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REGULATIONS COMPILER

1 CABINET FOR HEALTH AND FAMILY SERVICES
2 Department for Medicaid Services
3 Division of Policy and Operations
4 (New Administrative Regulation)
5 907 KAR 15:080. Coverage provisions and requirements regarding outpatient chemi-
6 cal dependency treatment center services.
7 RELATES TO: KRS 205.520, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23)
8 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)
9 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
10 Services, Department for Medicaid Services, has a responsibility to administer the Med-
11 icaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to
12 comply with any requirement that may be imposed or opportunity presented by federal
13 law to qualify for federal Medicaid funds. This administrative regulation establishes the
14 coverage provisions and requirements regarding Medicaid Program outpatient chemical
15 dependency treatment center services.
16 Section 1. General Coverage Requirements. (1) For the department to reimburse for
17 a service covered under this administrative regulation, the service shall be:
18 (a) Medically necessary; and
19 (b) Provided:
20 1. To a recipient; and
21 2. By a chemical dependency treatment center that meets the provider participation

1 requirements established in Section 2 of this administrative regulation.

2 (2)(a) Face-to-face contact between a practitioner and a recipient shall be required

3 for each service except for:

4 1. Collateral outpatient therapy for a recipient under the age of twenty-one (21) years

5 if the collateral outpatient therapy is in the recipient's plan of care;

6 2. A family outpatient therapy service in which the corresponding current procedural

7 terminology code establishes that the recipient is not present;

8 3. A psychological testing service comprised of interpreting or explaining results of an

9 examination or data to family members or others in which corresponding current proce-

10 dural terminology code establishes that the recipient is not present; or

11 4. A service planning activity in which the corresponding current procedural terminol-

12 ogy code establishes that the recipient is not present.

13 (b) A service that does not meet the requirement in paragraph (a) of this subsection

14 shall not be covered.

15 (3) A billable unit of service shall be actual time spent delivering a service in a face-

16 to-face encounter.

17 (4) A service shall be:

18 (a) Stated in the recipient's plan of care; and

19 (b) Provided in accordance with the recipient's plan of care.

20 (5)(a) A chemical dependency treatment center shall establish a plan of care for each

21 recipient receiving services from a chemical dependency treatment center.

22 (b) A plan of care shall meet the treatment plan requirements established in 902 KAR

23 20:160.

1 Section 2. Provider Participation. (1)(a) To be eligible to provide services under this
2 administrative regulation, a chemical dependency treatment center shall:
3 1. Be currently enrolled as a provider in the Kentucky Medicaid Program in accord-
4 ance with 907 KAR 1:672;
5 2. Except as established in subsection (2) of this section, be currently participating in
6 the Kentucky Medicaid Program in accordance with 907 KAR 1:671;
7 3. Be licensed as a chemical dependency treatment center to provide outpatient be-
8 havioral health services in accordance with 902 KAR 20:160; and
9 4. Have:
10 a. For each service it provides, the capacity to provide the full range of the service as
11 established in this administrative regulation;
12 b. Documented experience in serving individuals with behavioral health disorders;
13 c. The administrative capacity to ensure quality of services;
14 d. A financial management system that provides documentation of services and
15 costs; and
16 e. The capacity to document and maintain individual health records.
17 (b) The documentation referenced in paragraph (a)4.b. of this subsection shall be
18 subject to audit by:
19 1. The department;
20 2. The Cabinet for Health and Family Services, Office of Inspector General;
21 3. A managed care organization, if the chemical dependency treatment center is en-
22 rolled in its network;
23 4. The Centers for Medicare and Medicaid Services;

1 5. The Kentucky Office of the Auditor of Public Accounts; or

2 6. The United States Department of Health and Human Services, Office of the In-

3 spector General.

4 (2) In accordance with 907 KAR 17:015, Section 3(3), a chemical dependency treat-

5 ment center which provides a service to an enrollee shall not be required to be currently

6 participating in the fee-for-service Medicaid Program.

7 (3) A chemical dependency treatment center shall:

8 (a) Agree to provide services in compliance with federal and state laws regardless of

9 age, sex, race, creed, religion, national origin, handicap, or disability; and

10 (b) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and

11 any amendments to the Act.

12 Section 3. Covered Services. (1) The services covered may be provided for a sub-

13 stance use disorder.

14 (2) The following services shall be covered under this administrative regulation in ac-

15 cordance with the following requirements:

16 (a) A screening, crisis intervention, or intensive outpatient program service provided

17 by:

18 1. A licensed psychologist;

19 2. A licensed psychological practitioner;

20 3. A certified psychologist with autonomous functioning;

21 4. A licensed clinical social worker;

22 5. A licensed professional clinical counselor;

23 6. A licensed professional art therapist;

1 7. A licensed marriage and family therapist;

2 8. A physician;

3 9. A psychiatrist;

4 10. An advanced practice registered nurse;

5 11. A licensed psychological associate working under the supervision of a board-

6 approved licensed psychologist;

7 12. A certified psychologist working under the supervision of a board-approved li-

8 censed psychologist;

9 13. A licensed clinical alcohol and drug counselor in accordance with Section 11 of

10 this administrative regulation; or

11 14. A behavioral health practitioner under supervision:

12 a. In accordance with Section 11 of this administrative regulation; and

13 b. Except for a licensed assistant behavior analyst;

14 (b) An assessment provided by:

15 1. A licensed psychologist;

16 2. A licensed psychological practitioner;

17 3. A certified psychologist with autonomous functioning;

18 4. A licensed clinical social worker;

19 5. A licensed professional clinical counselor;

20 6. A licensed professional art therapist;

21 7. A licensed marriage and family therapist;

22 8. A physician;

23 9. A psychiatrist;

1 10. An advanced practice registered nurse;

2 11. A licensed behavior analyst;

3 12. A licensed psychological associate working under the supervision of a board-

4 approved licensed psychologist;

5 13. A certified psychologist working under the supervision of a board-approved li-

6 censed psychologist;

7 14. A licensed clinical alcohol and drug counselor in accordance with Section 11 of

8 this administrative regulation; or

9 15. A behavioral health practitioner under supervision in accordance with Section 11

10 of this administrative regulation;

11 (c) Psychological testing provided by:

12 1. A licensed psychologist;

13 2. A licensed psychological practitioner;

14 3. A certified psychologist with autonomous functioning;

15 4. A licensed psychological associate working under the supervision of a board-

16 approved licensed psychologist; or

17 5. A certified psychologist working under the supervision of a board-approved li-

18 censed psychologist;

19 (d) Day treatment or mobile crisis services provided by:

20 1. A licensed psychologist;

21 2. A licensed psychological practitioner;

22 3. A certified psychologist with autonomous functioning;

23 4. A licensed clinical social worker;

1 5. A licensed professional clinical counselor;

2 6. A licensed professional art therapist;

3 7. A licensed marriage and family therapist;

4 8. A physician;

5 9. A psychiatrist;

6 10. An advanced practice registered nurse;

7 11. A licensed psychological associate working under the supervision of a board-

8 approved licensed psychologist;

9 12. A certified psychologist working under the supervision of a board-approved li-

10 censed psychologist;

11 13. A licensed clinical alcohol and drug counselor in accordance with Section 11 of

12 this administrative regulation;

13 14. A behavioral health practitioner under supervision:

14 a. Except for a licensed assistant behavior analyst; and

15 b. In accordance with Section 11 of this administrative regulation; or

16 15. A peer support specialist working under the supervision of an approved behav-

17 ioral health services provider in accordance with Section 11 of this administrative regu-

18 lation;

19 (e) Peer support provided by a peer support specialist working under the supervision

20 of an approved behavioral health services provider in accordance with Section 11 of this

21 administrative regulation;

22 (f) Individual outpatient therapy, group outpatient therapy, or collateral outpatient

23 therapy provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A certified psychologist with autonomous functioning;

4. A licensed clinical social worker;

5. A licensed professional clinical counselor;

6. A licensed professional art therapist;

7. A licensed marriage and family therapist;

8. A physician;

9. A psychiatrist;

10. An advanced practice registered nurse;

11. A licensed behavior analyst;

12. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;

13. A certified psychologist working under the supervision of a board-approved licensed psychologist;

14. A licensed clinical alcohol and drug counselor in accordance with Section 11 of this administrative regulation; or

15. A behavioral health practitioner under supervision in accordance with Section 11 of this administrative regulation;

(g) Family outpatient therapy provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner;

3. A certified psychologist with autonomous functioning;

1 4. A licensed clinical social worker;

2 5. A licensed professional clinical counselor;

3 6. A licensed professional art therapist;

4 7. A licensed marriage and family therapist;

5 8. A physician;

6 9. A psychiatrist;

7 10. An advanced practice registered nurse;

8 11. A licensed psychological associate working under the supervision of a board-

9 approved licensed psychologist;

10 12. A certified psychologist working under the supervision of a board-approved li-

11 censed psychologist;

12 13. A licensed clinical alcohol and drug counselor in accordance with Section 11 of

13 this administrative regulation; or

14 14. A behavioral health practitioner under supervision:

15 a. Except for a licensed assistant behavior analyst; and

16 b. In accordance with Section 11 of this administrative regulation; or

17 (h) A screening, brief intervention, and referral to treatment for a substance use dis-

18 order or SBIRT provided by:

19 1. A licensed psychologist;

20 2. A licensed psychological practitioner;

21 3. A certified psychologist with autonomous functioning;

22 4. A licensed clinical social worker;

23 5. A licensed professional clinical counselor;

1 6. A licensed professional art therapist;

2 7. A licensed marriage and family therapist;

3 8. A physician;

4 9. A psychiatrist;

5 10. An advanced practice registered nurse;

6 11. A licensed psychological associate working under the supervision of a board-

7 approved licensed psychologist;

8 12. A certified psychologist working under the supervision of a board-approved li-

9 censed psychologist;

10 13. A licensed clinical alcohol and drug counselor in accordance with Section 12 of

11 this administrative regulation; or

12 14. A behavioral health practitioner under supervision:

13 a. Except for a licensed assistant behavior analyst; and

14 b. In accordance with Section 12 of this administrative regulation.

15 (3)(a) A screening shall:

16 1. Determine the likelihood that an individual has a substance use disorder;

17 2. Not establish the presence or specific type of disorder; and

18 3. Establish the need for an in-depth assessment.

19 (b) An assessment shall:

20 1. Include gathering information and engaging in a process with the individual that

21 enables the practitioner to:

22 a. Establish the presence or absence of a substance use disorder;

23 b. Determine the individual's readiness for change;

1 c. Identify the individual's strengths or problem areas that may affect the treatment
2 and recovery processes; and
3 d. Engage the individual in the development of an appropriate treatment relationship;
4 2. Establish or rule out the existence of a clinical disorder or service need;
5 3. Include working with the individual to develop a plan of care; and
6 4. Not include psychological or psychiatric evaluations or assessments.
7 (c) Psychological testing shall:
8 1. Include:
9 a. A psychodiagnostic assessment of personality, psychopathology, emotionality, or
10 intellectual disabilities; and
11 b. Interpretation and a written report of testing results; and
12 2. Be performed by an individual who has met the requirements of KRS Chapter 319
13 related to the necessary credentials to perform psychological testing.
14 (d) Crisis intervention:
15 1. Shall be a therapeutic intervention for the purpose of immediately reducing or elim-
16 inating the risk of physical or emotional harm to:
17 a. The recipient; or
18 b. Another individual;
19 2. Shall consist of clinical intervention and support services necessary to provide in-
20 tegrated crisis response, crisis stabilization interventions, or crisis prevention activities
21 for individuals;
22 3. Shall be provided:
23 a. On-site in the facility where the outpatient behavioral health services are provided;

1 b. As an immediate relief to the presenting problem or threat; and

2 c. In a face-to-face, one (1) on one (1) encounter between the provider and the recip-

3 ient;

4 4. Shall be followed by a referral to non-crisis services if applicable; and

5 5. May include:

6 a. Further service prevention planning that includes:

7 (i) Lethal means reduction for suicide risk; or

8 (ii) Substance use disorder relapse prevention; or

9 b. Verbal de-escalation, risk assessment, or cognitive therapy.

10 (e) Mobile crisis services shall:

11 1. Be available twenty-four (24) hours per day, seven (7) days per week, every day of

12 the year;

13 2. Ensure access to a board-certified or board-eligible psychiatrist twenty-four (24)

14 hours per day, seven (7) days per week, every day of the year;

15 3. Be provided for a duration of less than twenty-four (24) hours;

16 4. Not be an overnight service;

17 5. Be a multi-disciplinary team-based intervention in a home or community setting

18 that ensures access to substance use disorder services and supports to:

19 (i) Reduce symptoms or harm; or

20 (ii) Safely transition an individual in an acute crisis to the appropriate least restrictive

21 level of care;

22 6. Involve all services and supports necessary to provide:

23 a. Integrated crisis prevention;

1 b. Assessment and disposition;

2 c. Intervention;

3 d. Continuity of care recommendations; and

4 e. Follow-up services; and

5 7. Be provided face-to-face in a home or community setting.

6 (f)1. Day treatment shall be a non-residential, intensive treatment program for an in-

7 dividual under the age of twenty-one (21) years who has:

8 a. A substance use disorder; and

9 b. A high risk of out-of-home placement due to a behavioral health issue.

10 2. Day treatment shall:

11 a. Consist of an organized, behavioral health program of treatment and rehabilitative

12 services;

13 b. Include:

14 (i) Individual outpatient therapy, family outpatient therapy, or group outpatient thera-

15 py;

16 (ii) Behavior management and social skills training;

17 (iii) Independent living skills that correlate to the age and developmental stage of the

18 recipient; or

19 (iv) Services designed to explore and link with community resources before discharge

20 and to assist the recipient and family with transition to community services after dis-

21 charge; and

22 c. Be provided:

23 (i) In collaboration with the education services of the local education authority includ-

1 ing those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Educa-
2 tion Act) or 29 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);
3 (ii) On school days and on non-instructional weekdays during the school year includ-
4 ing scheduled school breaks;
5 (iii) In coordination with the recipient's individualized educational plan or Section 504
6 plan if the recipient has an individualized educational plan or Section 504 plan;
7 (iv) Under the supervision of a licensed or certified approved behavioral health ser-
8 vices provider in accordance with Section 11 of this administrative regulation or a be-
9 havioral health practitioner working under clinical supervision in accordance with Sec-
10 tion 11 of this administrative regulation; and
11 (v) With a linkage agreement with the local education authority that specifies the re-
12 sponsibilities of the local education authority and the day treatment provider.
13 3. To provide day treatment services, a chemical dependency treatment center shall
14 have:
15 a. The capacity to employ staff authorized to provide day treatment services in ac-
16 cordance with this section and to coordinate the provision of services among team
17 members; and
18 b. Knowledge of substance use disorders.
19 4. Day treatment shall not include a therapeutic clinical service that is included in a
20 child's individualized education plan.
21 (g)1. Peer support services shall:
22 a. Be emotional support that is provided to a recipient by:
23 (i) An individual who has been trained and certified in accordance with 908 KAR

1 2:220 or 907 KAR 2:240 and who is experiencing or has experienced a substance use
2 disorder to a recipient by sharing a similar substance use disorder in order to bring
3 about a desired social or personal change;
4 (ii) A parent who has been trained and certified in accordance with 908 KAR 2:230 of
5 a child having or who has had a substance use disorder to a parent or family member of
6 a child sharing a similar substance use disorder in order to bring about a desired social
7 or personal change; or
8 (iii) A family member who has been trained and certified in accordance with 908 KAR
9 2:230 of a child having or who has had a substance use disorder to a parent or family
10 member of a child sharing a similar substance use disorder in order to bring about a de-
11 sired social or personal change;
12 b. Be an evidence-based practice;
13 c. Be structured and scheduled non-clinical therapeutic activities with an individual
14 recipient or a group of recipients;
15 d. Promote socialization, recovery, self-advocacy, preservation, and enhancement of
16 community living skills for the recipient;
17 e. Be coordinated within the context of a comprehensive, individualized plan of care
18 developed through a person-centered planning process;
19 f. Be identified in each recipient's plan of care; and
20 g. Be designed to contribute directly to the recipient's individualized goals as speci-
21 fied in the recipient's plan of care.
22 2. To provide peer support services, a chemical dependency treatment center shall:
23 a. Have demonstrated:

1 (i) The capacity to provide peer support services for the behavioral health population
2 being served including the age range of the population being served; and
3 (ii) Experience in serving individuals with behavioral health disorders;
4 b. Employ peer support specialists who are qualified to provide peer support services
5 in accordance with 908 KAR 2:220, 908 KAR 2:230, or 908 KAR 2:240;
6 c. Use an approved behavioral health services provider in accordance with Section
7 11 of this administrative regulation to supervise peer support specialists;
8 d. Have the capacity to coordinate the provision of services among team members;
9 and
10 e. Have the capacity to provide on-going continuing education and technical assis-
11 tance to peer support specialists.
12 (h)1. Intensive outpatient program services shall:
13 a. Be an alternative to or transition from inpatient hospitalization or partial hospitaliza-
14 tion for a substance use disorder;
15 b. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that
16 is significantly more intensive than individual outpatient therapy, group outpatient thera-
17 py, or family outpatient therapy;
18 c. Be provided at least three (3) hours per day at least three (3) days per week; and
19 d. Include:
20 (i) Individual outpatient therapy, group outpatient therapy, or family outpatient therapy
21 unless contraindicated;
22 (ii) Crisis intervention; or
23 (iii) Psycho-education.

1 2. During psycho-education the recipient or recipient's family member shall be:

2 a. Provided with knowledge regarding the recipient's diagnosis, the causes of the

3 condition, and the reasons why a particular treatment might be effective for reducing

4 symptoms; and

5 b. Taught how to cope with the recipient's diagnosis or condition in a successful

6 manner.

7 3. An intensive outpatient program services treatment plan shall:

8 a. Be individualized; and

9 b. Focus on stabilization and transition to a lesser level of care.

10 4. To provide intensive outpatient program services, a chemical dependency treat-

11 ment center shall have:

12 a. Access to a board-certified or board-eligible psychiatrist for consultation;

13 b. Access to a psychiatrist, physician, or advanced practice registered nurse for med-

14 ication prescribing and monitoring;

15 c. Adequate staffing to ensure a minimum recipient-to-staff ratio of ten (10) recipients

16 to one (1) staff person;

17 d. The capacity to provide services utilizing a recognized intervention protocol based

18 on nationally accepted treatment principles; and

19 e. The capacity to employ staff authorized to provide intensive outpatient program

20 services in accordance with this section and to coordinate the provision of services

21 among team members.

22 (i) Individual outpatient therapy shall:

23 1. Be provided to promote the:

1 a. Health and well-being of the individual; and

2 b. Recovery from a substance use disorder;

3 2. Consist of:

4 a. A face-to-face, one (1) on one (1) encounter between the provider and recipient;

5 and

6 b. A behavioral health therapeutic intervention provided in accordance with the recip-

7 ient's identified plan of care;

8 3. Be aimed at:

9 a. Reducing adverse symptoms;

10 b. Reducing or eliminating the presenting problem of the recipient; and

11 c. Improving functioning; and

12 4. Not exceed three (3) hours per day unless additional time is medically necessary.

13 (j)1. Group outpatient therapy shall:

14 a. Be a behavioral health therapeutic intervention provided in accordance with a re-

15 cipient's identified plan of care;

16 b. Be provided to promote the:

17 (i) Health and wellbeing of the individual; and

18 (ii) Recovery from a substance use disorder;

19 c. Consist of a face-to-face behavioral health therapeutic intervention provided in ac-

20 cordance with the recipient's identified plan of care;

21 d. Be provided to a recipient in a group setting:

22 (i) Of nonrelated individuals except for multi-family group therapy; and

23 (ii) Not to exceed twelve (12) individuals;

1 e. Focus on the psychological needs of the recipients as evidenced in each recipi-
2 ent's plan of care;
3 f. Center on goals including building and maintaining healthy relationships, personal
4 goals setting, and the exercise of personal judgment;
5 g. Not include physical exercise, a recreational activity, an educational activity, or a
6 social activity; and
7 h. Not exceed three (3) hours per day per recipient unless additional time is medically
8 necessary.
9 2. The group shall have a:
10 a. Deliberate focus; and
11 b. Defined course of treatment.
12 3. The subject of group outpatient therapy shall relate to each recipient participating
13 in the group.
14 4. The provider shall keep individual notes regarding each recipient of the group and
15 within each recipient's health record.
16 (k)1. Family outpatient therapy shall consist of a face-to-face behavioral health thera-
17 peutic intervention provided:
18 a. Through scheduled therapeutic visits between the therapist and the recipient and
19 at least one (1) member of the recipient's family; and
20 b. To address issues interfering with the relational functioning of the family and to im-
21 prove interpersonal relationships within the recipient's home environment.
22 2. A family outpatient therapy session shall be billed as one (1) service regardless of
23 the number of individuals (including multiple members from one (1) family) who partici-

1 pate in the session.

2 3. Family outpatient therapy shall:

3 a. Be provided to promote the:

4 (i) Health and well-being of the individual; or

5 (ii) Recovery from a substance use disorder; and

6 b. Not exceed three (3) hours per day per individual unless additional time is medical-

7 ly necessary.

8 (l)1. Collateral outpatient therapy shall:

9 a. Consist of a face-to-face behavioral health consultation:

10 (i) With a parent or caregiver of a recipient, household member of a recipient, recipi-

11 ent's representative, school staff person, treating professional, or other person with cus-

12 todial control or supervision of the recipient; and

13 (ii) That is provided in accordance with the recipient's plan of care; and

14 b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21)

15 years of age.

16 2. Consent given to discuss a recipient's treatment with any person other than a par-

17 ent or legal guardian shall be signed by the recipient or recipient's representative and

18 filed in the recipient's health record.

19 (m) Screening, brief intervention, and referral to treatment for a substance use disor-

20 der shall:

21 1. Be an evidence-based early-intervention approach for an individual with non-

22 dependent substance use in order to provide an effective strategy for intervention prior

23 to the need for more extensive or specialized treatment; and

1 2. Consist of:

2 a. Using a standardized screening tool to assess an individual for risky substance

3 use behavior;

4 b. Engaging a recipient, who demonstrates risky substance use behavior, in a short

5 conversation and providing feedback and advice to the recipient; and

6 c. Referring a recipient to additional substance use disorder services if the recipient is

7 determined to need additional services to address substance use.

8 (4) The extent and type of a screening shall depend upon the nature of the problem

9 of the individual seeking or being referred for services.

10 (5) A diagnosis or clinical impression shall be made using terminology established in

11 the most current edition of the American Psychiatric Association Diagnostic and Statisti-

12 cal Manual of Mental Disorders™.

13 (6) The department shall not reimburse for a service billed by or on behalf of an entity

14 or individual who is not a billing provider.

15 Section 4. Additional Limits and Non-covered Services or Activities. (1)(a) Except as

16 established in paragraph (b) of this subsection, unless a diagnosis is made and docu-

17 mented in the recipient's health record within three (3) visits, the service shall not be

18 covered.

19 (b) The requirement established in paragraph (a) of this subsection shall not apply to:

20 1. Mobile crisis services;

21 2. Crisis intervention;

22 3. A screening; or

23 4. An assessment.

1 (2) The department shall not reimburse for both a screening and an SBIRT provided
2 to a recipient on the same date of service.
3 (3) The following services or activities shall not be covered under this administrative
4 regulation:
5 (a) A service provided to:
6 1. A resident of:
7 a. A nursing facility; or
8 b. An intermediate care facility for individuals with an intellectual disability;
9 2. An inmate of a federal, local, or state:
10 a. Jail;
11 b. Detention center; or
12 c. Prison; or
13 3. An individual with an intellectual disability without documentation of an additional
14 psychiatric diagnosis;
15 (b) A consultation or educational service provided to a recipient or to others;
16 (c) A telephone call, an email, a text message, or other electronic contact that does
17 not meet the requirements stated in the definition of "face-to-face" established in 907
18 KAR 15:005, Section 1(14);
19 (d) Travel time;
20 (e) A field trip;
21 (f) A recreational activity;
22 (g) A social activity; or
23 (h) A physical exercise activity group.

1 (4)(a) A consultation by one (1) provider or professional with another shall not be
2 covered under this administrative regulation except as established in Section 3(3)(l)1 of
3 this administrative regulation.
4 (b) A third-party contract shall not be covered under this administrative regulation.
5 (5) A billing supervisor arrangement between a billing supervisor and a behavioral
6 health practitioner under supervision shall not:
7 (a) Violate the clinical supervision rules or policies of the respective professional li-
8 censure boards governing the billing supervisor and the behavioral health practitioner
9 under supervision; or
10 (b) Substitute for the clinical supervision rules or policies of the respective profes-
11 sional licensure boards governing the billing supervisor and the behavioral health practi-
12 tioner under supervision.
13 Section 5. No Duplication of Service. (1) The department shall not reimburse for a
14 service provided to a recipient by more than one (1) provider, of any program in which
15 the same service is covered, during the same time period.
16 (2) For example, if a recipient is receiving a behavioral health service from an inde-
17 pendent behavioral health provider, the department shall not reimburse for the same
18 service provided to the same recipient during the same time period by a chemical de-
19 pendency treatment center.
20 Section 6. Records Maintenance, Documentation, Protection, and Security. (1) A
21 chemical dependency treatment center shall maintain a current health record for each
22 recipient.
23 (2)(a) A health record shall document each service provided to the recipient including

1 the date of the service and the signature of the individual who provided the service.

2 (b) The individual who provided the service shall date and sign the health record with-

3 in forty-eight (48) hours of the date that the individual provided the service except as es-

4 tablished in subsection (5)(a) of this section.

5 (3) A health record shall:

6 (a) Include:

7 1. An identification and intake record including:

8 a. Name;

9 b. Social Security number;

10 c. Date of intake;

11 d. Home (legal) address;

12 e. Health insurance or Medicaid participation information;

13 f. Referral source's name and address;

14 g. Primary care physician's name and address;

15 h. The reason the individual is seeking help including the presenting problem and di-

16 agnosis;

17 i. Any physical health diagnosis, if a physical health diagnosis exists for the individu-

18 al, and information regarding:

19 (i) Where the individual is receiving treatment for the physical health diagnosis; and

20 (ii) The physical health provider's name; and

21 j. The name of the informant and any other information deemed necessary by the

22 chemical dependency treatment center in order to comply with the requirements of:

23 (i) This administrative regulation;

1 (ii) The chemical dependency treatment center's licensure board;

2 (iii) State law; or

3 (iv) Federal law;

4 2. Documentation of the:

5 a. Screening;

6 b. Assessment if an assessment was performed; and

7 c. Disposition if a disposition was performed;

8 3. A complete history including mental status and previous treatment;

9 4. An identification sheet;

10 5. A consent for treatment sheet that is accurately signed and dated; and

11 6. The individual's stated purpose for seeking services; and

12 (b) Be:

13 1. Maintained in an organized central file;

14 2. Furnished upon request:

15 a. To the Cabinet for Health and Family Services; or

16 b. For an enrollee, to the managed care organization in which the recipient is enrolled

17 or has been enrolled in the past;

18 3. Made available for inspection and copying by:

19 a. Cabinet for Health and Family Services' personnel; or

20 b. Personnel of the managed care organization in which the recipient is enrolled if

21 applicable;

22 4. Readily accessible; and

23 5. Adequate for the purpose of establishing the current treatment modality and pro-

1 gress of the recipient if the recipient received services beyond a screening.

2 (4) Documentation of a screening shall include:

3 (a) Information relative to the individual's stated request for services; and

4 (b) Other stated personal or health concerns if other concerns are stated.

5 (5)(a) A chemical dependency treatment center's notes regarding a recipient shall:

6 1. Be made within forty-eight (48) hours of each service visit; and

7 2. Describe the:

8 a. Recipient's symptoms or behavior, reaction to treatment, and attitude;

9 b. Therapist's intervention;

10 c. Changes in the plan of care if changes are made; and

11 d. Need for continued treatment if deemed necessary.

12 (b)1. Any edit to notes shall:

13 a. Clearly display the changes; and

14 b. Be initialed and dated by the person who edited the notes.

15 2. Notes shall not be erased or illegibly marked out.

16 (c)1. Notes recorded by a behavioral health practitioner working under supervision

17 shall be co-signed and dated by the supervising professional within thirty (30) days.

18 2. If services are provided by a behavioral health practitioner working under supervi-

19 sion, there shall be a monthly supervisory note recorded by the supervising professional

20 which reflects consultations with the behavioral health practitioner working under super-

21 vision concerning the:

22 a. Case; and

23 b. Supervising professional's evaluation of the services being provided to the recipi-

1 ent.

2 (6) Immediately following a screening of a recipient, the practitioner shall perform a

3 disposition related to:

4 (a) A provisional diagnosis;

5 (b) A referral for further consultation and disposition, if applicable; or

6 (c)1. If applicable, termination of services and referral to an outside source for further

7 services; or

8 2. If applicable, termination of services without a referral to further services.

9 (7) Any change to a recipient's plan of care shall be documented, signed, and dated

10 by the rendering practitioner and by the recipient or recipient's representative.

11 (8)(a) Notes regarding services to a recipient shall:

12 1. Be organized in chronological order;

13 2. Be dated;

14 3. Be titled to indicate the service rendered;

15 4. State a starting and ending time for the service; and

16 5. Be recorded and signed by the rendering practitioner and include the professional

17 title (for example, licensed clinical social worker) of the provider.

18 (b) Initials, typed signatures, or stamped signatures shall not be accepted.

19 (c) Telephone contacts, family collateral contacts not covered under this administra-

20 tive regulation, or other non-reimbursable contacts shall:

21 1. Be recorded in the notes; and

22 2. Not be reimbursable.

23 (9)(a) A termination summary shall:

1 1. Be required, upon termination of services, for each recipient who received at least
2 three (3) service visits; and
3 2. Contain a summary of the significant findings and events during the course of
4 treatment including the:
5 a. Final assessment regarding the progress of the individual toward reaching goals
6 and objectives established in the individual's plan of care;
7 b. Final diagnosis of clinical impression; and
8 c. Individual's condition upon termination and disposition.
9 (b) A health record relating to an individual who has been terminated from receiving
10 services shall be fully completed within ten (10) days following termination.
11 (10) If an individual's case is reopened within ninety (90) days of terminating services
12 for the same or related issue, a reference to the prior case history with a note regarding
13 the interval period shall be acceptable.
14 (11)(a) Except as established in paragraph (b) of this subsection, if a recipient is
15 transferred or referred to a health care facility or other provider for care or treatment, the
16 transferring chemical dependency treatment center shall, within ten (10) business days
17 of awareness of the transfer or referral, transfer the recipient's records in a manner that
18 complies with the records' use and disclosure requirements as established in or re-
19 quired by:
20 1.a. The Health Insurance Portability and Accountability Act;
21 b. 42 U.S.C. 1320d-2 to 1320d-8; and
22 c. 45 C.F.R. Parts 160 and 164; or
23 2.a. 42 U.S.C. 290 ee-3; and

1 b. 42 C.F.R Part 2.

2 (b) If a recipient is transferred or referred to a residential crisis stabilization unit, a
3 psychiatric hospital, a psychiatric distinct part unit in an acute care hospital, a Level I
4 psychiatric residential treatment facility, a Level II psychiatric residential treatment facili-
5 ty, or an acute care hospital for care or treatment, the transferring chemical dependency
6 treatment center shall, within forty-eight (48) hours of the transfer or referral, transfer the
7 recipient's records in a manner that complies with the records' use and disclosure re-
8 quirements as established in or required by:

9 1.a. The Health Insurance Portability and Accountability Act;

10 b. 42 U.S.C. 1320d-2 to 1320d-8; and

11 c. 45 C.F.R. Parts 160 and 164; or

12 2.a. 42 U.S.C. 290 ee-3; and

13 b. 42 C.F.R Part 2.

14 (12)(a) If a chemical dependency treatment center's Medicaid Program participation
15 status changes as a result of voluntarily terminating from the Medicaid Program, invol-
16 untarily terminating from the Medicaid Program, a licensure suspension, or death of an
17 owner or deaths of owners, the health records of the chemical dependency treatment
18 center shall:

19 1. Remain the property of the chemical dependency treatment center; and

20 2. Be subject to the retention requirements established in subsection (13) of this sec-
21 tion.

22 (b) A chemical dependency treatment center shall have a written plan addressing
23 how to maintain health records in the event of death of an owner or deaths of owners.

1 (13)(a) Except as established in paragraph (b) or (c) of this subsection, a chemical
2 dependency treatment center shall maintain a health record regarding a recipient for at
3 least six (6) years from the last date of the service or until any audit dispute or issue is
4 resolved beyond six (6) years.
5 (b) After a recipient's death or discharge from services, a provider shall maintain the
6 recipient's record for the longest of the following periods:
7 1. Six (6) years unless the recipient is a minor; or
8 2. If the recipient is a minor, three (3) years after the recipient reaches the age of ma-
9 jority under state law.
10 (c) If the Secretary of the United States Department of Health and Human Services
11 requires a longer document retention period than the period referenced in paragraph (a)
12 of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary
13 shall be the required period.
14 (14)(a) A chemical dependency treatment center shall comply with 45 C.F.R. Part
15 164.
16 (b) All information contained in a health record shall:
17 1. Be treated as confidential;
18 2. Not be disclosed to an unauthorized individual; and
19 3. Be disclosed to an authorized representative of:
20 a. The department;
21 b. Federal government; or
22 c. For an enrollee, managed care organization in which the enrollee is enrolled.
23 (c)1. Upon request, a chemical dependency treatment center shall provide to an au-

1 thorized representative of the department, federal government, or managed care organ-
2 ization if applicable, information requested to substantiate:
3 a. Staff notes detailing a service that was rendered;
4 b. The professional who rendered a service; and
5 c. The type of service rendered and any other requested information necessary to de-
6 termine, on an individual basis, whether the service is reimbursable by the department.
7 2. Failure to provide information referenced in subparagraph 1 of this paragraph shall
8 result in denial of payment for any service associated with the requested information.
9 Section 7. Medicaid Program Participation Compliance. (1) A chemical dependency
10 treatment center shall comply with:
11 (a) 907 KAR 1:671;
12 (b) 907 KAR 1:672; and
13 (c) All applicable state and federal laws.
14 (2)(a) If a chemical dependency treatment center receives any duplicate payment or
15 overpayment from the department or a managed care organization, regardless of rea-
16 son, the chemical dependency treatment center shall return the payment to the depart-
17 ment or managed care organization in accordance with 907 KAR 1:671.
18 (b) Failure to return a payment to the department or managed care organization in
19 accordance with paragraph (a) of this subsection may be:
20 1. Interpreted to be fraud or abuse; and
21 2. Prosecuted in accordance with applicable federal or state law.
22 (3)(a) When the department makes payment for a covered service and the chemical
23 dependency treatment center accepts the payment:

1 1. The payment shall be considered payment in full;

2 2. A bill for the same service shall not be given to the recipient; and

3 3. Payment from the recipient for the same service shall not be accepted by the

4 chemical dependency treatment center.

5 (b)1. A chemical dependency treatment center may bill a recipient for a service that is

6 not covered by the Kentucky Medicaid Program if the:

7 a. Recipient requests the service; and

8 b. Chemical dependency treatment center makes the recipient aware in writing in ad-

9 vance of providing the service that the:

10 (i) Recipient is liable for the payment; and

11 (ii) Department is not covering the service.

12 2. If a recipient makes payment for a service in accordance with subparagraph 1 of

13 this paragraph, the:

14 a. Chemical dependency treatment center shall not bill the department for the ser-

15 vice; and

16 b. Department shall not:

17 (i) Be liable for any part of the payment associated with the service; and

18 (ii) Make any payment to the chemical dependency treatment center regarding the

19 service.

20 (4)(a) A chemical dependency treatment center attests by the chemical dependency

21 treatment center's staff's or representative's signature that any claim associated with a

22 service is valid and submitted in good faith.

23 (b) Any claim and substantiating record associated with a service shall be subject to

1 audit by the:

2 1. Department or its designee;

3 2. Cabinet for Health and Family Services, Office of Inspector General, or its design-

4 ee;

5 3. Kentucky Office of Attorney General or its designee;

6 4. Kentucky Office of the Auditor for Public Accounts or its designee;

7 5. United States General Accounting Office or its designee; or

8 6. For an enrollee, managed care organization in which the enrollee is enrolled.

9 (c)1. If a chemical dependency treatment center receives a request from the:

10 a. Department to provide a claim, related information, related documentation, or rec-

11 ord for auditing purposes, the chemical dependency treatment center shall provide the

12 requested information to the department within the timeframe requested by the depart-

13 ment; or

14 b. Managed care organization in which an enrollee is enrolled to provide a claim, re-

15 lated information, related documentation, or record for auditing purposes, the targeted

16 case management services provider shall provide the requested information to the

17 managed care organization within the timeframe requested by the managed care organ-

18 ization.

19 2.a. The timeframe requested by the department or managed care organization for a

20 chemical dependency treatment center to provide requested information shall be:

21 (i) A reasonable amount of time given the nature of the request and the circumstanc-

22 es surrounding the request; and

23 (ii) A minimum of one (1) business day.

1 b. A chemical dependency treatment center may request a longer timeframe to pro-
2 vide information to the department or a managed care organization if the chemical de-
3 pendency treatment center justifies the need for a longer timeframe.
4 (d)1. All services provided shall be subject to review for recipient or provider abuse.
5 2. Willful abuse by a chemical dependency treatment center shall result in the sus-
6 pension or termination of the chemical dependency treatment center from Medicaid
7 Program participation in accordance with 907 KAR 1:671.
8 Section 8. Third Party Liability. A chemical dependency treatment center shall comply
9 with KRS 205.622.
10 Section 9. Use of Electronic Signatures. (1) The creation, transmission, storage, and
11 other use of electronic signatures and documents shall comply with the requirements
12 established in KRS 369.101 to 369.120.
13 (2) A chemical dependency treatment center that chooses to use electronic signa-
14 tures shall:
15 (a) Develop and implement a written security policy that shall:
16 1. Be adhered to by each of the chemical dependency treatment center's employees,
17 officers, agents, or contractors;
18 2. Identify each electronic signature for which an individual has access; and
19 3. Ensure that each electronic signature is created, transmitted, and stored in a se-
20 cure fashion;
21 (b) Develop a consent form that shall:
22 1. Be completed and executed by each individual using an electronic signature;
23 2. Attest to the signature's authenticity; and

1 3. Include a statement indicating that the individual has been notified of his or her re-
2 sponsibility in allowing the use of the electronic signature; and
3 (c) Provide the department, immediately upon request, with:
4 1. A copy of the chemical dependency treatment center's electronic signature policy;
5 2. The signed consent form; and
6 3. The original filed signature.
7 Section 10. Auditing Authority. The department or managed care organization in
8 which an enrollee is enrolled shall have the authority to audit any:
9 (1) Claim;
10 (2) Health record; or
11 (3) Documentation associated with any claim or health record.
12 Section 11. Federal Approval and Federal Financial Participation. (1) The depart-
13 ment's reimbursement of services pursuant to this administrative regulation shall be
14 contingent upon:
15 (a) Receipt of federal financial participation for the coverage; and
16 (b) Centers for Medicare and Medicaid Services' approval for the coverage.
17 (2) The reimbursement of services provided by a licensed clinical alcohol and drug
18 counselor or licensed clinical alcohol and drug counselor associate shall be contingent
19 and effective upon approval by the Centers for Medicare and Medicaid Services.
20 Section 12. Appeals. (1) An appeal of an adverse action by the department regarding
21 a service and a recipient who is not enrolled with a managed care organization shall be
22 in accordance with 907 KAR 1:563.
23 (2) An appeal of an adverse action by a managed care organization regarding a ser-

1 vice and an enrollee shall be in accordance with 907 KAR 17:010.

907 KAR 15:080

REVIEWED:

3-3-15

Date

Lisa Lee, Commissioner
Department for Medicaid Services

APPROVED:

4/10/15

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

907 KAR 15:080

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on May 22, 2015 at 9:00 a.m. in the Health Services Auditorium, Suite B, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by May 15, 2015 five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business June 1, 2015. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

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

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 15:080
Contact person: Stuart Owen (502) 564-4321, extension 2015

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program outpatient chemical dependency treatment center (CDTC) services. This administrative regulation is being promulgated in conjunction with 907 KAR 15:085, Reimbursement for outpatient chemical dependency treatment center services. To qualify as a provider, a chemical dependency treatment center must be licensed in accordance with 902 KAR 20:160. CDTCs are authorized to provide, to Medicaid recipients, behavioral health services related to a substance use disorder. The array of services includes a screening; an assessment; psychological testing; crisis intervention; mobile crisis services; day treatment; peer support; intensive outpatient program services; individual outpatient therapy; group outpatient therapy; family outpatient therapy; collateral outpatient therapy; and a screening, brief intervention, and referral to treatment (SBIRT) for a substance use disorder.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal mandates. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment" for all recipients. 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base (to include chemical dependency treatment centers) will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by complying with federal mandates and enhancing and ensuring Medicaid recipients' access to behavioral health services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by complying with federal mandates and enhancing and ensuring Medicaid recipients' access to behavioral health services.

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

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

new administrative regulation.

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

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

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

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Entities licensed as chemical dependency treatment centers (CDTCs), behavioral health professionals authorized to provide services in CDTCs, and Medicaid recipients who receive services in CDTCs will be affected by the administrative regulation. The following behavioral health professionals are authorized to provide services in a CDTC: licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychological practitioners, certified psychologists with autonomous functioning, licensed psychological associates, certified psychologists, certified social workers, licensed professional counselor associates, marriage and family therapy associates, licensed professional art therapists, licensed professional art therapist associates, certified alcohol and drug counselors, licensed clinical alcohol and drug counselors (contingent and effective upon approval by the Centers for Medicare and Medicaid Services), licensed clinical alcohol and drug counselor associates (contingent and effective upon approval by the Centers for Medicare and Medicaid Services), and peer support specialists. Currently, there are four (4) licensed CDTCs in Kentucky.

(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. Entities that qualify as chemical dependency treatment center and who wish to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete an application and submit it to DMS) and sign agreements with managed care organizations if the individual wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). The entities referenced in paragraph (a) could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The entities referenced in paragraph (a) will benefit by receiving Medicaid Program reimbursement for providing behavioral health services to Medicaid recipients. Behavioral health professionals authorized to provide services in a chemical dependency treatment center will benefit by having more employment opportunities in Kentucky. Medicaid recipients in need of behavioral health services will benefit from an expanded

base of providers from which to receive these services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved as DMS cannot estimate the utilization of these services in CDTCs compared to utilization in other authorized provider settings (independent behavioral health providers, community mental health centers, federally-qualified health centers, rural health clinics, and primary care centers.) However, an actuary with whom DMS contracted has estimated an average per recipient per month increase (to DMS) of twenty-seven (27) dollars associated with DMS's expansion of behavioral health services (including substance use disorder services) as well as behavioral health providers this year.

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

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

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

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

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

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation #: 907 KAR 15:080
Contact person: Stuart Owen (502) 564-4321, extension 2015

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

2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Substance use disorder services are federally mandated for Medicaid programs. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid.) Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

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

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

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation #: 907 KAR 15:080
Contact person: Stuart Owen (502) 564-4321, extension 2015

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

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

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

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

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

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved as DMS cannot estimate the utilization of these services in CDTCs compared to utilization in other authorized provider settings (independent behavioral health providers, community mental health centers, federally-qualified health centers, rural health clinics, and primary care centers.) However, an actuary with whom DMS contracted has estimated an average per recipient per month increase (to DMS) of twenty-seven (27) dollars associated with DMS's expansion of behavioral health services (including substance use disorder services) as well as behavioral health providers this year.

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

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

Revenues (+/-):
Expenditures (+/-):
Other Explanation: