16 empowers the cabinet, by administrative regulation, to comply with any requirement that
17 may be imposed or opportunity presented by federal law for the provision of medical
18 assistance to Kentucky's indigent citizenry. KRS 205.8453(4) and 205.6318(6) direct the
19 cabinet to promulgate administrative regulations to identify misutilization of Medicaid
20 services, to institute other measures necessary or useful in controlling fraud and abuse.
21 This administrative regulation establishes[~~sets forth~~] the Medicaid lock-in provisions

1 relating to recipient overutilization of Medicaid services~~[the Medicaid Program]~~.

2 Section 1. Definitions. (1) “Advanced registered nurse practitioner” or “ARNP” is
3 defined by KRS 314.011(7).

4 (2) “Cabinet” is defined by KRS 205.010(1).

5 (3) “Controlled substance” means a drug or substance identified in 21 CFR 1308.12,
6 1308.13, or 1308.14.

7 (4) “Department” means the Department for Medicaid Services or its designee.

8 (5) “Emergency medical condition” is:

9 (a) Defined by 42 USC 1395dd(e); and

10 (b) Identified in the department’s Table of Lock-In Emergency Medical Conditions.

11 (6) “Emergency service” means a service:

12 (a) Defined by 42 CFR 447.53; and

13 (b) For a condition listed in the Table of Lock-in Emergency Medical Conditions.

14 (7) “Fraud” is defined by KRS 205.8451(2).

15 (8) “Lock-in program” means a department program which restricts a recipient to
16 receiving Medicaid services from a designated provider.

17 (9) “Lock-in recipient” means a recipient enrolled in the lock-in program.

18 (10) “Medicaid Management Information System” means the department’s
19 mechanized claims processing and information retrieval system as defined by, and in
20 accordance with, 42 CFR 433.111(b).

21 (11) “Non-emergency care” means a service for a non-emergency condition.

22 (12) “Overutilization” means the receipt of a treatment, drug, medical supply, or
23 other Medicaid service from one (1) or more providers in an amount, duration, or scope

1 that exceeds the amount that would reasonably be expected to result in a medical or
2 health benefit to the recipient.

3 (13) "Physician" is defined by KRS 311.550(12).

4 (14) "Physician assistant" or "PA" is defined by KRS 311.840(3).

5 (15) "Prescriber" means a physician who:

6 (a) Within the scope of practice under Kentucky licensing laws, has the legal
7 authority to write or order a prescription for the drug that is ordered;

8 (b) Is enrolled in the Medicaid program pursuant to 907 KAR 1:672; and

9 (c) Is currently participating in the Medicaid program pursuant to 907 KAR 1:671.

10 (16) "Primary care provider" means an advanced registered nurse practitioner, a
11 physician, or physician assistant.

12 (17) "Provider" is defined by KRS 205.8451(7).

13 (18) "Provider abuse" is defined by KRS 205.8451(8).

14 (19) "Recipient" is defined by KRS 205.8451(9).

15 (20) "Recipient abuse" is defined by KRS 205.8451(10)

16 (21) "Utilization review" means a department review and analysis:

17 (a) Of Medicaid claims for a twelve (12) consecutive month period including:

18 1. A recipient's medical conditions; and

19 2. Medicaid services received by the recipient; and

20 (b) To determine if recipient overutilization has occurred.

21 Section 2. Review of Complaints. (1) A complaint relating to potential fraud, recipient
22 abuse, provider abuse, or overutilization shall be reported to the department or Cabinet
23 for Health and Family Services, Office of Inspector General via the Medicaid and

1 Welfare Fraud and Abuse hotline at 1-800-372-2970.

2 (2) The department shall respond to a complaint referenced in subsection (1) of this
3 section by conducting a utilization review of the recipient.

4 (3) A utilization review of a recipient referenced in subsection (2) of this section shall
5 include a review of paid claims using data collected from the Medicaid Management
6 Information System to identify if the recipient:

7 (a) Utilized Medicaid services at a frequency or amount which meets criteria
8 established in Section 4 of this administrative regulation; and

9 (b)1. Shall be enrolled in the lock-in program to manage non-medically necessary
10 overutilization of Medicaid services by the recipient; or

11 2. Shall not be enrolled in the lock-in program if the recipient:

12 a. Resides in a long term care nursing facility;

13 b. Is under the age of eighteen (18) years;

14 c. Receives Medicare benefits; or

15 d. Over utilized Medicaid services necessarily to treat a complex health condition ,
16 as determined by the department's licensed pharmacist, physician, and registered
17 nurse.

18 Section 3. General Exemption. If the department determines that not enrolling a
19 recipient in the lock-in program is in the best interest of the recipient, the department
20 shall not enroll the recipient in the lock-in program.

21 Section 4. Lock-in Criteria. Except as established in Section 2 (3)(b)2, and Section 3
22 of this administration, the department shall initiate the lock-in process, as established in
23 Section 5 of this administrative regulation, for a recipient if:

1 (1) At least two (2) of the following situations occurred in any two (2) ninety (90)
2 calendar day periods within twelve (12) consecutive months:

3 (a) The recipient received services from at least eight (8) different providers,
4 including a physician, advanced registered nurse practitioner, or physician assistant;

5 (b) The recipient received at least fifteen (15) prescription drugs;

6 (c) The recipient received prescriptions from at least eight (8) different prescribers;

7 (d) The recipient received the same services from at least two (2) different providers
8 within the same day;

9 (e) The recipient had at least twelve (12) office visits;

10 (f) The recipient received services from at least three (3) different physicians,
11 ARNPs, or PAs:

12 1. Of the same type or specialty; and

13 2. For the same or a similar diagnosis; or

14 (g) The recipient received at least four (4) prescriptions for different controlled
15 substances as identified in the department's Lock-in Table Controlled Substances; or

16 (2) At least one (1) of the following conditions occurred in any two (2) ninety (90)
17 calendar day periods within twelve (12) consecutive months:

18 (a) The recipient had at least four (4) hospital emergency department visits for a
19 condition that was not an emergency medical condition;

20 (b) The recipient received services from at least three (3) different hospital
21 emergency departments for a condition that was not an emergency medical condition;

22 (c) The recipient had prescriptions for the same drugs dispensed on the same or
23 subsequent day at least twice;

1 (d) The recipient received drugs from at least three (3) different pharmacies;

2 (e) The recipient received at least twenty-four (24) prescriptions;

3 (f) The recipient received a prescription for a controlled substance, as identified the
4 department's Lock-in Table of Controlled Substances from at least two (2) different
5 prescribers;

6 (g) The recipient had duplicative or contraindicated utilization of:

7 1. Medications, medical supplies, or appliances dispensed by or prescribed by at
8 least two (2) prescribers; or

9 2. Medical visits, procedures, or diagnostic tests from at least two (2) providers; or

10 (h) The recipient received at least twelve (12) prescriptions for a controlled
11 substance as identified in the department's Lock-in Table of Controlled Substances.

12 (3) A recipient shall be locked in to one (1) designated hospital for non-emergency
13 care, except for a screening to determine if an emergency medical condition exists
14 pursuant to 907 KAR 1:014, if the recipient:

15 (a) Meets the lock-in utilization criteria pursuant to subsections (1) or (2) of this
16 section; and

17 (b) Meets the criteria in subsection(2)(a)(b) of this section.

18 Section 5. Lock-in Process. Upon identification of a recipient who shall be enrolled in
19 the lock-in program in accordance with Section 2(3)(a)(b)1. of this administrative
20 regulation, the department shall:

21 (1) Send a written notification to the recipient, which includes:

22 (a) A brief summary of the recipient's utilization review findings;

23 (b) The reason for enrolling the recipient in the lock-in program;

1 (c) A description of the lock-in program;

2 (d) The effective date of lock-in program enrollment;

3 (e) Identification of the recipient's designated providers as established in subsection
4 (2)(a) of this section;

5 (f) Information relating to the recipient's right to a hearing as established in Section 9
6 of this administrative regulation; and

7 (g) Contact information of an individual who may be contacted in writing or by
8 telephone for information relating to the lock-in program; and

9 (2) Except for a recipient who requests a hearing relating to a department lock-in
10 determination, enroll the recipient in the lock-in program within thirty (30) days of
11 sending the written notification referenced in subsection (1) of this section by:

12 (a) Restricting the lock-in recipient to receiving non-emergency care and services for
13 conditions which are not emergency medical conditions from designated providers
14 including:

15 1. One (1) primary care provider who:

16 a. Shall be accessible to the recipient within normal time and distance standards for
17 the community in which the recipient resides;

18 b. If the lock-in recipient has a designated hospital in accordance with subparagraph
19 4 of this paragraph:

20 (i) Shall have inpatient admission privileges at the recipient's designated hospital, or;

21 (ii) If the primary care provider does not have admission privileges at the recipient's
22 designated hospital, shall have an arrangement with a provider who does have inpatient
23 admission privileges at the recipient's designated hospital;

1 c. Shall provide services and manage the lock-in recipient's necessary health care
2 services;

3 d. If the lock-in recipient needs a Medicaid-covered service other than the service of
4 the designated primary care provider, shall complete and forward a Lock-in Recipient
5 Referral to a referred provider;

6 e. Shall participate in the recipient's periodic utilization review as identified in
7 subsection (2) (c) of this section; and

8 f. If the designated primary care provider is a physician, may serve as the lock-in
9 recipient's designated controlled substance prescriber;

10 2. One (1) controlled substance prescriber who shall serve as the sole prescriber
11 and manager of controlled substances for the lock-in recipient; and

12 3. One (1) pharmacy; and

13 4. If the recipient meets the criteria established in Section 4(3) of this administrative
14 regulation, one (1) hospital;

15 (b) Maintaining the restrictions identified in paragraph (a) of this subsection for at
16 least twenty-four (24) months; and

17 (c) Following the initial twenty-four (24) month period of lock-in enrollment as
18 established in paragraph (b) of this subsection, conducting a utilization review at twelve
19 (12) month intervals to:

20 1. Measure the effectiveness of the recipient's enrollment in the lock-in program; and

21 2. Determine if the recipient shall:

22 a. Continue enrollment in the lock-in program if the recipient:

23 (i) Does not use a designated provider; or

1 (ii) Meets the criteria as established in Section 4 of this administrative regulation; or

2 b. Be disenrolled if the recipient:

3 (i) Uses a designated provider; and

4 (ii) Does not meet the criteria established in Section 4 of this administrative
5 regulation; and

6 (d) Providing the lock-in recipient with a written notification of the findings of a
7 utilization review as identified in paragraph (c) of this subsection, including:

8 1. A decision to maintain enrollment in or disenrollment from the lock-in program;

9 and

10 2. Appeal rights in accordance with Section 9 of this administrative regulation.

11 Section 6. Designated Providers. A designated provider as identified in Section
12 5(2)(a) shall serve as a designated provider of a lock-in recipient for at least twenty-four
13 (24) months except for the following situations:

14 (1) The designated provider:

15 (a) Submits to the department a written request for a release from serving as the
16 recipient's designated provider; and

17 (b) Serves as the recipient's designated provider until a comparable designated
18 provider may be selected;

19 (2) The recipient relocates outside of the designated provider's geographic area;

20 (3) In accordance with Section 8(3) of this administrative regulation, the recipient
21 submits a written request to the department which:

22 (a) Requests a designated provider change; and

23 (b) Includes information to support cause or a necessary reason for the change.

1 including the recipient:

2 1. Was denied access to a needed medical service;

3 2. Received poor quality of care; or

4 3. Does not have access to a provider qualified to treat the recipient's health care

5 needs;

6 (4) The designated provider withdraws or is terminated from participation in the

7 Medicaid program; or

8 (5) The department determines that it is in the best interest of the lock-in recipient to

9 change the designated provider.

10 Section 7. Fees, Payments, and Non-payments. (1) On behalf of a lock-in recipient,

11 the department shall pay:

12 (a) At the beginning of each month:

13 1. A fee of ten (10) dollars to a designated primary care provider for the

14 management of a lock-in recipient's necessary health care; and

15 2. Except for a designated controlled substance prescriber who also serves as a

16 lock-in recipient's designated primary care provider, a fee of five (5) dollars to a

17 designated controlled substance prescriber; and

18 (b) For:

19 1. A medical screening examination performed in the emergency department of a

20 hospital to determine if an emergency medical condition exists; and

21 2. An emergency service.

22 (2) In addition to the fee established in subsection (1)(a)1. of this section, the

23 department shall pay for necessary services provided to the recipient by the recipient's

1 designated primary care provider.

2 (3) Except for a service as established in subsection (1)(b) of this section, the
3 department shall not pay for a service rendered by a provider other than the recipient's
4 designated primary care provider unless the designated primary care provider:

5 (a) Refers the recipient to the referred provider for a necessary service; and

6 (b) Completes and forwards a copy of the Lock-in Recipient Referral to the referred
7 provider of the service.

8 Section 8. Lock-in Recipient Requirements. A lock-in recipient:

9 (1) Shall be restricted to receiving necessary nonemergency health care services
10 from a designated provider as identified in Section 5(2)(a) of this administrative
11 regulation except for services rendered by a referred provider in accordance with
12 Section 7(3) of this administrative regulation;

13 (2) Shall be responsible for the payment of a service rendered by a provider who:

14 (a) Is not the recipient's designated primary care provider;

15 (b) Does not have a Lock-in Recipient Referral from the recipient's designated
16 primary care provider; and

17 (c) Informs the lock-in recipient that the recipient shall be responsible for the costs of
18 the provider's services before the service is rendered; and

19 (3) May request a change of a designated provider in accordance with Section 6(3)
20 of this administrative regulation:

21 (a) Within ninety (90) days of the date of the recipient notification letter as identified
22 in Section 5(1) of this administrative regulation; or

23 (b) At least once in a twelve (12) month period following initial enrollment in the lock-

1 in program.

2 Section 9. Appeal Rights. A recipient who is notified of a department decision to
3 enroll or maintain enrollment of the recipient in the lock-in program, shall have the right
4 to request a hearing in accordance with 907 KAR 1:563.

5 Section 10. Fraud and Abuse Referral. If fraud, provider abuse, or recipient abuse is
6 identified in the course of a department utilization review for lock-in purposes, the
7 department shall comply with KRS 205.8453(3).

8 Section 11. Incorporation by Reference. (1) The following is incorporated by
9 reference:

10 (a) The "Lock-in Table of Controlled Substances", April 2010 edition;

11 (b) The "Table of Lock-in Emergency Medical Conditions", April 2010 edition; and

12 (c) The "Lock-in Recipient Referral", June 2010 edition.

13 (2) The material incorporated by reference may be inspected, copied, or obtained,
14 subject to applicable copyright law, at the Department for Medicaid Services, 275 East
15 Main Street, 6C-C, Frankfort, KY 40601, Monday through Friday, 8:00 a.m. to 4:30 p.m.

16 ~~[(1) "Department" means the Department for Medicaid Services and its designated~~
17 ~~agents.~~

18 ~~(2) "Emergency services" means services for a medical condition for which a delay in~~
19 ~~treatment will likely result in the recipient's death, irreparable harm, immediate grave~~
20 ~~bodily harm, a life-threatening condition or permanent impairment of the recipient's~~
21 ~~health.~~

22 ~~(3) "Fraud" means as defined in KRS 205.8451.~~

23 ~~(4) "Immediate grave bodily harm" means the condition that would result from failure~~

1 ~~to provide emergency services for an emergency medical condition.~~

2 ~~(5) "Irreparable harm" means a medical condition characterized by chronic illness or~~
3 ~~body impairment which may result from a failure to provide medical services on an~~
4 ~~immediate or emergency basis.~~

5 ~~(6) "Life-threatening condition" means a medical condition which may result in the~~
6 ~~death of the individual unless medical services are provided on an immediate or~~
7 ~~emergency basis.~~

8 ~~(7) "Lock-in" means as defined in 907 KAR 1:002.~~

9 ~~(8) "Nonlife-threatening condition" means a medical condition which would not result~~
10 ~~in the death of the individual if medical services are not provided on an immediate or~~
11 ~~emergency basis.~~

12 ~~(9) "Overutilization" means as defined in 907 KAR 1:002.~~

13 ~~(10) "Provider" means as defined in KRS 205.8451.~~

14 ~~(11) "Recipient abuse" means as defined in KRS 205.8451.~~

15 ~~Section 2. Lock-in Program. (1)] All complaints concerning possible recipient abuse~~
16 ~~or overutilization of Medicaid services by eligible recipients shall be referred to the~~
17 ~~department for investigation.~~

18 ~~A potential Medicaid program abuser or overutilizer may be identified by:~~

19 ~~(a) Caseworkers;~~

20 ~~(b) Providers, including those that provide emergency services;~~

21 ~~(c) The Attorney General's office;~~

22 ~~(d) Hotline referrals;~~

23 ~~(e) Surveillance and utilization review system reports showing utilization which~~

1 exceeds a norm by at least a standard deviation; or

2 (f) Other staff or outside sources.

3 (2) If a recipient is identified as needing an overutilization review, an analysis shall
4 be made of that recipient's utilization of Medicaid services. If the review reveals that an
5 individual has utilization that may be warranted in view of the individual's medical
6 diagnosis, complicating conditions and treatment regime, the review shall be closed.

7 (3) If the review reveals that an individual does not have a medical condition,
8 complicating condition or treatment regime to warrant the individual's higher than normal
9 utilization, a second level review and investigation to determine if the recipient has
10 overutilized or abused the Medicaid program.

11 (4) Recipient overutilization or abuse of the Medicaid program may be:

12 (a) Intentional; or

13 (b) May result from a lack of knowledge by the recipient regarding the proper use of
14 medical services.

15 (5) If overutilization or abuse is determined to be the result of a lack of recipient
16 knowledge regarding proper use of medical services, a letter shall be sent to the
17 recipient advising of:

18 (a) The dangers of inappropriate utilization of medical services; and

19 (b) The importance of having one (1) physician responsible for directing an
20 individuals medical care.

21 (6) If the overutilization or abuse is determined to be intentional, the department
22 shall notify the recipient in writing of the pending lock-in action. The letter shall:

23 (a) Explain the right to a hearing regarding the proposed lock-in decision in

1 ~~accordance with Section 3 of this administrative regulation; and~~

2 ~~(b) Inform recipient of the date their lock-in status shall be implemented, if a hearing~~
3 ~~is not requested.~~

4 ~~(7) If a hearing is requested with regard to the proposed lock-in, action shall not be~~
5 ~~taken to lock the recipient in until a final hearing decision upholding the proposed lock-in~~
6 ~~action has been made.~~

7 ~~(8) A recipient who has been identified as intentionally abusing or overutilizing the~~
8 ~~Medicaid program based on an analysis of the recipient's medical history and utilization~~
9 ~~patterns shall be locked in to Medicaid providers including:~~

10 ~~(a) A physician; and~~

11 ~~(b) A pharmacy.~~

12 ~~(9) The lock-in physician and pharmacy shall be selected by the department.~~

13 ~~The selected providers shall be Accessible within normal time and distance standards~~
14 ~~for the community in which the recipient lives.~~

15 ~~(10) A recipient identified as abusing or overutilizing the program shall be locked in~~
16 ~~for a minimum of twelve (12) months. After the lock-in period, periodic determinations~~
17 ~~to be performed every twelve (12) months or more frequently, as needed, shall be made~~
18 ~~to:~~

19 ~~(a) Determine the effectiveness of the lock-in; and~~

20 ~~(b) Determine Whether the lock-in status shall continue for another twelve (12)~~
21 ~~month period.~~

22 ~~(11) Lock-in physicians shall serve as case managers for referrals to all health~~
23 ~~facilities and services, except for emergency services. A case management fee of ten~~

1 ~~(10) dollars shall be paid to the lock-in physician at the beginning of each month for~~
2 ~~each assigned lock-in recipient.~~

3 ~~(12) designated lock-in providers shall remain effective for twelve (12) months.~~

4 ~~Changes in lock-in providers shall be permitted only upon:~~

5 ~~(a) The request of the lock-in provider;~~

6 ~~(b) If the recipient moves out of the lock-in providers area;~~

7 ~~(c) If the recipient can show that it is inappropriate for him to be locked-in to a~~
8 ~~specific provider;~~

9 ~~(d) If the lock-in provider withdraws from the Medicaid program; or~~

10 ~~(e) For the convenience of the department.~~

11 ~~(13) The department shall consider whether or not a physician has contributed to~~
12 ~~overutilization when determining the selection for a lock-in physician or pharmacist.~~

13 ~~(14) Except as provided for in subsection (15) of this section, a Medicaid payment~~
14 ~~shall not be made on behalf of a lock-in recipient for the following:~~

15 ~~(a) Physician services provided by other than the lock-in physician or other medical~~
16 ~~services or supplies which have not been preauthorized through a referral from the lock-~~
17 ~~in physician;~~

18 ~~(b) Prescription drugs prescribed by other than the lock-in physician or a physician~~
19 ~~authorized by the lock-in physician;~~

20 ~~(c) Pharmacy services provided by other than the lock-in pharmacy; or~~

21 ~~(d) Emergency services provide for a nonlife-threatening condition or a condition that~~
22 ~~would not result in irreparable harm without prior approval of the lock-in provider, unless~~
23 ~~the provider has made a reasonable effort to obtain prior approval from the lock-in~~

1 provider.

2 ~~(15) Emergency services may be provided to prevent the death, irreparable harm,~~
3 ~~immediate grave bodily harm, a life-threatening condition, or a permanent impairment of~~
4 ~~the recipient's health without prior approval of the lock-in provider.~~

5 ~~(16) The recipient shall be issued a lock-in Medicaid identification card which~~
6 ~~specifies the designated lock-in providers and lock-in limitations.~~

7 ~~Section 3. Appeal Rights. A recipient who receives advance notice of a decision to~~
8 ~~place him in lock-in status shall have the right to request a hearing in accordance with~~
9 ~~907 KAR 1:563 prior to lock-in action by the department.~~

10 ~~Section 4. Fraud and Abuse Referral. At any point if a determination is made that~~
11 ~~fraud, or abuse involving a substantial allegation or indication of fraud, has likely~~
12 ~~occurred, the recipient's case shall be referred for investigation in accordance with KRS~~
13 ~~205.8453(3) and 205.8465.] (22 Ky.R. 1920; Am. 2307; eff. 7-5-96.)~~

907 KAR 1:677

REVIEWED:

Date

Elizabeth A. Johnson, Commissioner
Department for Medicaid Services

APPROVED:

Date

Janie Miller, Secretary
Cabinet for Health and Family Services

907 KAR 1:677

A public hearing on this administrative regulation shall, if requested, be held on August 23, 2010, 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 August 16, 2010, 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 August 31, 2010. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

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

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 1:677

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact: Brenda Parker (502) 564-9444, Lee Barnard (502) 564-9444 or Stuart Owen (502) 564-2015

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes the Kentucky Medicaid program's lock-in provisions. The program locks recipients who have excessively utilized Medicaid services into receiving services from a few select providers. If the individual attempts to receive services from a provider who is not one of their lock-in providers, the Department for Medicaid Services (DMS) will not reimburse for the service except for emergency care.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with KRS 205.8453 regarding utilization, fraud and abuse and to ensure that the funds allocated to Kentucky's Medicaid program are properly expended.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 194A.030(2), 194A.050(1), 205.520(3) and 205.8453 by establishing Medicaid lock-in requirements.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of KRS 194A.030(2), 194A.050(1), 205.520(3) and KRS 205.8453 by establishing Medicaid lock-in requirements.
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: The amendment adds hospitals (for nonemergency care) and controlled substance prescribers to the types of lock-in providers; establishes detailed lock-in criteria; establishes a lock-in referral form to be used by the recipient's designated primary care provider; and establishes a five (5) dollar payment per month for controlled substance prescribers. The amendment also entails language and formatting revisions to comply with KRS Chapter 13A requirements.
 - (b) The necessity of the amendment to this administrative regulation: The amendment is necessary to reduce excessive Medicaid utilization in accordance with KRS 205.8453, KRS 205.6310, and with 42 CFR 431.54 and to implement pharmacy efficiencies as mandated by Part I.G.3.b.(26) of HB 1 of the 2010 Extraordinary Session of the General Assembly.

- (c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to 205.8453 and KRS 205.6310 by reducing excessive Medicaid utilization and to Part I.G.3.b.(26) of HB 1 of the 2010 Extraordinary Session of the General Assembly by incorporating pharmacy efficiencies.
 - (d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of KRS 205.8453 and KRS 205.6310 by reducing excessive Medicaid utilization and with Part I.G.3.b.(26) of HB 1 of the 2010 Extraordinary Session of the General Assembly by incorporating pharmacy efficiencies.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid recipients who excessively utilize Medicaid services and providers who serve these Medicaid recipients will be affected by the amendment.
 - (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
 - (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Medicaid recipients who are locked in to certain providers will have to ensure that they only seek Medicaid services from their designated lock-in providers in order to ensure that DMS will pay for the services they received.
 - (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 on the entities identified in question (3).
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Regulated individuals will have the benefit of appropriately utilizing Medicaid services.
 - (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: DMS will experience a small costs due to the five (5) dollars a month payments to controlled substance prescribers; however, DMS projects that the amendment will reduce costs by \$5 million (federal and state combined) annually.
 - (b) On a continuing basis: DMS will experience a small costs due to the five (5) dollar a month payments to controlled substance prescribers; however, DMS projects that the amendment will reduce costs by \$5 million (federal and state combined) annually.
 - (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 will be necessary to implement the amendment to this administrative regulation.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation neither establishes nor increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used.) Tiering was not applied in this administrative regulation because it is applicable equally to all individuals or entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:677

Agency Contact: Brenda Parker (502) 564-9444, Lee Barnard (502) 564-9444 or Stuart Owen (502) 564-2015

1. Federal statute or regulation constituting the federal mandate. Recipient lock-in is not mandated but is authorized by 42 CFR 431.54.
2. State compliance standards. KRS 205.8453 states, "It shall be the responsibility of the Cabinet for Health and Family Services and the Department for Medicaid Services to control recipient and provider fraud and abuse by:
 - (1) Informing recipients and providers as to the proper utilization of medical services and methods of cost containment;
 - (2) Establishing appropriate checks and audits within the Medicaid Management Information System to detect possible instances of fraud and abuse;
 - (3) Sharing information and reports with other departments within the Cabinet for Health and Family Services, the Office of the Attorney General, and any other agencies that are responsible for recipient or provider utilization review; and
 - (4) Instituting other measures necessary or useful in controlling fraud and abuse."

KRS 205.520(3) states, "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."

KRS 205.6310 states, "The Cabinet for Health and Family Services shall establish a system within the Medical Assistance Program to reduce unnecessary hospital emergency room utilization and costs by redefining and controlling hospital emergency utilization. The cabinet shall establish by promulgation of administrative regulations, pursuant to KRS Chapter 13A, the following:

- (1) Criteria and procedures, at least annually updated, that differentiate children and adults, and which conform to the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. sec. 1395dd), as amended, and any other applicable federal law or regulation for determining if a medical emergency exists;
- (2) Reimbursement rates that provide for nominal reimbursement of emergency room care for care that does not meet the criteria established for a medical emergency;
- (3) Reimbursement, at rates determined by the cabinet, for ancillary services which, based upon the symptoms of the patient, are medically appropriate to determine if a medical emergency exists;
- (4) Except for emergency room services rendered to children under the age of six (6), prohibition of reimbursement at hospital emergency room rates for diagnosis and treatment for a condition that does not meet the criteria established for a medical emergency; and
- (5) The provisions of this section shall apply to any managed care program for Medicaid recipients."

3. Minimum or uniform standards contained in the federal mandate. 42 CFR 431.54 authorizes the locking in of recipients but requires the Medicaid agency to give recipients notice and a hearing opportunity prior to any lock-in action, requires that recipients have reasonable access to services and exempts emergency services from being locked in.
4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? Recipient lock-in is not mandated but is authorized by 42 CFR 431.54. The amendment complies with the federal requirements established in 42 CFR 431.54.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Recipient lock-in is not mandated but is authorized by 42 CFR 431.54 so one could argue that it is stricter as it is not mandatory. The amendment complies with the federal requirements established in 42 CFR 431.54.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 1:677

Agency Contact: Brenda Parker (502) 564-9444, Lee Barnard (502) 564-9444 or Stuart Owen (502) 564-2015

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 (DMS) will be impacted by the amendment.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 205.8453, KRS 205.6310, Part I.G.3.b.(26) of HB 1 of the 2010 Extraordinary Session of the General Assembly, and 42 CFR 431.54.

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? DMS anticipates no revenue being generated for the first year for state or local government due to the amendment to this administrative regulation.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS anticipates no revenue being generated for subsequent years for state or local government due to the amendment to this administrative regulation.

(c) How much will it cost to administer this program for the first year? DMS foresees some administrative costs will be necessary to implement the changes; however, DMS projects saving approximately \$5 million (federal and state funds combined) annually as a result of the amendment.

(d) How much will it cost to administer this program for subsequent years? DMS foresees some administrative costs will be necessary to implement the changes; however, DMS projects saving approximately \$5 million (federal and state funds combined) annually as a result of the amendment.

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

Revenues (+/-): .

Expenditures (+/-):

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

907 KAR 1:677, Medicaid recipient lock-in program

Summary of Material Incorporated by Reference

(1) The “Lock-in Table of Controlled Substances”, April 2010 edition is incorporated by reference. This two (2)-page form lists controlled substances most utilized by Medicaid recipients and will be used by the department in administering the lock-in program, particularly as it relates to enrollment of recipients in administering the lock-in program for meeting or exceeding established utilization criteria. some of the drugs or substances that the department considers to be controlled substances.

(2) The “Table of Lock-in Emergency Medical Conditions”, April 2010 edition is incorporated by reference. This form contains sixty-two (62) pages and lists diagnosis codes which correspond to emergency medical conditions. This document will be used by the department to determine payment of claims reporting emergency department screenings and emergency services for lock-in recipients. The document may also be used by providers who need information regarding the department’s emergency medical condition determinations.

(3) The “Lock-in Recipient Referral”, June 2010 edition is a one (1) page form to be used by designated primary care providers to authorize referrals for lock-in recipients to providers who are not designated providers.

A total of sixty-five (65) pages are incorporated by reference into this administrative regulation.