

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Commissioner's Office

4 (New Administrative Regulation)

5 907 KAR 17:025. Managed care organization requirements and policies related to
6 utilization management and quality.

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

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

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 a requirement that may be imposed or opportunity presented by federal law
14 to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 estab-
15 lish requirements relating to managed care. This administrative regulation establishes
16 the Medicaid managed care organization requirements and policies relating to utilization
17 management and quality.

18 Section 1. Utilization Management or UM. (1) An MCO shall:

19 (a) Have a utilization management program that shall:

20 1. Meet the requirements established in 42 C.F.R. Parts 431, 438, and 456, and the
21 private review agent requirements of KRS 304.17A, as applicable;

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

- 1 a. Is licensed to practice medicine or osteopathy in Kentucky;
- 2 b. Is responsible for treatment policies, protocols, and decisions; and
- 3 c. Supervises the UM program; and
- 4 3. Written policies and procedures that explain how prior authorization data will be in-
- 5 corporated into the MCO's quality improvement plan;
- 6 (e) Submit a request for a change in review criteria for authorization decisions to the
- 7 department for approval prior to implementation;
- 8 (f) Administer or use a CAHPS survey to evaluate and report enrollee satisfaction
- 9 with the quality of, and access to, care and services in accordance with 907 KAR
- 10 17:010; or
- 11 (g) Provide written confirmation of an approval of a request for a service within two
- 12 (2) business days of providing notification of a decision if:
- 13 1. The initial decision was not in writing; and
- 14 2. Requested by an enrollee or provider;
- 15 (h) If the MCO uses a subcontractor to perform UM, require the subcontractor to have
- 16 written policies, procedures, and a process to review, evaluate, and ensure consistency
- 17 with which physicians and other health care professionals involved in UM apply review
- 18 criteria for authorization decisions; and
- 19 (i) Not provide a financial or other type of incentive to an individual or entity that con-
- 20 ducts UM activities to deny, limit, or discontinue a medically necessary service to an en-
- 21 rollee pursuant to 42 C.F.R. 422.208, 42 C.F.R. 438.6(h), and 42 C.F.R. 438.210(e).
- 22 (2) A UM program description referenced in subsection (1)(a)5. of this section shall:
- 23 (a) Outline the UM program's structure;

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

3 (c) Include the:

4 1. Scope of the program;

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

7 3. Policies and procedures to evaluate:

8 a. Care coordination;

9 b. Discharge criteria;

10 c. Site of services;

11 d. Levels of care;

12 e. Triage decisions; and

13 f. Cultural competence of care delivery; and

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

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

19 (4) A medical necessity review process shall be in accordance with Section 2 of this
20 administrative regulation.

21 Section 2. Service Authorization and Notice. (1) For the processing of a request for
22 initial or continuing authorization of a service, an MCO shall identify what constitutes
23 medical necessity and establish a written policy and procedure, which includes a

1 timeframe for:

2 (a) Making an authorization decision; and

3 (b) If the service is denied or authorized in an amount, duration, or scope which is
4 less than requested, providing a notice to an enrollee and provider acting on behalf of
5 and with the consent of an enrollee.

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

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

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

9 (3) The timeframe for making an authorization decision referenced in subsection (2)
10 of this section may be extended:

11 (a) By the:

12 1. Enrollee, or the provider acting on behalf of and with consent of an enrollee, if the
13 enrollee requests an extension; or

14 2. MCO, if the MCO:

15 a. Justifies to the department, upon request, a need for additional information and
16 how the extension is in the enrollee's interest;

17 b. Gives the enrollee written notice of the extension, including the reason for extend-
18 ing the authorization decision timeframe and the right of the enrollee to file a grievance
19 if the enrollee disagrees with that decision; and

20 c. Makes and carries out the authorization decision as expeditiously as the enrollee's
21 health condition requires and no later than the date the extension expires; and

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

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

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

2 (a) To the:

3 1. Enrollee, in writing, as expeditiously as the enrollee's condition requires and within
4 two (2) business days of receipt of the request for service; and

5 2. Requesting provider, if applicable;

6 (b) Which shall:

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

8 2. Include the:

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

10 b. Reason for the action;

11 c. Right of the enrollee or provider who is acting on behalf of the enrollee to file an
12 MCO appeal;

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

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

15 f. Circumstance under which an expedited resolution is available and how to request
16 it; and

17 g. Right to have benefits continue pending resolution of the appeal, how to request
18 that benefits be continued, and the circumstance under which the enrollee may be re-
19 quired to pay the costs of these services; and

20 3. Be provided:

21 a. At least ten (10) days before the date of action if the action is a termination, sus-
22 pension, or reduction of a covered service authorized by the department, department
23 designee, or enrollee's MCO, except the department may shorten the period of advance

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

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

4 (i) The death of a member;

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

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

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

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

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

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

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

22 c. On the date of action, if the action is a denial of payment and the service has not
23 been provided to the member;

1 d. As expeditiously as the enrollee's health condition requires and within two (2)
2 business days following receipt of a request;

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

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

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

13 Section 3. Health Risk Assessment. An MCO shall:

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

17 (2) Use health care professionals in the health risk assessment process;

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

20 (4) If an enrollee is pregnant, refer the enrollee for prenatal care;

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

22 (a) Care management;

23 (b) Disease management;

- 1 (c) A behavioral health service;
- 2 (d) A physical health service or procedure; or
- 3 (e) A community service.

4 Section 4. Care Coordination and Management. An MCO shall:

- 5 (1) Have a care coordinator and a case manager who shall:

- 6 (a) Arrange, assure delivery of, monitor, and evaluate care, treatment, and services
- 7 for an enrollee; and

- 8 (b) Not duplicate or supplant services provided by a targeted case manager to:

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

- 10 2. Children with a severe emotional disability pursuant to 907 KAR 1:525;

- 11 (2) Have guidelines for care coordination that shall be approved by the department
- 12 prior to implementation;

- 13 (3) Develop a plan of care for an enrollee in accordance with 42 C.F.R. 438.208;

- 14 (4) Have policies and procedures to ensure access to care coordination for a DCBS
- 15 client or a DAIL client;

- 16 (5) Provide information on and coordinate services with the Women, Infants and
- 17 Children program; and

- 18 (6) Provide information to an enrollee and a provider regarding:

- 19 (a) An available care management service; and

- 20 (b) How to obtain a care management service.

21 Section 5. Quality Assessment and Performance Improvement (QAPI) Program. An

22 MCO shall:

- 23 (1) Have a quality assessment and performance improvement (QAPI) program that

1 shall:

2 (a) Conform to the requirements of 42 C.F.R. 438 Subpart D, 438.200 to 438.242;

3 (b) Assess, monitor, evaluate, and improve the quality of care provided to an enrol-
4 lee;

5 (c) Provide for the evaluation of:

6 1. Access to care;

7 2. Continuity of care;

8 3. Health care outcomes; and

9 4. Services provided or arranged for by the MCO;

10 (d) Demonstrate the linkage of quality improvement (QI) activities to findings from a
11 quality evaluation; and

12 (e) Be developed in collaboration with input from enrollees;

13 (2) Submit annually to the department a description of its QAPI program;

14 (3) Conduct and submit to the department an annual review of the program;

15 (4) Maintain documentation of:

16 (a) Enrollee input;

17 (b) The MCO's response to the enrollee input;

18 (c) A performance improvement activity; and

19 (d) MCO feedback to an enrollee;

20 (5) Have or obtain within four (4) years of initial implementation National Committee
21 for Quality Assurance (NCQA) accreditation for its Medicaid product line;

22 (6) If the MCO has obtained NCQA accreditation:

23 (a) Submit to the department a copy of its current certificate of accreditation with a

- 1 copy of the complete accreditation survey report; and
- 2 (b) Maintain the accreditation;
- 3 (7) Integrate behavioral health service indicators into its QAPI program;
- 4 (8) Include a systematic, on-going process for monitoring, evaluating, and improving
- 5 the quality and appropriateness of a behavioral health service provided to an enrollee;
- 6 (9) Collect data, monitor, and evaluate for evidence of improvement to a physical
- 7 health outcome resulting from integration of behavioral health into an enrollee's care;
- 8 and
- 9 (10) Annually review and evaluate the effectiveness of the QAPI program.

10 Section 6. Quality Assessment and Performance Improvement Plan. (1) An MCO
11 shall:

- 12 (a) Have a written QAPI work plan that:
 - 13 1. Outlines the scope of activities;
 - 14 2. Is submitted quarterly to the department; and
 - 15 3. Sets goals, objectives, and timelines for the QAPI program;
- 16 (b) Set new goals and objectives:
 - 17 1. At least annually; and
 - 18 2. Based on a finding from:
 - 19 a. A quality improvement activity or study;
 - 20 b. A survey result;
 - 21 c. A grievance or appeal;
 - 22 d. A performance measure; or
 - 23 e. The external quality review organization;

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

- 1 a. A description of the QAPI activities;
- 2 b. Progress on objectives; and
- 3 c. Improvements made;
- 4 (i) Require a provider to participate in QAPI activities in the provider agreement or
- 5 subcontract; and
- 6 (j) Provide feedback to a provider or a subcontractor regarding integration of or oper-
- 7 ation of a corrective action necessary in a QAPI activity if a corrective action is neces-
- 8 sary.

9 (2) If a QAPI activity of a provider or a subcontractor is separate from an MCO's QA-

10 PI program, the activity shall be integrated into the MCO's QAPI program.

11 Section 7. QAPI Monitoring and Evaluation. (1) Through its QAPI program, an MCO

12 shall:

- 13 (a) Monitor and evaluate the quality of health care provided to an enrollee;
- 14 (b) Study and prioritize health care needs for performance measurement, perfor-
- 15 mance improvement, and development of practice guidelines;
- 16 (c) Use a standardized quality indicator:
 - 17 1. To assess improvement, assure achievement of at least a minimum performance
 - 18 level, monitor adherence to a guideline, and identify a pattern of over and under utiliza-
 - 19 tion of a service; and
 - 20 2. Which shall be:
 - 21 a. Supported by a valid data collection and analysis method; and
 - 22 b. Used to improve clinical care and services;
 - 23 (d) Measure a provider performance against a practice guideline and a standard

1 adopted by the quality improvement committee;

2 (e) Use a multidisciplinary team to analyze and address data and systems issues;

3 and

4 (f) Have practice guidelines that shall:

5 1. Be:

6 a. Disseminated to a provider, or upon request, to an enrollee;

7 b. Based on valid and reliable medical evidence or consensus of health profession-
8 als;

9 c. Reviewed and updated; and

10 d. Used by the MCO in making a decision regarding utilization management, a cov-
11 ered service, or enrollee education;

12 2. Consider the needs of enrollees; and

13 3. Include consultation with network providers.

14 (2) If an area needing improvement is identified by the QAPI program, the MCO shall
15 take a corrective action and monitor the corrective action for improvement.

16 Section 8. Quality and Member Access Committee. (1) An MCO shall:

17 (a) Have a quality and member access committee (QMAC) composed of:

18 1. Enrollees who shall be representative of the enrollee population; and

19 2. Individuals from consumer advocacy groups or the community who represent the
20 interests of enrollees in the MCO; and

21 (b) Submit to the department annually a list of enrollee representatives participating
22 in the QMAC.

23 (2) A QMAC shall be responsible for reviewing:

- 1 (a) Quality and access standards;
- 2 (b) The grievance and appeals process;
- 3 (c) Policy modifications needed based on reviewing aggregate grievance and ap-
- 4 peals data;
- 5 (d) The member handbook;
- 6 (e) Enrollee education materials;
- 7 (f) Community outreach activities; and
- 8 (g) MCO and department policies that affect enrollees.

9 (3) The QMAC shall provide the results of its reviews to the MCO.

10 Section 9. External Quality Review. (1) In accordance with 42 U.S.C. 1396a(a)(30),
11 the department shall have an independent external quality review organization (EQRO)
12 annually review the quality of services provided by an MCO.

13 (2) An MCO shall:

14 (a) Provide information to the EQRO as requested to fulfill the requirements of the
15 mandatory and optional activities required in 42 C.F.R. Parts 433 and 438; and

16 (b) Cooperate and participate in external quality review activities in accordance with
17 the protocol established in 42 C.F.R. 438 Subpart E, 438.310 to 438.370.

18 (3) The department shall have the option of using information from a Medicare or pri-
19 vate accreditation review of an MCO in accordance with 42 C.F.R. 438.360.

20 (4) If an adverse finding or deficiency is identified by an EQRO conducting an exter-
21 nal quality review, an MCO shall correct the finding or deficiency.

22 Section 10. Health Care Outcomes. An MCO shall:

23 (1) Comply with the requirements established in 42 C.F.R. 438.240 relating to quality

1 assessment and performance improvement;

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

4 (a) Be aligned with national and state preventive initiatives; and

5 (b) Focus on improving health;

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

8 (4) Report activities on performance measures in the QAPI work plan established in
9 Section 6 of this administrative regulation;

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

12 (a) Medicaid eligibility category;

13 (b) Race;

14 (c) Ethnicity;

15 (d) Gender; and

16 (e) Age;

17 (6) Collect and report HEDIS data annually; and

18 (7) Submit to the department:

19 (a) The final auditor's report issued by the NCQA certified audit organization; and

20 (b) A copy of the interactive data submission system tool used by the MCO.

21 Section 11. Performance Improvement Projects (PIPs). (1) An MCO shall:

22 (a) Implement PIPs to address aspects of clinical care and nonclinical services;

23 (b) Collaborate with local health departments, behavioral health agencies, and other

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

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

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

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

7 (f) Include the following for a PIP:

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

9 2. Methodology for topic selection;

10 3. Goals of the PIP;

11 4. Data sources and collection methods;

12 5. An intervention; and

13 6. Results and interpretations.

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

16 (a) The enrollee population;

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

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

20 (3) A nonclinical PIP shall address improving the quality, availability, and accessibility
21 of services provided by an MCO to enrollees and providers.

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

23 (a) A finding from an EQRO review referenced in Section 9 of this administrative reg-

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

2 (b) Directed by CMS.

3 (5) The department shall be authorized to require an MCO to assist in a statewide
4 PIP which shall be limited to providing the department with data from the MCO's service
5 area.

6 Section 12. Centers for Medicare and Medicaid Services Approval and Federal Fi-
7 nancial Participation. A policy established in this administrative regulation shall be null
8 and void if the Centers for Medicare and Medicaid Services:

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

10 (2) Disapproves the policy.

907 KAR 17:025

REVIEWED:

Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

A public hearing on this administrative regulation shall, if requested, be held on February 21, 2013 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business February 28, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

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

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 17:025
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 utilization management and quality. 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. The only amended policy in this administrative regulation is the elimination of the MCO reporting requirements as incorporating the material is unnecessary.

- (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization requirements and policies relating to utilization management and quality. The amendment is necessary to prevent the unnecessary incorporation by reference of a document into an administrative regulation.
- (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 utilization management and quality.
- (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 man-

aged care organization requirements and policies relating to utilization management and quality.

- (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 im-

plementation 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 17:025
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 utilization management and quality requirements and policies. Quality assessment and performance improvement requirements are established in 42 CFR 438.200 through 438.242. External quality review is another required quality component and those requirements are established in 42 CFR 438.310 through 438.370.
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 utilization management and quality requirements. Quality assessment and performance improvement requirements are established in 42 CFR 438.200 through 438.242. External quality review is another required quality component and those requirements are established in 42 CFR 438.310 through 438.370. Quality requirements include the following:

States must develop and implement a quality assessment and improvement strategy, including: (1) standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care, adequate primary care, and specialized services; (2) examinations of other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards); (3) procedures for monitoring and evaluating the quality and propriety of care and services, including the submission of quality assurance data; and (4) regular, periodic examinations of the scope and content of the quality improvement strategies.

Also, states must provide for an annual external independent review conducted by a qualified independent entity (an external quality review organization or EQRO) of the quality outcomes, timeliness, and access to items and services for which the organization is responsible under the contract. The results are available to participating healthcare providers, enrollees, and potential enrollees of the organization in a manner that does not disclose the identity of an individual patient. An EQRO must meet

the experience and independence criteria at 42 C.F.R. §438.354, which require that there be no financial or contractual relationship between the state agency and the organization.

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 (which is not federally mandated) but does not impose additional or stricter requirements than the federal managed care organization requirements.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not being imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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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.