

## STATEMENT OF EMERGENCY

### 907 KAR 17:010E

(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 will accomplish this include this administrative regulation; 907 KAR 17:005 (Definitions for administrative regulations in Chapter 17 of Title 907); 907 KAR 17:015 (managed care organization requirements and policies related to providers); 907 KAR 17:020 (managed care organization service and service coverage requirements and policies); 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 different from this emergency administrative regulation in that it does not contain the January 1, 2013 effective date for the policy regarding retroactively eligible individuals who receive Supplemental Security Income benefits. The date is not in the ordinary administrative regulation as it will not be adopted prior to January 1, 2013.

---

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 17:010E. Managed care organization requirements and policies relating to  
6 enrollees.

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, Part I, Sec-  
10 tion G. Budget Unit 3. a.(b)(17) of House Bill 265 of the 2012 Session of the General  
11 Assembly

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

20 Section 1. Enrollment of Medicaid or KCHIP Recipients into Managed Care. (1) Ex-  
21 cept as provided in subsection (3) of this section, enrollment into a managed care

1 organization shall be mandatory for a Medicaid or KCHIP recipient.

2 (2) The provisions in this administrative regulation shall be applicable to a

3 (a) Medicaid recipient; or

4 (b) KCHIP recipient.

5 (3) The following recipients shall not be required to enroll, and shall not enroll, into a  
6 managed care organization:

7 (a) A recipient who resides in:

8 1. A nursing facility for more than thirty (30) days; or

9 2. An intermediate care facility for individuals with mental retardation or a develop-  
10 mental disability; or

11 (b) A recipient who is:

12 1. Determined to be eligible for Medicaid benefits due to a nursing facility admission;

13 2. Receiving:

14 a. Services through the breast and cervical cancer program pursuant to 907 KAR

15 1:805;

16 b. Medicaid benefits in accordance with the spend-down policies established in 907

17 KAR 1:640;

18 c. Services through a 1915(c) home and community based services waiver program;

19 d. Hospice services in a nursing facility or intermediate care facility for individuals

20 with mental retardation or a developmental disability; or

21 e. Medicaid benefits as a Medicaid Works individual;

22 4. A Qualified Medicare beneficiary who is not otherwise eligible for Medicaid bene-

23 fits;

1 5. A specified low-income Medicare beneficiary who is not otherwise eligible for Med-  
2 icaid benefits;

3 6. A Medicare qualified individual group 1 (QI-1) individual;

4 7. A qualified disabled and working individual;

5 8. A qualified alien eligible for Medicaid benefits for a limited period of time; or

6 9. A nonqualified alien eligible for Medicaid benefits for a limited period of time.

7 (4)(a) Except for a child in foster care, a recipient who is eligible for enrollment into  
8 managed care shall be enrolled with an MCO that provides services to an enrollee  
9 whose primary residence is within the MCO's service area.

10 (b) A child in foster care shall be enrolled with an MCO in the county where the  
11 child's DCBS case is located.

12 (5)(a) During the department's implementation of managed care in accordance with  
13 this administrative regulation, the department shall assign a recipient to an MCO based  
14 upon an algorithm that considers:

15 1. Continuity of care; and

16 2. Enrollee preference of an MCO provider; and

17 (b) An assignment shall focus on a need of a child or an individual with a special  
18 health care need.

19 (6)(a) A newly eligible recipient or a recipient who has had a break in eligibility of  
20 greater than two (2) months shall have an opportunity to choose an MCO during the eli-  
21 gibility application process.

22 (b) If a recipient does not choose an MCO during the eligibility application process,  
23 the department shall assign the recipient to an MCO.

1 (7) Each member of a household shall be assigned to the same MCO.

2 (8) The effective date of enrollment for a recipient described in subsection (6) of this  
3 section shall be:

4 (a) The date of Medicaid eligibility; and

5 (b) No earlier than January 1, 2013 for region three.

6 (9) A recipient shall be given a choice of MCOs.

7 (10) A recipient enrolled with an MCO who loses Medicaid eligibility for less than two  
8 (2) months shall be automatically reenrolled with the same MCO upon redetermination  
9 of Medicaid eligibility unless the recipient moves outside of the MCO's regional cover-  
10 age.

11 (11) A newborn who has been deemed eligible for Medicaid shall be automatically  
12 enrolled with the newborn's mother's MCO as an individual enrollee for up to sixty (60)  
13 days.

14 (12)(a) An enrollee may change an MCO for any reason, regardless of whether the  
15 MCO was selected by the enrollee or assigned by the department:

16 1. Within ninety (90) days of the effective date of enrollment;

17 2. Annually during an open enrollment period;

18 3. Upon automatic enrollment under subsection (10) of this section, if a temporary  
19 loss of Medicaid eligibility caused the recipient to miss the annual opportunity in sub-  
20 paragraph 2. of this paragraph; or

21 4. When the Commonwealth of Kentucky imposes an intermediate sanction specified  
22 in 42 C.F.R. 438.702(a)(3).

23 (b) An MCO shall accept an enrollee who changes MCOs under this section.

1 (13) Only the department shall have the authority to enroll a Medicaid recipient with  
2 an MCO in accordance with this section.

3 (14) Upon enrollment with an MCO, an enrollee shall receive two (2) identification  
4 cards.

5 (a) A card shall be issued from the department that shall verify Medicaid eligibility.

6 (b) A card shall be issued by the MCO that shall verify enrollment with the MCO.

7 (15)(a) Within five (5) business days after receipt of notification of a new enrollee, an  
8 MCO shall send, by a method that shall not take more than three (3) days to reach the  
9 enrollee, a confirmation letter to an enrollee.

10 (b) The confirmation letter shall include at least the following information:

- 11 1. The effective date of enrollment;
- 12 2. The name, location, and contact information of the PCP;
- 13 3. How to obtain a referral;
- 14 4. Care coordination;
- 15 5. The benefits of preventive health care;
- 16 6. The enrollee identification card;
- 17 7. A member handbook; and
- 18 8. A list of covered services.

19 (16) Enrollment with an MCO shall be without restriction.

20 (17) An MCO shall:

21 (a) Have continuous open enrollment for new enrollees; and

22 (b) Accept enrollees regardless of overall enrollment.

1 (18)(a) Except as provided in paragraph (b) through (e) of this subsection, a recipient  
2 eligible to enroll with an MCO shall be enrolled beginning with the first day of the month  
3 that the enrollee applied for Medicaid.

4 (b) A newborn shall be enrolled beginning with the newborn's date of birth.

5 (c) An unemployed parent shall be enrolled beginning with the date the unemployed  
6 parent met the definition of unemployment in accordance with 45 C.F.R. 233.100.

7 (d)1. If an enrollee is retroactively determined eligible for Medicaid, the retroactive el-  
8 igibility, except for an individual who has been determined to be eligible for SSI benefits,  
9 shall be for a period up to three (3) months prior to the month that the enrollee applied  
10 for Medicaid.

11 2. Except as established in paragraph (f) of this subsection, an MCO shall be respon-  
12 sible for reimbursing for covered services provided to a retroactively determined eligible  
13 individual referenced in subparagraph 1. of this paragraph during the individual's retro-  
14 active eligibility period.

15 (e) If an enrollee is retroactively determined eligible for Medicaid as a result of being  
16 determined retroactively eligible for SSI benefits:

17 1. The individual's enrollment date with an MCO shall be the first of the month follow-  
18 ing the month in which the department is notified of the individual's retroactive eligibility  
19 for SSI benefits; and

20 2. The department shall be responsible for reimbursing for any services provided dur-  
21 ing the retroactive eligibility period for an individual determined to be retroactively eligi-  
22 ble for SSI benefits.

1 (f) In addition to the reimbursement obligation described in paragraph (e)2. of this  
2 subsection, the department shall be responsible for reimbursing for services provided to  
3 an individual:

4 1. Determined to be retroactively eligible for any portion of the retroactive eligibility  
5 period which occurred prior to November 1, 2011 for regions one (1), two (2), four (4),  
6 five (5), six (6), seven (7) and eight (8) if the individual has a retroactive eligibility period  
7 prior to November 1, 2011; or

8 2. Determined to be retroactively eligible for any portion of the retroactive eligibility  
9 period which occurred prior to January 1, 2013 for region three (3) if the individual has a  
10 retroactive eligibility period prior to January 1, 2013.

11 (g) The policy stated in paragraph (e)2. and (f)2. of this subsection shall be:

12 1. Effective January 1, 2013 contingent upon approval by the Centers for Medicare  
13 and Medicaid Services (CMS); and

14 2. Implemented upon approval by CMS.

15 (19) For an enrollee whose eligibility resulted from a successful appeal of a denial of  
16 eligibility, the enrollment period shall begin:

17 (a)1. On the first day of the month of the original application for eligibility; or

18 2. On the first day of the month of retroactive eligibility as referenced in subsection  
19 (18)(d) or (e) of this section, if applicable; and

20 (b) No earlier than:

21 1. November 1, 2011 for regions one (1), two (2), four (4), five (5), six (6), seven (7),  
22 and eight (8); or

23 2. January 1, 2013 for region three (3).

1 (20) A provider shall be responsible for verifying an individual's eligibility for Medicaid  
2 and enrollment in a managed care organization when providing a service.

3 Section 2. Disenrollment. (1) The policies established in 42 C.F.R. 438.56 shall apply  
4 to an MCO.

5 (2) Only the department shall have the authority to disenroll a recipient from an MCO.

6 (3) A disenrollment of a recipient from an MCO shall:

7 (a) Become effective on the first day of the month following disenrollment; and

8 (b) Occur:

9 1. If the enrollee:

10 a. No longer resides in an area served by the MCO;

11 b. Becomes incarcerated or deceased; or

12 c. Is exempt from managed care enrollment in accordance with Section 1(3) of this  
13 administrative regulation; or

14 2. In accordance with 42 C.F.R. 438.56.

15 (4) An MCO may recommend to the department that an enrollee be disenrolled if the  
16 enrollee:

17 (a) Is found guilty of fraud in a court of law or administratively determined to have  
18 committed fraud related to the Medicaid Program;

19 (b) Is abusive or threatening but not for uncooperative or disruptive behavior resulting  
20 from his or her special needs (except if his or her continued enrollment in the MCO seri-  
21 ously impairs the entity's ability to furnish services to either this particular enrollee or  
22 other enrollees) pursuant to 42 C.F.R. 438.56(b)(2);

23 (c) Becomes deceased; or

1 (d) No longer resides in an area served by the MCO.

2 (5) An enrollee shall not be disenrolled by the department, nor shall the managed  
3 care organization recommend disenrollment of an enrollee, due to an adverse change in  
4 the enrollee's health.

5 (6)(a) An approved disenrollment shall be effective no later than the first day of the  
6 second month following the month the enrollee or the MCO files a request in accord-  
7 ance with 42 C.F.R. 438.56(e)(1).

8 (b) If the department fails to make a determination within the timeframe specified in  
9 paragraph (a) of this subsection, the disenrollment shall be considered approved in ac-  
10 cordance with 42 C.F.R. 438.56(e)(2).

11 (7) If an enrollee is disenrolled from an MCO, the:

12 (a) Enrollee shall be enrolled with a new MCO if the enrollee is:

- 13 1. Eligible for Medicaid; and  
14 2. Not excluded from managed care participation; and

15 (b) MCO shall:

- 16 1. Assist in the selection of a new primary care provider, if requested;  
17 2. Cooperate with the new primary care provider in transitioning the enrollee's care;

18 and

19 3. Make the enrollee's medical record available to the new primary care provider in  
20 accordance with state and federal law.

21 (8) An MCO shall notify the department or Social Security Administration in an enrol-  
22 lee's county of residence within five (5) working days of receiving notice of the death of  
23 an enrollee.

1 Section 3. Enrollee Rights and Responsibilities. (1) An MCO shall have written poli-  
2 cies and procedures:

3 (a) To protect the rights of an enrollee that includes the:

4 1. Protection against liability for payment in accordance with 42 U.S.C. 1396u-2(b)(6);

5 2. Rights specified in 42 C.F.R. 438.100;

6 3. Right to prepare an advance medical directive pursuant to KRS 311.621 through  
7 KRS 311.643;

8 4. Right to choose and change a primary care provider;

9 5. Right to file a grievance or an appeal;

10 6. Right to receive assistance in filing a grievance or an appeal;

11 7. Right to a state fair hearing;

12 8. Right to a timely referral and access to medically indicated specialty care; and

13 9. Right to access the enrollee's medical records in accordance with federal and state  
14 law; and

15 (b) Regarding the responsibilities of enrollees that include the responsibility to:

16 1. Become informed about:

17 a. Enrollee rights specified in paragraph (a) of this subsection; and

18 b. Service and treatment options;

19 2. Abide by the MCO's and department's policies and procedures;

20 3. Actively participate in personal health and care decisions;

21 4. Report suspected fraud or abuse; and

22 5. Keep appointments or call to cancel if unavailable to keep an appointment.

23 (2) The information specified in subsection (1) of this section shall meet the infor-

1 mation requirements established in 42 C.F.R. 438.10.

2 Section 4. MCO Internal Appeal Process. (1) An MCO shall have written policies and  
3 procedures describing how an enrollee shall submit a request for a:

4 (a) Grievance with the MCO;

5 (b) An appeal with the MCO; or

6 (c) State fair hearing in accordance with KRS Chapter 13B.

7 (2) An enrollee shall have thirty (30) calendar days from the date of an event causing  
8 dissatisfaction to file a grievance orally or in writing with the MCO.

9 (a) Within five (5) working days of receipt of a grievance, an MCO shall provide the  
10 enrollee with written notice that the grievance has been received and the expected date  
11 of its resolution.

12 (b) An investigation and final resolution of a grievance shall:

13 1. Be completed within thirty (30) calendar days of the date the grievance is received  
14 by the MCO; and

15 2. Include a resolution letter to the enrollee that shall include:

16 i. All information considered in investigating the grievance;

17 ii. Findings and conclusions based on the investigation; and

18 iii. The disposition of the grievance.

19 (3) An MCO shall have an internal appeal process in place that allows an enrollee to  
20 challenge a denial of coverage of, or payment for, a service in accordance with 42  
21 C.F.R. 438.400 through 438.424 and 42 U.S.C. 1396u-2(b)(4).

22 (4)(a) A provider shall not be an authorized representative of an enrollee without the  
23 enrollee's written consent for the specific action that is being appealed or that is the

1 subject of a state fair hearing.

2 (b) The written consent referenced in paragraph (a) of this subsection, shall be  
3 signed and dated by the enrollee no earlier than the date of the MCO's action.

4 (5) A legal guardian of an enrollee who is a minor or an incapacitated adult or an au-  
5 thorized representative of an enrollee in accordance with subsection (4) of this section,  
6 shall have the right to file an appeal on behalf of the enrollee.

7 (6) An enrollee shall have thirty (30) calendar days from the date of receiving a notice  
8 of adverse action from an MCO to file an appeal either orally or in writing with the MCO.

9 (7) An MCO shall resolve an appeal within thirty (30) calendar days from the date the  
10 initial oral or written appeal is received by the MCO.

11 (8) An MCO shall have a process in place that ensures that an oral or written inquiry  
12 from an enrollee seeking to appeal an adverse action is treated as an appeal to estab-  
13 lish the earliest possible filing date for the appeal.

14 (9) An oral appeal shall be followed by a written appeal that is signed by the enrollee  
15 within ten (10) calendar days.

16 (10)(a) Within five (5) working days of receipt of an appeal, an MCO shall provide the  
17 enrollee with written notice that the appeal has been received and the expected date of  
18 its resolution.

19 (b) An MCO shall confirm in writing receipt of an oral appeal unless an expedited  
20 resolution has been requested.

21 (11) An MCO shall extend the thirty (30) day timeframe for resolution of an appeal es-  
22 tablished in subsection (10) of this section by fourteen (14) calendar days if:

23 (a) The enrollee requests the extension; or

1 (b)1. The MCO demonstrates to the department that there is need for additional in-  
2 formation; and

3 2. The extension is in the enrollee's interest.

4 (12) For an extension requested by an MCO, the MCO shall give the enrollee written  
5 notice of the extension and the reason for the extension within two (2) working days of  
6 the decision to extend.

7 (13)(a) For an appeal, an MCO shall provide written notice of its decision within thirty  
8 (30) calendar days to an enrollee or a provider, if the provider filed the appeal.

9 (b) The provider shall:

10 1. Give a copy of the notice to the enrollee; or

11 2. Inform the enrollee of the provisions of the notice.

12 (14) An MCO shall:

13 (a) Continue to provide benefits to an enrollee, if the enrollee requested a continua-  
14 tion of benefits, until one of the following occurs:

15 1. The enrollee withdraws the appeal;

16 2. Fourteen (14) days have passed since the date of the resolution letter, if the reso-  
17 lution of the appeal was against the enrollee and the enrollee has not requested a state  
18 fair hearing or taken any further action; or

19 3. A state fair hearing decision adverse to the enrollee has been issued;

20 (b) Have an expedited review process for appeals if the MCO determines that allow-  
21 ing the time for a standard resolution could seriously jeopardize an enrollee's life or  
22 health or ability to attain, maintain, or regain maximum function;

23 (c) Resolve an expedited appeal within three (3) working days of receipt of the re-

1 quest; and

2 (d) Extend the timeframe for an expedited appeal established in paragraph (c) of this  
3 subsection by up to fourteen (14) calendar days if:

4 1. The enrollee requests the extension; or

5 2.a. The MCO demonstrates to the department that there is need for additional infor-  
6 mation; and

7 b. The extension is in the enrollee's interest.

8 (14) For an extension requested by an MCO, the MCO shall give the enrollee written  
9 notice of the reason for the extension.

10 (15) If an MCO denies a request for an expedited resolution of an appeal, it shall:

11 (a) Transfer the appeal to the thirty (30) day timeframe for a standard resolution, in  
12 which the thirty (30) day period shall begin on the date the MCO received the original  
13 request for appeal;

14 (b) Give prompt oral notice of the denial; and

15 (c) Follow up with a written notice within two (2) calendar days of the denial.

16 (16) An MCO shall document in writing an oral request for an expedited resolution  
17 and shall maintain the documentation in the enrollee case file.

18 (17) An MCO shall:

19 (a) Provide information specified in 42 C.F.R. 438.10(g)(1) about the grievance sys-  
20 tem to a service provider and a subcontractor at the time they enter into a contract;

21 (b) Maintain a grievance or an appeal file in a secure and designated area;

22 (c) Make a grievance or an appeal file accessible to the department or its designee  
23 upon request;

1 (d) Retain a grievance or an appeal file for ten (10) years following a final decision by  
2 the MCO, the department, an administrative law judge, judicial appeal, or closure of a  
3 file, whichever occurs later;

4 (e) Have procedures for assuring that a grievance or an appeal file contains:

- 5 1. Information to identify the grievance or appeal;
- 6 2. The date a grievance or appeal was received;
- 7 3. The nature of the grievance or appeal;
- 8 4. A notice to the enrollee of receipt of the grievance or appeal;
- 9 5. Correspondence between the MCO and the enrollee;
- 10 6. The date the grievance or appeal is resolved;
- 11 7. The decision made by the MCO of the grievance or appeal;
- 12 8. The notice of a final decision to the enrollee; and
- 13 9. Information pertaining to the grievance or appeal; and

14 (f) Make available to an enrollee documentation regarding a grievance or an appeal.

15 (18) An MCO shall designate an individual to:

- 16 (a) Execute the policies and procedures for resolution of a grievance or appeal;
- 17 (b) Review patterns or trends in grievances or appeals; and
- 18 (c) Initiate a corrective action, if needed.

19 (19) If an MCO takes adverse action at the conclusion of an internal appeal process,  
20 the MCO shall issue an adverse action letter to the enrollee that complies with KRS  
21 13B.050(3)(d) and (e).

22 (20)(a) The requirements and policies stated in this section of this administrative reg-  
23 ulation regarding an MCO appeal shall apply to an MCO.

1 (b) If a requirement or policy regarding an appeal or an MCO appeal stated in another  
2 Kentucky Administrative Regulation within Title 907 of the Kentucky Administrative  
3 Regulations contradicts a requirement or policy regarding an MCO appeal that is stated  
4 in this section of this administrative regulation, the requirement or policy stated in the  
5 other administrative regulation shall not apply to an MCO.

6 Section 5. Department's State Fair Hearing for an Enrollee. (1) An enrollee shall have  
7 a right to a state fair hearing administered by the department in accordance with KRS  
8 Chapter 13B only after exhausting an MCO's internal appeal process.

9 (2) The department shall provide an enrollee with a hearing process that shall adhere  
10 to 907 KAR 1:563; 42 CFR 438, Subpart F; and 42 CFR 431, Subpart E.

11 (3)(a) An enrollee or authorized representative may request a state fair hearing by fil-  
12 ing a written request with the department.

13 (b) If an enrollee or authorized representative requests a hearing, the request shall:

14 1. Be in writing and specify the reason for the request;

15 2. Indicate the date of service or the type of service denied; and

16 3. Be postmarked or filed within forty five (45) days from the date of the MCO ad-  
17 verse action letter issued at the conclusion of the MCO internal appeal process.

18 (4) A document supporting an MCO's adverse action shall be:

19 (a) Received by the department no later than five (5) days from the date a notice is  
20 sent to the MCO from the department that a request for a state fair hearing has been  
21 filed by an enrollee; and

22 (b) Made available to an enrollee upon request by either the enrollee or the enrollee's  
23 legal counsel.

1 (5) An automatic ruling shall be made by the department in favor of an enrollee if an  
2 MCO fails to:

3 (a) Comply with the requirements of:

4 1. Section 4 of this administrative regulation; and

5 2. Subsection (4) of this section; or

6 (b) Participate in and present evidence at the state fair hearing.

7 Section 6. Member Services. (1) An MCO shall have a member services function that  
8 includes a member call center and a behavioral health call center that shall:

9 (a) Be staffed Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern Time; and

10 (b) Meet the call center standards, which shall:

11 1. Be approved by the American Accreditation Health Care Commission or Utilization  
12 Review Accreditation Committee (URAC); and

13 2. Include provisions addressing the call center abandonment rate, blockage rate,  
14 and average speed of answer.

15 (2)(a) An MCO shall provide access to medical advice to an enrollee through a toll-  
16 free call-in system, available twenty-four (24) hours a day, seven (7) days a week.

17 (b) The call-in system shall be staffed by medical professionals to include:

18 1. Physicians;

19 2. Physician assistants;

20 3. Licensed practical nurses; or

21 4. Registered nurses.

22 (3) An MCO shall:

23 (a) Provide foreign language interpreter services, free of charge, for an enrollee;

- 1 (b) Respond to the special communication needs of the disabled, blind, deaf, or  
2 aged;
- 3 (c) Facilitate direct access to a specialty physician for an enrollee:  
4 1. With a chronic or complex health condition;  
5 2. Who is aged, blind, deaf, or disabled; or  
6 3. Identified as having a special healthcare need and requiring a course of treatment  
7 or regular healthcare monitoring;
- 8 (d) Arrange for and assist with scheduling an EPSDT service in conformance with  
9 federal law governing EPSDT;
- 10 (e) Provide an enrollee with information or refer the enrollee to a support service;
- 11 (f) Facilitate direct access to a covered service in accordance with 907 KAR 17:020;
- 12 (g) Facilitate access to a:  
13 1. Behavioral health service;  
14 2. Pharmaceutical service; or  
15 3. Service provided by a public health department, community mental health center,  
16 rural health clinic, federally qualified health center, the Commission for Children with  
17 Special Health Care Needs, or a charitable care provider;
- 18 (h) Assist an enrollee in:  
19 1. Scheduling an appointment with a provider;  
20 2. Obtaining transportation for an emergency or non-emergency service;  
21 3. Completing a health risk assessment; or  
22 4. Accessing an MCO health education program;
- 23 (i) Process, record, and track an enrollee grievance and appeal; or

1 (j) Refer an enrollee to case management or disease management.

2 Section 7. Enrollee Selection of Primary Care Provider. (1) Except for an enrollee de-  
3 scribed in subsection (2) of this section, an MCO shall have a process for enrollee se-  
4 lection and assignment of a primary care provider.

5 (2) The following shall not be required to have, but may request, a primary care pro-  
6 vider:

7 (a) A dual eligible;

8 (b) A child in foster care;

9 (c) A child under the age of eighteen (18) years who is disabled; or

10 (d) A pregnant woman who is presumptively eligible pursuant to 907 KAR 1:810.

11 (3)(a) For an enrollee who is not receiving supplemental security income benefits:

12 1. An MCO shall notify the enrollee within ten (10) days of notification of enrollment  
13 by the department of the procedure for choosing a primary care provider; and

14 2. If the enrollee does not choose a primary care provider, an MCO shall assign to  
15 the enrollee a primary care provider who:

16 a. Has historically provided services to the enrollee; and

17 b. Meets the requirements of subsection (6) of this section.

18 (b) If no primary care provider meets the requirements of paragraph (a)2 of this sub-  
19 section, an MCO shall assign the enrollee to a primary care provider who is within:

20 1. Thirty (30) miles or thirty (30) minutes from the enrollee's residence if the enrollee  
21 is in an urban area; or

22 2. Forty-five (45) miles or forty-five (45) minutes from the enrollee's residence if the  
23 enrollee is in a rural area.

1 (4)(a) For an enrollee who is receiving supplemental security income benefits and  
2 is not a dual eligible, an MCO shall notify the enrollee of the procedure for choosing a  
3 primary care provider.

4 (b) If an enrollee has not chosen a primary care provider within thirty (30) days, an  
5 MCO shall send a second notice to the enrollee.

6 (c) If an enrollee has not chosen a primary care provider within thirty (30) days of the  
7 second notice, the MCO shall send a third notice to the enrollee.

8 (d) If an enrollee has not chosen a primary care provider after the third notice, the  
9 MCO shall assign a primary care provider.

10 (e) Except for an enrollee who was previously enrolled with the MCO, an MCO shall  
11 not automatically assign a primary care provider within ninety (90) days of the enrollee's  
12 initial enrollment.

13 (5)(a) An enrollee shall be allowed to select from at least two (2) primary care provid-  
14 ers within an MCO's provider network.

15 (b) At least one (1) of the two (2) primary care providers referenced in paragraph (a)  
16 of this subsection shall be a physician.

17 (6) A primary care provider shall:

18 (a) Be a licensed or certified health care practitioner who functions within the provid-  
19 er's scope of licensure or certification, including:

20 1. A physician;

21 2. An advanced practice registered nurse;

22 3. A physician assistant; or

23 4. A clinic, including a primary care center, federally qualified health center, or rural

1 health clinic;

2 (b) Have admitting privileges at a hospital or a formal referral agreement with a pro-  
3 vider possessing admitting privileges;

4 (c) Agree to provide twenty-four (24) hours a day, seven (7) days a week primary  
5 health care services to enrollees; and

6 (d) For an enrollee who has a gynecological or obstetrical health care need, a disabil-  
7 ity, or chronic illness, be a specialist who agrees to provide or arrange for primary and  
8 preventive care.

9 (7) Upon enrollment in an MCO, an enrollee shall have the right to change primary  
10 care providers:

11 (a) Within the first ninety (90) days of assignment;

12 (b) Once a year regardless of reason;

13 (c) At any time for a reason approved by the MCO;

14 (d) If during a temporary loss of eligibility, an enrollee loses the opportunity provided  
15 by paragraph (b) of this subsection;

16 (e) If Medicare or Medicaid imposes a sanction on the PCP;

17 (f) If the PCP is no longer in the MCO provider network; or

18 (g) At any time with cause which shall include the enrollee:

19 1. Receiving poor quality of care;

20 2. Lacking access to providers qualified to treat the enrollee's medical condition; or

21 3. Being denied access to needed medical services.

22 (8) A PCP shall not be able to request the reassignment of an enrollee to a different  
23 PCP for the following reasons:

- 1 (a) A change in the enrollee's health status or treatment needs;
- 2 (b) An enrollee's utilization of health services;
- 3 (c) An enrollee's diminished mental capacity; or
- 4 (d) Disruptive behavior of an enrollee due to the enrollee's special health care needs
- 5 unless the behavior impairs the PCP's ability to provide services to the enrollee or oth-
- 6 ers.

7 (9) A PCP change request shall not be based on race, color, national origin, disabil-  
8 ity, age, or gender.

9 (10) An MCO shall have the authority to approve or deny a primary care provider  
10 change.

11 (11) An enrollee shall be able to obtain the following services outside of an MCO's  
12 provider network:

13 (a) A family planning service in accordance with 42 C.F.R. 431.51;

14 (b) An emergency service in accordance with 42 C.F.R. 438.114;

15 (c) A poststabilization service in accordance with 42 C.F.R. 438.114 and 42 C.F.R.  
16 422.113(c); or

17 (d) An out-of-network service that an MCO is unable to provide within its network to  
18 meet the medical need of the enrollee in accordance with 42 C.F.R. 438.206(b)(4) sub-  
19 ject to any prior authorization requirements of the MCO.

20 (12) An MCO shall:

21 (a) Notify an enrollee within:

22 1. Thirty (30) days of the effective date of a voluntary termination of the enrollee's  
23 primary care provider; or

1        2. Fifteen (15) days of an involuntary termination of the enrollee's primary care pro-  
2 vider; and

3        (b) Assist the enrollee in selecting a new primary care provider.

4        Section 8. Member Handbook. (1) An MCO shall:

5        (a) Send a member handbook to an enrollee, by a method that shall not take more  
6 than three (3) days to reach the enrollee, within five (5) business days of enrollment;

7        (b) Review the member handbook at least annually;

8        (c) Communicate a change to the member handbook to an enrollee in writing; and

9        (d) Add a revision date to the member handbook after revising the member hand-  
10 book.

11        (2) A member handbook shall:

12        (a) Be available:

13        1. In hardcopy in English, Spanish, and any other language spoken by at least five  
14 (5) percent of the potential enrollee or enrollee population; and

15        2. On the MCO's Web site;

16        (b) Be written at no higher than a sixth grade reading comprehension level; and

17        (c) Include at a minimum the following information:

18        1. The MCO's network of primary care providers, including the names, telephone  
19 numbers, and service site addresses of available primary care providers, and, if desired  
20 by the MCO, the names and contact information for other providers included in the  
21 MCO's network;

22        2. The procedures for:

23        a. Selecting a PCP and scheduling an initial health appointment;

- 1 b. Obtaining:
  - 2 (i) Emergency or non-emergency care after hours;
  - 3 (ii) Transportation for emergency or non-emergency care;
  - 4 (iii) An EPSDT service;
  - 5 (iv) A covered service from an out-of-network provider; or
  - 6 (v) A long term care service;
- 7 c. Notifying DCBS of a change in family size or address, a birth, or a death of an en-  
8 rollee;
- 9 d.(i) Selecting or requesting to change a PCP;
- 10 (ii) A reason a request for a change may be denied by the MCO;
- 11 (iii) A reason a provider may request to transfer an enrollee to a different PCP; and
- 12 e. Filing a grievance or appeal, including the title, address, and telephone number of  
13 the person responsible for processing and resolving a grievance or appeal;
- 14 3. The name of the MCO, address, and telephone number from which it conducts its  
15 business;
- 16 4. The MCO's:
  - 17 a. Business hours; and
  - 18 b. Member service and toll-free medical call-in telephone numbers;
- 19 5. Covered services, an explanation of any service limitation or exclusion from cover-  
20 age, and a notice stating that the MCO shall be liable only for those services authorized  
21 by the MCO, except for the services excluded in Section 7(11) of this administrative  
22 regulation;
- 23 6. Member rights and responsibilities;

1 7. For a life-threatening situation, instructions to use the emergency medical services  
2 available or to activate emergency medical services by dialing 911;

3 8. Information on:

4 a. The availability of maternity and family planning services, and for the prevention  
5 and treatment of sexually transmitted diseases;

6 b. Accessing the services referenced in clause a. of this paragraph;

7 c. Accessing care before a primary care provider is assigned or chosen;

8 d. The Cabinet for Health and Family Services' independent ombudsman program;

9 and

10 e. The availability of, and procedures for, obtaining:

11 (i) A behavioral health or substance abuse service;

12 (ii) A health education service; and

13 (iii) Care coordination, case management, and disease management services;

14 9. Direct access services that may be accessed without a referral; and

15 10. An enrollee's right to obtain a second opinion and information on obtaining a se-  
16 cond opinion; and

17 (c) Meet the information requirements established in Section 11 of this administrative  
18 regulation.

19 (3) Changes to the member handbook shall be approved by the department prior to  
20 the publication of the handbook.

21 Section 9. Member Education and Outreach. (1) An MCO shall:

22 (a) Have an enrollee and community education and outreach program throughout the  
23 MCO's service area;

1 (b) Submit an annual outreach plan to the department for approval;

2 (c) Assess the homeless population within its service area by implementing and  
3 maintaining an outreach plan for homeless individuals, including victims of domestic vio-  
4 lence; and

5 (d) Not differentiate between a service provided to an enrollee who is homeless and  
6 an enrollee who is not homeless.

7 (2) An MCO's outreach plan shall include:

8 (a) Utilizing existing community resources including shelters and clinics; and

9 (b) Face-to-face encounters.

10 Section 10. Enrollee Non-Liability for Payment. (1) Except as specified in 907 KAR  
11 17:030, an enrollee shall not be required to pay for a medically necessary covered ser-  
12 vice provided by the enrollee's MCO.

13 (2) An MCO shall not impose cost sharing on an enrollee greater than the limits es-  
14 tablished by the department in 907 KAR 1:604.

15 Section 11. Provision of Information Requirements. (1) An MCO shall:

16 (a) Comply with the requirements established in 42 U.S.C. 1396u-2(a)(5) and 42  
17 C.F.R. 438.10; and

18 (b) Provide translation services to an enrollee on site or via telephone.

19 (2) Written material provided by an MCO to an enrollee or potential enrollee shall:

20 (a) Be written at a sixth grade reading comprehension level;

21 (b) Be published in at least a fourteen (14) point font;

22 (c) Comply with the requirements established in 42 U.S.C. Chapter 126, the Ameri-  
23 cans with Disabilities Act;

1 (d) Be updated as necessary to maintain accuracy;

2 (e) Be available in Braille or in an audio format for an individual who is partially blind  
3 or blind; and

4 (f) Be provided and printed in each language spoken by five (5) percent or more of  
5 the enrollees in each county.

6 (3)(a) All written material intended for an enrollee, unless unique to an individual en-  
7 rollee or exempted by the department, shall be submitted to the department for review  
8 and approval prior to publication or distribution to the enrollee.

9 (b) Written material submitted to the department for review by an MCO shall be con-  
10 sidered approved by the department if the department does not object or notify an MCO  
11 within:

12 1. Thirty (30) days regarding a standard submission; or

13 2. Five (5) days regarding an expedited submission.

14 (c)1. Written material submitted to the department for review and approval shall be  
15 considered received for review beginning with the date that the commissioner or a  
16 deputy commissioner of the department acknowledge, to the MCO, receipt of the sub-  
17 mission.

18 2. The acknowledgement referenced in subparagraph 1 of this paragraph may be  
19 demonstrated by evidence of a return receipt if sent via U.S. Mail, a read receipt if sent  
20 via e-mail, or the signature of a Cabinet for Health and Family Services employee taking  
21 receipt of the submission in the case of hand-delivery, including overnight mail or couri-  
22 er delivery.

23 Section 12. Confidentiality of Medical Information. (1) An MCO shall:

1 (a) Maintain confidentiality of all enrollee eligibility information and medical records;

2 (b) Prevent unauthorized disclosure of the information referenced in this subsection  
3 in accordance with KRS 194A.060, KRS 214.185, KRS 434.840 to 434.860, and 42  
4 C.F.R. 431 Subpart F, 431.300 to 431.307;

5 (c) Have written policies and procedures for maintaining the confidentiality of enrollee  
6 records;

7 (d) Comply with 42 U.S.C. 1320d-2, the Health Insurance Portability and Accountabil-  
8 ity Act, and 45 C.F.R. Parts 160 and 164;

9 (e) On behalf of its employees and agents:

10 1. Sign a confidentiality agreement attesting that it will comply with the confidentiality  
11 requirements established in this section; and

12 2. Submit the confidentiality agreement referenced in subparagraph 1. of this para-  
13 graph to the department;

14 (f) Limit access to medical information to a person or agency which requires the in-  
15 formation in order to perform a duty related to the department's administration of the  
16 Medicaid program, including the department, the United States Department of Health  
17 and Human Services, the United States Attorney General, the CHFS OIG, the Kentucky  
18 Attorney General, or other agency required by the department; and

19 (g) Submit a request for disclosure of information referenced in this subsection which  
20 has been received by the MCO to the department within twenty-four (24) hours.

21 (2) Information referenced in subsection (1)(g) of this section shall not be disclosed  
22 by an MCO pursuant to the request without prior written authorization from the depart-  
23 ment.

1 Section 13. Americans with Disabilities Act and Cabinet Ombudsman. (1) An MCO  
2 shall:

3 (a) Require by contract with its network providers and subcontractors that a service  
4 location meets:

5 1. The requirements established in 42 U.S.C. Chapter 126, the Americans with Disa-  
6 bilities Act; and

7 2. All local requirements which apply to health facilities pertaining to adequate space,  
8 supplies, sanitation, and fire and safety procedures;

9 (b) Fully cooperate with the Cabinet for Health and Family Services independent om-  
10 budsman; and

11 (c) Provide immediate access to the Cabinet for Health and Family Services inde-  
12 pendent ombudsman, to an enrollee's records if the enrollee has given consent.

13 (2) An MCO's member handbook shall contain information regarding the Cabinet for  
14 Health and Family Services independent ombudsman program.

15 Section 14. Marketing. (1) An MCO shall:

16 (a) Comply with the requirements established in 42 C.F.R. 438.104 regarding market-  
17 ing activities;

18 (b) Have a system of control over the content, form, and method of dissemination of  
19 its marketing and information materials;

20 (c) Submit a marketing plan and marketing materials to the department for written  
21 approval prior to implementation or distribution;

22 (d) If conducting mass media marketing, direct the marketing activities to enrollees in  
23 the entire service area pursuant to the marketing plan;

1 (e) Not conduct face-to-face marketing;

2 (f) Not use fraudulent, misleading, or misrepresentative information in its marketing  
3 materials;

4 (g) Not offer material or financial gain to a:

5 1. Potential enrollee as an inducement to select a particular provider or use a prod-  
6 uct; or

7 2. Person for the purpose of soliciting, referring, or otherwise facilitating the enroll-  
8 ment of an enrollee;

9 (h) Not conduct:

10 1. Direct telephone marketing to enrollees or potential enrollees who do not reside in  
11 the MCO service area; or

12 2. Direct or indirect door-to-door, telephone, or other cold-call marketing activity; and

13 (i) Not include in its marketing materials an assertion or statement that CMS, the fed-  
14 eral government, the Commonwealth, or another entity endorses the MCO.

15 (2) An MCO's marketing material shall meet the information requirements established  
16 in Section 11 of this administrative regulation.

17 Section 15. Legal Guardians. (1) A parent, custodial parent, person exercising custo-  
18 dial control or supervision, or an agency with a legal responsibility for a child by virtue of  
19 a voluntary commitment or of an emergency or temporary custody order shall be author-  
20 ized to act on behalf of an enrollee who is under the age of eighteen (18) years, a po-  
21 tential enrollee, or a former enrollee for the purpose of:

22 (a) Selecting a primary care provider;

23 (b) Filing a grievance or appeal; or

1 (c) Taking an action on behalf of the child regarding an interaction with an MCO.

2 (2)(a) A legal guardian who has been appointed pursuant to KRS 387.500 to 387.800  
3 shall be allowed to act on behalf of an enrollee who is a ward of the commonwealth.

4 (b) A person authorized to make a health care decision pursuant to KRS 311.621 to  
5 311.643 shall be allowed to act on behalf of an enrollee, potential enrollee, or former en-  
6 rollee.

7 (c) An enrollee shall have the right to:

- 8 1. Represent the enrollee; or
- 9 2. Use legal counsel, a relative, a friend, or other spokesperson.

10 Section 16. Enrollee Surveys. (1) An MCO shall:

11 (a) Conduct an annual survey of enrollee satisfaction of the quality and accessibility  
12 to a service provided by an MCO;

13 (b) Satisfy a member satisfaction survey requirement by participating in the Agency  
14 for Health Research and Quality's current Consumer Assessment of Healthcare Provid-  
15 ers and Systems Survey (CAHPS) for Medicaid Adults and Children, which shall be  
16 administered by an NCQA-certified survey vendor;

17 (c) Provide a copy of the current CAHPS survey referenced in paragraph (b) of this  
18 subsection to the department;

19 (d) Annually assess the need for conducting other surveys to support quality and per-  
20 formance improvement initiatives;

21 (e) Submit to the department for approval the survey tool used to conduct the survey  
22 referenced in paragraph (a) of this subsection; and

23 (f) Provide to the department:

- 1 1. A copy of the results of the enrollee surveys referenced in paragraph (a) of this
- 2 subsection;
- 3 2. A description of a methodology to be used to conduct surveys;
- 4 3. The number and percentage of enrollees surveyed;
- 5 4. Enrollee survey response rates;
- 6 5. Enrollee survey findings; and
- 7 6. Interventions conducted or planned by the MCO related to activities in this section.

8 (2) The department shall:

- 9 (a) Approve enrollee survey instruments prior to implementation; and
- 10 (b) Approve or disapprove an MCO's enrollee survey tool within fifteen (15) days of
- 11 receipt of the survey tool.

12 (3) If an MCO conducts a survey that targets a subpopulation's perspective or expe-  
13 rience with access, treatment, or services, the MCO shall comply with the requirements  
14 established in subsection (1)(e) and (f) of this section.

15 Section 17. Enrollees with Special Health Care Needs. (1) In accordance with 42  
16 C.F.R. 438.208:

17 (a) The following shall be considered an individual with a special health care need:

- 18 1. A child in or receiving foster care or adoption assistance;
- 19 2. A homeless individual;
- 20 3. An individual with a chronic physical or behavioral illness;
- 21 4. A blind or disabled child;
- 22 5. An individual who is eligible for SSI benefits; or
- 23 6. An adult who is a ward of the Commonwealth in accordance with 910 KAR Chap-

1 ter 2; and

2 (b) An MCO shall:

3 1. Have a process to target enrollees for the purpose of screening and identifying  
4 those with special health care needs;

5 2. Assess each enrollee identified by the department as having a special health care  
6 need to determine if the enrollee needs case management or regular care monitoring;

7 3. Include the use of appropriate health care professionals to perform an assess-  
8 ment; and

9 4. Have a treatment plan for an enrollee with a special health care need who has  
10 been determined, through an assessment, to need a course of treatment or regular care  
11 monitoring.

12 (2) A treatment plan referenced in subsection (1)(b)4 of this section shall be devel-  
13 oped:

14 (a) With participation from the enrollee or the enrollee's legal guardian as referenced  
15 in Section 15 of this administrative regulation; and

16 (b) By the enrollee's primary care provider, if the enrollee has a primary care provid-  
17 er.

18 (3) An MCO shall:

19 (a)1. Develop materials specific to the needs of an enrollee with a special health care  
20 need; and

21 2. Provide the materials referenced in subparagraph 1. of this paragraph to the enrol-  
22 lee, caregiver, parent, or legal guardian;

23 (b) Have a mechanism to allow an enrollee identified as having a special health care

1 need to directly access a specialist, as appropriate, for the enrollee's condition and  
2 identified need; and

3 (c) Be responsible for the ongoing care coordination for an enrollee with a special  
4 health care need.

5 (4) The information referenced in subsection (3)(a) of this section shall include health  
6 educational material to assist the enrollee with a special health care need or the enrol-  
7 lee's caregiver, parent, or legal guardian in understanding the enrollee's special need.

8 (5)(a) An enrollee who is a child in foster care or receiving adoption assistance shall  
9 be enrolled with an MCO through a service plan that shall be completed for the enrollee  
10 by DCBS prior to being enrolled with the MCO.

11 (b) The service plan referenced in paragraph (a) of this subsection shall be used by  
12 DCBS and the MCO to determine the enrollee's medical needs and identify the need for  
13 case management.

14 (c) The MCO shall be available to meet with DCBS at least once a month to discuss  
15 the health care needs of the child as identified in the service plan.

16 (d) If a service plan identifies the need for case management or DCBS requests case  
17 management for an enrollee, the foster parent of the child or DCBS shall work with the  
18 MCO to develop a case management plan of care.

19 (e) The MCO shall consult with DCBS prior to developing or modifying a case man-  
20 agement plan of care.

21 (6)(a) An enrollee who is a ward of the Commonwealth shall be enrolled with an MCO  
22 through a service plan that shall be completed for the enrollee by DAIL prior to being  
23 enrolled with the MCO.

1 (b) If the service plan referenced in paragraph (a) of this subsection identifies the  
2 need for case management, the MCO shall work with DAILE or the enrollee to develop a  
3 case management plan of care.

4 Section 18. Second Opinion. An enrollee shall have the right to a second opinion  
5 within the MCO's provider network for a surgical procedure or diagnosis and treatment  
6 of a complex or chronic condition.

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

- 10 (1) Denies or does not provide federal financial participation for the policy; or  
11 (2) Disapproves the policy.

907 KAR 17:010E

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 17:010E  
Cabinet for Health and Family Services  
Department for Medicaid Services  
Agency Contact Person: Stuart Owen (502) 564-4321

- (1) Provide a brief summary of:
  - (a) What this administrative regulation does: This is a new administrative regulation which establishes Kentucky Medicaid program managed care organization (MCO) requirements and policies relating to providers. 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. Though this is a new administrative regulation, it does contain some amended policies. The amendments include eliminating cost (MCO capitation rate for the individual) as a factor in the Department for Medicaid Services' (DMS's) algorithm used to assign individuals to a managed care organization (MCO); removing the requirement that an enrollee's annual open enrollment opportunity (with an MCO) occurs at the enrollee's annual time to recertify Medicaid eligibility or during the birth month for enrollees who receive supplemental security income (SSI) benefits; establishing that DMS will be responsible for reimbursing for services provided to individuals determined to be retroactively eligible for SSI benefits that were provided during the retroactive eligibility period; requiring a provider who wishes to file an appeal on behalf of an enrollee to have written consent to file an appeal for the specific circumstances related to the appeal; establishing a requirement that an enrollee is entitled to a state fair hearing (in accordance with KRS 13B) process only after the enrollee has exhausted the MCO's appeal process first; clarifying that certain individuals who

are not required to have a primary care provider may choose to have one; and clarifying that access to out-of-network services are subject to prior authorization by an MCO.

- (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization requirements and policies relating to individuals enrolled with a managed care organization. Eliminating cost (MCO capitation rate for the given individual) as a factor in the algorithm used to assign enrollees to MCOs is necessary to prevent excessive assignments of enrollees to the MCO with the lowest capitation rate; eliminating the statement that enrollee's annual open enrollment period occurs during their annual Medicaid eligibility re-certification period or (for SSI recipients) during their birth month, is necessary as DMS is adopting a mass annual open enrollment period annually; establishing that DMS will reimburse for services to retro-eligible SSI benefit recipients is necessary as SSI retro eligibility can extend back to long periods of time and typically the individuals have substantial medical claims during the retro eligibility period and the MCOs obviously had no opportunity to manage the care [a non-SSI retro eligibility period can only extend back three (3) months]; requiring a provider who wishes to file an appeal on behalf of an enrollee to have written consent to file an appeal specific to the circumstances related to the appeal is necessary to prevent providers from obtaining blanket authority to file appeals on behalf of enrollees; requiring enrollees to exhaust the MCO appeal process before requesting a state fair hearing is necessary to eliminate duplication between MCOs and DMS as some individuals initiated both appeal processes concurrently which resulted in DMS and the MCO both spending time and efforts attempting to resolve the given matter only to discover that the other party had resolved the matter; stating that certain individuals who are not required to have a primary care provider but may have one is necessary to clarify existing policy; stating that out-of-network services (other than those exempt from prior authorization) are subject to MCO prior authorization is necessary to clarify current policy.
- (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to individuals enrolled with a managed care organization. The amended policies conform to the content of the authorizing statutes by clarifying or enhancing Medicaid managed care organization policies and requirements based on a year of experience and analysis.
- (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 clarifying or enhancing Medicaid managed care organization policies and requirements based on a year of experience and analysis.

- (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 policies apply equally to the regulated entities.

## FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 17:010E

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 requirements and policies regarding individuals enrolled in a managed care organization. Those requirements are established in 42 CFR 438.10, 42 CFR 438.52, 42 CFR 438.56, 42 CFR 438.62, 42 CFR 438.66, 42 CFR 438.100-108, 42 CFR 438.224-228 and 42 CFR 438.400 – 408.
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.”

Part I, Section G. Budget Unit 3. a.(b)(17) of House Bill 265 of the 2012 Session of the General Assembly states:

“(17) Appeals: An appeal from denial of a service or services provided by a Medicaid managed care organization for medical necessity, or denial, limitation, or termination of a health care service in a case involving a medical or surgical specialty or subspecialty, shall, upon request of the recipient, authorized person, or provider, include a review by a board-eligible or board-certified physician in the appropriate specialty or subspecialty area; except in the case of a health care service rendered by a chiropractor or optometrist, in which case, the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky as specified in KRS 304.17A-607(1)(b). The physician reviewer shall not have participated in the initial review and denial of service and shall not be the provider of service or services under consideration in the appeal.”

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 requirements regarding individuals enrolled with a managed care organization. Those requirements include: DMS must approve all material to be distributed by anyone intended to affect a Medicaid recipient's choice of managed care plan; all written material relating to any plan must be designed to be easily understood; alternative formats must be available to meet the needs of individuals with visual disabilities or limited reading proficiency; written material must be available in every prevalent non-English language in the service area, and oral translation must be available in any non-English

language; information required to make a choice about enrollment must be provided in time to help the beneficiary choose; MCOs must make detailed disclosures to enrollees on the provider network and the terms of the plan; all enrollment notices and informational and instructional materials must be in an easily understood form; information concerning providers, enrollee rights and responsibilities, and appeal procedures, and information on covered items and services must be provided; each potential enrollee must be given detailed information about the basic features of managed care generally, the populations who are required, permitted or excluded from enrollment in a managed care plan; DMS or the MCOs must disclose at least:

- any Medicaid services that are excluded from coverage;
- cost sharing requirements;
- the service area;
- the names, locations and contact information for participating providers, any non-English languages spoken and whether they are accepting new Medicaid patients;
- all services provided, the procedures for obtaining services, and the transportation provided. If the managed care entity does not provide counseling or referral for any services on moral or religious grounds, the state must provide the information necessary for enrollees to obtain those services;]

DMS must assure that all enrollees in Medicaid managed care are notified annually of their right to disenroll; all enrollees have a right to be informed of the same information available to potential enrollees (in greater detail), the amount, duration and scope of services available, their rights with respect to emergency care, the grievance and appeal procedure, the termination of a participating provider and of significant changes in the plan; an MCO must give Medicaid enrollees the right to appeal adverse decisions which include:

1. the denial or limited authorization of a requested service or level of service;
2. the suspension, termination or reduction of a previously authorized service;
3. The failure to provide services in a timely manner, as defined by the State;
4. the denial, in whole or in part, of payment for a service;
5. the failure of an MCO or PIHP to act within the timeframes provided for grievances and appeals; and
6. for a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network;

MCOs must have a system which includes an appeal process and access to a state fair hearing process; states, may require the exhaustion of the appeals process before requesting a state fair hearing; an oral request for an appeal must be followed by a signed, written request except when an expedited appeal is requested; MCOs and s must give written notice of an action within specified time limits; the written notice must meet the clarity requirements of [42 C.F.R. §438.10](#); the notice must state the action taken, give the reason(s) for an action and inform the enrollee of the right and the method to file an appeal, including the procedures for expedited resolution; Notification of decisions to terminate, suspend or reduce services must be given within the

time limits required for Medicaid services under 42 CFR Part 431; any appeal of a denial based on medical necessity or of any other action involving clinical issues must be decided by health care professionals who have appropriate clinical expertise in treating the enrollee's condition; and all appeals must be decided by individuals who were not involved in the decision or in any previous level of review.

DMS must give individuals a choice of at least two managed care entities or managers. In rural areas, eligible individuals must be permitted a choice of at least two physicians or case managers, to the extent that at least two such individuals are available.; Enrollees may terminate or change plans at any time for cause, and may terminate or change plans without cause during the 90-day period beginning on the date on which the individual receives notice of enrollment and at least once annually thereafter; DMS must establish notice of termination requirements as well as a method for establishing enrollment priorities in the event a managed care entity does not have sufficient capacity to enroll all persons seeking enrollment; MCOs must provide that eligible enrollees may not be held liable for: (1) the debts of the organization in the event of its insolvency; (2) services provided to the enrollee if the organization or healthcare provider fails to receive payment from the state for such services; or (3) payments to a provider in excess of the amount that would be owed by the enrollee if the organization had directly provided the services; providers and subcontractors may charge enrollees only for any unpaid cost-sharing amounts that the state has lawfully imposed, not for the difference between the rate the provider agreed to accept from the MCO and the provider's usual fee; all marketing materials must be approved by the state and cannot contain false or materially misleading information; an MCO must distribute marketing materials to its entire service area, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance, and must comply with procedures and conditions prescribed by the Health and Human Services (HHS) Secretary to ensure that a potential enrollee is provided accurate oral and written information sufficient to make an informed enrollment decision; and an MCO may not, directly or indirectly, conduct door-to-door, telephone, or other "cold-call" marketing.

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 17:010E

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.