

STATEMENT OF EMERGENCY

907 KAR 17:020E

(1) This is a new emergency administrative regulation which is being promulgated concurrently with five (5) other administrative regulations which will establish the Kentucky Medicaid Program managed care organization requirements and policies. Currently, there is one administrative regulation (907 KAR 17:005) which establishes Kentucky Medicaid program managed care organization requirements and policies for every region except region three (3). Region three (3) is comprised of Jefferson County and fifteen (15) other counties neighboring or nearby Jefferson County and its requirements and policies are established in 907 KAR 1:705. One (1) managed care organization has been responsible for managed care in region three (3) since the mid-1990s; however, managed care in that region did not encompass behavioral health services and having one (1) entity does not satisfy the Centers for Medicare and Medicaid Services (CMS) requirement of providing individuals choice of managed care organizations. Consequently, DMS has contracted with four (4) entities – including the entity that has been performing managed care organization functions since the mid-1990s – to be responsible for managed care in region three (3) and the scope of managed care in region three (3) will now include behavioral health services.

As a result, DMS is repealing the existing region three (3) managed care administrative regulation (907 KAR 1:705) and establishing uniform managed care organization requirements and policies for all Medicaid managed care organizations in Kentucky. The six (6) administrative regulations which accomplish this include this administrative regulation; 907 KAR 17:005 (Definitions for administrative regulations in Chapter 17 of Title 907); 907 KAR 17:010 (managed care organization requirements and policies related to enrollees); 907 KAR 17:015 (managed care organization requirements and policies relating to providers); 907 KAR 17:025 (managed care organization utilization management and quality requirements and policies); and 907 KAR 17:030 (managed care organization operational and related requirements and policies.) DMS is establishing managed care organization requirements across multiple administrative regulations in response to urging from the Administrative Regulation Review Subcommittee (ARRS) and ARRS staff when this administrative regulation was reviewed by the committee earlier this year. Providing a choice of managed care organizations to individuals is necessary to comply with a federal mandate and expanding the scope of managed care in region three (3) to include behavioral health services is also necessary to establish the same managed care benefit package for all Medicaid recipients enrolled in managed care in Kentucky.

(2) This action must be implemented on an emergency basis to comply with a federal mandate and to prevent a loss of federal funds as CMS has approved DMS's revised

managed care model - four (4) entities and the scope of services includes behavioral health services – for region three (3).

(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 Commissioner's Office

4 (New Emergency Administrative Regulation)

5 907 KAR 17:020E. Managed care organization service and service coverage re-
6 quirements and policies.

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

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

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
11 Services, Department for Medicaid Services, has responsibility to administer the Medi-
12 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to
13 comply with a requirement that may be imposed or opportunity presented by federal law
14 to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 estab-
15 lish requirements relating to managed care. This administrative regulation establishes
16 the Medicaid managed care organization service and service coverage requirements
17 and policies.

18 Section 1. MCO Service Areas. An MCO's service areas shall be as established in
19 the MCO Service Areas.

20 Section 2. Covered Services. (1) Except as established in subsection (2) of this sec-
21 tion, an MCO shall be responsible for the provision of a covered health service:

1 (a) Which is established in Title 907 of the Kentucky Administrative Regulations;

2 (b) Which shall be in the amount, duration, and scope that the services are covered
3 for recipients pursuant to the department's administrative regulations located in Title
4 907 of the Kentucky Administrative Regulations; and

5 (c) Beginning on the date of enrollment of a recipient into the MCO.

6 (2) Other than a nursing facility cost referenced in subsection (3)(i) of this section, an
7 MCO shall be responsible for the cost of a non-nursing facility covered service provided
8 to an enrollee during the first thirty (30) days of a nursing facility admission in accord-
9 ance with this administrative regulation.

10 (3) An MCO shall not be responsible for the provision or costs of the following:

11 (a) A service provided to a recipient in an intermediate care facility for individuals with
12 mental retardation or a developmental disability;

13 (b) A service provided to a recipient in a 1915(c) home and community based waiver
14 program;

15 (c) A hospice service provided to a recipient in an institution;

16 (d) A nonemergency transportation service provided in accordance with 907 KAR
17 3:066;

18 (e) Except as established in Section 6 of this administration regulation, a school-
19 based health service;

20 (f) A service not covered by the Kentucky Medicaid program;

21 (g) A health access nurturing developing service pursuant to 907 KAR 3:140;

22 (h) An early intervention program service pursuant to 907 KAR 1:720; or

23 (i) A nursing facility service for an enrollee during the first thirty (30) days of a nursing

1 facility admission.

2 (4) The following covered services provided by an MCO shall be accessible to an en-
3 rollee without a referral from the enrollee's primary care provider:

4 (a) A primary care vision service;

5 (b) A primary dental or oral surgery service;

6 (c) An evaluation by an orthodontist or a prosthodontist;

7 (d) A service provided by a women's health specialist;

8 (e) A family planning service;

9 (f) An emergency service;

10 (g) Maternity care for an enrollee under age eighteen (18);

11 (h) An immunization for an enrollee under twenty-one (21);

12 (i) A screening, evaluation, or treatment service for a sexually transmitted disease or
13 tuberculosis;

14 (j) Testing for HIV, HIV-related condition, or other communicable disease; and

15 (k) A chiropractic service.

16 (5) An MCO shall:

17 (a) Not require the use of a network provider for a family planning service;

18 (b) In accordance with 42 C.F.R. 431.51(b), reimburse for a family planning service
19 provided within or outside of the MCO's provider network;

20 (c) Cover an emergency service:

21 1. In accordance with 42 U.S.C. 1396u-2(b)(2)(A)(i);

22 2. Provided within or outside of the MCO's provider network; or

23 3. Out-of-state in accordance with 42 C.F.R. 431.52;

1 (d) Comply with 42 U.S.C. 1396u-2(b)(A)(ii); and

2 (e) Be responsible for the provision and reimbursement of a covered service as de-
3 scribed in this section beginning on or after the beginning date of enrollment of a recipi-
4 ent with an MCO as established in 907 KAR 17:010.

5 (6)(a) If an enrollee is receiving a medically necessary covered service the day be-
6 fore enrollment with an MCO, the MCO shall be responsible for the reimbursement of
7 continuation of the medically necessary covered service without prior approval and
8 without regard to whether services are provided within or outside the MCO's network
9 until the MCO can reasonably transfer the enrollee to a network provider.

10 (b) An MCO shall comply with paragraph (a) of this subsection without impeding ser-
11 vice delivery or jeopardizing the enrollee's health.

12 Section 3. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Ser-
13 vices. (1) An MCO shall provide an enrollee under the age of twenty-one (21) years with
14 EPSDT services in compliance with:

15 (a) 907 KAR 11:034; and

16 (b) 42 U.S.C. 1396d(r).

17 (2) A provider of an EPSDT service shall meet the requirements established in 907
18 KAR 11:034.

19 Section 4. Emergency Care, Urgent Care, and Poststabilization Care. (1) An MCO
20 shall provide to an enrollee:

21 (a) Emergency care twenty-four (24) hours a day, seven (7) days a week; and

22 (b) Urgent care within forty-eight (48) hours.

23 (2) Poststabilization services shall be provided and reimbursed in accordance with 42

1 C.F.R. 422.113(c) and 438.114(e).

2 Section 5. Maternity Care. An MCO shall:

3 (1) Have procedures to assure:

4 (a) Prompt initiation of prenatal care; or

5 (b) Continuation of prenatal care without interruption for a woman who is pregnant at
6 the time of enrollment;

7 (2) Provide maternity care that includes:

8 (a) Prenatal;

9 (b) Delivery;

10 (c) Postpartum care; and

11 (d) Care for a condition that complicates a pregnancy; and

12 (3) Perform all the newborn screenings referenced in 902 KAR 4:030.

13 Section 6. Pediatric Interface. (1) An MCO shall:

14 (a) Have procedures to coordinate care for a child receiving a school-based health
15 service or an early intervention service; and

16 (b) Monitor the continuity and coordination of care for the child receiving a service
17 referenced in paragraph (a) of this subsection as part of its quality assessment and per-
18 formance improvement (QAPI) program established in 907 KAR 17:025.

19 (2) Except when a child's course of treatment is interrupted by a school break, after-
20 school hours, or summer break, an MCO shall not be responsible for a service refer-
21 enced in subsection (1)(a) of this section.

22 (3) A school-based health service provided by a school district shall not be covered
23 by an MCO.

1 (4) A school-based health service provided by a local health department shall be
2 covered by an MCO.

3 Section 7. Pediatric Sexual Abuse Examination. (1) An MCO shall enroll at least one
4 (1) provider in its network who has the capacity to perform a forensic pediatric sexual
5 abuse examination.

6 (2) A forensic pediatric sexual abuse examination shall be conducted for an enrollee
7 at the request of the DCBS.

8 Section 8. Lock-in Program. (1) An MCO shall have a program to control utilization of:

9 (a) Drugs and other pharmacy benefits; and

10 (b) Non-emergency care provided in an emergency setting.

11 (2)(a) The program referenced in subsection (1) of this section shall be approved by
12 the department.

13 (b) An MCO shall not be required to use the criteria established in 907 KAR 1:677 for
14 placing an enrollee in the MCO's lock-in program if:

15 1. The MCO provides notice to the enrollee, in accordance with the adverse action
16 notice requirements established in 907 KAR 17:010, of being placed in the MCO's lock-
17 in program; and

18 2. The enrollee is granted the opportunity to appeal being placed in a lock-in program
19 in accordance with the:

20 a. MCO internal appeal process requirements established in 907 KAR 17:010; and

21 b. The department's state fair hearing requirements established in 907 KAR 17:010.

22 Section 9. Pharmacy Benefit Program. (1) An MCO shall:

23 (a) Have a pharmacy benefit program that shall have:

- 1 1. A point-of-sale claims processing service;
- 2 2. Prospective drug utilization review;
- 3 3. An accounts receivable process;
- 4 4. Retrospective utilization review services;
- 5 5. Formulary and non-formulary drugs;
- 6 6. A prior authorization process for drugs;
- 7 7. Pharmacy provider relations;
- 8 8. A toll-free call center that shall respond to a pharmacy or a physician prescriber
- 9 twenty-four (24) hours a day, seven (7) days a week; and
- 10 9. A seamless interface with the department's management information system;
- 11 (b) Maintain a preferred drug list (PDL);
- 12 (c) Provide the following to an enrollee or a provider:
- 13 1. PDL information; and
- 14 2. Pharmacy cost sharing information; and
- 15 (d) Have a Pharmacy and Therapeutics Committee (P&T Committee), which shall:
- 16 1. Meet periodically throughout the calendar year as necessary; and
- 17 2. Make recommendations to the MCO for changes to the drug formulary.
- 18 (2)(a) The department shall comply with the drug rebate collection requirement estab-
- 19 lished in 42 U.S.C. 1396b(m)(2)(A)(xiii).
- 20 (b) An MCO shall:
- 21 1. Cooperate with the department in complying with 42 U.S.C. 1396b(m)(2)(A)(xiii);
- 22 2. Assist the department in resolving a drug rebate dispute with a manufacturer; and
- 23 3. Be responsible for drug rebate administration in a non-pharmacy setting.

1 (3) An MCO's P&T committee shall meet and make recommendations to the MCO for
2 changes to the drug formulary.

3 (4) If a prescription for an enrollee is for a non-preferred drug and the pharmacist
4 cannot reach the enrollee's primary care provider or the MCO for approval and the
5 pharmacist determines it necessary to provide the prescribed drug, the pharmacist
6 shall:

7 (a) Provide a seventy-two (72) hour supply of the prescribed drug; or

8 (b) Provide less than a seventy-two (72) hour supply of the prescribed drug, if the re-
9 quest is for less than a seventy-two (72) hour supply.

10 (5) Cost sharing imposed by an MCO shall not exceed the cost sharing limits estab-
11 lished in 907 KAR 1:604.

12 Section 10. MCO Interface with the Department Regarding Behavioral Health. An
13 MCO shall:

14 (1) Meet with the department monthly to discuss:

15 (a) Serious mental illness and serious emotional disturbance operating definitions;

16 (b) Priority populations;

17 (c) Targeted case management and peer support provider certification training and
18 processes;

19 (d) IMPACT Plus program operations;

20 (e) Satisfaction survey requirements;

21 (f) Priority training topics;

22 (g) Behavioral health services hotline; or

23 (h) Behavioral health crisis services;

1 (2) Coordinate:

2 (a) An IMPACT Plus covered service provided to an enrollee in accordance with 907

3 KAR 3:030;

4 (b) With the department:

5 1. An enrollee education process for:

6 a. Individuals with a serious mental illness; and

7 b. Children or youth with a serious emotional disturbance; and

8 2. On establishing a collaborative agreement with a:

9 a. State-operated or stated-contracted psychiatric hospital; and

10 b. Facility that provides a service to an individual with a co-occurring behavioral

11 health and developmental and intellectual disabilities; and

12 (c) With the department and community mental health centers a process for integrat-

13 ing a behavioral health service hotline; and

14 (3) Provide the department with proposed materials and protocols for the enrollee

15 education referenced in subsection (2)(b) of this section.

16 Section 11. Behavioral Health Services. (1) An MCO shall:

17 (a) Provide a medically necessary behavioral health service to an enrollee in accord-

18 ance with the access standards established in 907 KAR 17:015;

19 (b) Use the DSM-IV multi-axial classification system to assess an enrollee for a be-

20 havioral service;

21 (c) Have an emergency or crisis behavioral health toll-free hotline staffed by trained

22 personnel twenty-four (24) hours a day, seven (7) days a week;

23 (d) Not operate one (1) hotline to handle both an emergency or crisis call and a rou-

1 tine enrollee call; and

2 (e) Not impose a maximum call duration limit.

3 (2) Staff of a hotline referenced in subsection (1)(c) of this section shall:

4 (a) Communicate in a culturally competent and linguistically accessible manner to an
5 enrollee; and

6 (b) Include or have access to a qualified behavioral health professional to assess and
7 triage a behavioral health emergency.

8 (3) A face-to-face emergency service shall be available:

9 (a) Twenty-four (24) hours a day; and

10 (b) Seven (7) days a week.

11 Section 12. Coordination Between a Behavioral Health Provider and a Primary Care
12 Provider. (1) An MCO shall:

13 (a) Require a PCP to have a screening and evaluation procedure for the detection
14 and treatment of, or referral for, a known or suspected behavioral health problem or dis-
15 order;

16 (b) Provide training to a PCP in its network on:

17 1. Screening and evaluating a behavioral health disorder;

18 2. The MCO's referral process for a behavioral health service;

19 3. Coordination requirements for a behavioral health service; and

20 4. Quality of care standards;

21 (c) Have policies and procedures that shall be approved by the department regarding
22 clinical coordination between a behavioral health service provider and a PCP;

23 (d) Establish guidelines and procedures to ensure accessibility, availability, referral,

1 and triage to physical and behavioral health care;

2 (e) Facilitate the exchange of information among providers to reduce inappropriate or
3 excessive use of psychopharmacological medications and adverse drug reactions;

4 (f) Identify a method to evaluate continuity and coordination of care; and

5 (g) Include the monitoring and evaluation of the MCO's compliance with the require-
6 ments established in paragraphs (a) to (f) of this subsection in the MCO's quality im-
7 provement plan.

8 (2) With consent from an enrollee or the enrollee's legal guardian, an MCO shall re-
9 quire a behavioral health service provider to:

10 (a) Refer an enrollee with a known or suspected and untreated physical health prob-
11 lem or disorder to their PCP for examination and treatment; and

12 (b) Send an initial and quarterly summary report of an enrollee's behavioral health
13 status to the enrollee's PCP.

14 Section 13. Court-Ordered Psychiatric Services. (1) An MCO shall:

15 (a) Provide an inpatient psychiatric service to an enrollee under the age of twenty-
16 one (21) and over the age of sixty-five (65) who has been ordered to receive the service
17 by a court of competent jurisdiction under the provisions of KRS Chapters 202A and
18 645;

19 (b) Not deny, reduce, or negate the medical necessity of an inpatient psychiatric ser-
20 vice provided pursuant to a court-ordered commitment for an enrollee under the age of
21 twenty-one (21) or over the age of sixty-five (65);

22 (c) Coordinate with a provider of a behavioral health service the treatment objectives
23 and projected length of stay for an enrollee committed by a court of law to a state psy-

1 psychiatric hospital; and

2 (d) Enter into a collaborative agreement with the state-operated or state-contracted
3 psychiatric hospital assigned to the enrollee's region in accordance with 908 KAR 3:040
4 and in accordance with the Olmstead decision.

5 (2) An MCO shall present a modification or termination of a service referenced in
6 subsection (1)(b) of this section to the court with jurisdiction over the matter for determi-
7 nation.

8 (3)(a) An MCO behavioral health service provider shall:

9 1. Participate in a quarterly continuity of care meeting with a state-operated or state-
10 contracted psychiatric hospital;

11 2. Assign a case manager prior to or on the date of discharge of an enrollee from a
12 state-operated or state-contracted psychiatric hospital; and

13 3. Provide case management services to an enrollee with a severe mental illness and
14 co-occurring developmental disability who is discharged from a:

15 a. State-operated or state-contracted psychiatric hospital; or

16 b. State-operated nursing facility for individuals with severe mental illness.

17 (b) A case manager and a behavioral health service provider shall participate in dis-
18 charge planning to ensure compliance with the Olmstead decision.

19 Section 14. Centers for Medicare and Medicaid Services Approval and Federal Fi-
20 nancial Participation. A policy established in this administrative regulation shall be null
21 and void if the Centers for Medicare and Medicaid Services:

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

23 (2) Disapproves the policy.

1 Section 15. Incorporation by Reference. (1) The “MCO Service Areas”, November
2 2012 edition, is incorporated by reference.

3 (2) This material may be:

4 (a) Inspected, copied, or obtained, subject to applicable copyright law, at the Depart-
5 ment for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday
6 through Friday, 8 a.m. to 4:30 p.m.; or

7 (b) Obtained online at the department’s Web site at
8 <http://www.chfs.ky.gov/dms/incorporated.htm>.

907 KAR 17:020E

REVIEWED:

Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 17:020E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This is a new administrative regulation which establishes Kentucky Medicaid program managed care organization (MCO) service and service coverage requirements and policies. Previously, those policies were contained in one (1) administrative regulation - (907 KAR 17:005) – which contained all MCO policies and requirements (excluding policies related to the MCO operating in region three (3)). Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3).

The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than the aforementioned 907 KAR 17:005. DMS is dividing the policies across multiple regulations in response to urging from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. Thus, this is a new administrative regulation but it contains policies that were previously stated in 907 KAR 17:005. The only amended policies in this administrative regulation are the inclusion of region three (3) counties for all MCOs; the elimination of the requirement that an MCO's lock-in program must be in accordance with DMS's lock-in regulation (907 KAR 1:677); and eliminating the Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule from being incorporated by reference. MCOs must submit their lock-in programs to DMS for approval but the MCOs' lock-in programs will no longer be required to be in accordance with DMS's lock-in regulation. The lock-in program is a program which identifies high utilizers of services and implements controls to ensure that utilization is necessary and not excessive.

- (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization service and service coverage requirements and policies. Amending the service coverage regions is necessary as the MCO service coverage policies now apply to MCOs operating in region three (3) as DMS is now contracting with four (4) such enti-

ties and is repealing the old administrative regulation which applied to the lone entity which was responsible for managed care in region three (3). The lock-in program amendment is necessary to give MCOs more flexibility in designing a lock-in program. Deleting the Early and Periodic Screening, Diagnosis and Treatment Program Periodicity Schedule from being incorporated by reference is necessary as there is no need to incorporate the document by reference into this administrative regulation.

- (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid managed care organization service and service coverage requirements and policies. The amended policy conforms to the content of the authorizing statutes by giving MCOs more flexibility in designing a lock-in program (which also may benefit DMS as DMS can monitor the success of the MCOs' lock-in programs and learn from the MCOs' experiences.)
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing Medicaid managed care organization service and service coverage requirements and policies. The amended policy will assist in the effective administration of the authorizing statutes by giving MCOs more flexibility in designing a lock-in program (which also may benefit DMS as DMS can monitor the success of the MCOs' lock-in programs and learn from the MCOs' experiences.)
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
- (a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
 - (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
 - (c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
 - (d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.
- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS's projected managed care expenditures for state fiscal year (SFY 2013) are \$3,198,870,633.
 - (b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS's projected managed care expenditures for state fiscal year (SFY 2013) are \$3,303,448,347.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly or indirectly increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is neither applied nor necessary as the administrative regulation applies equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 17:020E

Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 CFR Part 438. This administrative regulation established MCO service and service coverage requirements and policies. Those requirements are established in 42 CFR 438.114, 42 CFR 438.206 through 438.210.
2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."
3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 CFR Part 438. This administrative regulation establishes MCO service and service coverage requirements. Federal MCO service and service coverage requirements include that MCOs must offer members all services available under the state Medicaid program's state plan; MCOs must cover emergency services without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager; An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of a bodily organ or part; MCOs must cover services needed to evaluate the emergency and stabilize the patient for transfer or discharge and if the treating physician or provider deems necessary, a nonparticipating provider may continue treatment to improve or resolve the patient's condition if the MCO does not respond to a request for authorization within one hour, no plan physician assumes responsibility for the patient's care, or the emergency professional and the plan physician disagree about the appropriate treatment; and MCOs must comply with the maternity and mental health requirements of the Public Health Service Act (PubLNo 94-484) insofar as they apply to a health insurance issuer that offers group health insurance coverage.
4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No,

this change relates to provision of managed care but does not impose additional or stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. A managed care method of administering the program is being implemented but stricter requirements are not imposed. A managed care program is not federally mandated for Medicaid programs.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 17:020E

Agency Contact Person: Stuart Owen (502) 564-4321

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

Yes X No _____

If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.
3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 CFR 438 and this administrative regulation authorizes the action taken by this administrative regulation.
4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
 - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.
 - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.
 - (c) How much will it cost to administer this program for the first year? No cost is necessary to implement this amended administrative regulation. DMS's projected managed care expenditures for SFY 2013 are \$3,198,870,633.
 - (d) How much will it cost to administer this program for subsequent years? No cost is necessary to implement this amended administrative regulation. DMS's projected managed care expenditures for SFY 2014 are \$3,303,448,347.

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

907 KAR 17:020, Managed care organization service and service coverage requirements and policies

Summary of Material Incorporated by Reference

The "MCO Service Areas", November 2012 edition is incorporated by reference into this administrative regulation. This four (4)-page document establishes the service areas for each managed care organization.

A total of four (4) pages are incorporated by reference into this administrative regulation.