CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amended After Comments)

907 KAR 15:070. Coverage provisions and requirements regarding services provided by residential crisis stabilization units.

RELATES TO: KRS 205.520, 21 U.S.C. 823(g)(2), 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 coverage provisions and requirements regarding Medicaid Program behavioral health services provided by residential crisis stabilization units.

Section 1. General Coverage Requirements. (1) For the department to reimburse for a service covered under this administrative regulation, the service shall be:

(a) Medically necessary; and

(b) Provided:

1. To a recipient; and

2. By a residential crisis stabilization unit that meets the provider participation requirements established in Section 2 of this administrative regulation.

(2)(a) Direct contact between a practitioner and a recipient shall be required for each service.

(b) A service that does not meet the requirement in paragraph (a) of this subsection shall not be covered.

(3) A service shall be:

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

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

(4) A residential crisis stabilization unit shall establish a plan of care for each recipient receiving services.

Section 2. Provider Participation. (1) To be eligible to provide services under this administrative regulation, a residential crisis stabilization unit shall:

(a) Be currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

(b) Except as established in subsection (3) of this section, be currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671;

(c) Be licensed as a residential crisis stabilization unit in accordance with 902 KAR 20:440;

(d) Comply with the requirements established in 902 KAR 20:440;

(e) Have:

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

2. Demonstrated experience in serving individuals with behavioral health disorders;

3. The administrative capacity to ensure quality of services;

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

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

(f) Be a community-based, residential program that offers an array of services including:

1. Screening;

2. Assessment;

3. Treatment planning;

4. Individual [~~outpatient~~]-therapy;

5. Group [~~outpatient~~] therapy;

6. Psychiatric services;

7. Family [~~outpatient~~] therapy at the option of the residential crisis stabilization unit; [~~or~~]

8. Peer support at the option of the residential crisis stabilization unit;

9. **Medically monitored** withdrawal management if treating substance use disorders; or

10. Medication assisted treatment if treating substance use disorders;

(g) Provide services in order to:

1. Stabilize a crisis and divert an individual from a higher level of care;

2. Stabilize an individual and provide treatment for acute withdrawal, if applicable; and

3. Re-integrate an individual into the individual's community or other appropriate setting in a timely fashion;

(h) Not be part of a hospital;

(i) Be used when an individual:

1. Is experiencing a behavioral health crisis that cannot be safely accommodated within the individual's community; and

2. Needs overnight care that is not hospitalization;

(j) Except as established in subsection (2)(a) of this section, not contain more than sixteen (16) beds;

(k) Except as established in subsection (2)(b) of this section, not be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate;

(l) Agree to provide services in compliance with federal and state laws regardless of age, sex, race, creed, religion, national origin, handicap, or disability;

(m) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and any amendments to the Act;

(n) Have the capacity to employ staff authorized to provide treatment services in accordance with this section and to coordinate the provision of services among team members;

(o) Have the capacity to provide the full range of residential crisis stabilization services as stated in Section 3(2) of this administrative regulation and on a twenty-four (24) hour a day, seven (7) day a week, every day of the year basis;

(p) Have access to a board certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days a week, every day of the year; [~~and~~]

(q) Have knowledgeable staff regarding mental health, substance use, or co-occurring disorders based on the population being served; and

(r) For the treatment or stabilization of withdrawal management symptoms for substance use disorder or co-occurring disorders**:**

1. Meet all requirements established by the most recent version of the American Society for Addiction Medicine (ASAM) relating to level of care certification for medically monitored intensive inpatient services for adults and medically monitored high-intensity inpatient services for adolescents, currently described by ASAM as a 3.7 level of care; and

2.[;] Have**:**

a. A planned and structured regimen of twenty-four (24) hour professionally directed evaluation, observation, medical monitoring, and addiction treatment**;**

b. Twenty-four (24) hour nursing care, including a comprehensive assessment at admission by a registered nurse;

c. Twenty-four (24) hour access to a psychiatrist, including availability within eight (8) hours by telephone and within twenty-four (24) hours in person;

d. Twenty-four (24) hour access to a physician, advanced practice registered nurse, or a physician assistant, to include:

(i) An assessment and physical examination in person within twenty-four (24) hours of admission, and after admission as medically necessary; and

(ii) Responsibility for overseeing the treatment of each recipient; and

e. Clinical staff:

(i) Knowledgeable about the biological and psychosocial dimensions of addiction and other behavioral health disorders with training in behavior management techniques and evidence-based practices; and

(ii) Able to provide twenty-four (24) hour professionally directed evaluation, care, and treatment services[~~disorders~~].

(2) If every recipient receiving services in the:

(a) Single unit is under the age of twenty-one (21) years or over the age of sixty-five (65) years, the limit of sixteen (16) beds established in subsection (1)(j) of this section shall not apply; or

(b) Multiple units is under the age of twenty-one (21) years or over the age of sixty-five (65) years, the limit of sixteen (16) beds established in subsection (1)(k) of this section shall not apply.

(3) In accordance with 907 KAR 17:015, Section 3(3), a residential crisis stabilization unit that[~~which~~] provides a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

Section 3. Covered Services. (1)(a) Except as specified in the requirements stated for a given service, the services covered may be provided for:

1. A mental health disorder;

2. A substance use disorder; or

3. Co-occurring **[~~mental health and substance use~~]** disorders.

(b) Residential crisis stabilization services shall be provided in a residential crisis stabilization unit.

(2) Residential crisis stabilization services shall include the services established in this subsection.[~~:~~

~~(a) A screening provided by:~~

~~1. A licensed psychologist;~~

~~2. A licensed psychological practitioner;~~

~~3. A licensed clinical social worker;~~

~~4. A licensed professional clinical counselor;~~

~~5. A licensed professional art therapist;~~

~~6. A licensed marriage and family therapist;~~

~~7. A physician;~~

~~8. A psychiatrist;~~

~~9. An advanced practice registered nurse; or~~

~~10. A behavioral health practitioner under supervision except for a licensed assistant behavior~~

~~analyst;~~

~~(b) An assessment provided by:~~

~~1. A licensed psychologist;~~

~~2. A licensed psychological practitioner;~~

~~3. A licensed clinical social worker;~~

~~4. A licensed professional clinical counselor;~~

~~5. A licensed professional art therapist;~~

~~6. A licensed marriage and family therapist;~~

~~7. A physician;~~

~~8. A psychiatrist;~~

~~9. An advanced practice registered nurse;~~

~~10. A licensed behavior analyst; or~~

~~11. A behavioral health practitioner under supervision;~~

~~(c) Individual outpatient therapy or group outpatient therapy provided by:~~

~~1. A licensed psychologist;~~

~~2. A licensed psychological practitioner;~~

~~3. A licensed clinical social worker;~~

~~4. A licensed professional clinical counselor;~~

~~5. A licensed professional art therapist;~~

~~6. A licensed marriage and family therapist;~~

~~7. A physician;~~

~~8. A psychiatrist;~~

~~9. An advanced practice registered nurse;~~

~~10. A licensed behavior analyst; or~~

~~11. A behavioral health practitioner under supervision;~~

~~(d) Treatment planning provided by:~~

~~1. A licensed psychologist;~~

~~2. A licensed psychological practitioner;~~

~~3. A licensed clinical social worker;~~

~~4. A licensed professional clinical counselor;~~

~~5. A licensed professional art therapist;~~

~~6. A licensed marriage and family therapist;~~

~~7. A physician;~~

~~8. A psychiatrist;~~

~~9. An advanced practice registered nurse;~~

~~10. A licensed behavior analyst; or~~

~~11. A behavioral health practitioner under supervision except for a certified alcohol and drug counselor;~~

~~(e) Psychiatric services provided by:~~

~~1. A psychiatrist; or~~

~~2. An APRN; or~~

~~(f) At the option of the residential crisis stabilization unit:~~

~~1. Family outpatient therapy provided by:~~

~~a. A licensed psychologist;~~

~~b. A licensed psychological practitioner;~~

~~c. A licensed clinical social worker;~~

~~d. A licensed professional clinical counselor;~~

~~e. A licensed professional art therapist;~~

~~f. A licensed marriage and family therapist;~~

~~g. A physician;~~

~~h. A psychiatrist;~~

~~i. An advanced practice registered nurse; or~~

~~j. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst; or~~

~~2. Peer support provided by a peer support specialist working under the supervision of:~~

~~a. An approved behavioral health service provider; or~~

~~b. A certified alcohol and drug counselor.~~

~~(3)~~](a) A screening shall:

1. Establish the need for a level of care evaluation to determine the most appropriate and least restrictive service to maintain the safety of the individual who may have a mental health disorder, substance use disorder, or co-occurring disorders;

2. Not establish the presence or specific type of disorder; [~~and~~]

3. Establish the need for an in-depth assessment of the number and duration of risk factors including:

a. Imminent danger and availability of lethal weapons;

b. Verbalization of suicidal or homicidal risk;

c. Need of immediate medical attention, including **medically monitored** withdrawal management needs;

d. Positive and negative coping strategies;

e. Lack of family or social supports;

f. Active psychiatric diagnosis; or

g. Current drug and alcohol use;

4. Be provided face-to-face or via telehealth as appropriate pursuant to 907 KAR 3:170; and

5. Be provided by:

a. An approved behavioral health practitioner; or

b. An approved behavioral health practitioner under supervision.

(b) An assessment shall:

1. Include gathering information and engaging in a process with the individual that enables the practitioner to:

a. Establish the presence or absence of a mental health disorder, a substance use disorder, or co-occurring disorders;

b. Determine the individual's readiness for change;

c. Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and

d. Engage the individual in developing an appropriate treatment relationship;

2. Establish or rule out the existence of a clinical disorder or service need;

3. Include working with the individual to develop a treatment and service plan; [~~and~~]

4. Not include psychological or psychiatric evaluations or assessments;

5. If being made for the treatment of a substance use disorder, utilize a multi-dimensional assessment that complies with The ASAM Criteria**, and shall address at a minimum:**

a. Acute intoxication or withdrawal potential;

b. Biomedical conditions and complications;

c. Emotional, behavioral, or cognitive conditions and complications;

d. Readiness to change;

e. Relapse;

f. Continued use or continued problem potential; and

g. Recovery and living environment; and

6. Be provided by:

a. An approved behavioral health practitioner; or

b. An approved behavioral health practitioner under supervision.

(c) Individual [~~outpatient~~] therapy shall:

1. Be provided to promote the:

a. Health and wellbeing of the individual; or

b. Restoration of a recipient to their best possible functional level[~~Recovery~~] from a substance use disorder, a mental health disorder, or co-occurring disorders;

2. Consist of:

a. A face-to-face, **or via telehealth as appropriate pursuant to the most recent version of The ASAM Criteria and 907 KAR 3:170**, one (1) on one (1) encounter between the provider and recipient; and

b. A behavioral health therapeutic intervention provided in accordance with the recipient's identified crisis treatment plan;

3. Be aimed at:

a. Reducing adverse symptoms;

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

c. Improving functioning; [~~and~~]

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

5. Be provided by:

a. An approved behavioral health practitioner; or

b. An approved behavioral health practitioner under supervision.

(d)1. Group [~~outpatient~~] therapy shall:

a. Be a behavioral health therapeutic intervention provided in accordance with a recipient's identified crisis treatment plan;

b. Be provided to promote the:

(i) Health and wellbeing of the individual; or

(ii) Restoration of a recipient to their best possible functional level[~~Recovery~~] from a substance use disorder, a mental health disorder, or co-occurring disorders;

c. Consist of a face-to-face, **or via telehealth as appropriate pursuant to the most recent version of The ASAM Criteria and 907 KAR 3:170,** behavioral health therapeutic intervention provided in accordance with the recipient's identified crisis treatment plan;

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

(i) Of nonrelated individuals; and

(ii) Not to exceed twelve (12) individuals in size;

e. Focus on the psychological needs of the recipients as evidenced in each recipient's crisis treatment plan;

f. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;

g. Not include physical exercise, a recreational activity, an educational activity, or a social activity; and

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

2. The group shall have a:

a. Deliberate focus; and

b. Defined course of treatment.

3. The subject of group outpatient therapy shall relate to each recipient participating in the group.

4. The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.

5. The group shall be provided by:

a. An approved behavioral health practitioner; or

b. An approved behavioral health practitioner under supervision.

(e)1. **Service[~~Treatment~~]** planning shall:

a. Involve assisting a recipient in creating an individualized plan for services needed;

b. Involve restoring a recipient's functional level to the recipient's best possible functional level; and

c. Be performed using a person-centered planning process.

2. A service plan:

a. Shall be directed by the recipient;

b. Shall include practitioners of the recipient's choosing; and

c. May include:

(i) A mental health advance directive being filed with a local hospital;

(ii) A crisis plan; or

(iii) A relapse prevention strategy or plan.

3. A service plan shall be completed by:

a. An approved behavioral health practitioner; or

b. An approved behavioral health practitioner under supervision.

(f)[~~1.~~] Family [~~outpatient~~] therapy shall:

1. Consist of a face-to-face, **or via telehealth as appropriate pursuant to the most recent version of The ASAM Criteria and 907 KAR 3:170,** behavioral health therapeutic intervention provided:

a. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and

b. To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment;[~~.~~]

2. [~~Family outpatient therapy shall:~~]

a. Be provided to promote:

(i) The health and wellbeing of the individual; or

(ii) Restoration of a recipient to their best possible functional level[~~Recovery~~] from a substance use disorder, a mental health disorder, or co-occurring disorders; and

b. Not exceed three (3) hours per day per individual unless additional time is medically necessary; and

3. Be provided by:

a. An approved behavioral health practitioner; or

b. An approved behavioral health practitioner under supervision.

(g)1. Peer support services provided by a peer support specialist working under the supervision of an approved behavioral health practitioner shall:

a. Be social and emotional support that is provided by an individual who is experiencing a mental health disorder, a substance use disorder, or co-occurring mental health and substance use disorders to a recipient by sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorders in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled non-clinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified consumer, parent, or family member:

(i) Of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health disorder services and substance use disorder services; and

(ii) Who has been trained and certified in accordance with 908 KAR 2:220, 908 KAR 2:230, or 908 KAR 2:240;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient;

f. Be coordinated within the context of a comprehensive, individualized treatment plan developed through a person-centered planning process;

g. Be identified in each recipient's treatment plan; and

h. Be designed to directly contribute to the recipient's individualized goals as specified in the recipient's treatment plan.

2. To provide peer support services, a residential crisis stabilization unit shall:

a. Employ peer support specialists who are qualified to provide peer support services in accordance with 908 KAR 2:220, 908 2:230, or 908 2:240;

b. [~~Use an approved behavioral health services provider or certified alcohol and drug counselor to supervise peer support specialists;~~

~~c.~~]Have the capacity to coordinate the provision of services among team members; [~~and~~]

c.[~~d.~~] Have the capacity to provide on-going continuing education and technical assistance to peer support specialists;

d. Require individuals providing peer support services to recipients to provide no more than thirty (30) hours per week of direct recipient contact; and

e. Require peer support services provided to recipients in a group setting to not exceed eight (8) individuals within any group at one (1) time.

(h)1. **Medically monitored** withdrawal management services for substance use disorder shall:

a. Meet the service criteria for medically monitored **[~~intensive~~]** inpatient services **[~~for adults and medically monitored high-intensity inpatient services for adolescents~~]** in accordance with **the most current version of** The ASAM Criteria; and

b. Comply with services pursuant to the requirements of 902 KAR **20:440[~~20:111~~]**.

2. A recipient who is receiving withdrawal management services shall:

a. Meet the current dimensional admissions criteria for **medically monitored inpatient** withdrawal management **[~~level of care~~]** as found in **the most current version of** The ASAM Criteria; and

b. Not require the full resources of an acute care hospital or a medically managed inpatient treatment program.

3. **Medically monitored** withdrawal management services shall be provided by:

a. A physician or psychiatrist;

b. A physician assistant;

c. An advanced practice registered nurse; or

d. Any other approved behavioral health practitioner or nurse with oversight by a physician, advanced practice registered nurse, or a physician assistant.

(i)1. Medication assisted treatment shall be available per patient choice for the treatment of a substance use disorder or co-occurring disorders.

2. Medication assisted treatment shall be provided by a provider who:

a. Is:

(i) A physician licensed to practice medicine under KRS Chapter 311;

(ii) An advanced practice registered nurse (APRN); or

(iii) A physician assistant **licensed to practice medicine under KRS Chapter 311[~~who has appropriately updated department provider enrollment information~~]**;

b. Meets standards in accordance with 201 KAR 9:270 or 201 KAR 20:065;

c. Maintains a current waiver under 21 U.S.C 823(g)(2) to prescribe buprenorphine products**, including any waiving or expansion of buprenorphine prescribing authority by the federal government**; and

d. Has experience and knowledge in addiction medicine.

(3) For those recipients being treated for a substance use disorder, care coordination shall include at minimum:

(a) Referring the recipient to appropriate community services;

(b) Facilitating medical and behavioral health follow-ups;

(c) Linking to appropriate levels of substance use treatment within the continuum in order to provide on-going support; and

(d) Facilitating medication assisted treatment as necessary, per patient choice**[~~, if the~~**

~~medication is not offered on-site~~].

(4) The extent and type of a screening shall depend upon the problem of the individual seeking or being referred for services.

(5) A diagnosis or clinical impression shall be made using terminology established in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(6) After July 1, **2022[~~2021~~]**, if treating substance use disorders, the facility shall possess an appropriate ASAM level of care certification **for medically monitored intensive inpatient service** in accordance with **the most current version of** The ASAM Criteria.

(7) The department shall not reimburse for a service billed by or on behalf of an entity or individual who is not a billing provider.

Section 4. Additional Limits and Non-covered Services or Activities. (1) The following services or activities shall not be covered under this administrative regulation:

(a) A service provided to:

1. A resident of:

a. A nursing facility; or

b. An intermediate care facility for individuals with an intellectual disability;

2. An inmate of a federal, local, or state:

a. Jail;

b. Detention center; or

c. Prison; or

3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;

(b) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the residential crisis stabilization unit;

(c) A consultation or educational service provided to a recipient or to others;

(d) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of "face-to-face";

(e) Travel time;

(f) A field trip;

(g) A recreational activity;

(h) A social activity; or

(i) A physical exercise activity group.

(2) Residential crisis stabilization services shall not include:

(a) Room and board;

(b) Educational services;

(c) Vocational services;

(d) Job training services;

(e) Habilitation services;

(f) Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;

(g) Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;

(h) Recreational activities;

(i) Social activities; or

(j) Services required to be covered elsewhere in the state plan.

(3)(a) A consultation by one (1) provider or professional with another shall not be covered under this administrative regulation.

(b) A third party contract shall not be covered under this administrative regulation.

Section 5. 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, during the same time period.

(2) For example, if a recipient is receiving a residential crisis stabilization service from a community mental health center, the department shall not reimburse for the same service provided to the same recipient during the same time period by a residential crisis stabilization unit.

Section 6. Records Maintenance, Documentation, Protection, and Security. A residential crisis stabilization unit shall maintain a current health record for each recipient in accordance with 902 KAR 20:440.

Section 7. Medicaid Program Participation Compliance. (1) A residential crisis stabilization unit 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 residential crisis stabilization unit receives any duplicate payment or overpayment from the department, regardless of reason, the residential crisis stabilization unit shall return the payment to the department.

(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.

(3)(a) When the department makes payment for a covered service and the residential crisis stabilization unit accepts the payment:

1. The payment shall be considered payment in full;

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

3. Payment from the recipient for the same service shall not be accepted by the residential crisis stabilization unit.

(b)1. A residential crisis stabilization unit may bill a recipient for a service that is not covered by the Kentucky Medicaid Program if the:

a. Recipient requests the service; and

b. Residential crisis stabilization unit makes the recipient aware in advance of providing the service that the:

(i) Recipient is liable for the payment; and

(ii) Department is not covering the service.

2. If a recipient makes payment for a service in accordance with subparagraph 1. of this paragraph, the:

a. Residential crisis stabilization unit shall not bill the department for the service; and

b. Department shall not:

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

(ii) Make any payment to the residential crisis stabilization unit regarding the service.

(4)(a) The signature of the residential crisis stabilization unit's staff or representative shall indicate that the residential crisis stabilization unit attests that any claim associated with a service is valid and submitted in good faith.

(b) Any claim and substantiating record associated with a service shall be subject to audit by the:

1. Department or its designee;

2. Cabinet for Health and Family Services, Office of Inspector General or its designee;

3. Kentucky Office of Attorney General or its designee;

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

5. United States General Accounting Office or its designee.

(c) If a residential crisis stabilization unit receives a request from the department or its designee to provide a claim, related information, related documentation, or record for auditing purposes, the residential crisis stabilization unit shall provide the requested information to the department within the timeframe requested by the department.

(d)1. All services provided shall be subject to review for recipient or provider fraud or abuse; and compliance with this administrative regulation and state and federal law.

2. Willful abuse by a residential crisis stabilization unit shall result in the suspension or termination of the residential crisis stabilization unit from Medicaid Program participation.

Section 8. Third Party Liability. A residential crisis stabilization unit shall comply with KRS 205.622.

Section 9. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A residential crisis stabilization unit that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the residential crisis stabilization unit's employees, officers, agents,

or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using 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

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

1. A copy of the residential crisis stabilization unit's electronic signature policy;

2. The signed consent form; and

3. The original filed signature.

Section 10. Auditing Authority. The department shall have the authority to audit any:

(1) Claim;

(2) Medical record; or

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

Section 11. Federal Approval and Federal Financial Participation. The department’s coverage of services pursuant to this administrative regulation shall be contingent upon:

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

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

Section 12. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

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

907 KAR 15:070

REVIEWED:

February 10, 2021
Date

Lisa Lee, Commissioner
Department for Medicaid Services

APPROVED:

DocuSigned by:
Eric Friedlander
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2/11/2021
Date

Eric Friedlander, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 15:070
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSregs@ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program behavioral health services provided by residential crisis stabilization units (RCSUs).

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

(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 amendments to this administrative regulation combine a previously separate description of who may perform a service and a description of the service itself. In addition, the amendments implement additional requirements relating to withdrawal management and medication assisted treatment, including a requirement that the services be conducted in accordance with the ASAM Criteria.

The Amended After Comments version makes changes to further clarify that an RCSU is to provide ASAM Level 3.7 medically monitored intensive inpatient services. The administrative regulation is further amended to more clearly and specifically include the ASAM 3.7 level of care requirements. In addition, the availability of telehealth has been further clarified and made

potentially allowable for three (3) services, as long as ASAM requirements are met. The medication assisted treatment authority of physician assistants has been clarified, and the potential for a federal waiver for certain buprenorphine prescribing by physicians has been accommodated. Finally, due to the COVID-19 pandemic, the date by which any RCSU providing SUD withdrawal services must have an ASAM certification has been extended to July 1, 2022.

(b) The necessity of the amendment to this administrative regulation: These amendments are necessary to comply with existing OIG administrative regulations, implement an SUD 1115 waiver, provide additional formatting improvements, and respond to comments received during the public comment process.

(c) How the amendment conforms to the content of the authorizing statutes: The amendments conform to the content of the authorizing statutes by implementing an SUD 1115 waiver.

(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 residential crisis stabilization units.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There are currently fifteen (15) entities that are providing residential crisis stabilization unit (RCSU) services under this administrative regulation. Medicaid recipients who qualify for behavioral health services provided by an RCSU will also be affected by this administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Facilities and providers may need to comply with the ASAM Criteria in order to provide certain services.

(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, and the benefit of providing additional services. Behavioral health professionals authorized to provide services in a residential crisis stabilization unit will benefit by having more employment opportunities in Kentucky. Medicaid recipients in need of behavioral health services will benefit from an expanded base of providers from which to receive these services.

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

(a) Initially: DMS does not anticipate additional costs in implementing this administrative regulation.

(b) On a continuing basis: DMS does not anticipate additional costs in implementing 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? Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 15:070
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSregs@ky.gov

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(10)(B) and 42 U.S.C. 1396a(a)(30)(A).

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."

KRS 205.6311 requires the Department for Medicaid Services to "promulgate administrative regulations . . . to expand the behavioral health network to allow providers to provide services within their licensure category."

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. Medicaid reimbursement for services is required to be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

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

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

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 15:070
Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, 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.010(1), 194A.030(2), 194A.050(1), 205.520(3), 205.6311, 42 U.S.C. 1396a(a)(10)(B), and 42 U.S.C. 1396a(a)(30)(A).

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

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate revenue for state or local government.
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment is not expected to generate revenue for state or local government.
(c) How much will it cost to administer this program for the first year? DMS does not expect any additional costs in administering these amendments during the first year.
(d) How much will it cost to administer this program for subsequent years? DMS does not expect any additional costs in administering these amendments during 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:

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 15:070.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations

Amended After Comments

I. A public hearing on 907 KAR 15:070 was not requested, and therefore, not held. However, written comments were received during the public comment period.

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

Name and Title	**Agency/Organization/Entity/Other**
Nancy Galvagni, President and CEO	Kentucky Hospital Association
Steve Shannon, Executive Director	Kentucky Association of Regional Programs
Sheila Schuster, PhD, Executive Director	Kentucky Mental Health Coalition
Rebecca Randall, Senior Director of Operations	WellCare Health Plans of Kentucky
Kathy Adams, Director of Public Policy	Children's Alliance
Adam Haley, Executive Director	Kentucky Academy of Physician Assistants
Sherri Staley, Behavioral Health Specialist	Department for Medicaid Services
Leigh Ann Fitzpatrick, Behavioral Health Specialist	Department for Medicaid Services
Ann Hollen, Senior Behavioral Health Policy Advisor	Department for Medicaid Services
Angela Sparrow, Behavioral Health Specialist	Department for Medicaid Services

III. The following individuals from the promulgating agency responded to comments received regarding 907 KAR 15:070

Name and Title	**Agency/Organization/Entity/Other**
Lisa Lee, Commissioner	Department for Medicaid Services, Commissioner's Office

Veronica Cecil, Senior Deputy Commissioner	Department for Medicaid Services, Commissioner's Office
Leslie Hoffman, Chief Behavioral Health Officer	Department for Medicaid Services, Commissioner's Office
Lee Guice, Director	Department for Medicaid Services, Division of Policy and Operations
Ann Hollen, Senior Behavioral Health Policy Advisor	Department for Medicaid Services, Division of Policy and Operations
Angela Sparrow, Behavioral Health Specialist	Department for Medicaid Services, Division of Policy and Operations
Sherri Staley, Behavioral Health Specialist	Department for Medicaid Services, Division of Policy and Operations
Jonathan Scott, Regulatory and Legislative Advisor	Department for Medicaid Services, Commissioner's Office

IV. SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Removal of face-to-face restrictions for certain services.

(a) Comment: Kathy Adams, Director of Public Policy for the Children's Alliance; Steve Shannon, Executive Director of the Kentucky Association of Regional Programs; and Sheila Schuster, Ph.D., Executive Director of the Kentucky Mental Health Coalition, submitted comments requesting that telehealth be allowed in the following services: individual therapy, group therapy, and family therapy.

(b) Response: The department intends to modify 907 KAR 3:170 to apply to all telehealth services, including any services that are currently face-to-face within 907 KAR Chapter 15. During the current state of emergency, these services have been able to be delivered via telehealth. DMS will amend this administrative regulation to clarify that if 907 KAR 3:170, the ASAM criteria, or current federal law allows, then these services may be delivered via telehealth. It is important to note, however, that even if a telehealth service is delivered, it cannot be separately billed from a per diem rate, if applicable. This administrative regulation will be amended in response to these comments.

(2) Subject: Improvement of physician assistant medication assisted treatment reference.

(a) Comment: Adam Haley, Executive Director of the Kentucky Academy of Physician Assistants, and Rebecca Randall, Senior Director of Operations, Wellcare Health Plans of Kentucky, submitted comments requesting more clarity in describing the medication assisted treatment authority of physician assistants.

(b) Response: The department agrees with this comment and will modify Section 3(2)(i)2.a.(iii) of this administrative regulation to state "A physician assistant licensed to practice medicine under KRS Chapter 311".

(3) Subject: Importance of effective, accessible, and inclusive substance use disorder treatment

(a) Comment: Sheila Schuster, Ph.D., Executive Director of the Kentucky Mental Health Coalition, submitted comments discussing the importance of Kentucky's expanded substance use disorder treatment, and how SUD treatment is a critically important issue for the Commonwealth to successfully address.

(b) Response: The department appreciates these comments and is committed to expanding and ensuring broad availability of evidence-based SUD treatment to all beneficiaries. This administrative regulation will not be amended in response to the comment.

(4) Subject: Inpatient medical detoxification services within an RCSU setting

(a) Comment: Nancy Galvagni, President and CEO of the Kentucky Hospital Association, submitted comments requesting clarification as to whether medically managed intensive inpatient withdrawal management is covered in the RCSU setting. In particular, these comments discuss the ASAM criteria, and the medical needs of patients receiving treatment at a medically managed withdrawal service level of care.

(a) Comment: Rebecca Randall, Senior Director of Operations, Wellcare Health Plans of Kentucky, submitted comments addressing WellCare's understanding that RCSUs are not being allowed to provide medical detoxification and requesting further clarification within this administrative regulation.

(b) Response: The ASAM Criteria establishes what was previously termed "medical detoxification" as two different types of services. These services are called "medically managed withdrawal services" and "medically monitored withdrawal services". This administrative regulation, the state plan amendment, and the 1115 SUD Waiver explicitly only allow medically monitored inpatient services to be provided within an RCSU. Medically monitored withdrawal services are those services that meet the 3.7 Level of Care (LOC) from ASAM. Furthermore, DMS is requiring all RCSUs providing SUD treatment to receive an ASAM-CARF certification to provide ASAM 3.7 LOC medically monitored withdrawal services.

The department considers medically managed withdrawal services (those that are ASAM LOC 4.0 and higher) to be acute care services. Therefore, medically managed withdrawal services are only reimbursable at this time when provided within a hospital setting. It is DMS' understanding that ASAM LOC certifications for LOC 4.0 are not available.

In reviewing this administrative regulation, however, some confusion has resulted due to the reference to 902 KAR 20:111. At this time, 902 KAR 20:111 conflates medically managed and medically monitored withdrawal services in a way that is not reflective of modern practice, the ASAM Criteria, or Kentucky's negotiated state plan and 1115 SUD Waiver. Fortunately, 902 KAR 20:111 is not the licensure regulation for RCSUs or chemical dependency treatment centers (CDTCs). Therefore, this administrative regulation will be amended to remove the reference to 902 KAR 20:111 and to instead reference 902 KAR 20:440, which is the Office of Inspector General's licensing administrative regulation for RCSUs.

(5) Subject: Expansion of MAT prescribing by physicians due to recent federal changes.

(a) Comment: Sherri Staley, Behavioral Health Specialist, with the Department for Medicaid Services, submitted comments referencing a recent change in federal law relating to the relaxing of a requirement for physicians to receive a waiver from the Drug Enforcement Administration (DEA) to prescribe buprenorphine.

(b) Response: The department agrees that this requirement has changed and will modify the administrative regulation to meet the modified federal standard. As DMS currently understands the changed federal authority, physicians working in specialized SUD treatment facilities, such as a Residential Crisis Stabilization Unit, may continue to need a DEA waiver in order to meaningfully serve the volume of patients that will be present in any outpatient or residential SUD treatment setting. However, this change is important, and this practice opportunity should be reflected in DMS administrative regulations, even if DMS anticipates that the most meaningful adoption of expanded buprenorphine prescribing will occur in other health settings. DMS, therefore, will endeavor to amend all behavioral health administrative regulations to comply.

However, within existing Medicaid administrative regulations, DMS further believes that providers can immediately utilize this expanded authority. First, DMS will broadly construe the Federal Approval clause located in each behavioral health administrative regulation to encompass this scenario of expanded federal authority. Second, the phrase in the administrative regulation necessarily contemplates federal regulatory authority and its associated processes. Therefore, this federal regulatory change allowing for expanded practice is included within the concept of "a current waiver under 21 U.S.C. 823(g)(2)".

Section 3(2)(i)2.c. of the administrative regulation will be amended to include the new federal authority as follows:

> c. Maintains a current waiver under 21 U.S.C 823(g)(2) to prescribe buprenorphine products**, including any waiving or expansion of buprenorphine prescribing authority by the federal government**; and

(6) Subject: Certified Alcohol and Drug Counselor Associates

(a) Comment: Rebecca Randall, Senior Director of Operations, WellCare Health Plans of Kentucky, submitted comments acknowledging the creation of two (2) new behavioral health practitioners, a certified alcohol and drug counselor associate I (CADCA I) and a certified alcohol and drug counselor associate II (CADCA II), and asking whether they would be incorporated into this administrative regulation.

(b) Response: At this time, DMS is continuing to monitor the development of this new practitioner. The licensure or certification requirements for this new practitioner are continuing to be developed by various stakeholder boards, commissions, and other CHFS agencies. At this time, DMS does not have enough guidance from licensing or certifying bodies to introduce these new practitioners into the Medicaid program. Due to the structure of 907 KAR Chapter 15, however, as this provider type evolves, DMS will be able to integrate CADCA I and IIs into the Medicaid program by amending only the definitions administrative regulation for this chapter, 907 KAR 15:005.

(7) Subject: Reimbursement clarification

(a) Comment: Rebecca Randall, Senior Director of Operations, Wellcare Health Plans of Kentucky, submitted comments discussing the per diem rate for services provided within an RCSU and asking if there is any additional reimbursement for "unbundled" services provided within RCSUs.

(b) Response: That is correct, RCSUs are paid via a per diem reimbursement process established in 907 KAR 15:075. In general, and as contemplated in this administrative regulation, and 907 KAR 15:075, there is no additional reimbursement for any unbundled service. However, this would not supersede any separately bargained agreement between an MCO and RCSU provider to provide additional services or supports for a Medicaid member that are outside the scope of this administrative regulation.

(8) Subject: Service name and ASAM reference updates

(a) Comment: Leigh Ann Fitzpatrick, Behavioral Health Specialist, Department for Medicaid Services, submitted agency comments indicating that references to the ASAM criteria should be to the most current version, and not the most current edition. Also, the updating of certain service category names was requested.

(b) Response: The department agrees with these comments, and the administrative regulation will be amended.

(9) Subject: ASAM medically monitored withdrawal management references updates

(a) Comment: Ann Hollen, Senior Behavioral Health Policy Advisor, and Angela Sparrow, Behavioral Health Specialist, Department for Medicaid Services, submitted agency comments indicating that references to the ASAM criteria should be to the most current version, recommending

service criteria updates to better reflect the current ASAM criteria, and to make additional clarifications to covered services.

(b) Response: The department agrees with these comments, and the administrative regulation will be amended to reflect additional service criteria and requirements related to the ASAM criteria.

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 15:070. This administrative regulation is being amended after comments. DMS is amending the administrative regulations as follows:

Page 3
Section 2(1)(f)9.
Line 12

After "9.", insert "Medically monitored".
Lowercase "Withdrawal".

Page 4
Section 2(1)(r)
Line 19

After "co-occurring disorders", insert the following:

:
1. Meet all requirements established by the most recent version of the American Society for Addiction Medicine (ASAM) relating to level of care certification for medically monitored intensive inpatient services for adults and medically monitored high-intensity inpatient services for adolescents, currently described by ASAM as a 3.7 level of care; and
2.

Delete the comma.
Capitalize "have".
After the newly capitalized "Have", insert ": a.".

Lines 20 and 21

After "and addiction treatment", insert the following:

;
b. Twenty-four (24) hour nursing care, including a comprehensive assessment at admission by a registered nurse;
c. Twenty-four (24) hour access to a psychiatrist, including availability within eight (8) hours by telephone and within twenty-four (24) hours in person;
d. Twenty-four (24) hour access to a physician, advanced practice registered nurse, or a physician assistant, to include:
(i) An assessment and physical examination in person within twenty-four (24) hours of admission, and after admission as medically necessary; and
(ii) Responsibility for overseeing the treatment of each recipient; and
e. Clinical staff:
(i) Knowledgeable about the biological and psychosocial dimensions of addiction and other behavioral health disorders with training in behavior management techniques and evidence-based practices; and

(ii) Able to provide twenty-four (24) hour professionally directed evaluation, care, and treatment services

Page 5
Section 3(1)(a)3.
Line 11
After "Co-occurring", delete the following:
mental health and substance use

Page 9
Section 3(2)(a)3.c.
Line 1
After ", including", insert "medically monitored".

Page 9
Section 3(2)(b)5.
Line 23
After "The ASAM Criteria", insert the following:
, and shall address at a minimum:
a. Acute intoxication or withdrawal potential;
b. Biomedical conditions and complications;
c. Emotional, behavioral, or cognitive conditions and complications;
d. Readiness to change;
e. Relapse;
f. Continued use or continued problem potential; and
g. Recovery and living environment

Page 10
Section 3(2)(c) 2.a.
Line 10
After "A face-to-face,", insert the following:
or via telehealth as appropriate pursuant to the most recent version of The ASAM Criteria and 907 KAR 3:170,

Page 10
Section 3(2)(d)1.c.
Line 10
After "A face-to-face,", insert the following:
or via telehealth as appropriate pursuant to the most recent version of The ASAM Criteria and 907 KAR 3:170,

Page 12
Section 3(2)(e)1.
Line 4
After "(e)1.", insert "Service".
Delete "Treatment".

Page 12
Section 3(2)(f)1.
Line 20
After "A face-to-face,", insert the following:
or via telehealth as appropriate pursuant to the most recent version of The ASAM Criteria and 907 KAR 3:170,

Page 14
Section 3(2)(h)1.
Line 23
After "(h)1.", insert "Medically monitored".
Lowercase "Withdrawal".

Page 15
Section 3(2)(h)1.a.
Line 1
After "medically monitored", delete "intensive".
Lines 1-2
After "inpatient services", delete the following:
for adults and medically monitored high intensity inpatient services for adolescents
Line 2
After "in accordance with", insert the following:
the most current version of

Page 15
Section 3(2)(h)1.b.
Line 4
After "902 KAR", insert "20:440".
Delete "20:111".

Page 15
Section 3(2)(h)2.a.
Line 6
After "admissions criteria for", insert "medically monitored inpatient".
After "withdrawal management", delete "level of care".
Line 7
After "as found in", insert the following:
the most current version of

Page 15
Section 3(2)(h)3.
Line 10
After "(h)3.", insert "Medically monitored".
Lowercase "Withdrawal".

Page 15
Section 3(2)(i)2.a.(iii)
Lines 22-23
After "A physician assistant", insert the following:
licensed to practice medicine under KRS Chapter 311
Delete the following:
who has appropriately updated department provider enrollment information

Page 16
Section 3(2)(i)2.c.
Line 2
After "buprenorphine products", insert the following:
, including any waiving or expansion of buprenorphine prescribing authority by the federal government

Page 16
Section 3(3)(d)
Lines 11-12
After "per patient choice", delete the following:
, if the medication is not offered on-site

Page 16
Section 3(6)
Line 18
After "July 1,", insert "2022".
Delete "2021".
Line 19
After "level of care certification", insert the following:
for medically monitored intensive inpatient service
After "in accordance with", insert the following:
the most current version of