TIME: 10 a.m.

SEP 16 2014

Donna Little
REGULATIONS COMPILER

STATEMENT OF EMERGENCY

907 KAR 15:040E

(1) This emergency administrative regulation is being promulgated in conjunction with 907 KAR 15:045E, Reimbursement provisions and requirements regarding targeted case management for individuals with a substance use disorder - to comply with a federal mandate. The Affordable Care Act mandates coverage of substance use disorder services for all Medicaid recipients (who meet qualifying criteria) and federal law requires Medicaid Programs to ensure that recipients have access to services. These two (2) administrative regulations will help ensure that Medicaid recipients are able to access mandated substance use disorder services.

(2) Targeted case management ensures that Medicaid recipients with a mental health diagnosis and a substance use disorder are monitored to ensure that they receive the services most beneficial to their particular illness. As mental illness and substance use disorders are often life-threatening and require long-term treatment, targeted case management gives continuity of care to a Medicaid recipient whose illness needs long-term monitoring. This action must be taken on an emergency basis to prevent a loss of Medicaid federal funds, to meet a deadline for the promulgation of an administrative regulation necessary under federal law and regulation, and so as not to delay providing this service to Medicaid recipients at risk.

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

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

Steven L. Beshear
Governor

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (New Emergency Administrative Regulation)

5 907 KAR 15:040E. Coverage provisions and requirements regarding targeted case

6 management for individuals with a substance use disorder.

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), 42 U.S.C.

9 1396n(g).

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family

11 Services, Department for Medicaid Services, has a responsibility to administer the Med-

12 icaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to

13 comply with any requirement that may be imposed or opportunity presented by federal

14 law to qualify for federal Medicaid funds. This administrative regulation establishes the

15 coverage provisions and requirements regarding Medicaid Program targeted case man-

16 agement services for Medicaid recipients with a substance use disorder.

17 Section 1. General Coverage Requirements. For the department to reimburse for a

18 service covered under this administrative regulation, the service shall be:

19 (1) Medically necessary; and

20 (2) Provided:

21 (a) To a recipient; and

1 (b) By a provider that meets the provider participation requirements established in
2 Section 3 of this administrative regulation.
3 Section 2. Eligibility Criteria. To be eligible to receive targeted case management
4 services under this administrative regulation, a recipient shall:
5 (1) Have a primary moderate or severe substance use disorder diagnosis or co-
6 occurring moderate or severe substance use disorder and mental health diagnoses;
7 (2) Have:
8 (a) A lack of access to recovery supports;
9 (b) A need for assistance with access to housing, vocational, medical, social, educa-
10 tional, or other community services and supports; or
11 (c) Involvement with one (1) or more child welfare or criminal justice agencies but not
12 be an inmate of a public institution; and
13 (3) Not be:
14 (a) Between the age of twenty-one (21) years and sixty-four (64) years while receiv-
15 ing services in an institution for mental diseases; or
16 (b) An inmate of a public institution.
17 Section 3. Provider Requirements. (1) To be eligible to provide services under this
18 administrative regulation, an individual, entity, or organization shall:
19 (a) Be currently enrolled in the Kentucky Medicaid Program in accordance with 907
20 KAR 1:672;
21 (b) Except as established in subsection (2) of this section, be currently participating in
22 the Kentucky Medicaid Program in accordance with 907 KAR 1:671;
23 (c) Be:

1. A community mental health center authorized to provide services pursuant to 907 KAR 1:044;

2. An individual or provider group authorized to provide behavioral health services pursuant to 907 KAR 15:010; or

3. A behavioral health services organization authorized to provide behavioral health services pursuant to 907 KAR 15:020;

(d) Have:

1. For each service it provides, the capacity to provide the full range of the service as established in this administrative regulation;

2. Demonstrated experience in serving the population of individuals with behavioral health disorders relevant to the particular services provided;

3. The administrative capacity to ensure quality of services;

4. A financial management system that provides documentation of services and costs;

5. The capacity to document and maintain individual case records;

6. Demonstrated programmatic and administrative experience in providing comprehensive case management services; and

7. Demonstrated referral systems and linkages and referral ability with essential social and health services' agencies.

(2) In accordance with 907 KAR 17:015, Section 3(3), a targeted case management services provider which provides a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(3) A targeted case management services provider shall:

1 (a) Agree to provide services in compliance with federal and state laws regardless of
2 age, sex, race, creed, religion, national origin, handicap, or disability; and
3 (b) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and
4 any amendments to the Act.
5 Section 4. Case Manager Requirements. (1)(a) A case manager shall:
6 1. Have at least a bachelor of arts or sciences degree in a behavioral science includ-
7 ing:
8 a. Psychology;
9 b. Sociology;
10 c. Social work;
11 d. Family studies;
12 e. Human services;
13 f. Counseling;
14 g. Nursing; or
15 h. Another human service degree program approved by the department;
16 2. Have successfully completed case management training approved by the Depart-
17 ment for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) within
18 six (6) months of employment; and
19 3. Successfully completed recertification requirements approved by DBHDID every
20 three (3) years.
21 (b)1. Supervision by a behavioral health professional who has completed case man-
22 agement training approved by DBHDID shall occur at least twice per month.

1 2. At least one (1) of these supervisory contacts shall be on an individual basis and
2 face-to-face.
3 (c)1. Except as established in subparagraph 2 of this paragraph, a case manager
4 shall have at least one (1) year of full-time employment working directly with individuals
5 in a human service setting after completing the educational requirements.
6 2. A master's degree in one of the following behavioral science disciplines may sub-
7 stitute for the one (1) year of experience:
8 a. Psychology;
9 b. Sociology;
10 c. Social work;
11 d. Family studies;
12 e. Human services;
13 f. Counseling;
14 g. Nursing; or
15 h. Another human service degree program approved by the department.
16 (d) A behavioral health professional shall be:
17 1. An advanced practice registered nurse;
18 2. A licensed clinical social worker;
19 3. A licensed marriage and family therapist;
20 4. A licensed professional clinical counselor;
21 5. A licensed psychological practitioner;
22 6. A licensed psychologist;
23 7. A licensed professional art therapist;

1 8. A physician;

2 9. A psychiatrist;

3 10. A behavioral health practitioner under supervision;

4 11. A registered nurse working under the supervision of a physician or advanced

5 practice registered nurse; or

6 12. An individual with a bachelor's degree in a behavioral science program or other

7 human service degree program approved by the department who:

8 a. Is working under the supervision of a billing supervisor; and

9 b. Has at least five (5) years of documented full-time experience providing special-

10 ized case management services.

11 Section 5. Freedom of Choice of Provider. (1) A recipient shall have the freedom to

12 choose from which:

13 (a) Case manager to receive services within the recipient's geographic area identified

14 in the recipient's care plan; and

15 (b) Provider of non-targeted case management Medicaid covered services to receive

16 services.

17 (2) A case manager shall not have the authority to authorize or deny the provision of

18 non-targeted case management Medicaid covered services to a recipient.

19 (3) A recipient shall not be required to receive targeted case management services

20 as a condition of receiving non-targeted case management Medicaid-covered services.

21 Section 6. Covered Services. (1) Targeted case management services covered under

22 this administrative regulation shall:

23 (a) Be services furnished to assist a recipient in gaining access to needed medical,

1 social, educational, or other services; and

2 (b) Include:

3 1. A comprehensive assessment and periodic reassessments of the recipient's needs

4 to determine the need for any medical, educational, social, or other services;

5 2. The development and periodic revision of a specific care plan for the recipient;

6 3. A referral or related activities to help the recipient obtain needed services;

7 4. Monitoring or follow-up activities; or

8 5. Contacts with non-recipients who are directly related to identifying the recipient's

9 needs and care for the purpose of:

10 a. Helping the recipient access services;

11 b. Identifying supports necessary to enable the recipient to obtain services;

12 c. Providing a case manager with useful input regarding the recipient's past or current

13 functioning, symptoms, adherence to treatment, or other information relevant to the re-

14 cipient's behavioral health condition; or

15 d. Alerting a case manager to a change in the recipient's needs.

16 (2)(a) An assessment or reassessment shall include:

17 1. Taking the recipient's history;

18 2. Identifying the recipient's strengths and needs and completing related documenta-

19 tion; and

20 3. Gathering information from other sources including family members, medical pro-

21 viders, social workers, or educators, to form a complete assessment of the recipient.

22 (b) A face-to-face assessment or reassessment shall be completed:

23 1. At least annually; or

1 2. More often if needed based on changes in the recipient's condition.

2 (3) The development and periodic revision of the recipient's care plan shall:

3 (a) Specify the goals and actions to address the medical, social, educational, or other

4 services needed by the recipient;

5 (b) Include ensuring the active participation of the recipient and working with the re-

6 cipient, the recipient's authorized health care decision maker, or others to develop the

7 goals; or

8 (c) Identifying a course of action to respond to the assessed needs of the recipient.

9 (4) A referral or related activities shall include activities that help link the recipient with

10 medical providers, social providers, educational providers, or other programs and ser-

11 vices that are capable of providing needed services to:

12 (a) Address the identified needs; and

13 (b) Achieve goals specified in the care plan.

14 (5)(a) Monitoring and follow-up activities shall:

15 1. Be activities and contacts that:

16 a. Are necessary to ensure that the recipient's care plan is implemented;

17 b. Adequately addresses the recipient's strengths and needs; and

18 c. May be with the recipient, the recipient's family members, the recipient's service

19 providers, or other entities or individuals;

20 2. Be conducted as frequently as necessary;

21 3. Include making necessary adjustments in the recipient's care plan and service ar-

22 rangements with providers.

23 (b) Monitoring shall:

1 1. Occur at least once every three (3) months;

2 2. Be face-to-face; and

3 3. Determine if:

4 a. The services are being furnished in accordance with the recipient's care plan;

5 b. The services in the recipient's care plan are adequate to meet the recipient's

6 needs; and

7 c. Changes in the needs or status of the recipient are reflected in the care plan.

8 Section 7. No Duplication of Service. (1) The department shall not pay for targeted

9 case management services which duplicate services provided by another public agency

10 or a private entity.

11 (2)(a) The department shall not reimburse for a service provided to a recipient by

12 more than one (1) provider of any program in which the service is covered during the

13 same time period.

14 (b) For example, if a recipient is receiving targeted case managements service from

15 an independent behavioral health provider, the department shall not reimburse for tar-

16 geted case management services provided to the same recipient during the same time

17 period by a behavioral health services organization.

18 Section 8. Exclusions and Limits. (1) Targeted case management services shall not

19 include services defined in 42 C.F.R. 440.169 if the:

20 (a) Activities are an integral and inseparable component of another covered Medicaid

21 service; or

22 (b) Constitute the direct delivery of underlying medical, educational, social, or other

23 services to which an eligible recipient has been referred, including:

1 1. Foster care programs;

2 2. Research gathering and completing documentation required by the foster care

3 program;

4 3. Assessing adoption placements;

5 4. Recruiting or interviewing potential foster care parents;

6 5. Serving legal papers;

7 6. Home investigations;

8 7. Providing transportation;

9 8. Administering foster care subsidies; or

10 9. Making placement arrangements.

11 (2) A recipient who is receiving case management services under a 1915(c) home

12 and community based waiver program shall not be eligible to receive targeted case

13 management services under this administrative regulation.

14 (3) An individual who provides targeted case management to a recipient shall not

15 provide any Medicaid covered service other than targeted case management.

16 Section 9. Records Maintenance, Documentation, Protection, and Security. (1) A tar-

17 geted case management service provider shall maintain a current case record for each

18 recipient.

19 (2)(a) A case record shall document each service provided to the recipient including

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

21 (b) The individual who provided the service shall date and sign the case record on

22 the date that the individual provided the service.

23 (3) A case record shall:

1 (a) Include:

2 1. The recipient's name;

3 2. The time and date corresponding to each occasion in which a targeted case man-

4 agement service was provided to the recipient;

5 3. The name of the targeted case management services:

6 a. Provider agency, if an agency; and

7 b. Name of the practitioner who provided the targeted case management services;

8 4. The nature, content, and units of the targeted case management services provid-

9 ed;

10 5. Whether or not goals in the recipient's care plan have been achieved;

11 6. Whether or not the recipient has declined to receive any services in the recipient's

12 care plan;

13 7. A timeline for obtaining needed services; and

14 8. A timeline for reevaluating the recipient's care plan; and

15 (b) Be:

16 1. Maintained in an organized and secure central file;

17 2. Furnished to the:

18 a. Cabinet for Health and Family Services upon request; or

19 b. For an enrollee, managed care organization in which the recipient is enrolled;

20 3. Made available for inspection and copying by:

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

22 b. For enrollees, personnel of the managed care organization in which the recipient is

23 enrolled if the recipient is enrolled with a managed care organization;

1 4. Readily accessible; and

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

3 gress of the recipient.

4 (4)(a) A discharge summary shall:

5 1. Be required, upon termination of services, for each recipient who received at least

6 three (3) service visits; and

7 2. Contain a summary of the significant findings and events during the course of

8 treatment including the:

9 a. Final assessment regarding the progress of the recipient toward reaching goals

10 and objectives established in the recipient's care plan; and

11 b. Recipient's condition upon termination and disposition.

12 (b) A case record relating to a recipient who was terminated from receiving services

13 shall be fully completed within ten (10) days following termination.

14 (5) If a recipient's case is reopened within ninety (90) days of terminating services for

15 the same or related issue, a reference to the prior case history with a note regarding the

16 interval period shall be acceptable.

17 (6) If a recipient is transferred or referred to a health care facility or other provider for

18 care or treatment, the transferring targeted case management services provider shall,

19 within ten (10) business days of the transfer or referral, transfer the recipient's records

20 in a manner that complies with the records' use and disclosure requirements as estab-

21 lished in or required by:

22 (a)1. The Health Insurance Portability and Accountability Act;

23 2. 42 U.S.C. 1320d-2 to 1320d-8; and

1 3. 45 C.F.R. Parts 160 and 164; or

2 (b)1. 42 U.S.C. 290 ee-3; and

3 2. 42 C.F.R Part 2.

4 (7)(a) If a targeted case management service's Medicaid Program participation status
5 changes as a result of voluntarily terminating from the Medicaid Program, involuntarily
6 terminating from the Medicaid Program, a licensure suspension, or death of an owner or
7 deaths of owners, the case records of the targeted case management service shall:

8 1. Remain the property of the targeted case management service; and

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

11 (b) A targeted case management service shall have a written plan addressing how to
12 maintain case records in the event of an owner's death or owners' deaths.

13 (8)(a) Except as established in paragraph (b) or (c) of this subsection, a targeted
14 case management service provider shall maintain a case record regarding a recipient
15 for at least six (6) years from the date of the service or until any audit dispute or issue is
16 resolved beyond six (6) years.

17 (b) After a recipient's death or discharge from services, a provider shall maintain the
18 recipient's record for the longest of the following periods:

19 1. Six (6) years unless the recipient is a minor; or

20 2. If the recipient is a minor, three (3) years after the recipient reaches the age of ma-
21 jority under state law.

22 (c) If the Secretary of the United States Department of Health and Human Services
23 requires a longer document retention period than the period referenced in paragraph (a)

1 of this section, pursuant to 42 C.F.R. 431.17 the period established by the secretary
2 shall be the required period.
3 (9)(a) A targeted case management service shall comply with 45 C.F.R. Chapter 164.
4 (b) All information contained in a case record shall:
5 1. Be treated as confidential;
6 2. Not be disclosed to an unauthorized individual; and
7 3. Be disclosed to an authorized representative of the:
8 a. Department; or
9 b. Federal government.
10 (c)1. Upon request, a targeted case management service shall provide to an author-
11 ized representative of the department or federal government information requested to
12 substantiate:
13 a. Staff notes detailing a service that was rendered;
14 b. The professional who rendered a service; and
15 c. The type of service rendered and any other requested information necessary to de-
16 termine, on an individual basis, whether the service is reimbursable by the department.
17 2. Failure to provide information referenced in subparagraph 1 of this paragraph shall
18 result in denial of payment for any service associated with the requested information.
19 Section 10. Medicaid Program Participation Compliance. (1) A targeted case man-
20 agement services provider shall comply with:
21 (a) 907 KAR 1:671;
22 (b) 907 KAR 1:672; and
23 (c) All applicable state and federal laws.

1 (2)(a) If a targeted case management services provider receives any duplicate pay-
2 ment or overpayment from the department, regardless of reason, the targeted case
3 management services provider shall return the payment to the department.
4 (b) Failure to return a payment to the department in accordance with paragraph (a) of
5 this section may be:
6 1. Interpreted to be fraud or abuse; and
7 2. Prosecuted in accordance with applicable federal or state law.
8 (3)(a) When the department makes payment for a covered service and the targeted
9 case management services provider accepts the payment:
10 1. The payment shall be considered payment in full;
11 2. No bill for the same service shall be given to the recipient; and
12 3. No payment from the recipient for the same service shall be accepted by the pro-
13 vider.
14 (b)1. A targeted case management services provider may bill a recipient for a service
15 that is not covered by the Kentucky Medicaid Program if the:
16 a. Recipient requests the service; and
17 b. Targeted case management services provider makes the recipient aware in ad-
18 vance of providing the service that the:
19 (i) Recipient is liable for the payment; and
20 (ii) Department is not covering the service.
21 2. If a recipient makes payment for a service in accordance with subparagraph 1 of
22 this paragraph, the:
23 a. Targeted case management services provider shall not bill the department for the

1 service; and

2 b. Department shall not:

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

4 (ii) Make any payment to the targeted case management services provider regarding

5 the service.

6 (4)(a) A targeted case management services provider attests by the targeted case

7 management services provider signature that any claim associated with a service is val-

8 id and submitted in good faith.

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

10 audit by the:

11 1. Department or its designee;

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

13 ee;

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

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

16 5. United States General Accounting Office or its designee.

17 (c) If a targeted case management services provider receives a request from the de-

18 partment to provide a claim, related information, related documentation, or record for

19 auditing purposes, the targeted case management services provider shall provide the

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

21 ment.

22 (d)1. All services provided shall be subject to review for recipient or provider abuse.

23 2. Willful abuse by a targeted case management services provider shall result in the

1 suspension or termination of the targeted case management services provider from
2 Medicaid Program participation.
3 Section 11. Third Party Liability. (1) A targeted case management service provider
4 shall comply with KRS 205.622.
5 (2) If a third party is liable to pay for targeted case management services, the de-
6 partment shall not pay for the services.
7 Section 12. Use of Electronic Signatures. (1) The creation, transmission, storage, and
8 other use of electronic signatures and documents shall comply with the requirements
9 established in KRS 369.101 to 369.120.
10 (2) A targeted case management services provider that chooses to use electronic
11 signatures shall:
12 (a) Develop and implement a written security policy that shall:
13 1. Be adhered to by each of the targeted case management services' provider's em-
14 ployees, officers, agents, or contractors;
15 2. Identify each electronic signature for which an individual has access; and
16 3. Ensure that each electronic signature is created, transmitted, and stored in a se-
17 cure fashion;
18 (b) Develop a consent form that shall:
19 1. Be completed and executed by each individual using an electronic signature;
20 2. Attest to the signature's authenticity; and
21 3. Include a statement indicating that the individual has been notified of his responsi-
22 bility in allowing the use of the electronic signature; and
23 (c) Provide the department, immediately upon request, with:

1. A copy of the targeted case management services' provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature.

Section 13. Auditing Authority. The department shall have the authority to audit any:

(1) Claim;

(2) Medical record; or

(3) Documentation associated with any claim or medical record.

Section 14. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

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

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

Section 15. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

907 KAR 15:040E

REVIEWED:

8/19/14
Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

9/9/14
Date

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

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 15:040E
Contact person: Stuart Owen (502) 564-4321

(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 targeted case management services for Medicaid recipients with a substance use disorder. This administrative regulation is being promulgated in conjunction with 907 KAR 15:045E (Reimbursement for targeted case management service services for individuals with a substance use disorder). Targeted case management services are services that assist Medicaid recipients in accessing needed medical, social, educational, and other services. The components of targeted case management include assessing the recipient's need for services by taking the recipient's history, identifying the recipient's needs, and gathering information from other sources (family members, medical providers, social workers, and educators) to form a complete assessment; developing a customized care plan for the recipient; referring the recipient or related activities to help the recipient obtain needed services; and monitoring activities to ensure that the recipient's care plan is implemented effectively and adequately addresses the recipient's strengths and needs.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to help ensure that recipients (who have a substance use disorder) receive necessary services and care. The targeted case manager provider is the individual or entity responsible for coordinating the recipient's services/care, facilitating access to services/care, and monitoring individual's progress or difficulties while receiving services/care. Targeted case management helps ensure that the recipient receives the appropriate and necessary services and care they need rather than randomly receive services/care or fail to receive any services/care at all.

(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 helping ensure that recipients with a substance use disorder receive necessary services and care.

(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 helping ensure that recipients with a substance use disorder receive necessary services and care.

(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 rather than an amendment.

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

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

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

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Entities eligible to provide targeted case management services (such as community mental health centers, individual behavioral health service providers/provider group or behavioral health services organizations) will be affected by this administrative regulation as well as the various professionals who are authorized to provide services either independently or via the aforementioned providers. Medicaid recipients who qualify for targeted case management services will also be affected by this 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. Entities that qualify and wish to provide targeted case management services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation [complete and application and submit it to the Department for Medicaid Services (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. The professionals authorized to provide services will benefit by having more employment opportunities in Kentucky. Medicaid recipients in need of targeted case management will benefit from having the option to receive these services.

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

(a) Initially: DMS estimates that implementing the administrative regulation will cost approximately $1.05 million state funds/$3.87 million federal funds initially.

(b) On a continuing basis: DMS estimates that implementing the administrative regulation will cost approximately $1.79 million state funds/$6.64 million federal funds for the second year of implementation. The federal matching percent will decrease somewhat when the federal matching percent for recipients eligible under "Medicaid expansion" recedes from its current 100% to 90%.

(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 un-

der 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 15:040E
Contact person: Stuart Owen (502) 564-4321

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)(23), and 42 U.S.C. 1396a(a)(10)(B).

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

3. Minimum or uniform standards contained in the federal mandate. Targeted case management services are not federally mandated however, 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 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. Expanding the targeted case management service provider base to include targeted case management for substance use disorders will help ensure Medicaid recipient access to these services.

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 15:040E
Contact person: Stuart Owen (502) 564-4321

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 regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

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) Initially: DMS estimates that implementing the administrative regulation will cost approximately $1.05 million state funds/$3.87 million federal funds initially.

(d) On a continuing basis: DMS estimates that implementing the administrative regulation will cost approximately $1.79 million state funds/$6.64 million federal funds for the second year of implementation. The federal matching percent will decrease somewhat when the federal matching percent for recipients eligible under "Medicaid expansion" recedes from its current 100% to 90%.

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: