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REGULATIONS COMPILER

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amended After Comments)

907 KAR 1:044. Coverage provisions and requirements regarding community mental health center behavioral health services.

RELATES TO: KRS 194A.060, 202A.011,[~~205.520(3),~~] 205.8451(7), (9), 205.622, 369.101 - 369.120, 422.317, 434.840-434.860, 42 C.F.R. Part 2, 400.203, 415.208, 431.17, 431.52, 431 Subpart F, 45 C.F.R. Parts 160 and 164, 42 U.S.C. 290ee-3, 1320d-2 to 1320d-8

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 210.450[~~, 42 U.S.C. 1396a-d~~]

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid program coverage provisions and requirements regarding community mental health center (CMHC) behavioral health services provided to Medicaid recipients.

Section 1. Definitions.

(1) "Approved behavioral health practitioner" means an independently licensed practitioner who is:

(a) A physician;

(b) A psychiatrist;

(c) An advanced practice registered nurse;

(d) A physician assistant;

(e) A licensed psychologist;

(f) A licensed psychological practitioner;

(g) A certified psychologist with autonomous functioning;

(h) A licensed clinical social worker;

(i) A licensed professional clinical counselor;

(j) A licensed marriage and family therapist;

(k) A licensed professional art therapist;

(l) A licensed clinical alcohol and drug counselor;

(m) A licensed behavior analyst; or

(n) A behavioral health associate.

(2) "Approved behavioral health practitioner under supervision" means an individual who is under the billing supervision of an approved behavioral health practitioner and who is:

(a)

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

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

3. A marriage and family therapy associate;

4. A certified social worker;

5. A licensed professional counselor associate;

6. A licensed professional art therapist associate;

7. A licensed clinical alcohol and drug counselor associate;

8. A certified alcohol and drug counselor;

9. A licensed assistant behavior analyst;

10. A behavioral health associate; or

11. A licensed alcohol and drug counselor; and

(b) Employed by the same CMHC or under contract with the same CMHC as the billing supervisor.

(3) "ASAM Criteria" means the most recent edition of "The ASAM Criteria, Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions" published by the American Society of Addiction Medicine.

(4) "Behavioral health associate" means an individual:

(a) With a minimum of a Bachelor of Arts or Sciences degree in a human service field;

(b) Who only provides outpatient services;

(c)

1.**a.** Who is currently enrolled in a graduate program for a master's degree or doctoral degree in[~~:~~

~~**a. Psychology;**~~

~~**b. Social work; or**~~

~~**c.**~~] in a behavioral science field that leads to a credential or license; **and**

b. Who is currently participating in an internship or practicum program as part of an accredited educational institution; or

2. Who is currently working toward a specialized credential [~~or licensure~~] in the field of [~~mental health or~~] substance use disorder, **and is employed by a narcotic treatment program**;

(d) Who has a collaborative educational agreement with the graduate program and the employing provider;

(e) **Who complies with the supervision requirements of the collaborative educational agreement and complies with billing supervision requirements for rendering Medicaid services**[~~That receives, at a minimum, weekly supervision by an approved behavioral health practitioner employed by the provider of services~~];

(f) Who is designated as a behavioral health associate by the department during the application process;

(g) **Who does not render a diagnosis for a client;**

(h) Who is designated as a behavioral health associate for no longer than five (5) years; and

(i)[~~(h)~~] That is currently employed by one of the following outpatient treatment providers:

1. A behavioral health services organization;

2. A behavioral health multi-specialty group;

3. A certified community behavioral health clinic;

4. A community mental health center;

5. A federally qualified Health Center or a federally qualified health center look-alike;

6. A rural health clinic;

7. A provider of crisis continuum services, such as:

a. A mobile crisis intervention service provider;

b. A crisis observation stabilization unit; or

c. A behavioral health crisis transportation provider; or

8. An outpatient behavioral health provider approved by the department.

(5) "Community mental health center" or "CMHC" means a facility that[~~which~~] meets the community mental health center requirements established in 902 KAR 20:091.

(6)[~~(2)~~] "Department" means the Department for Medicaid Services or its designee.

(7)[~~(3)~~] "Enrollee" means a recipient who is enrolled with a managed care organization.

(8)[~~(4)~~] "Face-to-face" means occurring[~~:~~]

[~~(a)~~] in person[~~; or~~]

[~~(b)~~] [~~If authorized by 907 KAR 3:170, via a real-time, electronic communication that involves two (2) way interactive video and audio communication~~].

(9)[~~(5)~~] "Federal financial participation" is defined by[~~in~~] 42 C.F.R. 400.203.

(10)[~~(6)~~] "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

[~~(7)~~] [~~"Mental health associate" means an individual who meets the mental health associate requirements established in the Community Mental Health Center Behavioral Health Services Manual.~~]

(11) "Paraprofessional practitioner under supervision" means an individual who performs services under the billing supervision of an approved behavioral health practitioner who is employed by the same CMHC or under contract with the same CMHC as the billing supervisor. Paraprofessional practitioners include:

(a) Peer support specialists;

(b) Community support associates;

(c) Registered behavior technicians; or

(d) A targeted case manager, as established pursuant to 907 KAR Chapter 15.

(12)[~~(8)~~] "Professional equivalent" means an individual who:

(a) Met[~~meets~~] the professional equivalent requirements established in the [~~Community Mental Health Center~~]Behavioral Health Services Manual for Community Mental Health Centers prior to January 1, 2018; and

(b) Performs services under the billing supervision of an approved behavioral health practitioner, who is employed by the same CMHC or under contract with the same CMHC as the billing supervisor.

(13)[~~(9)~~] "Provider" is defined by KRS 205.8451(7).

(14)[~~(10)~~] "Qualified mental health professional" means an individual who meets the requirements established in KRS 202A.011[~~202A.0011~~](12).

(15)[~~(11)~~] "Recipient" is defined by KRS 205.8451(9).

(16) "Telehealth" is defined by KRS 205.510(16).

Section 2. Requirements for a Psychiatric Nurse. A registered nurse employed by a participating community mental health center shall be considered a psychiatric or mental health nurse if the individual:

(1) Possesses a Master of Science in nursing with a specialty in psychiatric or mental health nursing;

(2)

(a) Is a graduate of a four (4) year nursing educational program with a Bachelor of Science in nursing; and

(b) Possesses at least one (1) year of experience in a mental health setting;

(3)

(a) Is a graduate of a three (3) year nursing educational program; and

(b) Possesses at least two (2) years of experience in a mental health setting; or

(4)

(a) Is a graduate of a two (2) year nursing educational program with an associate degree in nursing; and

(b) Possesses at least three (3) years of experience in a mental health setting.

Section 3. [~~Community Mental Health Center~~]Behavioral Health Services Manual for Community Mental Health Centers. The conditions for participation, services covered, and limitations for the community mental health center behavioral health services component of the Medicaid program shall be as specified in:

(1) This administrative regulation; and

(2) The [~~Community Mental Health Center~~]Behavioral Health Services Manual for Community Mental Health Centers.

Section 4. Covered Services.

(1) Behavioral health services covered pursuant to this administrative regulation and pursuant to the [~~Community Mental Health Center~~]Behavioral Health Services Manual for Community Mental Health Centers shall be rehabilitative mental health and substance use disorder services including:

(a) Individual [~~outpatient~~]therapy;

(b) Group [~~outpatient~~]therapy;

(c) Family [~~outpatient~~]therapy;

(d) Collateral [~~outpatient~~]therapy;

(e) Therapeutic rehabilitation services;

(f) Psychological testing;

(g) Screening;

(h) An assessment;

(i) Crisis intervention;

(j) Service planning;

(k) A screening, brief intervention, and referral to treatment;

(l) Mobile crisis services;

(m) Assertive community treatment;

(n) Intensive outpatient program services;

(o) Residential crisis stabilization services;

(p) Partial hospitalization;

(q) Residential services for substance use disorders;

(r) Day treatment;

(s) Comprehensive community support services;

(t) Peer support services;[~~or~~]

(u) Withdrawal management;

(v) Medication assisted treatment (MAT);

(w) Applied behavior analysis;

(x) Chemical dependency treatment center services;

(y) Prevention education with substance use risk factors and case management services for pregnant or postpartum individuals with a substance use disorder; or

(z) A narcotic treatment program (NTP), if separately licensed pursuant to 908 KAR 1:374[~~Parent or family peer support services~~].

(2)

(a) To be covered under this administrative regulation, a service listed in subsection (1) of this section shall be:

1. Provided by a community mental health center that is:

a. Currently enrolled in the Medicaid program in accordance with 907 KAR 1:672; and

b. Except as established in paragraph (b) of this subsection, currently participating in the Medicaid program in accordance with 907 KAR 1:671;

2. Provided in accordance with:

a. This administrative regulation; and

b. The [~~Community Mental Health Center~~]Behavioral Health Services Manual for Community Mental Health Centers; and

3. Medically necessary.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid program.

Section 5. Electronic Documents and Signatures.

(1) The creation, transmission, storage, or other use of electronic signatures and documents shall comply with requirements established in KRS 369.101 to 369.120 and all applicable state and federal laws and regulations.

(2) A CMHC choosing to utilize electronic signatures shall:

(a) Develop and implement a written security policy that[~~which~~] shall:

1. Be complied with by each of the center's employees, officers, agents, and contractors; and

2. Stipulate which individuals have access to which electronic signatures and password

authorization;

(b) Ensure that electronic signatures are created, transmitted, and stored securely;

(c) Develop a consent form that shall:

1. Be completed and executed by each individual utilizing an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(d) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature.

Section 6. No Duplication of Service.

(1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, on the same day of service.

(2) For example, if a recipient is receiving a behavioral health service from an independently enrolled approved behavioral health practitioner[~~behavioral health service provider~~], the department shall not reimburse for the same service provided to the same recipient by a community mental health center on the same day of service.

Section 7. Records Maintenance, Protection, and Security.

(1) A provider shall maintain a current health record for each recipient.

(2) A health record shall:

(a) Include:

1. An identification and intake record including:

a. Name;

b. Social Security number;

c. Date of intake;

d. Home (legal) address;

e. Health insurance information;

f. Referral source and address of referral source;

g. Primary care physician and address;

h. The reason the individual is seeking help including the presenting problem and diagnosis;

i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information, if available, regarding:

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

(ii) The name of the physical health provider; and

j. The name of the informant and any other information deemed necessary by the independent provider to comply with the requirements of:

(i) This administrative regulation;

(ii) The provider's licensure board;

(iii) State law; or

(iv) Federal law;

2. Documentation of the:

a. Screening if the community mental health center performed the screening;

b. Assessment; and

c. Disposition;

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

4. An identification sheet;

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

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

(b) Be:

1. Maintained in an organized central file;

2. Furnished to the:

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

b. Managed care organization in which the recipient is enrolled if the recipient is enrolled with a managed care organization;

3. Made available for inspection and copying by:

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

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

4. Readily accessible; and

5. Adequate for the purpose of establishing the current treatment modality and progress of the recipient; and

(c) Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

(3) The individual who provided the service shall date and sign the health record within forty-eight (48) hours of the date that the individual provided the service.

(4)

(a) Except as established in paragraph (b) or (c) of this subsection, a provider shall maintain

a health record regarding a recipient for at least six (6) years from the date of the service or until any audit dispute or issue is resolved beyond six (6) years.

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

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

2. If the recipient is a minor, three (3) years after the recipient reaches the age of majority under state law.

(c) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) or (b) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(5) A provider shall comply with 45 C.F.R. Part 164.

(6) Documentation of a screening shall include:

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

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

(7)

(a) A provider's notes regarding a recipient shall:

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

2. Describe the:

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

b. Therapist's intervention;

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

d. Need for continued treatment if continued treatment is needed.

(b) Include the following:

1. The specific service rendered;

2. The date and actual time the service or services were rendered;

3. The name and practitioner level of the individual who rendered the service;

4. The setting of the service rendered and the amount of time to deliver the service;

5. The relationship of the service or services to the treatment goals and objectives in the plan of care; and

6. The individual's progress toward the treatment goals and objectives in the plan of care.

(c)

1. Any edit to notes shall:

a. Clearly display the changes; and

b. Be initialed and dated.

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

(d)[~~(c)~~] If services are provided by a practitioner working under supervision or a paraprofessional practitioner working under supervision, there shall be:

1. A billing supervisor co-signature on the service note within thirty (30) days; and

2. A monthly supervisory note recorded by the supervising professional reflecting consultations with the practitioner working under supervision or the paraprofessional practitioner working under supervision concerning the:

a.[~~1.~~] Case; and

b.[~~2.~~] Supervising professional's evaluation of the services being provided to the recipient.

(8) Immediately following a screening of a recipient, the provider shall perform a disposition related to:

(a) A provisional diagnosis;

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

(c)

1. If applicable, termination of services and referral to an outside source for further services; or

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

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

(a) Rendering practitioner; and

(b) Recipient or recipient's representative.

(10)

(a) Notes regarding services to a recipient shall:

1. Be organized in chronological order;

2. Be dated;

3. Be titled to indicate the service rendered;

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

5. Be recorded and signed by the rendering provider and include the professional title (for example, licensed clinical social worker) of the provider.

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

(c) Telephone contacts, family collateral contacts not covered under this administrative regulation, or other nonreimbursable contacts shall:

1. Be recorded in the notes; and

2. Not be reimbursable.

(11)

(a) A termination summary shall:

1. Be required, upon termination of services, for each recipient who received at least three (3) service visits; and

2. Contain a summary of the significant findings and events during the course of treatment including the:

a. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's plan of care;

b. Final diagnosis of clinical impression; and

3. Individual's condition upon termination and disposition.

(b) A health record relating to an individual who was terminated from receiving services shall be fully completed within ten (10) days following termination.

(12) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.

(13)

(a) Except as established in paragraph (b) of this subsection, if a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring CMHC shall, if the recipient gives the CMHC written consent to do so, within ten (10) business days of the transfer or referral, transfer the recipient's health records in a manner that complies with the health records' use and disclosure requirements as established in or required by:

1.

a. The Health Insurance Portability and Accountability Act;

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

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

2.

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

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

(b) If a recipient is transferred or referred to a residential crisis stabilization unit, a psychiatric hospital, a psychiatric distinct part unit in an acute care hospital, or an acute care hospital for care or treatment, the transferring CMHC shall, within forty-eight (48) hours of the transfer or referral, transfer the recipient's health records in a manner that complies with the health records' use and disclosure requirements as established in or required by:

1.

a. The Health Insurance Portability and Accountability Act;

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

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

2.

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

b. 42 C.F.R Part 2.

(14)

(a) If a CMHC's Medicaid program participation status changes as a result of voluntarily terminating from the Medicaid program, involuntarily terminating from the Medicaid program, a licensure suspension, or death of a provider, the health records regarding recipients to whom the CMHC has provided services shall:

1. Remain the property of the CMHC; and

2. Be subject to the retention requirements established in subsection (4) of this section.

(b) A CMHC shall have a written plan addressing how to maintain health records if there is[~~in the event of~~] a provider's death.

Section 8. Medicaid Program Participation Compliance.

(1) A CMHC shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)

(a) If a CMHC receives any duplicate payment or overpayment from the department or managed care organization, regardless of reason, the CMHC shall return the payment to the department or managed care organization that issued the duplicate payment or overpayment.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 9. Third Party Liability. A provider shall comply with KRS 205.622.

Section 10. Auditing Authority. The department or the managed care organization in which an enrollee is enrolled shall have the authority to audit any:

(1) Claim;

(2) Health record; or

(3) Documentation associated with the claim or health record.

Section 11. Federal Approval and Federal Financial Participation.

[~~(1)~~] The department's coverage of services pursuant to this administrative regulation shall

be contingent upon:

(1)[~~(a)~~] Receipt of federal financial participation for the coverage; and

(2)[~~(b)~~] Centers for Medicare and Medicaid Services' approval for the coverage.

[~~(2)~~] [~~The coverage of services provided by a licensed clinical alcohol and drug counselor or licensed clinical alcohol and drug counselor associate shall be contingent and effective upon approval by the Centers for Medicare and Medicaid Services.~~]

Section 12. Appeal Rights.

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

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

Section 13. Incorporation by Reference.

(1) The "Behavioral Health Services Manual for Community Mental Health Centers", November 2023[~~"Community Mental Health Center Behavioral Health Services Manual", May 2015~~], is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, 6th Floor West, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. or online at the department's Web site at https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/cmhc.aspx[~~http://www.chfs.ky.gov/dms/incorporated.htm~~].

907 KAR 1:044
REVIEWED:

2-14-2024
Date

Lisa D. Lee, Commissioner
Department for Medicaid Services

APPROVED:

2/14/2024
Date

Eric C. Friedlander, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 1:044
Agency Contact: Jonathan Scott
Phone Number: (502) 564-4321, ext. 2015
Email: jonathant.scott@ky.gov

Contact Person: Krista Quarles
Phone Number: (502) 564-7476
Email: CHFSregs@ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does:

This administrative regulation establishes the behavioral health coverage provisions and requirements regarding Medicaid program services provided within a community mental health center (CMHC).

(b) The necessity of this administrative regulation:

This administrative regulation is necessary to comply with federal mandates. Section 1302(b)(1)(E) of the Affordable Care Act (42 U.S.C. Sec. 18022). mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment" for all recipients.

(c) How this administrative regulation conforms to the content of the authorizing statutes:

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

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes:

This administrative regulation will assist in the effective administration of the authorizing statutes by complying with federal mandates and enhancing and ensuring Medicaid recipients' access to behavioral health services.

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

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

The amendment to this administrative regulation incorporates a new manual that is titled the Behavioral Health Services Manual for Community Mental Health Centers. This amendment also contains a definition for "approved behavioral health practitioner" and "approved behavioral health practitioner under supervision" instead of a listing of each provider and each service. This provides for more transparency and compactness in the administrative regulation and manual. The administrative regulation also contains a definition for the "ASAM Criteria", "paraprofessional practitioner under supervision", and "telehealth." New covered services include withdrawal management, medication assisted treatment, applied behavior analysis, chemical dependency treatment center services, and narcotic treatment programs if separately licensed. The amendment also updates language relating to prevention education with substance use risk factors and case management services for pregnant or postpartum individuals with a substance use disorder. The administrative regulation also requires a billing supervisor's signature within thirty (30) days when

a service is delivered by an approved behavioral health practitioner under supervision.

The Amended After Comments version modifies the definition of BHA to include compliance with both supervision requirements of the collaborative educational agreement and compliance with the billing supervision requirements for rendering Medicaid services. The definition now includes that the BHA- with the exception of a narcotic treatment program - must be in a graduate level program and be participating in an internship or practicum at an accredited educational institution. The regulation has been further amended to specify that a BHA cannot render a diagnosis for a client.

(b) The necessity of the amendment to this administrative regulation:
This administrative regulation is necessary to align with existing Office of Inspector General (OIG) administrative regulations, to implement an SUD 1115 waiver, to require compliance with the ASAM Criteria, and to provide additional formatting improvements.

(c) How the amendment conforms to the content of the authorizing statutes:
This administrative regulation conforms to the content of the authorizing statutes by implementing an SUD 1115 waiver and making conforming amendments following amendments to 907 KAR Chapter 15.

(d) How the amendment will assist in the effective administration of the statutes:
The amendments will assist in the effective administration of the statutes by providing additional clarity and requirements relating to all behavioral health services performed in CMHCs.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation:
CMHCs that wish to expand their behavioral health practice to include the newly covered services. There are currently 14 CMHCs.

(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:
All CMHCs utilizing approved practitioner under supervision will need to begin having a billing supervisor sign appropriate documents within 30 days. CMHCs that provide chemical dependency treatment center services or narcotic treatment program services will also need to acquire appropriate certification or licensure.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3):
The entities referenced in paragraph (a) will benefit by receiving Medicaid program reimbursement for providing behavioral health services to Medicaid recipients. Medicaid recipients in need of behavioral health services will benefit from an expanded base of providers from which to receive certain services. (5) Provide an estimate of how much it will cost to implement this administrative regulation:

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

(a) Initially:

DMS does not anticipate additional costs as a result of this administrative regulation.

(b) On a continuing basis:

DMS does not anticipate additional costs as a result of this administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation:

The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX, and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment:

Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees:

This administrative regulation neither establishes nor increases any fees.

(9) TIERING: Is tiering applied? (Explain why or why not)

Tiering is not applied as the policies apply equally to the regulated entities.

FISCAL NOTE

Administrative Regulation: 907 KAR 1:044
Agency Contact: Jonathan Scott
Phone Number: (502) 564-4321, ext. 2015
Email: jonathant.scott@ky.gov

Contact Person: Krista Quarles
Phone Number: (502) 564-7476
Email: CHFSregs@ky.gov

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

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

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

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

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

(c) How much will it cost to administer this program for the first year?
The amendment is not expected to cause additional costs in administering this program in the first year.

(d) How much will it cost to administer this program for subsequent years?
The amendment is not expected to cause additional costs in administering this program in subsequent years.

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

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

(4) Estimate the effect of this administrative regulation on the expenditures and cost savings of regulated entities for the first full year the administrative regulation is to be in effect.

(a) How much cost savings will this administrative regulation generate for the regulated entities for the first year?
DMS does not anticipate that cost savings will be generated for regulated entities as a result of the

amendments to this administrative regulation in the first year. This administrative regulation could result in higher reimbursement for regulated entities by opening up additional practice opportunities for some provider types.

(b) How much cost savings will this administrative regulation generate for the regulated entities for subsequent years?

DMS does not anticipate that cost savings will be generated for regulated entities as a result of the amendments to this administrative regulation in subsequent years. This administrative regulation could result in higher reimbursement for regulated entities by opening up additional practice opportunities for some provider types.

(c) How much will it cost the regulated entities for the first year?

DMS does not anticipate that regulated entities will incur costs as a result of this amendment in the first year.

(d) How much will it cost the regulated entities for subsequent years?

DMS does not anticipate that regulated entities will incur costs as a result of this amendment in subsequent years.

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

Cost Savings (+/-):

Expenditures (+/-):

Other Explanation:

(5) Explain whether this administrative regulation will have a major economic impact, as defined below.

"Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars ($500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies. [KRS 13A.010(13)] The administrative regulation will not have a major economic impact – as defined by KRS 13A.010 – on regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 907 KAR 1:044
Agency Contact: Jonathan Scott
Phone Number: (502) 564-4321, ext. 2015
Email: jonathant.scott@ky.gov

Contact Person: Krista Quarles
Phone Number: (502) 564-7476
Email: CHFSregs@ky.gov

(1) Federal statute or regulation constituting the federal mandate.
Section 1302(b)(1)(E) of the Affordable Care Act (42 U.S.C. Sec. 18022).

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

(3) Minimum or uniform standards contained in the federal mandate.
Substance use disorder services are federally mandated for Medicaid programs. Section 1302(b)(1)(E) of the Affordable Care Act (42 U.S.C. Sec. 18022) mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment."

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

(5) Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. A stricter standard is not imposed.

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 1:044

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Health Care Policy
Amended After Comments

I. A public hearing on 907 KAR 1:044 was requested, and held on January 22, 2024 via Zoom. Written comments were also received during the public comment period.

II. The following individuals submitted comments during the public comment period:

Name and Title	Agency/Organization/Entity/Other
Kathy Adams, Director of Policy	Children's Alliance
Hank Cecil, Chair	Kentucky Board of Social Work
Eric Russ, Executive Director	Kentucky Psychological Association
Brenda Rosen, Executive Director	National Association of Social Workers, KY
Steve Shannon, Executive Director	Kentucky Association of Regional Programs
Scarlet Thomas, Executive Director	Kentucky Society for Clinical Social Work

III. The following individuals from the promulgating agency responded to comments received regarding 907 KAR 1:044.

Name and Title	Agency/Organization/Entity/Other
Lisa Lee, Commissioner	Department for Medicaid Services, Commissioner's Office
Veronica Judy-Cecil, Senior Deputy Commissioner	Department for Medicaid Services, Commissioner's Office
Leslie Hoffman, Deputy Commissioner	Department for Medicaid Services, Commissioner's Office
Jonathan Scott, Chief Legislative and Regulatory Officer	Department for Medicaid Services, Commissioner's Office
Angela Sparrow, Behavioral Health Supervisor	Department for Medicaid Services Division of Health Care Policy
Sherri Staley, Behavioral Health Supervisor	Department for Medicaid Services Division of Health Care Policy

Anne Hollen, Behavioral Health Lead	Department for Medicaid Services Division of Health Care Policy
Justin Dearinger, Assistant Director	Department for Medicaid Services
Nicole Lesniewski, Executive Staff Advisor	Department for Medicaid Services, Commissioner's Office

IV. SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Definition and inclusion of "behavioral health associate" (BHA)
(a) Comment: Kathy Adams, Director of Policy, Children's Alliance submitted comments that a BHA is not an independently license practitioner and should not be included in the definition of an approved behavioral health practitioner. They request that BHA be deleted in (1)(n) and the "or" after (1)(m) be moved after (1)(l).
Additionally, they commented that "advanced practice registered nurse" (APRN) is not defined in Section 1 and should be defined here and match the definition found defined in 907 KAR 15:005 (Section 1(3)) and refers to KRS 314.011(7).

(b) Response: The BHA definition establishes eight major requirements that must be met before the BHA can provide services in any facility. DMS expects that a governing collaborative education agreement with the provider and the graduate program will address scope of practice requirements. This agreement is expected to be comprehensive and may be more restrictive than the applicable professional licensure board requirements. The BHA utilizes the practice model of the mental health associate (MHA) which has been used within the community mental health centers for decades. A substantial need currently exists within the state for additional behavioral and mental health providers. Extending the ability of our currently licensed and employed behavioral health providers and their employers through the use of a BHA-level practitioner is necessary at this point of time to best serve Kentucky's Medicaid members. The APRN is a term established in Kentucky law and does not require definition. DMS is operating under the prevailing statutory definition.

The regulation has been amended to modify the definition of BHA to include compliance with both supervision requirements of the collaborative educational agreement and compliance with the billing supervision requirements for rendering Medicaid services. The definition now

includes that the BHA- except for an individual working in a narcotic treatment program - must be in a graduate level program and be participating in an internship or practicum at an accredited educational institution. The regulation has been further amended to specify that a BHA cannot render a diagnosis for a client.

(a) Comment: Hank Cecil, Chair, Kentucky Board of Social Work, submitted comments that a student in a graduate program who would qualify as a BHA participate in unpaid internship and practicums as part of their education and would not be able to establish long-term therapist-client relationship. They state that these students would qualify as a BHA but are not under the authority of the Board as they are not licensed. They note concerns about potential student misconduct that would result in sanction of termination of their practicum causing difficulties with completing their education. They note concerns about Medicaid revoking the BHA credential from the student because of misconduct. Additionally, they commented that students do not have a scope of practice under their intended licensure, and suggested the phrasing, "Services will be provided within the scope of the student's academic coursework and school transcript." Finally, they conclude that "the Board has no direct jurisdiction over such persons unless they are practicing social work without a license, which is evidenced by their education, training, and experience at the graduate level when they are awarded a master's degree."

(b) Response: The BHA definition establishes eight major requirements that must be met before the BHA can provide services in any facility. DMS expects that a governing collaborative education agreement with the provider and the graduate program will address scope of practice requirements. This agreement is expected to be comprehensive and may be more restrictive than the applicable professional licensure board requirements. The BHA utilizes the practice model of the mental health associate (MHA) which has been used within the community mental health centers for decades. A substantial need currently exists within the state for additional behavioral and mental health providers. Extending the ability of our currently licensed and employed behavioral health providers and their employers through the use of a BHA-level practitioner is necessary at this point of time to best serve Kentucky's Medicaid members. Educational programs, providers, facilities, and students have operated in this space for a long period of time and DMS anticipates that they will continue to be capable of educating and training in this space with this expansion of an established practitioner.

The regulation has been amended to modify the definition of BHA to include compliance with both supervision requirements of the collaborative educational agreement and compliance with the billing supervision requirements for rendering Medicaid services. The definition now includes that the BHA- except for an individual working in a narcotic treatment program - must be in a graduate level program and be participating in an internship or practicum at an accredited educational institution. The regulation has been further amended to specify that a BHA cannot render a diagnosis for a client.

(a) Comment: Eric Russ, Executive Director, Kentucky Psychological Association commented that they do not support the inclusion of BHA. They state that this regulation does not provide clinical oversight for services to be delivered effectively and note that licensing boards would be better suited to define pre-licensure practices and allow the boards to provide oversite of practice and supervision. Additionally, they stated that there should be additional limitations on the BHA

scope of practice (if the regulation moves forward). Suggested limitations are to exclude initial psychological evaluation, adding new diagnoses and psychological and neuropsychological testing. They suggest defining the educational requirements and oversight as required by the BHA/student's university, and that education requirements should be mandated and tracked and include suicide assessment and prevention, and ethics.

(b) Response: The BHA definition establishes eight major requirements that must be met before the BHA can provide services in any facility. DMS expects that a governing collaborative education agreement with the provider and the graduate program will address scope of practice requirements. This agreement is expected to be comprehensive and may be more restrictive than the applicable professional licensure board requirements. The BHA utilizes the practice model of the mental health associate (MHA) which has been used within the community mental health centers for decades. A substantial need currently exists within the state for additional behavioral and mental health providers. Extending the ability of our currently licensed and employed behavioral health providers and their employers through the use of a BHA-level practitioner is necessary at this point of time to best serve Kentucky's Medicaid members.

The BHA utilizes the practice model of the mental health associate (MHA) which has been used within the community mental health centers for decades. A substantial need currently exists within the state for additional behavioral and mental health providers. Extending the ability of our currently licensed and employed behavioral health providers and their employers through the use of a BHA-level practitioner is necessary at this point of time to best serve Kentucky's Medicaid members. This is a practice model that has been in use in Kentucky for decades and is a familiar and needed option for many behavioral health providers. Kentucky's behavioral health providers and graduate schools are familiar with this model as it is used throughout Kentucky and other states. The collaborative educational agreements will give graduate programs and employers the ability to govern the conduct of BHAs adequately and effectively while also allowing a serious gap in the behavioral health care workforce to be met. DMS has not typically required a single accreditation for institutions in the past as multiple accrediting bodies are present in this space. The governing regulations for the institutions in (7)(h) do require accreditation and DMS will continue to enforce the relevant administrative regulation.

The regulation has been amended to modify the definition of BHA to include compliance with both supervision requirements of the collaborative educational agreement and compliance with the billing supervision requirements for rendering Medicaid services. The definition now includes that the BHA- except for an individual working in a narcotic treatment program - must be in a graduate level program and be participating in an internship or practicum at an accredited educational institution. The regulation has been further amended to specify that a BHA cannot render a diagnosis for a client.

(a) Comment: Brenda Rosen, Executive Director, Kentucky Chapter of National Association of Social Workers commented that a master's level practicum student should not be performing a level of clinical practice that they are not competent to do prior to their licensure as a Certified Social Worker and LCSW contract for supervision. They stated their concern with the phrasing, "all services provided with a BHA designation will be provided within the scope of licensure

they are working to obtain" as a MSW student would not have the competency to provide these services. Scope of practice should only apply to those with a license. Practicum students cannot have an independent caseload, diagnose, or provide therapy. They also note concerns with "a collaborative educational agreement with the provider and the graduate program" as this could put both social work programs and LCSW supervisors at risk as practicum students do not have a scope of practice. They note that the required supervision should include both the college program and the practicum site. Additionally, they note that a practicum student can participate in psycho-educational groups, bio-psycho-social assessments, staff meetings and trainings, and observation and participation with a licensed mental health provider.

(a) Comment: Scarlet Thomas, Executive Director, Kentucky Society for Clinical Social Work submitted comments on behalf of the Kentucky Society for Clinical Social Work Board. The comments express "firm opposition" to allowing a BHA to provide clinical work. The comments allege a significant risk of harm to clients and the exploitation of students in a practicum setting.

(b) Response: The BHA definition establishes eight major requirements that must be met before the BHA can provide services in any facility. DMS expects that a governing collaborative education agreement with the provider and the graduate program will address scope of practice requirements. This agreement is expected to be comprehensive and may be more restrictive than the applicable professional licensure board requirements. The BHA utilizes the practice model of the mental health associate (MHA) which has been used within the community mental health centers for decades. A substantial need currently exists within the state for additional behavioral and mental health providers. Extending the ability of our currently licensed and employed behavioral health providers and their employers through the use of a BHA-level practitioner is necessary at this point of time to best serve Kentucky's Medicaid members.

The regulation has been amended to modify the definition of BHA to include compliance with both supervision requirements of the collaborative educational agreement and compliance with the billing supervision requirements for rendering Medicaid services. The definition now includes that the BHA- except for an individual working in a narcotic treatment program - must be in a graduate level program and be participating in an internship or practicum at an accredited educational institution. The regulation has been further amended to specify that a BHA cannot render a diagnosis for a client.

(a) Comment: Steve Shannon, Executive Director, Kentucky Association of Regional Programs, submitted comments on behalf of their twelve member CMHCs. They note that the CMHCs have used MHAs effectively for more than 30 years and would like to assist with developing an effective approach to manage, supervise, and provide quality services. They also note that the if the availability of BHA/MHAs are negatively impacted, that the effectiveness of the Mobile Crisis initiative should be considered.

(b) Response: The Department agrees with the need to monitor and effectively monitor the BHA. The CMHC experience with MHAs will be invaluable with extending and implementing this practitioner type. DMA anticipates further discussion in this area with the behavioral health TAC and other providers. As necessary, DMS will be prepared to implement additional restrictions

should concerning patterns of utilization develop. This administrative regulation will not be amended in response to the comment.

(2) Subject: Include re-evaluation and application process for the BHA designation.
(a) Comment: Kathy Adams, Director of Policy at the Children's Alliance submitted comments that there is not a requirement for a BHA to be reevaluated during their 5-year limit. They suggest a reevaluation requirement be added in regulation including a required application every 2 years for BHA designees to determine their eligibility as a BHA. They request that any application process and timeline be included in regulation and that an application form be incorporated by reference in the regulation, if applicable.

(b) Response: The Department is comfortable establishing a five-year limit for BHAs. This length of time gives an individual the time to gain experience and evaluate educational options in multiple behavioral science fields. The Department is not prepared to incorporate a form by reference at this time. The regulation will not be amended in response to this comment.

(a) Hank Cecil, Chair, Kentucky Board of Social Work commented that there have been cases where a graduate student is employed by a mental health clinic and continue their employment upon graduation without obtaining a credential from the Board. They state that this would constitute unlicensed practice of social work (KRS 335.030).

(b) Response: Under the reimbursement model that is proposed for BHAs, this would create an ongoing under-utilization of an individuals earning potential. Furthermore, the administrative regulation establishes a point beyond which this individual could no longer operate as a BHA. This regulation should serve to curb this potential practice, because a BHA will not be able to request as much reimbursement as a licensed professional. The regulation will not be amended in response to this comment.

(a) Hank Cecil, Chair, Kentucky Board of Social Work submitted comments that a LCSW would not be able to supervise a BHA as this would constitute aiding and abetting the unlicensed practice of social work (KRS 335.150(1)(j)).

(b) Response: If LCSWs are currently providing supervision to MHAs, it is unclear why a BHA would be unable to proceed under the identical legal theory as they are the same provider. If the Social Work Board is signaling that it will now prosecute LCSWs working at CMHCs, then this departure from existing policy will have a negative effect on Kentucky's behavioral health workforce and would be a policy change outside of this administrative regulation. The Department would encourage the Board of Social Work to reconsider and also meet with stakeholders including the CMHCs, legislators in the General Assembly, and the administration if they intend to go forward with this policy change. The regulation will not be amended in response to this comment.

V. SUMMARY OF STATEMENT OF CONSIDERATION AND ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 1:044. This administrative regulation is being amended after comments. DMS is amending the administrative regulation as follows:

Section 1(4)
Page 3
Line 14
After "(c)1." Insert "a.".

Section 1(4)
Page 3
Line 15
Delete ":".

Section 1(4)
Page 3
Line 16
Delete "a. Psychology;".

Section 1(4)
Page 3
Line 17
Delete "b. Social work; or".

Section 1(4)
Page 3
Line 18
Delete "c."
Insert the following after "license;":
and
b. Who is currently participating in a internship or practicum program as part of an accredited educational institution;

Section 1(4)
Page 3
Line 19
Delete "or licensure"
Delete "mental"

Section 1(4)
Page 3
Line 20 Delete "health or"
After "disorder" add "<u>, and is only employed by a narcotic treatment program</u>".

Section 1(7)
Page 4
Line 1
Insert "<u>Who complies with the supervision requirements of the collaborative educational agreement and complies with billing supervision requirements for rendering Medicaid services</u>"
Delete "That receives, at a minimum, weekly supervision by an approved behavioral health practitioner employed by the provider of services".

Section 1(7)
Page 4
Line 5
After (g) insert "<u>Who does not render a diagnosis for a client;</u>"
Before "Who is designated" insert "<u>(h)</u>".

Section 1(7)
Page 4
Line 6
Insert "<u>(i)</u>"
Delete "(h)"