

STATEMENT OF EMERGENCY

907 KAR 1:045E

(1) This emergency administrative regulation is being promulgated to establish a new reimbursement methodology for community mental health center services.

(2) This action must be taken on an emergency basis to comply with a federal mandate (Centers for Medicare and Medicaid Services) and to prevent the loss of federal funds.

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

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

Matthew G. Bevin
Governor

Vickie Yates Brown Glisson, Secretary
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Community Alternatives

4 (Emergency Amendment)

5 907 KAR 1:045E. Reimbursement provisions and requirements regarding community
6 mental health center services.

7 RELATES TO: KRS 205.520(3), 210.370

8 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6313,

9 42 C.F.R. 447.325, 42 U.S.C. 1396a-d

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

18 Section 1. Definitions. (1) "Community board for mental health or individuals with an
19 intellectual disability" means a board established pursuant to KRS 210.380.

20 (2)"Community mental health center" or "CMHC" means a facility which meets the

1 community mental health center requirements established in 902 KAR 20:091.

2 (3) "CPT code" means a code used for reporting procedures and services performed
3 by medical practitioners and published annually by the American Medical Association in
4 Current Procedural Terminology.

5 (4)[(2)] "Department" means the Department for Medicaid Services or its designee.

6 (5)[(3)] "Enrollee" means a recipient who is enrolled with a managed care organiza-
7 tion.

8 (6)[(4)] "Federal financial participation" is defined by 42 C.F.R. 400.203.

9 (7) "Federal indirect rate" means the rate approved by the United States Department
10 for Health and Human Services (HHS) for grantee institutions to be used to calculate
11 indirect costs as a percentage of direct costs.

12 (8) "Federal Register" means the official journal of the United States federal govern-
13 ment that publishes government agency rules and public notices.

14 (9) "Healthcare Common Procedure Coding System code" means a billing code:

15 (a) Recognized by Medicare; and

16 (b) Monitored by the Centers for Medicare and Medicaid Services.

17 (10) "Injectable drug" means an injectable, infused, or inhaled drug or biological that:

18 (a) Is not excluded as a non-covered immunization or vaccine;

19 (b) Requires special handling, storage, shipping, dosing, or administration; and

20 (c) Is a rebatable drug.

21 (11) "Interim reimbursement" means a reimbursement:

22 (a) In effect for a temporary period of time; and

23 (b) That does not represent final reimbursement for services provided during the pe-

1 riod of time.

2 (12)[(5)] "Managed care organization" means an entity for which the Department for
3 Medicaid Services has contracted to serve as a managed care organization as defined
4 in 42 C.F.R. 438.2.

5 (13) "Medicaid allowable costs" means the costs:

6 (a) Associated with the Medicaid-covered services covered pursuant to 907 KAR
7 1:046 and 907 KAR 1:044:

8 1. Rendered to recipients who are not enrollees; and

9 2. Not rendered as a 1915(c) home and community based waiver services provider;

10 and

11 (b) Determined to be allowable costs by the department.

12 (14) "Medical Group Management Association (MGMA) Physician Compensation
13 and Production Survey Report" means a report developed and owned by the Medical
14 Group Management Association that:

15 (a) Highlights the critical relationship between physician salaries and productivity;

16 (b) Is used to align physician salaries and benefits with provider production; and

17 (c) Contains:

18 1. Performance ratios illustrating the relationship between compensation and produc-
19 tion; and

20 2. Comprehensive and summary data tables that cover many specialties.

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

23 (16) "Medicare Economic Index" means a measure of inflation:

1 (a) Associated with the costs of physicians' practices; and

2 (b) Published in the Federal Register.

3 (17) "Outreach services" means provider programs specifically designed to:

4 (a) Engage recipients for the purposes of supporting Medicaid or Children's Health
5 Insurance Program (CHIP) enrollment efforts;

6 (b) Assist recipients with finding healthcare or coverage options;

7 (c) Promote preventive services for recipients; and

8 (d) That are directly assigned or allocated to a cost report line that is not cost settled
9 by the department.

10 (18) "Payment plan request" means a request to pay an amount owed to the depart-
11 ment over a period of time approved by the department.

12 (19) "Primary care services" means services covered as established in 907 KAR
13 1:046.

14 (20) [(6)] "Provider" is defined by KRS 205.8451(7).

15 (21) "Rebatable drug" means a drug for which the drug's manufacturer has entered
16 into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).

17 (22) [(7)] "Recipient" is defined by KRS 205.8451(9).

18 (23) "State fiscal year" means the period beginning on July 1 of a calendar year and
19 ending on June 30 of the following calendar year.

20 Section 2. General Reimbursement Provisions. (1) The department shall reimburse a
21 participating in-state community mental health center under this administrative regula-
22 tion for services:

23 (a) If the services are:

1 1. Covered pursuant to:

2 a. 907 KAR 1:044; or

3 b. 907 KAR 1:046;

4 2. Not provided by the CMHC acting as a 1915(c) home and community based waiv-
5 er services provider, as those services are reimbursed based on the home and com-
6 munity based waiver;

7 3. Provided to recipients who are not enrolled with a managed care organization; and

8 4. Medically necessary; and

9 (b) Based on the community mental health center's Medicaid allowable costs.

10 (2) The department's reimbursement shall include reimbursing:

11 (a) On an interim basis during the course of a cost report period; and

12 (b) A final reimbursement for the state fiscal year that results from a reconciliation of
13 the interim reimbursement amount paid to the CMHC compared to the CMHC's Medi-
14 caid allowable cost by Cost Center for the state fiscal year.

15 Section 3. Interim Reimbursement for Primary Care Services and Injectable Drugs.

16 (1) The department's interim reimbursement to a CMHC for primary care services
17 shall depend upon the type of primary care service.

18 (2) The department's interim reimbursement for:

19 (a)1. Physician services shall be the reimbursement established for the service on
20 the current Kentucky-specific Medicare Physician Fee Schedule unless no reimburse-
21 ment for the service exists on the current Kentucky-specific Medicare Physician Fee
22 Schedule for the given service.

23 2. If no reimbursement for a given physician service exists on the current Kentucky-

1 specific Medicare Physician Fee Schedule, the department shall reimburse on an inter-
2 im basis for the service as it reimburses for services pursuant to 907 KAR 3:010;

3 (b) Laboratory services shall be the reimbursement established for the service on the
4 current Kentucky-specific Medicare Laboratory Fee Schedule unless no reimbursement
5 for the service exists on the current Kentucky-specific Medicare Laboratory Fee Sched-
6 ule for the given service.

7 2. If no reimbursement for a given laboratory service exists on the current Kentucky-
8 specific Medicare Laboratory Fee Schedule, the department shall reimburse on an in-
9 terim basis for the service as it reimburses for services pursuant to 907 KAR 3:010;

10 (c) Radiological services shall be the reimbursement established for the service on
11 the current Kentucky-specific Medicare Physician Fee Schedule unless no reimburse-
12 ment for the service exists on the current Kentucky-specific Medicare Physician Fee
13 Schedule for the given service.

14 2. If no reimbursement for a given radiological service exists on the current Ken-
15 tucky-specific Medicare Physician Fee Schedule, the department shall reimburse on an
16 interim basis for the service as it reimburses for services pursuant to 907 KAR 3:010;

17 (d)1. Occupational therapy service shall be the reimbursement established for the
18 service on the current Kentucky-specific Medicare Physician Fee Schedule unless no
19 reimbursement for the given service exists on the current Kentucky-specific Medicare
20 Physician Fee Schedule.

21 2. If no reimbursement for a given occupational therapy service exists on the current
22 Kentucky-specific Medicare Physician Fee Schedule, the department shall reimburse
23 on an interim basis for the service as it reimburses for the service pursuant to 907 KAR

1 8:045;

2 (e)1. Physical therapy service shall be the reimbursement established for the service
3 on the current Kentucky-specific Medicare Physician Fee Schedule unless no reim-
4 bursement for the given service exists on the current Kentucky-specific Medicare Physi-
5 cian Fee Schedule.

6 2. If no reimbursement for a given physical therapy service exists on the current Ken-
7 tucky-specific Medicare Physician Fee Schedule, the department shall reimburse on an
8 interim basis for the service as it reimburses for the service pursuant to 907 KAR 8:045;
9 or

10 (f)1. Speech-language pathology service shall be the reimbursement established for
11 the service on the current Kentucky-specific Medicare Physician Fee Schedule unless
12 no reimbursement for the given service exists on the current Kentucky-specific Medi-
13 care Physician Fee Schedule.

14 2. If no reimbursement for a given speech-language pathology service exists on the
15 current Kentucky-specific Medicare Physician Fee Schedule, the department shall re-
16 imburse on an interim basis for the service as it reimburses for the service pursuant to
17 907 KAR 8:045.

18 (3) The department's interim reimbursement for the cost of injectable drugs adminis-
19 tered in a CMHC shall be the reimbursement methodology established in 907 KAR
20 3:010 for injectable drugs.

21 Section 4. Interim Reimbursement for Behavioral Health Services through June 30,
22 2018. (1)(a) To establish interim rates for behavioral health services effective for dates
23 of service through June 30, 2018, the department shall use the CMHC rates paid effec-

1 tive July 1, 2015.

2 (b) To establish interim rates for behavioral health services effective for dates of ser-
3 vice July 1, 2018, and each subsequent July 1, the department shall use a CMHC's
4 most recently submitted cost report that meets the requirements established in para-
5 graph (c) of this subsection.

6 (c) The cost report shall comply with all requirements established in Section 5(1) of
7 this administrative regulation.

8 (2) The department shall:

9 (a) Review the cost report referenced in subsection (1) of this section; and

10 (b) Establish interim rates for Medicaid-covered behavioral health services:

11 1. To be effective July 1, 2018;

12 2. Based on Medicaid allowable costs as determined by the department through its
13 review;

14 3. Intended to result in a reimbursement for Medicaid-covered behavioral health ser-
15 vices:

16 a. Provided to recipients who are not enrollees; and

17 b. That equals the department's estimate of behavioral health services' costs for the
18 CMHC for the period; and

19 4. That shall be updated effective July 1, 2019, and each July 1 thereafter, based on
20 the most recently received cost report referenced in subsection (1) of this section.

21 (3) Interim rates for behavioral health services effective July 1 each calendar year
22 shall have been trended and indexed from the midpoint of the cost report period to the
23 midpoint of the rate year using the Medicare Economic Index.

1 (4) To illustrate the timeline referenced in paragraph (2)(b) of this section, a cost re-
2 port submitted by a CMHC to the department on December 31, 2017, shall be used by
3 the department to establish behavioral health services' interim rates effective July 1,
4 2018.

5 (5)(a) A behavioral health services interim rate shall not be subject to retroactive ad-
6 justment except as specified in this section.

7 (b) The department shall adjust a behavioral health services interim rate during the
8 state fiscal year if the rate that was established appears likely to result in a substantial
9 cost settlement that could be avoided by adjusting the rate.

10 (c)1. If the cost report from a CMHC has not been audited or desk-reviewed by the
11 department prior to establishing interim rates for the next state fiscal year, the depart-
12 ment shall use the cost report under the condition that interim rates shall be subject to
13 adjustment as established in subparagraph 2 of this paragraph.

14 2. A behavioral health services interim rate based on a cost report that has not been
15 audited or desk-reviewed shall be subject to adjustment when the audit or desk review
16 is completed.

17 3. An unaudited cost report shall be subject to an adjustment to the audited amount
18 after the auditing has occurred.

19 (d) Upon receipt of the cost report filed December 31, 2017, the department shall re-
20 view the cost report to determine if the interim rates established in accordance with
21 subsection (1)(a) of this section need to be revised to more closely reflect the costs of
22 services for the interim period.

23 Section 5. Final Reimbursement Beginning with the State Fiscal Year that Begins Ju-

1 ly 1, 2018. (1)(a) For the state fiscal year spanning July 1, 2017, through June 30, 2018.
2 and for subsequent state fiscal years, by December 31 following the end of the state
3 fiscal year, a CMHC shall submit a cost report to the department:

4 1. In a format that has been approved by the Centers for Medicare and Medicaid
5 Services;

6 2. That has been audited by an independent auditing entity; and

7 3. That states all of the:

8 a. CMHC's Medicaid allowable direct costs for:

9 (i) Medicaid-covered services rendered to eligible recipients during the cost report
10 period; and

11 (ii) Medicaid-covered injectable drugs rendered to eligible recipients during the cost
12 report period;

13 b. CMHC's costs associated with:

14 (i) Medicaid-covered services rendered to enrollees during the cost report period;
15 and

16 (ii) Medicaid-covered injectable drugs rendered to enrollees during the cost report
17 period;

18 c. Costs of the community board for mental health or individuals with an intellectual
19 disability under which the CMHC operates for the cost report period; and

20 d. CMHC's costs associated with services rendered to individuals:

21 (i) That were reimbursed by an insurer or party other than the department or a man-
22 aged care organization; and

23 (ii) During the cost report period.

1 (b) To illustrate the timeline referenced in paragraph (a) of this subsection, an inde-
2 pendently audited cost report stating costs associated with services and injectable
3 drugs provided during the state fiscal year spanning July 1, 2017, through June 30,
4 2018, shall be submitted to the department by December 31, 2018.

5 (2) By October 1 following the department's receipt of a CMHC's completed cost re-
6 port submitted to the department by the prior December 31, the department shall:

7 (a) Review the cost report referenced in subsection (1) of this section; and

8 (b) Compare the Medicaid allowable costs to the department's interim reimburse-
9 ment for Medicaid-covered services and injectable drugs rendered during the same
10 state fiscal year.

11 (3)(a) After the department compares a CMHC's interim reimbursement with the
12 CMHC's Medicaid allowable costs for the period, if the department determines that the
13 interim reimbursement:

14 1. Was less than the CMHC's Medicaid allowable costs for the period, the depart-
15 ment shall send a payment to the CMHC equal to the difference between the CMHC's
16 total interim reimbursement and the CMHC's Medicaid allowable costs; or

17 2. Exceeded the CMHC's Medicaid allowable costs for the period, the:

18 a. Department shall send written notification to the CMHC requesting the amount of
19 the overpayment; and

20 b. CMHC shall, within thirty (30) days of receiving the department's written notice,
21 send a:

22 (i) Payment to the department equal to the excessive amount; or

23 (ii) Payment plan request to the department.

1 (b) A CMHC shall not implement a payment plan unless the department has ap-
2 proved the payment plan in writing.

3 (c) If a CMHC fails to comply with the requirements established in paragraph (a)2 of
4 this subsection, the department shall:

5 1. Suspend payment to the CMHC; and

6 2. Recoup the amount owed by the CMHC to the department.

7 Section 6. Final Reimbursement for the Cost Report Period Spanning November 1,
8 2016, through June 30, 2017. (1) The provisions established in Section 5 of this admin-
9 istrative regulation shall apply to final reimbursement for the period beginning Novem-
10 ber 1, 2016, through June 30, 2017, except that the cost report period shall begin No-
11 vember 1, 2016, and end June 30, 2017.

12 Section 7. New Services. (1) Reimbursement regarding a projection of the cost of a
13 new Medicaid-covered service or expansion shall be made on a prospective basis in
14 that the costs of the new service or expansion shall be considered when actually in-
15 curring as an allowable cost.

16 (2)(a) A CMHC may request an adjustment to an interim rate after reaching the mid-
17 year point of the new service or expansion.

18 (b) An adjustment shall be based on actual costs incurred.

19 Section 8. Auditing and Accounting Records. (1)(a) The department shall perform a
20 desk review of each cost report to determine whether an audit is necessary and, if so,
21 the scope of the audit.

22 (b) If the department determines that an audit is not necessary, the cost report shall
23 be settled without an audit.

1 (c) A desk review or audit shall be used to verify costs to be used in setting the inter-
2 im behavioral health services rate, to adjust interim behavioral health services rates that
3 have been set based on unaudited data, or for final settlement to cost.

4 (2)(a) A CMHC shall maintain and make available any records and data necessary to
5 justify and document:

6 1. Costs to the CMHC;

7 2. Services provided by the CMHC;

8 3. The cost of injectable drugs provided, if any, by the CMHC;

9 4. Cost allocations utilized including overhead statistics and supportive documenta-
10 tion;

11 5. Any amount reported on the cost report; and

12 6. Chart of accounts

13 (b) The department shall have unlimited on-site access to all of a CMHC's fiscal and
14 service records for the purpose of:

15 1. Accounting;

16 2. Auditing;

17 3. Medical review;

18 4. Utilization control; or

19 5. Program planning.

20 (3) A CMHC shall maintain an acceptable accounting system to account for the:

21 (a) Cost of total services provided;

22 (b) Charges for total services rendered; and

23 (c) Charges for covered services rendered to eligible recipients.

1 (4) An overpayment discovered as a result of an audit or desk review shall be settled
2 through recoupment or withholding.

3 Section 9. Allowable and Non-allowable Costs. (1) The following shall be allowable
4 costs:

5 (a) Services' or drugs' costs associated with the services or drugs;

6 (b) Depreciation as follows:

7 1. A straight line method shall be used;

8 2. The edition of the American Hospital Association's useful life guidelines currently
9 used by the Centers for Medicare and Medicaid Services' Medicare program shall be
10 used;

11 3. The maximum amount for expensing an item in a single cost report shall be
12 \$5000; and

13 4. Only the depreciation of assets actually being used to provide services shall be
14 recognized;

15 (c) Interest costs;

16 (d) Costs incurred for research purposes are allowable to the extent that they are re-
17 lated to usual patient services and are not covered by separate research funding;

18 (ef) Costs of motor vehicles used by management personnel up to \$25,000;

19 (f) Costs for training or educational purposes for licensed professional staff outside of
20 Kentucky excluding transportation costs to travel to the training or education;

21 (g) Costs associated with any necessary legal expense incurred in the normal admin-
22 istration of the CMHC;

23 (h) The cost of administrative staff salaries, which shall be limited to the average sal-

1 ary for the given position as established for the geographic area on www.salary.com;

2 and

3 (i)1. The cost of practitioner salaries, which shall be limited to the median salary for
4 the southern region as reported in the Medical Group Management Association
5 (MGMA) Physician Compensation and Production Survey Report, if available.

6 2. A per visit amount using MGMA median visits shall be utilized.

7 3. The most recently available MGMA publication that relates to the cost report peri-
8 od shall be used;

9 (j)1. Indirect costs calculated utilizing the approved federal indirect rate, if the provid-
10 er has an approved federal indirect rate. Providers shall include in indirect costs on line
11 1 of the cost report the same category of costs identified as indirect within the approved
12 federal indirect rate supporting documentation. Similarly, direct costs shall be those
13 costs identified as direct within the approved federal indirect rate. The Federal indirect
14 rate will be applied to the same category of expenses identified as direct during the
15 Federal rate determination. or

16 2. For providers that do not have a federal indirect rate, indirect costs are defined as
17 those costs of an organization which are not specifically identified with a particular pro-
18 ject, service, program, or activity but nevertheless are necessary to the general opera-
19 tion of the organization and the conduct of the activities it performs. The actual allowa-
20 ble cost of indirect services as reported on the cost report shall be allocated to direct
21 cost centers based on accumulated cost if no Federal indirect rate is available; and

22 (k) Services provided in leased or donated space outside the walls of the facility shall
23 be allowable costs.

1 (2) To be allowable, costs shall comply with reasonable cost principles established in
2 42 C.F.R. 413.

3 (3) The allowable cost for a service or good purchased by a facility from a related or-
4 ganization shall be in accordance with 42 C.F.R. 413.17.

5 (4)(a) The following shall not be allowable costs:

6 1. Bad debt;

7 2. Charity;

8 3. Courtesy allowances;

9 4. Political contributions;

10 5. Costs associated with an unsuccessful lawsuit against the department or the Cab-
11 inet for Health and Family Services;

12 6. Costs associated with any legal expense incurred related to a judgment granted as
13 a result of an unlawful activity or pursuit;

14 7. The value of services provided by non-paid workers;

15 8. Travel or related costs or expenses associated with non-licensed staff attending:

16 a. A convention;

17 b. A meeting;

18 c. An assembly; or

19 d. A conference;

20 9. Costs related to lobbying;

21 10. Costs related to outreach services; or

22 11. Costs incurred for transporting recipients to services.

23 (b) Outreach services' costs shall either be directly assigned or allocated to a cost

1 report line that is not cost-settled by the department.

2 (5) A discount or other allowance received regarding the purchase of a good or ser-
3 vice shall be deducted from the cost of the good or service for cost reporting purposes,
4 including in-kind donations.

5 (6)(a) Maximum allowable costs shall be the maximum amount that may be allowed
6 as reasonable cost for the provision of a service or drug.

7 (b) To be considered allowable, a cost shall:

8 1. Be necessary and appropriate for providing services; and

9 2. Not exceed usual and customary charges

10 (7) For direct and indirect personnel costs, 100% time reporting methods shall be uti-
11 lized to group/report expenses to each cost category. Detailed documentation shall be
12 available upon request.

13 ~~[as established in this subsection.~~

14 ~~(a) The payment rate that was in effect on June 30, 2002, for the community mental~~
15 ~~health center for community mental health center services shall remain in effect and~~
16 ~~there shall be no cost settling.~~

17 ~~(b) Allowable costs shall not:~~

18 ~~1. Exceed customary charges which are reasonable; or~~

19 ~~2. Include:~~

20 ~~a. The costs associated with political contributions;~~

21 ~~b. Travel or related costs for trips outside the state (for purposes of conventions,~~
22 ~~meetings, assemblies, conferences, or any related activities);~~

23 ~~c. The costs of motor vehicles used by management personnel which exceed~~

1 ~~\$20,000 total valuation annually (unless the excess cost is considered as compensation~~
2 ~~to the management personnel); or~~

3 ~~d. Legal fees for unsuccessful lawsuits against the cabinet.~~

4 ~~(c) Costs (excluding transportation costs) for training or educational purposes outside~~
5 ~~the state shall be allowable costs.~~

6 ~~(2) To be reimbursable, a service shall:~~

7 ~~(a) Meet the requirements of 907 KAR 1:044, Section 4(2); and~~

8 ~~(b) Be medically necessary].~~

9 Section 10. Units of Service [~~3. Implementation of Payment System~~]. (1) Interim[(~~a~~)
10 payments for behavioral health services, physician services, physical therapy services,
11 occupational therapy services, speech-language pathology services, laboratory ser-
12 vices, or radiological services shall be based on units of service.

13 (2) A unit for a behavioral health service, physician service, a physical therapy ser-
14 vice, a speech-language pathology service, an occupational therapy service, a laborato-
15 ry service, or radiological service shall be the amount indicated for the corresponding:

16 1. CPT code; or

17 2. Healthcare Common Procedure Coding System code.

18 ~~[(b) (One (1) unit for each service shall be defined as follows:~~

Service	Unit of Service
Individual Outpatient Therapy	15 minutes
Group Outpatient Therapy	15 minutes
Family Outpatient Therapy	15 minutes

Collateral Outpatient Therapy	15 minutes
Psychological Testing	15 minutes
Therapeutic Rehabilitation	15 minutes
Medication Prescribing and Monitoring	15 minutes
Physical Examinations	15 minutes
Screening	15 minutes
Assessment	15 minutes
Crisis Intervention	15 minutes
Service Planning	15 minutes
Screening, Brief Intervention, and Referral to Treatment	15 minutes
Mobile Crisis Services	1 hour
Assertive Community Treatment	Per Diem
Intensive Outpatient Program Services	Per Diem
Residential Crisis Stabilization Services	Per Diem
Residential Services for Substance Use Disorders	Per Diem
Partial Hospitalization	Per Diem
Day Treatment	1 hour

Comprehensive Community Support Services	15 minutes
Peer Support Services	15 minutes

1 ~~(2) An initial unit of service which lasts less than fifteen (15) minutes may be billed as~~
2 ~~one (1) unit.~~

3 ~~(3) Except for an initial unit of a service, a service that is:~~

4 ~~(a) Less than one-half (1/2) of one (1) unit shall be rounded down; or~~

5 ~~(b) Equal to or greater than one-half (1/2) of one (1) unit shall be rounded up.~~

6 ~~(4) An individual provider shall not exceed four (4) units of service in one (1) hour.~~

7 ~~(5) An overpayment discovered as a result of an audit shall be settled through re-~~
8 ~~coupment or withholding.~~

9 ~~(6) A community mental health center shall maintain an acceptable accounting sys-~~
10 ~~tem to account for the:~~

11 ~~(a) Cost of total services provided;~~

12 ~~(b) Charges for total services rendered; and~~

13 ~~(c) Charges for covered services rendered eligible recipients.~~

14 ~~(7) A community mental health center shall make available to the department all re-~~
15 ~~cipient records and fiscal records:~~

16 ~~(a) At the end of each fiscal reporting period;~~

17 ~~(b) Upon request by the department; and~~

18 ~~(c) Subject to reasonable prior notice by the department.~~

19 ~~(8) Payments due a community mental health center shall be made at least once a~~

1 month.

2 ~~Section 4. Nonallowable Costs. The department shall not reimburse:~~

3 ~~(1) Under the provisions of this administrative regulation for a service that is not cov-~~
4 ~~ered by 907 KAR 1:044; or~~

5 ~~(2) For a community mental health center's costs found unreasonable or nonallowa-~~
6 ~~ble in accordance with the Community Mental Health Center Reimbursement Manual.]~~

7 Section 11.~~[5.]~~ Reimbursement of Out-of-state Providers. Reimbursement to a partic-
8 ipating out-of-state community mental health center shall be the lesser of the:

9 (1) Charges for the service;

10 (2) Facility's rate as set by the state Medicaid Program in the other state; or

11 (3) The state-wide average of payments for in-state community mental health centers
12 ~~[Upper limit for that type of service in effect for Kentucky providers].~~

13 Section 12.~~[6.]~~ Appeal Rights. A community mental health center may appeal a De-
14 partment for Medicaid Services decision as to the application of this administrative
15 regulation in accordance with 907 KAR 1:671.

16 Section 13.~~[7.]~~ Not Applicable to Managed Care Organization. A managed care or-
17 ganization shall not be required to reimburse for community mental health center ser-
18 vices in accordance with this administrative regulation.

19 Section 14.~~[8.]~~ Federal Approval and Federal Financial Participation. The depart-
20 ment's reimbursement for services pursuant to this administrative regulation shall be
21 contingent upon:

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

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

907 KAR 1:045E

REVIEWED:

Date

Stephen P. Miller, Commissioner
Department for Medicaid Services

APPROVED:

Date

Vickie Yates Brown Glisson, Secretary
Cabinet for Health and Family Service

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 1:045E

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(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes the Department for Medicaid Services' (DMS's) reimbursement provisions and requirements regarding community mental health center services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish DMS's reimbursement provisions and requirements regarding community mental health center services.

(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 DMS's reimbursement provisions and requirements regarding community mental health center services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assist in the effective administration of the authorizing statutes by establishing DMS's reimbursement provisions and requirements regarding community mental health center 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: The amendment introduces a new cost-based reimbursement methodology and establishes reimbursement for primary care services (in concert with a companion administrative regulation – 907 KAR 1:046, Coverage provisions and requirements regarding community mental health center primary care service services.) Via the cost-based model, the Department for Medicaid Services (DMS) will ultimately reimburse for all services (behavioral health as well as primary care services) rendered during a given year based on Medicaid allowable costs after a thorough review of cost data reported by each CMHC to determine such costs for each CMHC. As a given CMHC's costs for a year is reported after the year concludes and DMS must review the cost data before determining the CMHC's total Medicaid allowable costs for the year, DMS reimburses each CMHC on an interim basis during the course of the year. After completing the review and determination of a CMHC's Medicaid allowable costs for a year, DMS will compare its interim reimbursement paid to the CMHC during the course of the year to the CMHC's actual Medicaid allowable costs for the year. If DMS's interim reimbursement to the CMHC exceeded the CMHC's Medicaid allowable costs, the CMHC will send the overpayment amount to DMS. If DMS's interim reimbursement was less than the CMHC's Medicaid allowable costs for the year, DMS will issue a lump sum payment to the CMHC equaling the amount owed. DMS's interim reimbursement for behavioral health services will initially be the reimbursement it currently pays CMHCs for behavioral health services, but after the first full twelve-month cost report has been audited and approved (and going forward) interim behavioral health reimbursement will be rates based on the most re-

cently audited and approved cost report. DMS's interim reimbursement for physician services, laboratory services, and radiological services will be the reimbursement stated on the Kentucky-specific Medicare Physician Fee Schedule for the given service. If no reimbursement exists on the fee schedule for a given service, DMS will reimburse (again, on an interim basis) for the service in the manner that it reimburses for physician's services pursuant to 907 KAR 3:010, Reimbursement for physician's services. DMS's interim reimbursement for occupational therapy, physical therapy, and speech-language pathology services will be the reimbursement stated on the Kentucky-specific Medicare Physician Fee Schedule for the given service. If no reimbursement exists on the fee schedule for a given service, DMS will reimburse (again, on an interim basis) for the service in the manner that it reimburses for physician's services pursuant to 907 KAR 3:010, Reimbursement for physician's services. DMS's interim reimbursement for the cost of injectable drugs administered in a CMHC will be DMS's reimbursement for such pursuant to its physician's services reimbursement administrative regulation (907 KAR 3:010). The reimbursement established in this administrative regulation only applies to services rendered to Medicaid "fee-for-service" recipients. These are Medicaid recipients who are not enrolled with a managed care organization. Managed care organizations are not required to reimburse for CMHC services in accordance with this administrative regulation.

(b) The necessity of the amendment to this administrative regulation: The amendment establishing a new cost-based reimbursement methodology results from a mandate from the Centers for Medicare and Medicaid Services (CMS). DMS's reimbursement of primary care services is necessary to comply with legislation (HB 527) enacted during the 2014 Regular Session of the General Assembly which was codified into KRS 205.6313.

(c) How the amendment conforms to the content of the authorizing statutes: The amendments conform to the content of the authorizing statutes by revising Medicaid reimbursement for community mental health centers in a manner that complies with a federal mandate and with a state mandate.

(d) How the amendment will assist in the effective administration of the statutes: The amendments will assist in the effective administration of the authorizing statutes by revising Medicaid reimbursement for community mental health centers in a manner that complies with a federal mandate and with a state mandate.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Community mental health centers will be affected by the administrative regulation. There are centers located across Kentucky under the governance of fourteen regional boards.

(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. In order to be reimbursed by the Department for Medicaid Services CMHCs will have to annually submit cost report information to DMS stating all of the CMHCs Medicaid allowable

costs, costs associated with care provided to recipients who are enrolled with a managed care organization, costs experienced by the Community Board for Mental Health or Individuals with an Intellectual Disability which oversees the CMHC; and costs associated with services covered by another payor/party. As mandated by the Centers for Medicare and Medicaid Services (CMS) the Medicaid "fee-for-service" costs of the CMHC must be clearly demarcated from the board's costs as well as the costs associated with care to recipients enrolled in an MCO.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). CMHCs will experience administrative costs associated with tracking and reporting costs data (including employing or contracting with personnel capable of accurately tracking and reporting the data).

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). CMHCs will benefit by receiving a cost-based reimbursement from DMS for services to Medicaid recipient who are not enrolled with a managed care organization.

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

(a) Initially: Due to the uncertainty of how many CMHCs will elect to expand their scope of services to include primary care services and to the uncertainty of when such CMHCs will meet the associated licensure requirements established by the Office of Inspector General, DMS is unable to project a cost associated with this action. DMS does not anticipate a substantial change in costs associated with implementing the new cost-based reimbursement methodology mandated by CMS, but won't know the full impact until after receiving cost reports from CMHCs in the future. DMS spent an aggregate (state and federal funds combined) of \$9.67 million on CMHC services during the state fiscal year that ended June 30, 2015.

(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 Number: 907 KAR 1:045E

Contact person: Sharley Hughes (502) 564-4321; Sharley.hughes@ky.gov

Tricia Orme (502) 564-7905; tricia.orme@ky.gov

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(10)(B).

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." KRS 205.6313 mandates that the Medicaid Program pay community mental health centers for primary service services at the same rates it pays primary care providers for such services.

3. Minimum or uniform standards contained in the federal mandate. 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 primary care 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.

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 Number: 907 KAR 1:045E

Contact person: Sharley Hughes (502) 564-4321; Sharley.hughes@ky.gov

Tricia Orme (502) 564-7905; tricia.orme@ky.gov

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? 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), 205.6313.

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? Due to the uncertainty of how many CMHCs will elect to expand their scope of services to include primary care services and to the uncertainty of when such CMHCs will meet the associated licensure requirements established by the Office of Inspector General, DMS is unable to project a cost associated with this action. DMS does not anticipate a substantial change in costs associated with implementing the new cost-based reimbursement methodology mandated by CMS, but won't know the full impact until after receiving cost reports from CMHCs in the future. DMS spent an aggregate (state and federal funds combined) of \$9.67 million on CMHC services during the state fiscal year that ended June 30, 2015.

(d) How much will it cost to administer this program for subsequent years? The response in (c) above 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: