

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (Amendment)

5 907 KAR 1:604. Recipient cost-sharing.

6 RELATES TO: KRS 205.560, 205.6312, 205.6485, 205.8451, 319A.010, 327.010, 334A.020,
7 42 C.F.R. 430.10, 431.51, 447.15, 447.20, 447.21, 447.50, 447.52, [447.53,] 447.54, 447.55,
8 447.56, 447.57[447.59], 457.224, 457.310, 457.505, 457.510, 457.515, 457.520, 457.530,
9 457.535, 457.570, 42 U.S.C. 1396a, 1396b, 1396c, 1396d, 1396o, 1396r-6, 1396r-8, 1396u-1,
10 1397aa -1397jj, 2014 Ky. Acts ch. 117, Part I.G.3.b.(10)

11 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6312(5),
12 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.50-447.90[447.82], 457.535, 457.560, 42 U.S.C.
13 1396r-6(b)(5)

14 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Ser-
15 vices, Department for Medicaid Services has responsibility to administer the Medicaid Program.
16 KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any re-
17 quirement that may be imposed, or opportunity presented, by federal law to qualify for federal
18 Medicaid funds. KRS 205.6312(5) requires the cabinet to promulgate administrative regulations
19 that implement copayments for Medicaid recipients. This administrative regulation establishes
20 the provisions relating to Medicaid Program copayments.

21 Section 1. Definitions. (1) "Community spouse" means the individual who is married to an in-

1 institutionalized spouse and who:

2 (a) Remains at home in the community; and

3 (b) Is not:

4 1. Living in a medical institution;

5 2. Living in a nursing facility; or

6 3. Participating in a 1915(c) home and community based services waiver program.

7 (2) "Copayment" means a dollar amount representing the portion of the cost of a Medicaid
8 benefit that a recipient is required to pay.

9 (3) "Department" means the Department for Medicaid Services or its designee.

10 (4) "Dependent child" means a [couple's] child, including a child gained through adoption,
11 who:

12 (a) Lives with the community spouse; and

13 (b) Is claimed as a dependent by either spouse under the Internal Revenue Service Code.

14 (5) "DMEPOS" means durable medical equipment, prosthetics, orthotics, and supplies.

15 (6) "Drug" means a covered drug provided in accordance with 907 KAR 23:010 for which the
16 Department for Medicaid Services provides reimbursement.

17 (7) "Enrollee" means a Medicaid recipient who is enrolled with a managed care organization.

18 (8) "Federal Poverty Level" or "FPL" means guidelines that are updated annually in the Fed-
19 eral Register by the United States Department of Health and Human Services under authority of
20 42 U.S.C. 9902(2).

21 (9) "KCHIP" means the Kentucky Children's Health Insurance Program.

22 (10) "KCHIP - Separate Program" means a health benefit program for individuals with eligi-
23 bility determined in accordance with 907 KAR 4:030, Section 2.

1 (11) "Managed care organization" or "MCO" means an entity for which the Department for
2 Medicaid Services has contracted to serve as a managed care organization as defined in 42
3 C.F.R. 438.2.

4 (12) "Medicaid Works individual" means an individual who:

5 (a) But for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B)
6 would be considered to be receiving supplemental security income;

7 (b) Is at least sixteen (16), but less than sixty-five (65), years of age;

8 (c) Is engaged in active employment verifiable with:

9 1. Paycheck stubs;

10 2. Tax returns;

11 3. 1099 forms; or

12 4. Proof of quarterly estimated tax;

13 (d) Meets the income standards established in 907 KAR 20:020; and

14 (e) Meets the resource standards established in 907 KAR 20:025.

15 (13) "Nonemergency" means a condition which does not require an emergency service pursu-
16 ant to 42 C.F.R. 447.54[447.53].

17 (14) "Nonpreferred brand name drug" means a brand name drug that is not on the depart-
18 ment's preferred drug list.

19 (15) "Preferred brand name drug" means a brand name drug:

20 (a) For which no generic equivalent exists which has a more favorable cost to the department;
21 and

22 (b) Which prescribers are encouraged to prescribe, if medically appropriate.

23 (16) "Preventive service" means:

1 (a)1. All of the preventive services assigned a grade of A or B by the United States Preventive
2 Services Task Force (USPSTF); or

3 2. All approved adult vaccines, including their administration, recommended by the Advisory
4 Committee on Immunization Practices;

5 (b) Preventive care and screening for infants, children, and adults recommended by the Health
6 Resources and Services Administration Bright Futures Program Project; or

7 (c) Preventive services for women recommended by the Institute of Medicine.

8 (17) "Recipient" is defined in KRS 205.8451(9).

9 (18) "Transitional medical assistance" or "TMA" means an extension of Medicaid benefits in
10 accordance with 907 KAR 20:005, Section 5(5).

11 Section 2. Copayments. (1) The following table shall establish the:

12 (a) Copayment amounts that a recipient shall pay, unless the recipient is exempt from cost
13 sharing pursuant to Section 3(1) of this administrative regulation; and

14 (b) Corresponding provider reimbursement deductions.

Benefit	Copayment Amount
Acute inpatient hospital admission	\$50
Outpatient hospital or ambulatory surgical center visit	\$4
[Generic prescription drug]	[\$1]
[Preferred brand name]	[\$4]

drug]	
[Nonpreferred brand name drug]	[\$8]
Emergency room for a nonemergency visit	\$8
DMEPOS	\$4
Podiatry office visit	\$3
Chiropractic office visit	\$3
Dental office visit	\$3
Optometry office visit	\$3
General ophthalmological office visit	\$3
Physician office visit	\$3
Office visit for care by a physician assistant, an ad- vanced practice registered nurse, a certified pediatric and family nurse practi- tioner, or a nurse midwife	\$3
Office visit for behavioral health care	\$3
Office visit to a rural health clinic	\$3

Office visit to a federally qualified health center or a federally qualified health center look-alike	\$3
Office visit to a primary care center	\$3
Physical therapy office visit	\$3
Occupational therapy office visit	\$3
Speech-language pathology services office visit	\$3
Laboratory, diagnostic, or radiological service	\$3
<u>A Medicaid or KCHIP beneficiary who is younger than nineteen (19) years of age.</u>	<u>\$0</u>
<u>Brand name drug</u>	<u>\$4</u>
<u>Generic drug</u>	<u>\$1</u>
<u>Brand name drug preferred over generic drug</u>	<u>\$1</u>
<u>Pharmacy product class:</u>	<u>\$1</u>

<u>certain antipsychotic drug</u>	
<u>Pharmacy product class:</u> <u>contraceptives for family</u> <u>planning</u>	<u>\$0</u>
<u>Pharmacy product class:</u> <u>tobacco cessation</u>	<u>\$0</u>
<u>Pharmacy product class:</u> <u>diabetes supplies, blood</u> <u>glucose meters</u>	<u>\$0</u>
<u>Pharmacy product class:</u> <u>Diabetes supplies, all other</u> <u>covered diabetic supplies</u>	<u>\$4 for first</u> <u>fill, \$0 for</u> <u>second fill</u> <u>and beyond,</u> <u>per day</u>
<u>Pharmacy patient attribute:</u> <u>pregnant</u>	<u>\$0</u>
<u>Pharmacy patient attribute:</u> <u>long-term care resident</u>	<u>\$0</u>
<u>Pharmacy patient attribute:</u> <u>under eighteen (18) years</u> <u>of age, and not a KCHIP</u> <u>beneficiary.</u>	<u>\$0</u>
<u>KI-HIPP participant</u>	<u>\$0</u>

<u>Kentucky HEALTH: Med- ically Frail</u>	<u>\$0</u>
<u>Kentucky HEALTH: For- mer Foster Care Youth up to 26 years of age</u>	<u>\$0</u>
<u>Kentucky HEALTH: enrol- lee current on premiums</u>	<u>\$0</u>

(2) The full amount of the copayment established in the table in subsection (1) of this section shall be deducted from the provider reimbursement.

(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

Section 3. Copayment General Provisions and Exemptions. (1) A Medicaid or KCHIP beneficiary who is younger than nineteen (19) years of age shall be exempt from the copayment or cost-sharing requirements established pursuant to this administrative regulation.

~~(2)(a)[(a) Except for a foster care child, a recipient shall not be exempt from paying the eight (8) dollar copayment for a nonpreferred brand name drug prescription.~~

~~—(b)] A copayment shall not be imposed for a service, prescription, item, supply, equipment, or any type of Medicaid benefit provided to a foster care child.~~

~~(b)[(e) Except for the mandatory copayment referenced in paragraph (a) of this subsection,]~~
The department shall impose no cost sharing for an individual or recipient who is exempt pursuant to 42 C.F.R. 447.56.~~[the following:~~

~~—1. A service furnished to an individual who has reached his or her 18th birthday, but has not~~

1 ~~turned nineteen (19), and who is required to be provided medical assistance under 42 U.S.C.~~
2 ~~1396a(a)(10)(A)(i)(I), including services furnished to an individual with respect to whom aid or~~
3 ~~assistance is made available under Title IV, Part B (42 U.S.C. 620 to 629i) to children in foster~~
4 ~~care and individuals with respect to whom adoption or foster care assistance is made available~~
5 ~~under Title IV, Part E (42 U.S.C. 670 to 679b), without regard to age;~~

6 ~~—2. A preventive service;~~

7 ~~—3. A service furnished to a pregnant woman;~~

8 ~~—4. A service furnished to a terminally ill individual who is receiving hospice care as defined in~~
9 ~~42 U.S.C. 1396d(o);~~

10 ~~—5. A service furnished to an individual who is an inpatient in a hospital, nursing facility, in-~~
11 ~~termediate care facility for individuals with an intellectual disability, or other medical institution,~~
12 ~~if the individual is required, as a condition of receiving services in the institution under Ken-~~
13 ~~tucky's Medicaid Program, to spend for costs of medical care all but a minimal amount of the in-~~
14 ~~dividual's income required for personal needs;~~

15 ~~—6. An emergency service as defined by 42 C.F.R. 447.53;~~

16 ~~—7. A family planning service or supply as described in 42 U.S.C. 1396d (a)(4)(C); or~~

17 ~~—8. A service furnished to a woman who is receiving medical assistance via the application of~~
18 ~~42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa).~~

19 ~~—(2) The department has determined that any individual liable for a copayment shall:~~

20 ~~—(a) Be able to pay a required copayment; and~~

21 ~~—(b) Be responsible for a required copayment.]~~

22 (3) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined in
23 42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor or agent of a

1 pharmaceutical manufacturer, shall not make a copayment for a recipient.

2 (4) A parent or guardian shall be responsible for a copayment imposed on a dependent child
3 under the age of twenty-one (21).

4 (5) Any amount of uncollected copayment by a provider from a recipient shall be considered a
5 debt to the provider.

6 (6)~~[(a)]~~ A provider shall:

7 (a)[1-] Collect from a recipient the copayment as imposed by the department for a recipient in
8 accordance with this administrative regulation;

9 (b)[2-] Not waive a copayment obligation as imposed by the department for a recipient; and

10 (c)[3-] Collect a copayment at the time a benefit is provided or at a later date.

11 ~~[(b) Regarding a service or item for an enrollee in which the managed care organization in
12 which the enrollee is enrolled does not impose a copayment, the provider shall not collect a co-
13 payment from the enrollee.]~~

14 (7) Cumulative cost sharing for copayments for a family with children who receive benefits
15 under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be limited to five (5) percent of the annual
16 family income.

17 (8) In accordance with 42 C.F.R. 447.15 and 447.20~~[447.82]~~, the department shall not in-
18 crease its reimbursement to a provider to offset an uncollected copayment from a recipient.

19 Section 4. Premiums for Medicaid Works Individuals. (1)(a) A Medicaid Works individual
20 shall pay a monthly premium that is:

- 21 1. Based on income used to determine eligibility for the program; and
- 22 2. Established in subsection (2) of this section.

23 (b) The monthly premium shall be:

1 1. Thirty-five (35) dollars for an individual whose income is greater than 100 percent but no
2 more than 150 percent of the FPL;

3 2. Forty-five (45) dollars for an individual whose income is greater than 150 percent but no
4 more than 200 percent of the FPL; and

5 3. Fifty-five (55) dollars for an individual whose income is greater than 200 percent but no
6 more than 250 percent of the FPL.

7 (2) An individual whose family income is equal to or below 100 percent of the FPL shall not
8 be required to pay a monthly premium.

9 (3) A Medicaid Works individual shall begin paying a premium with the first full month of
10 benefits after the month of application.

11 (4) Benefits shall be effective with the date of application if the premium specified in subsec-
12 tion (1) of this section has been paid.

13 (5) Retroactive eligibility pursuant to 907 KAR 20:010, Section 1(3), shall not apply to a
14 Medicaid Works individual.

15 (6) If a recipient fails to make two (2) consecutive premium payments, benefits shall be dis-
16 continued at the end of the first benefit month for which the premium has not been paid.

17 (7) A Medicaid Works individual shall be eligible for reenrollment upon payment of the
18 missed premium providing all other technical eligibility, income, and resource standards contin-
19 ue to be met.

20 (8) If twelve (12) months have elapsed since a missed premium, a Medicaid Works individual
21 shall not be required to pay the missed premium before reenrolling.

22 Section 5. Provisions for Enrollees. A managed care organization shall[-

23 ~~—(1) Shall]~~ not impose a copayment on an enrollee that exceeds a copayment established in this

administrative regulation[; and

—(2) May impose on an enrollee:

—(a) A lower copayment than established in this administrative regulation; or

—(b) No copayment].

Section 6. Freedom of Choice. (1) In accordance with 42 C.F.R. 431.51, a recipient who is not an enrollee may obtain services from any qualified provider who is willing to provide services to that particular recipient.

(2) A managed care organization may restrict an enrollee's choice of providers to the providers in the provider network of the managed care organization in which the enrollee is enrolled except as established in:

(a) 42 C.F.R. 438.52; or

(b) 42 C.F.R. 438.114(c).

Section 7. Appeal Rights. An appeal of a department decision regarding the Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

Section 8. Applicability of Title 895 KAR. If eligible for Kentucky HEALTH, an individual subject to this administrative regulation shall also comply with any applicable requirements established pursuant to Title 895 KAR, including 895 KAR 1:010[Effective Date. The cost sharing provisions and requirements established in this administrative regulation shall be effective beginning January 1, 2014].

Section 9. Federal Approval and Federal Financial Participation. The department's copayment provisions and any coverage of services established in this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation; and

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

2 Section 10. This administrative regulation was found deficient by the Administrative Regula-
3 tion Review Subcommittee on May 13, 2014.

907 KAR 1:604

REVIEWED:

11/30/18

Date



Carol H. Steckel, Commissioner
Department for Medicaid Services

APPROVED:

12-20-18

Date



Adam M. Meier, Secretary
Cabinet for Health and Family Services

PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall, if requested, be held on February 25, 2019, at 9:00 a.m. in Suites A & B, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 18, 2019, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until February 28, 2019. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Chase Coffey, Executive Administrative Assistant, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, KY 40621; Phone: 502-564-6746; Fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:604

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov;
and Chase Coffey, (502) 564-6746, CHFSRegs@ky.gov

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes the cost sharing requirements and provisions for the Kentucky Medicaid program.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the cost sharing requirements and provisions for the Kentucky Medicaid program.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the cost sharing requirements and provisions for the Kentucky Medicaid program.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the cost sharing requirements and provisions for the Kentucky Medicaid program.
- (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 synchronize co-pay exemptions with federal regulations, include additional co-pays and categories of co-pays, and prohibit MCOs from waiving or reducing Medicaid copays. The amendments also exempt certain Medicaid beneficiaries and KCHIP beneficiaries from paying copayments, and update the amount and types of copayments required for beneficiaries to pay. The amendments exempt various types of Kentucky HEALTH beneficiaries, including the medically frail, pregnant women, former foster youth, and individuals who are current on Kentucky HEALTH premiums.
 - (b) The necessity of the amendment to this administrative regulation: The amendments to this administrative regulation are necessary to clarify Medicaid policy relating to copayments and to clarify how certain co-pays should be charged for certain types of visits at certain types of providers.
 - (c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by implementing a copayment requirement, synchronizing co-payment exemptions with the federal regulations, and updating certain copayments.
 - (d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the statutes by instituting a clear policy on the use of copayments and updating certain copayments.
- (3) List the type and number of individuals, businesses, organizations, or state and local

government affected by this administrative regulation: All Medicaid recipients who are not exempt from cost sharing will be affected by the amendment as well as Medicaid providers for whose services cost sharing is applied.

- (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. Enrollees and recipients will be required to remit a copayment when accessing a Medicaid service and that requirement cannot be waived or reduced by an MCO. Providers of services for which cost sharing is imposed will be required to impose cost sharing when providing the given service and recipients are responsible for paying cost sharing.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Enrollees and recipients will have to pay copayments as listed in this administrative regulation. Providers may experience administrative costs resulting from a Medicaid recipient refusing to pay a copayment obligation.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Enrollees and recipients will be able to fully access Medicaid benefits, and providers will be able to charge for services provided.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: The Department for Medicaid Services (DMS) anticipates no additional costs as a result of the amendments to this administrative regulation.
 - (b) On a continuing basis: The Department for Medicaid Services (DMS) anticipates no additional costs as a result of the amendments to 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 Title XIX of the Social Security Act and matching funds from 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 will be necessary to implement the amendment.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation neither establishes nor increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is applied in that some Medicaid recipients are exempt (by federal regulation or law) from most cost sharing obligations.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:604

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov;
and Chase Coffey, (502) 564-6746, CHFSRegs@ky.gov

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(14), 42 U.S.C. 1396o, 42 C.F.R. 447.50 through 447.90, 42 C.F.R. 447.15 and 447.20, and 42 C.F.R. 438.108

2. State compliance standards. KRS 205.520(3) and KRS 194A.050(1).

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(14) authorizes a state's Medicaid program to impose cost sharing only as allowed by 42 U.S.C. 1396o. 42 U.S.C. 1396o establishes categories of individuals for whom a state's Medicaid program may not impose cost sharing as well as cost sharing and premium limits.

42 C.F.R. 447.50 through 447.60 also establishes limits on cost sharing (based on income of the given Medicaid eligibility group); Medicaid populations exempt from cost sharing (children, pregnant women, institutionalized individuals for example); services exempt from cost sharing (emergency services, family planning services to child-bearing age individuals); prohibition against multiple cost sharing for one (1) service; and a requirement that managed care organizations' cost sharing must comply with the aforementioned federal regulations.

42 C.F.R. 438.108 establishes that a managed care organization's cost sharing must comply with the federal cost sharing requirements for Medicaid established in 42 C.F.R. 447.50 through 42 C.F.R. 447.90.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 1:604

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov;
and Chase Coffey, (502) 564-6746, CHFSRegs@ky.gov

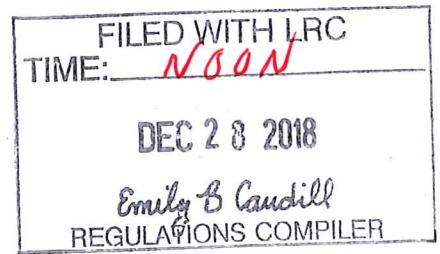
1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be affected by the amendment to this administrative regulation.
2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. Federal regulations 42 C.F.R. 447.50 through 42 C.F.R. 447.90, 42 C.F.R. 447.15 and 447.20, and this administrative regulation authorize the action taken by this administrative regulation.
3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
 - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS does not expect the amendment to this administrative regulation 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? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.
 - (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) anticipates no additional costs as a result of the amendments to this administrative regulation.
 - (d) How much will it cost to administer this program for subsequent years? The Department for Medicaid Services (DMS) anticipates no additional costs as a result of the amendments to this administrative regulation.

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:



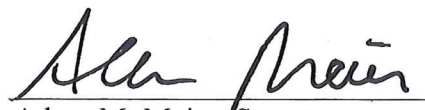
STATEMENT OF EMERGENCY

907 KAR 1:604E

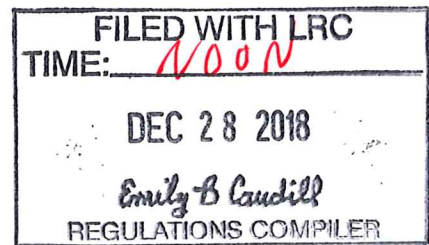
This emergency administrative regulation is being promulgated to implement copayment requirements and to clarify how copayments should be charged for certain types of health care encounters. This emergency administrative regulation is needed pursuant to KRS 13A.190(1)(a)2. to prevent a loss of federal and state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation. The ordinary administrative regulation is identical to this emergency administrative regulation.



Matthew G. Bevin
Governor



Adam M. Meier, Secretary
Cabinet for Health and Family Services



1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (Amendment)

5 907 KAR 3:170. Telehealth service~~[consultation]~~ coverage and reimbursement.

6 RELATES TO: KRS 194A.060, 194A.125, 205.510(15), 205.559, 205.560, 304.38-240,
7 422.317, 434.840-434.860, 42 C.F.R. 160, 162, 164, 415.174, 400.203, 415.184, 431.300-
8 431.307, 440.50, 455.440, 45 C.F.R. 162.406

9 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.559(2), (7),
10 205.560

11 NECESSITY, FUNCTION, AND CONFORMITY: In accordance with KRS 194A.030(2),
12 the Cabinet for Health and Family Services, Department for Medicaid Services, has responsibil-
13 ity to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administra-
14 tive regulation, to comply with any requirement that may be imposed or opportunity presented
15 by federal law to qualify for federal Medicaid funds. KRS 205.559 establishes the requirements
16 regarding Medicaid reimbursement of telehealth providers and KRS 205.559(2) and (7) require
17 the cabinet to promulgate an administrative regulation relating to telehealth ser-
18 vices~~[consultations]~~ and reimbursement. This administrative regulation establishes the Depart-
19 ment for Medicaid Services' coverage and reimbursement policies relating to telehealth ser-
20 vices~~[consultations]~~ in accordance with KRS 205.559.

21 Section 1. Definitions. (1) [~~"Advanced practice registered nurse" or "APRN" is defined by~~

1 KRS 314.011(7). (2) "Certified nutritionist" is defined by KRS 310.005(12).

2 ~~—(3) "Chiropractor" is defined by KRS 312.015(3).~~

3 ~~—(4) "Community mental health center" or "CMHC" means a facility that provides a compre-~~
4 ~~hensive range of mental health services to Medicaid recipients of a designated area in accordance~~
5 ~~with KRS 210.370 to 210.485.~~

6 ~~—(5)] "Department" means the Department for Medicaid Services or its designated agent.~~

7 ~~[(6) "Diabetes self-management training consultation" means the ongoing process of facilitat-~~
8 ~~ing the knowledge, skill, and ability necessary for diabetes self-care.~~

9 ~~—(7) "Direct physician contact" means that the billing physician is physically present with and~~
10 ~~evaluates, examines, treats, or diagnoses the recipient.~~

11 ~~—(8) "Encounter" means one (1) visit by a recipient to a telehealth spoke site where the recipi-~~
12 ~~ent receives a telehealth consultation in real time, during the visit, from a telehealth provider or~~
13 ~~telehealth practitioner at a telehealth hub site.]~~

14 ~~(2)[(9)] "Face-to-face" means[, except as established in Section 4(4)(g) of this administrative~~
15 ~~regulation]:~~

16 (a) In person; and

17 (b) Not via telehealth.

18 ~~(3)[(10)] "Federal financial participation" is defined in 42 C.F.R. 400.203.~~

19 ~~(4) "Health Insurance Portability and Accountability Act of 1996" or "HIPAA" means the~~
20 ~~federal law codified at 45 C.F.R. Parts 160, 162, and 164 that covers the use of a patient's pro-~~
21 ~~tected health information.~~

22 ~~[—(11) "GT modifier" means a modifier that identifies a telehealth consultation which is ap-~~
23 ~~proved by the healthcare common procedure coding system (HCPCS).~~

1 ~~—(12) "Health care provider" means a Medicaid provider who is:~~

2 ~~—(a) Currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672; and~~

3 ~~—(b) Currently participating as a Medicaid provider in accordance with 907 KAR 1:671.~~

4 ~~—(13) "Hub site" means a telehealth site:~~

5 ~~—(a) Where the telehealth provider or telehealth practitioner performs telehealth; and~~

6 ~~—(b) That is considered the place of service.~~

7 ~~—(14) "Legally authorized representative" means a Medicaid recipient's parent or guardian if a~~
8 ~~recipient is a minor child, or a person with power of attorney for a recipient.~~

9 ~~—(15) "Licensed clinical social worker" means an individual meeting the licensure requirements~~
10 ~~established in KRS 335.100.~~

11 ~~—(16) "Licensed dietitian" is defined by KRS 310.005(11).~~

12 ~~—(17) "Licensed marriage and family therapist" is defined by KRS 335.300(2).~~

13 ~~—(18) "Licensed professional clinical counselor" is defined by KRS 335.500(3).]~~

14 (5)[(19)] "Medical necessity" or "medically necessary" means a covered benefit is determined
15 to be needed in accordance with 907 KAR 3:130 or pursuant to the process established in KRS
16 304.38-240.

17 (6)[(20)] "National Provider Identifier" or "NPI" means a standard unique health identifier for
18 health care providers which:

19 (a) Is required by 42 C.F.R. 455.440; and

20 (b) Meets the requirements of 45 C.F.R. 162.406.

21 (7) "Place of service" means the originating site, where the patient is located, of a telehealth
22 service as defined by Kentucky or federal law.

23 (8) "Telehealth" includes the delivery of HIPAA compliant health care services and public

1 health via information and communication technologies or use of other electronic media to facili-
2 tate the diagnosis, consultation, treatment, education, care management, and self-management of
3 a patient's health care and includes remote patient monitoring, synchronous interactions and
4 asynchronous store and forward transfers of images and data.

5 (9) "Telehealth care provider" means a Medicaid provider who is:

6 (a) Currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672; and

7 (b) Currently participating as a Medicaid provider in accordance with 907 KAR 1:671.

8 (10) "Telehealth service" means any:

9 (a) Event;

10 (b) Encounter;

11 (c) Consultation;

12 (d) Visit;

13 (e) Store and forward transfer;

14 (f) Remote patient monitoring;

15 (g) Referral;

16 (h) Treatment; or

17 (i) Other healthcare activity between a:

18 1. Telehealth care provider and Medicaid beneficiary; or

19 2. Telehealth care provider and specialist with regard to a Medicaid beneficiary, including
20 services offered direct to patient.

21 ~~[(21) "Occupational therapist" is defined by KRS 319A.010(3).~~

22 ~~—(22) "Optometrist" means an individual licensed to engage in the practice of optometry in ac-~~
23 ~~cordance with KRS 320.210(2).~~

- 1 ~~—(23) "Physical therapist" is defined by KRS 327.010(2).~~
- 2 ~~—(24) "Physician" is defined by KRS 311.550(12).~~
- 3 ~~—(25) "Physician assistant" is defined by KRS 311.840(3).~~
- 4 ~~—(26) "Psychologist" is defined by KRS 319.010(9).~~
- 5 ~~—(27) "Registered nurse" is defined by KRS 314.011(5).~~
- 6 ~~—(28) "Speech language pathologist" is defined by KRS 334A.020(3).~~
- 7 ~~—(29) "Spoke site" means a telehealth site where the recipient receiving the telehealth consulta-~~
8 ~~tion is located.~~
- 9 ~~—(30) "Telehealth consultation" is defined by KRS 205.510(15).~~
- 10 ~~—(31) "Telehealth practitioner" means an individual who is:~~
- 11 ~~—(a) Authorized to perform a telehealth consultation in accordance with this administrative~~
12 ~~regulation;~~
- 13 ~~—(b) Employed by or is an agent of a telehealth provider; and~~
- 14 ~~—(c) Not the individual or entity who:~~
- 15 ~~—1. Bills the department for a telehealth consultation; or~~
- 16 ~~—2. Is reimbursed by the department for a telehealth consultation.~~
- 17 ~~—(32) "Telehealth provider" means a health care provider who:~~
- 18 ~~—(a) Performs a telehealth consultation at a hub site; or~~
- 19 ~~—(b) Is the employer of or entity that contracts with a telehealth practitioner who performs a~~
20 ~~telehealth consultation:~~
- 21 ~~—1. At a hub site; and~~
- 22 ~~—2. That is billed under the telehealth provider's national provider identifier.~~
- 23 ~~—(33) "Telehealth site" means a hub site or spoke site that has been approved as part of a tele-~~

health network established in accordance with KRS 194A.125.

~~—(34) "Telepresenter" means an individual operating telehealth equipment at a spoke site to enable a recipient to receive a telehealth consultation.~~

~~—(35) "Transmission cost" means the cost of the telephone line and related costs incurred during the time of the transmission of a telehealth consultation.~~

~~—(36) "Two (2) way interactive video" means a type of advanced telecommunications technology that permits a real time telehealth consultation to take place between a recipient and a telepresenter at the spoke site and a telehealth provider or telehealth practitioner at the hub site.]~~

Section 2. General Policies. (1)(a) Except as provided in paragraph (b) of this subsection, the coverage policies established in this administrative regulation shall apply to:

1. Medicaid services for individuals not enrolled in a managed care organization; and

2. A managed care organization's coverage of Medicaid services for individuals enrolled in the managed care organization for the purpose of receiving Medicaid or Kentucky Children's Health Insurance Program services.

(b) A managed care organization shall ~~[not be required to]~~ reimburse the same amount for a telehealth service~~[consultation]~~ as the department reimburses unless a different payment rate is negotiated~~[, but may reimburse the same as the department reimburses if the managed care organization chooses to do so].~~

(2) A telehealth service~~[consultation]~~ shall not be reimbursed by the department if:

(a) It is not medically necessary;

(b) The equivalent service is not covered by the department if provided in a face-to-face setting;

(c) ~~[It requires a face-to-face contact with a recipient in accordance with 42 C.F.R. 447.371;~~

1 ~~—(d)]~~The telehealth care provider of the telehealth service~~[consultation]~~ is:

2 1. Not currently enrolled in the Medicaid program pursuant to 907 KAR 1:672;

3 2. Not currently participating in the Medicaid program pursuant to 907 KAR 1:671;

4 3. Not in good standing with the Medicaid program;

5 4. Currently listed on the Kentucky DMS Provider Terminated and Excluded Provider List [~~of~~
6 ~~Excluded Providers~~], which is available at

7 <https://chfs.ky.gov/agencies/dms/dpi/pe/Pages/terminated.aspx>~~[<http://chfs.ky.gov/dms/provEnr>];~~

8 or

9 5. Currently listed on the United States Department of Health and Human Services, Office of
10 Inspector General List of Excluded Individuals and Entities, which is available at
11 <https://oig.hhs.gov/exclusions/>~~[; or~~

12 ~~—(e) It is provided by a telehealth practitioner or telehealth provider not recognized or author-~~
13 ~~ized by the department to provide the telehealth consultation or equivalent service in a face-to-~~
14 ~~face setting.]~~

15 (3)(a) [A telehealth provider shall:

16 ~~—1. Be an approved member of the Kentucky Telehealth Network; and~~

17 ~~—2. Comply with the standards and protocols established by the Kentucky Telehealth Board.~~

18 ~~—(b) To become an approved member of the Kentucky Telehealth Network, a provider shall:~~

19 ~~—1. Send a written request to the Kentucky Telehealth Board requesting membership in the~~
20 ~~Kentucky Telehealth Network; and~~

21 ~~—2. Be approved by the Kentucky Telehealth Board as a member of the Kentucky Telehealth~~
22 ~~Network.~~

23 ~~—(4)(a) A telehealth consultation referenced in Section 3 or 4 of this administrative regulation~~

1 shall be provided to the same extent and with the same coverage policies and restrictions that ap-
2 ply, except as established in Section 4(4)(g) and 4(5) of this administrative regulation to the
3 equivalent service if provided in a face-to-face setting.

4 —(b) If a telehealth coverage policy or restriction is not stated in this administrative regulation
5 but is stated in another administrative regulation within Title 907 of the Kentucky Administrative
6 Regulations, the coverage policy or restriction stated elsewhere within Title 907 of the Kentucky
7 Administrative Regulations shall apply.

8 —(5)(a) A telehealth service[~~consultation~~] shall be subject to utilization review for:

- 9 1. Medical necessity;
- 10 2. Compliance with this administrative regulation; and
- 11 3. Compliance with applicable state and federal law.

12 (b) The department shall not reimburse for a telehealth service if the department determines
13 that a telehealth service[~~consultation~~] is not:

- 14 1. [Not] Medically necessary;[~~is not~~]
- 15 2. Compliant with this administrative regulation;
- 16 3. Applicable to this administrative regulation;[~~is~~] or [~~is not~~]
- 17 4. Compliant with applicable state or federal law[~~, the department shall not reimburse for the~~
18 ~~telehealth consultation~~].

19 (c) The department shall recoup the reimbursement for a previously reimbursed telehealth
20 service if the department determines that a telehealth service[~~consultation that it has already re-~~
21 ~~imbursed for~~] was not:

- 22 1. Medically necessary;[~~was not~~]
- 23 2. Compliant with this administrative regulation;

1 3. Applicable to this administrative regulation;¹~~;~~ or ~~[was not]~~

2 4. Compliant with applicable state or federal law~~[, the department shall recoup the reim-~~
3 ~~bursement for the telehealth consultation from the provider].~~

4 ~~[(6) A telehealth consultation shall require:~~

5 ~~—(a) The use of two (2) way interactive video;~~

6 ~~—(b) A referral by a health care provider; and~~

7 ~~—(c) A referral by a recipient's lock-in provider if the recipient is locked in pursuant to:~~

8 ~~—1. 42 C.F.R. 431.54; and~~

9 ~~—2. 907 KAR 1:677.]~~

10 Section 3. Telehealth Reimbursement. (1)(a) Until July 1, 2020, the department shall reim-
11 burse an eligible telehealth care provider for a telehealth service in an amount equal to the
12 amount paid for a comparable in-person service unless a managed care organization and provider
13 establish a different rate.

14 (b) After July 1, 2020, the department shall reimburse an eligible telehealth care provider for a
15 telehealth service in an amount that is at least eighty-five (85) percent of the amount paid for a
16 comparable in-person service unless a managed care organization and provider establish a differ-
17 ent rate.

18 (c) It is the department's goal that the enhanced amount reimbursed until July 1, 2020 allows
19 for Kentucky Medicaid providers to:

20 1. Educate patients about the availability of expanded telehealth services; and

21 2. Purchase, expand, and implement any technological upgrades needed to more fully adopt
22 the use of telehealth services.

23 (2) The department shall not be liable for reimbursing a practitioner who is employed by a

1 provider or is an agent of a provider.

2 (3) A provider shall appropriately denote telehealth services by place of service, modifiers or
3 other means as designated by the department or as required in a managed care organization's
4 contract with the provider or member.~~[Consultation Coverage in a Setting That is Not a Commu-~~
5 ~~nity Mental Health Center. (1) The policies in this section shall apply to a telehealth consultation~~
6 ~~provided in a setting that is not a community mental health center.~~

7 ~~—(2) The following telehealth consultations shall be covered by the department as follows:~~

8 ~~—(a) A physical health evaluation or management consultation provided by:~~

9 ~~—1. A physician including a physician:~~

10 ~~—a. With an individual physician practice;~~

11 ~~—b. Who belongs to a group physician practice; or~~

12 ~~—c. Who is employed by a federally-qualified health center, federally-qualified health center~~
13 ~~look-alike, rural health clinic, or primary care center;~~

14 ~~—2. An advanced practice registered nurse including an advanced practice registered nurse:~~

15 ~~—a. With an individual advanced practice registered nurse practice;~~

16 ~~—b. Who belongs to a group advanced practice registered nurse practice; or~~

17 ~~—c. Who is employed by a physician, federally-qualified health center, federally-qualified~~
18 ~~health center look-alike, rural health clinic, or primary care center;~~

19 ~~—3. An optometrist; or~~

20 ~~—4. A chiropractor;~~

21 ~~—(b) A mental health evaluation or management service provided by:~~

22 ~~—1. A psychiatrist;~~

23 ~~—2. A physician in accordance with the limit established in 907 KAR 3:005;~~

- 1 ~~—3. An APRN in accordance with the limit established in 907 KAR 1:102;~~
- 2 ~~—4. A psychologist:~~
- 3 ~~—a. With a license in accordance with KRS 319.010(6);~~
- 4 ~~—b. With a doctorate degree in psychology;~~
- 5 ~~—c. Who is directly employed by a psychiatrist; and~~
- 6 ~~—d. If:~~
- 7 ~~—(i) The psychiatrist by whom the psychologist is directly employed also interacts with the re-~~
- 8 ~~cipient during the encounter; and~~
- 9 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the psy-~~
- 10 ~~chologist is directly employed;~~
- 11 ~~—5. A licensed professional clinical counselor:~~
- 12 ~~—a. Who is directly employed by a psychiatrist; and~~
- 13 ~~—b. If:~~
- 14 ~~—(i) The psychiatrist by whom the licensed professional clinical counselor is directly employed~~
- 15 ~~also interacts with the recipient during the encounter; and~~
- 16 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the li-~~
- 17 ~~censed professional clinical counselor is directly employed;~~
- 18 ~~—6. A licensed clinical social worker:~~
- 19 ~~—a. Who is directly employed by a psychiatrist; and~~
- 20 ~~—b. If:~~
- 21 ~~—(i) The psychiatrist by whom the licensed clinical social worker is directly employed also in-~~
- 22 ~~teracts with the recipient during the encounter; and~~
- 23 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the li-~~

1 ~~icensed clinical social worker is directly employed; or~~
2 ~~—7. A licensed marriage and family therapist:~~
3 ~~—a. Who is directly employed by a psychiatrist; and~~
4 ~~—b. If:~~
5 ~~—(i) The psychiatrist by whom the licensed marriage and family therapist is directly employed~~
6 ~~also interacts with the recipient during the encounter; and~~
7 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the li-~~
8 ~~censed marriage and family therapist is directly employed;~~
9 ~~—(c) Individual or group psychotherapy provided by:~~
10 ~~—1. A psychiatrist;~~
11 ~~—2. A physician in accordance with the limit established in 907 KAR 3:005;~~
12 ~~—3. An APRN in accordance with the limit established in 907 KAR 1:102;~~
13 ~~—4. A psychologist:~~
14 ~~—a. With a license in accordance with KRS 319.010(6);~~
15 ~~—b. With a doctorate degree in psychology;~~
16 ~~—c. Who is directly employed by a psychiatrist; and~~
17 ~~—d. If:~~
18 ~~—(i) The psychiatrist by whom the psychologist is directly employed also interacts with the re-~~
19 ~~cipient or recipients during the encounter; and~~
20 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the psy-~~
21 ~~chologist is directly employed;~~
22 ~~—5. A licensed professional clinical counselor:~~
23 ~~—a. Who is directly employed by a psychiatrist; and~~

1 ~~—b. If:~~

2 ~~—(i) The psychiatrist by whom the licensed professional clinical counselor is directly employed~~
3 ~~also interacts with the recipient or recipients during the encounter; and~~

4 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the li-~~
5 ~~censed professional clinical counselor is directly employed;~~

6 ~~—6. A licensed clinical social worker:~~

7 ~~—a. Who is directly employed by a psychiatrist; and~~

8 ~~—b. If:~~

9 ~~—(i) The psychiatrist by whom the licensed clinical social worker is directly employed also in-~~
10 ~~teracts with the recipient or recipients during the encounter; and~~

11 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the li-~~
12 ~~censed clinical social worker is directly employed; or~~

13 ~~—7. A licensed marriage and family therapist:~~

14 ~~—a. Who is directly employed by a psychiatrist; and~~

15 ~~—b. If:~~

16 ~~—(i) The psychiatrist by whom the licensed marriage and family therapist is directly employed~~
17 ~~also interacts with the recipient or recipients during the encounter; and~~

18 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the li-~~
19 ~~censed marriage and family therapist is directly employed;~~

20 ~~—(d) Pharmacologic management provided by:~~

21 ~~—1. A physician in accordance with the limit established in 907 KAR 3:005;~~
22 ~~—2. An APRN in accordance with the limit established in 907 KAR 1:102; or~~
23 ~~—3. A psychiatrist;~~

1 ~~—(e) A psychiatric, psychological, or mental health diagnostic interview examination provided~~
2 ~~by:~~
3 ~~—1. A psychiatrist;~~
4 ~~—2. A physician in accordance with the limit established in 907 KAR 3:005;~~
5 ~~—3. An APRN in accordance with the limit established in 907 KAR 1:102;~~
6 ~~—4. A psychologist:~~
7 ~~—a. With a license in accordance with KRS 319.010(6);~~
8 ~~—b. With a doctorate degree in psychology;~~
9 ~~—c. Who is directly employed by a psychiatrist; and~~
10 ~~—d. If:~~
11 ~~—(i) The psychiatrist by whom the psychologist is directly employed also interacts with the re-~~
12 ~~cipient during the encounter; and~~
13 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the psy-~~
14 ~~chologist is directly employed;~~
15 ~~—5. A licensed professional clinical counselor:~~
16 ~~—a. Who is directly employed by a psychiatrist; and~~
17 ~~—b. If:~~
18 ~~—(i) The psychiatrist by whom the licensed professional clinical counselor is directly employed~~
19 ~~also interacts with the recipient during the encounter; and~~
20 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the li-~~
21 ~~censed professional clinical counselor is directly employed;~~
22 ~~—6. A licensed clinical social worker:~~
23 ~~—a. Who is directly employed by a psychiatrist; and~~

1 ~~—b. If:~~

2 ~~—(i) The psychiatrist by whom the licensed clinical social worker is directly employed also in-~~
3 ~~teracts with the recipient during the encounter; and~~

4 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the li-~~
5 ~~censed clinical social worker is directly employed; or~~

6 ~~—7. A licensed marriage and family therapist:~~

7 ~~—a. Who is directly employed by a psychiatrist; and~~

8 ~~—b. If:~~

9 ~~—(i) The psychiatrist by whom the licensed marriage and family therapist is directly employed~~
10 ~~also interacts with the recipient during the encounter; and~~

11 ~~—(ii) The telehealth consultation is billed under the NPI of the psychiatrist by whom the li-~~
12 ~~censed marriage and family therapist is directly employed;~~

13 ~~—(f) Individual medical nutrition therapy consultation services provided by a:~~

14 ~~—1. Licensed dietitian:~~

15 ~~—a. Who is directly employed by a physician, federally qualified health care center, rural health~~
16 ~~clinic, primary care center, a hospital's outpatient department, or the Department for Public~~
17 ~~Health; and~~

18 ~~—b. If the telehealth consultation is billed under the:~~

19 ~~—(i) NPI of the physician, federally qualified health care center, rural health clinic, hospital's~~
20 ~~outpatient department, or primary care center by whom the licensed dietitian is directly em-~~
21 ~~ployed; or~~

22 ~~—(ii) Department for Public Health if the licensed dietitian works for the Department for Public~~
23 ~~Health; or~~

1 ~~—2. Certified nutritionist:~~

2 ~~—a. Who is directly employed by a physician, federally qualified health care center, rural health~~

3 ~~clinic, primary care center, a hospital's outpatient department, or the Department for Public~~

4 ~~Health; and~~

5 ~~—b. If the telehealth consultation is billed under the:~~

6 ~~—(i) NPI of the physician, federally qualified health care center, rural health clinic, hospital's~~

7 ~~outpatient department, or primary care center by whom the certified nutritionist is directly em-~~

8 ~~ployed; or~~

9 ~~—(ii) Department for Public Health if the certified nutritionist works for the Department for~~

10 ~~Public Health;~~

11 ~~—(g) Individual diabetes self-management training consultation if:~~

12 ~~—1. Ordered by a:~~

13 ~~—a. Physician;~~

14 ~~—b. APRN directly employed by a physician; or~~

15 ~~—c. Physician assistant directly employed by a physician;~~

16 ~~—2. Provided by a:~~

17 ~~—a. Physician;~~

18 ~~—b. APRN directly employed by a physician;~~

19 ~~—c. Physician assistant directly employed by a physician;~~

20 ~~—d. Registered nurse directly employed by a physician; or~~

21 ~~—e. Licensed dietitian directly employed by a physician, federally qualified health care center,~~

22 ~~rural health clinic, primary care center, a hospital's outpatient department, or the Department for~~

23 ~~Public Health; and~~

- 1 ~~—3. The telehealth consultation is billed under the:~~
- 2 ~~—a. NPI of the physician, federally qualified health care center, rural health clinic, hospital's~~
- 3 ~~outpatient department, or primary care center by whom the provider is directly employed; or~~
- 4 ~~—b. Department for Public Health if the provider works for the Department for Public Health;~~
- 5 ~~—(h) An occupational therapy evaluation or treatment provided by an occupational therapist~~
- 6 ~~who is directly employed by a physician:~~
- 7 ~~—1. If direct physician contact occurs during the evaluation;~~
- 8 ~~—2. If the telehealth consultation is billed under the physician's NPI; and~~
- 9 ~~—3. In accordance with the limits established in 907 KAR 3:005;~~
- 10 ~~—(i) An occupational therapy evaluation or treatment provided by an occupational therapist~~
- 11 ~~who is directly employed by or is an agent of a nursing facility:~~
- 12 ~~—1. If the telehealth consultation is billed under the nursing facility's NPI; and~~
- 13 ~~—2. In accordance with the limits established in 907 KAR 1:065;~~
- 14 ~~—(j) An occupational therapy evaluation or treatment provided by an occupational therapist~~
- 15 ~~who is directly employed by or is an agent of a home health agency:~~
- 16 ~~—1. If the telehealth consultation is billed under the home health agency's NPI; and~~
- 17 ~~—2. In accordance with the limits established in 907 KAR 1:030;~~
- 18 ~~—(k) A physical therapy evaluation or treatment provided by a physical therapist who is directly~~
- 19 ~~employed by a physician:~~
- 20 ~~—1. If direct physician contact occurs during the evaluation;~~
- 21 ~~—2. If the telehealth consultation is billed under the physician's NPI; and~~
- 22 ~~—3. In accordance with the limits established in 907 KAR 3:005;~~
- 23 ~~—(l) A physical therapy evaluation or treatment provided by a physical therapist who is directly~~

employed by or is an agent of a hospital's outpatient department:

— 1. If the telehealth consultation is billed under the hospital's outpatient department's NPI; and

— 2. In accordance with the limits established in 907 KAR 10:014;

(m) A physical therapy evaluation or treatment provided by a physical therapist who is directly employed by or is an agent of a home health agency:

— 1. If the telehealth consultation is billed under the home health agency's NPI; and

— 2. In accordance with the limits established in 907 KAR 1:030;

(n) A physical therapy evaluation or treatment provided by a physical therapist who is directly employed by or is an agent of a nursing facility:

— 1. If the telehealth consultation is billed under the nursing facility's NPI; and

— 2. In accordance with the limits established in 907 KAR 1:065;

(o) A speech therapy evaluation or treatment provided by a speech language pathologist who is directly employed by a physician:

— 1. If direct physician contact occurs during the evaluation or treatment;

— 2. If the telehealth consultation is billed under the physician's NPI; and

— 3. In accordance with the limits established in 907 KAR 3:005;

(p) A speech therapy evaluation or treatment provided by a speech language pathologist who is directly employed by or is an agent of a hospital's outpatient department:

— 1. If the telehealth consultation is billed under the hospital's outpatient department's NPI; and

— 2. In accordance with the limits established in 907 KAR 10:014;

(q) A speech therapy evaluation or treatment provided by a speech language pathologist who is directly employed by or is an agent of a home health agency:

— 1. If the telehealth consultation is billed under the home health agency's NPI; and

1 ~~—2. In accordance with the limits established in 907 KAR 1:030;~~
2 ~~—(r) A speech therapy evaluation or treatment provided by a speech language pathologist who~~
3 ~~is directly employed by or is an agent of a nursing facility:~~
4 ~~—1. If the telehealth consultation is billed under the nursing facility's NPI; and~~
5 ~~—2. In accordance with the limits established in 907 KAR 1:065;~~
6 ~~—(s) A neurobehavioral status examination provided by:~~
7 ~~—1. A psychiatrist;~~
8 ~~—2. A physician in accordance with the limit established in 907 KAR 3:005; or~~
9 ~~—3. A psychologist:~~
10 ~~—a. With a license in accordance with KRS 319.010(6);~~
11 ~~—b. With a doctorate degree in psychology; and~~
12 ~~—c. Who is directly employed by a physician or a psychiatrist:~~
13 ~~—(i) In accordance with the limits established in 907 KAR 3:005;~~
14 ~~—(ii) If the physician or psychiatrist by whom the psychologist is directly employed also inter-~~
15 ~~acts with the recipient during the encounter; and~~
16 ~~—(iii) If the telehealth consultation is billed under the NPI of the physician or psychiatrist by~~
17 ~~whom the psychologist is directly employed; or~~
18 ~~—(t) End-stage renal disease monitoring, assessment, or counseling consultations for a home di-~~
19 ~~alysis recipient provided by:~~
20 ~~—1. A physician directly employed by a hospital's outpatient department if the telehealth con-~~
21 ~~sultation is billed under the hospital's outpatient department's NPI; or~~
22 ~~—2. An APRN directly employed by a hospital's outpatient department if the telehealth consul-~~
23 ~~tation is billed under the hospital's outpatient department's NPI.~~

~~Section 4. Telehealth Consultation Coverage in a Community Mental Health Center. (1) The policies in this section shall apply to a telehealth consultation provided via a community mental health center.~~

~~(2) The limits, restrictions, exclusions, or policies:~~

~~(a) Which apply to a service provided face-to-face in a community mental health center shall apply to a telehealth consultation or service provided via telehealth via a community mental health center; and~~

~~(b) Established in 907 KAR 1:044 shall apply to a telehealth consultation or service provided via:~~

~~1. Telehealth; and~~

~~2. A community mental health center.~~

~~(3) The department shall not reimburse for a telehealth consultation provided via a community mental health center if:~~

~~(a) The consultation is not billed under the community mental health center's national provider identifier; or~~

~~(b) The person who delivers the telehealth consultation is not:~~

~~1. Directly employed by the community mental health center; or~~

~~2. An agent of the community mental health center.~~

~~(4) The following telehealth consultations provided via a community mental health center shall be covered by the department as follows:~~

~~(a) A psychiatric diagnostic interview examination provided:~~

~~1. In accordance with 907 KAR 1:044; and~~

~~2. By:~~

- 1 ~~—a. A psychiatrist; or~~
- 2 ~~—b. An APRN who:~~
- 3 ~~—(i) Is certified in the practice of psychiatric mental health nursing; and~~
- 4 ~~—(ii) Meets the requirements established in 201 KAR 20:057;~~
- 5 ~~—(b) A psychological diagnostic interview examination provided:~~
- 6 ~~—1. In accordance with 907 KAR 1:044; and~~
- 7 ~~—2. By:~~
- 8 ~~—a. A psychiatrist; or~~
- 9 ~~—b. A psychologist with a license in accordance with KRS 319.010(6);~~
- 10 ~~—(c) Pharmacologic management provided:~~
- 11 ~~—1. In accordance with 907 KAR 1:044; and~~
- 12 ~~—2. By:~~
- 13 ~~—a. A physician;~~
- 14 ~~—b. A psychiatrist; or~~
- 15 ~~—c. An APRN who:~~
- 16 ~~—(i) Is certified in the practice of psychiatric mental health nursing; and~~
- 17 ~~—(ii) Meets the requirements established in 201 KAR 20:057;~~
- 18 ~~—(d) Group psychotherapy provided:~~
- 19 ~~—1. In accordance with 907 KAR 1:044; and~~
- 20 ~~—2. By:~~
- 21 ~~—a. A psychiatrist;~~
- 22 ~~—b. A psychologist with a license in accordance with KRS 319.010(6);~~
- 23 ~~—c. A licensed professional clinical counselor;~~

- 1 ~~—d. A licensed marriage and family therapist;~~
- 2 ~~—e. A licensed clinical social worker;~~
- 3 ~~—f. A psychiatric registered nurse; or~~
- 4 ~~—g. An APRN who:~~
 - 5 ~~—(i) Is certified in the practice of psychiatric mental health nursing; and~~
 - 6 ~~—(ii) Meets the requirements established in 201 KAR 20:057;~~
- 7 ~~—(e) Mental health evaluation or management emergency services provided:~~
 - 8 ~~—1. In accordance with 907 KAR 1:044; and~~
 - 9 ~~—2. By:~~
 - 10 ~~—a. A psychiatrist;~~
 - 11 ~~—b. A psychologist with a license in accordance with KRS 319.010(6);~~
 - 12 ~~—c. A licensed professional clinical counselor;~~
 - 13 ~~—d. A licensed marriage and family therapist;~~
 - 14 ~~—e. A licensed clinical social worker;~~
 - 15 ~~—f. A psychiatric medical resident;~~
 - 16 ~~—g. A psychiatric registered nurse; or~~
 - 17 ~~—h. An APRN who:~~
 - 18 ~~—(i) Is certified in the practice of psychiatric mental health nursing; and~~
 - 19 ~~—(ii) Meets the requirements established in 201 KAR 20:057;~~
 - 20 ~~—(f) A mental health assessment provided:~~
 - 21 ~~—1. In accordance with 907 KAR 1:044; and~~
 - 22 ~~—2. By a psychologist with a license in accordance with KRS 319.010(6); or~~
 - 23 ~~—(g) Individual psychotherapy provided:~~

1 ~~—1. In accordance with 907 KAR 1:044 except that “face-to-face” shall include two (2) way in-~~
2 ~~teractive video for the purposes of individual psychotherapy provided via a community mental~~
3 ~~health center; and~~

4 ~~—2. By:~~

5 ~~—a. A psychiatrist;~~

6 ~~—b. A psychologist with a license in accordance with KRS 319.010(6);~~

7 ~~—c. A licensed professional clinical counselor;~~

8 ~~—d. A licensed marriage and family therapist;~~

9 ~~—e. A licensed clinical social worker;~~

10 ~~—f. A psychiatric registered nurse; or~~

11 ~~—g. An APRN who:~~

12 ~~—(i) Is certified in the practice of psychiatric mental health nursing; and~~

13 ~~—(ii) Meets the requirements established in 201 KAR 20:057.~~

14 ~~—(5) If a provision established in 907 KAR 1:044 or the material incorporated by reference into~~
15 ~~907 KAR 1:044 is in contrast with subsection (4)(g)1. of this section, the policy established in~~
16 ~~subsection (4)(g)1 of this section shall supersede the contrary statement.~~

17 ~~—Section 5. Reimbursement. (1)(a) The department shall reimburse a telehealth provider who is~~
18 ~~eligible for reimbursement from the department for a telehealth consultation an amount equal to~~
19 ~~the amount paid for a comparable in-person service in accordance with:~~

20 ~~—1. 907 KAR 3:010 if the service was provided:~~

21 ~~—a. By a physician; and~~

22 ~~—b. Not in the circumstances described in subparagraphs 3., 4., 5., or 6. of this paragraph;~~

23 ~~—2. 907 KAR 1:104 if the service was provided:~~

1 —a. By an advanced practice registered nurse; and

2 —b. Not in the circumstances described in subparagraphs 3., 4., 5., or 6. of this paragraph;

3 —3. 907 KAR 1:055 if the service was provided and billed through a federally-qualified health
4 center, federally-qualified health center look-alike, rural health clinic, or primary care center;

5 —4. 907 KAR 10:015 if the service was provided and billed through a hospital outpatient de-
6 partment;

7 —5. 907 KAR 1:031 if the service was provided and billed through a home health agency; or

8 —6. 907 KAR 1:065 if the service was provided and billed through a nursing facility.

9 —(b)1. Reimbursement for a telehealth consultation provided by a practitioner who is employed
10 by a provider or is an agent of a provider shall be a matter between the provider and the practi-
11 tioner.

12 —2. The department shall not be liable for reimbursing a practitioner who is employed by a pro-
13 vider or is an agent of a provider.

14 —(c) A managed care organization shall not be required to reimburse the same amount for a
15 telehealth consultation as the department reimburses, but may reimburse the same amount as the
16 department reimburses if the managed care organization chooses to do so.

17 —(2) A telehealth provider shall bill for a telehealth consultation using the appropriate two (2)
18 letter "GT" modifier.

19 —(3) The department shall not require the presence of a health care provider requesting a tele-
20 health consultation at the time of the telehealth consultation unless it is requested by a telehealth
21 provider or telehealth practitioner at the hub site.

22 —(4) The department shall not reimburse for transmission costs.

23 —Section 6. Confidentiality and Data Integrity. (1) A telehealth consultation shall be performed

~~on a secure telecommunications line or utilize a method of encryption adequate to protect the confidentiality and integrity of the telehealth consultation information.~~

~~—(2) Both a hub site and a spoke site shall use authentication and identification to ensure the confidentiality of a telehealth consultation.~~

~~—(3) A telehealth provider or telehealth practitioner of a telehealth consultation shall implement confidentiality protocols that include:~~

~~—(a) Identifying personnel who have access to a telehealth transmission;~~

~~—(b) Usage of unique passwords or identifiers for each employee or person with access to a telehealth transmission; and~~

~~—(c) Preventing unauthorized access to a telehealth transmission.~~

~~—(4) A telehealth provider's or telehealth practitioner's protocols and guidelines shall be available for inspection by the department upon request.~~

~~—Section 7. Informed Consent. (1) Before providing a telehealth consultation to a recipient, a telehealth provider or telehealth practitioner shall document written informed consent from the recipient and shall ensure that the following written information is provided to the recipient in a format and manner that the recipient is able to understand:~~

~~—(a) The recipient shall have the option to refuse the telehealth consultation at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of a Medicaid benefit to which the recipient is entitled;~~

~~—(b) The recipient shall be informed of alternatives to the telehealth consultation that are available to the recipient;~~

~~—(c) The recipient shall have access to medical information resulting from the telehealth consultation as provided by law;~~

1 ~~—(d) The dissemination, storage, or retention of an identifiable recipient image or other infor-~~
2 ~~mation from the telehealth consultation shall comply with 42 U.S.C. 1301 et seq., 45 C.F.R.~~
3 ~~Parts 160, 162, 164, KRS 205.566, 216.2927, and any other federal law or regulation or state law~~
4 ~~establishing individual health care data confidentiality policies;~~

5 ~~—(e) The recipient shall have the right to be informed of the parties who will be present at the~~
6 ~~spoke site and the hub site during the telehealth consultation and shall have the right to exclude~~
7 ~~anyone from either site; and~~

8 ~~—(f) The recipient shall have the right to object to the video taping of a telehealth consultation.~~

9 ~~—(2) A copy of the signed informed consent shall be retained in the recipient's medical record~~
10 ~~and provided to the recipient or the recipient's legally authorized representative upon request.~~

11 ~~—(3) The requirement to obtain informed consent before providing a telehealth consultation~~
12 ~~shall not apply to an emergency situation if the recipient is unable to provide informed consent~~
13 ~~and the recipient's legally authorized representative is unavailable.~~

14 ~~—Section 8. Medical Records. (1) A request for a telehealth consultation from a health care pro-~~
15 ~~vider and the medical necessity for the telehealth consultation shall be documented in the recipi-~~
16 ~~ent's medical record.~~

17 ~~—(2) A health care provider shall keep a complete medical record of a telehealth consultation~~
18 ~~provided to a recipient and follow applicable state and federal statutes and regulations for medi-~~
19 ~~cal recordkeeping and confidentiality in accordance with KRS 194A.060, 422.317, 434.840—~~
20 ~~434.860, 42 C.F.R. 431.300 to 431.307, and 45 C.F.R. 164.530(j).~~

21 ~~—(3)(a) A medical record of a telehealth consultation shall be maintained in compliance with~~
22 ~~907 KAR 1:672 and 45 C.F.R. 164.530(j).~~

23 ~~—(b) A health care provider shall have the capability of generating a hard copy of a medical~~

1 ~~record of a telehealth consultation.~~

2 ~~—(4) Documentation of a telehealth consultation by the referring health care provider shall be~~
3 ~~included in the recipient's medical record and shall include:~~

4 ~~—(a) The diagnosis and treatment plan resulting from the telehealth consultation and a progress~~
5 ~~note by the referring health care provider if present at the spoke site during the telehealth consul-~~
6 ~~tation;~~

7 ~~—(b) The location of the hub site and spoke site;~~

8 ~~—(c) A copy of the document signed by the recipient indicating the recipient's informed consent~~
9 ~~to the telehealth consultation;~~

10 ~~—(d) Documentation supporting the medical necessity of the telehealth consultation; and~~

11 ~~—(e) The referral order and complete information from the referring health care provider who~~
12 ~~requested the telehealth consultation for the recipient.~~

13 ~~—(5)(a) A telehealth provider's or telehealth practitioner's diagnosis and recommendations re-~~
14 ~~sulting from a telehealth consultation shall be documented in the recipient's medical record at the~~
15 ~~office of the health care provider who requested the telehealth consultation.~~

16 ~~—(b) Except as established in paragraph (c) of this subsection, a telehealth provider or telehealth~~
17 ~~practitioner shall send a written report regarding a telehealth consultation within thirty (30) days~~
18 ~~of the consultation to the referring health care provider.~~

19 ~~—(c) If a community mental health center was the referring health care provider and the provid-~~
20 ~~er of the telehealth consultation for a recipient, the requirement in paragraph (b) of this subsec-~~
21 ~~tion shall not apply.]~~

22 Section 5[9]. Federal Financial Participation. A policy established in this administrative regu-
23 lation shall be null and void if the Centers for Medicare and Medicaid Services:

1 (1) Denies federal financial participation for the policy; or

2 (2) Disapproves the policy.

3 Section 6.[10]. Appeal Rights. (1) An appeal of a department determination regarding a Med-
4 icaid beneficiary shall be in accordance with 907 KAR 1:563.

5 (2) An appeal of a department determination regarding Medicaid eligibility of an individual
6 shall be in accordance with 907 KAR 1:560.

7 (3) A provider may appeal a department-written determination as to the application of this
8 administrative regulation in accordance with 907 KAR 1:671.

9 (4) An appeal of a managed care organization's determination regarding a Medicaid benefi-
10 ciary shall be in accordance with 907 KAR 17:010.

907 KAR 3:170

REVIEWED:

11/30/18

Date



Carol H. Steckel, Commissioner
Department for Medicaid Services

APPROVED:

12-20-18

Date



Adam M. Meier, Secretary
Cabinet for Health and Family Services

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on February 25, 2019, at 9:00 a.m. in Suites A & B, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 18, 2019, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until February 28, 2019. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Chase Coffey, Executive Administrative Assistant, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, KY 40621; Phone: 502-564-6746; Fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 3:170

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Person: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes Department for Medicaid Services (DMS) policies relating to telehealth. The coverage policies in this administrative regulation shall apply to a managed care organization's (MCO's) coverage of Medicaid services for individuals enrolled in the MCO for the purpose of receiving Medicaid or Kentucky Children's Health Insurance Program services. An MCO is only required to reimburse according to this administrative regulation depending on the rates negotiated with providers.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish DMS policies relating to telehealth in accordance with KRS 194A.125 and KRS 205.559.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing DMS telehealth policies.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing DMS telehealth policies.
- (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 provide new definitions for "telehealth", "telehealth service", "place of service", and "telehealth care provider". A new section relates to telehealth reimbursement. The administrative regulation is amended to allow a telehealth care provider to be reimbursed in an amount equal to the amount paid for a comparable in-person service until July 2020, after which time a telehealth care provider shall be reimbursed at least 85% of the amount paid for a comparable in-person service, and to require providers to appropriately denote telemedicine services. In addition, many of the previous provisions are being repealed.
 - (b) The necessity of the amendment to this administrative regulation: The amendment is necessary to ensure that policies stated in the administrative regulation are consistent with policies approved by CMS for federal funding.
 - (c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with KRS 205.559 and conforming the administrative regulation's policies to those approved by CMS; thus, ensuring federal funding for the policies.
 - (d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by con-

forming the administrative regulation's policies to those approved by CMS; thus, ensuring federal funding for the policies.

- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The Department for Medicaid Services, MCOs, any enrolled and credentialed provider who could provide appropriate telehealth services, and Medicaid members.
- (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: To be reimbursed for a telehealth service, a provider will have to comply with the policies and requirements established in this administrative regulation. Participation is optional, not mandatory.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed on the entities regulated by the administrative regulation as participation is optional.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Those who opt to perform telehealth services in compliance with this administrative regulation will be reimbursed for services rendered.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: The department anticipates that it will incur no additional expenses in the implementation of these amendments in the first year of operation.
 - (b) On a continuing basis: The department anticipates that it will incur no additional expenses in implementing these amendments on a continuing basis.
- (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 will be 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 tiering was or was not used) Tiering was not applied as telehealth services standards are applied equally to all affected individuals.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 3:170

Agency Contact Person: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov

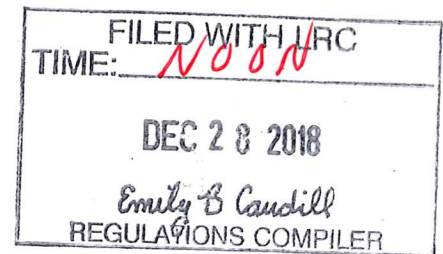
1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be impacted by the amendment.
2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by KRS 194A.010, 194A.030(2), 194A.125, 205.520, 205.559
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 department anticipates no additional costs in administering these amendments in the first year.
 - (d) How much will it cost to administer this program for subsequent years? The department anticipates no additional costs in administering these amendments 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:



1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Community Based Services

3 Division of Family Support

4 (Amendment)

5 921 KAR 2:015^{TE}. Supplemental programs for persons who are aged, blind, or have a
6 disability.

7 RELATES TO: KRS Chapter 194A, 202A.011(12), 205.245, 209.020(4), 216.530,
8 216.557(1), 216.750(2), 216.765(2), Chapter 216B, Chapter 514, 20 C.F.R. 416.120,
9 416.212, 416.2030, 416.2095, 416.2096, 416.2099, 8 U.S.C. 1621, 1641, 42 U.S.C.
10 1381-1383

11 STATUTORY AUTHORITY: KRS 194A.050(1), 205.245, 42 U.S.C. 1382e-g

12 NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.050(1) requires the
13 secretary to promulgate administrative regulations necessary under applicable state
14 laws to protect, develop, and maintain the welfare, personal dignity, integrity, and
15 sufficiency of the citizens of the Commonwealth and to operate the programs and fulfill
16 the responsibilities of the cabinet. 42 U.S.C. 1382 authorizes the cabinet to administer a
17 state funded program of supplementation to all former recipients of the Aid to the Aged,
18 Blind, and Disabled Program as of December 13, 1973, and who were disadvantaged
19 by the implementation of the Supplemental Security Income Program. KRS 205.245
20 establishes the mandatory supplementation program and the supplementation to other
21 needy persons who are aged, blind, or have a disability. In addition, any state that

1 makes supplementary payments on or after June 30, 1977, and does not have a pass-
2 along agreement in effect with the Commissioner of the Social Security Administration,
3 formerly a part of the U.S. Department of Health, Education, and Welfare, shall be
4 determined by the commissioner to be ineligible for payments under Title XIX of the
5 Social Security Act in accordance with 20 C.F.R. 416.2099. This administrative
6 regulation establishes the provisions of the supplementation program.

7 Section 1. Definitions. (1) "Activities of daily living" is defined by KRS 194A.700(1).

8 (2) "Adult" is defined by KRS 209.020(4).

9 (3)[(2)] "Aid to the Aged, Blind and Disabled Program" means the former state-funded
10 program for an individual who was aged, blind, or had a disability.

11 (4)[(3)] "Care coordinator" means an individual designated by a community
12 integration supplementation applicant or recipient to fulfill responsibilities specified in
13 Section 6(2) of this administrative regulation.

14 (5)[(4)] "Department" means the Department for Community Based Services or its
15 designee.

16 (6)[(5)] "Full-time living arrangement" means a residential living status that is seven
17 (7) days a week, not part time.

18 (7) "Instrumental activities of daily living" is defined by KRS 194A.700(9).

19 (8)[(6)] "Private residence" means a dwelling that meets requirements of Section
20 4(2)(d) of this administrative regulation.

21 (9)[(7)] "Qualified alien" means an alien who, at the time the person applies for,
22 receives, or attempts to receive state supplementation, meets the U.S. citizenship
23 requirements of 907 KAR 20:001.

1 ~~(10)~~~~[(8)]~~ "Qualified mental health professional" is defined by KRS 202A.011(12).

2 ~~(11)~~~~[(9)]~~ "Serious mental illness" or "SMI" means a mental illness or disorder in
3 accordance with Section 6(1) of this administrative regulation.

4 ~~(12)~~~~[(10)]~~ ~~"Specialized personal care home" means a licensed personal care home~~
5 ~~that receives funding from the Department for Behavioral Health, Developmental and~~
6 ~~Intellectual Disabilities to employ a mental health professional who has specialized~~
7 ~~training in the care of a resident with mental illness or intellectual disability.~~

8 ~~(11)~~ "Supplemental security income" or "SSI" means a monthly cash payment made
9 pursuant to 42 U.S.C. 1381 to 1383f to the aged, blind, or disabled.

10 Section 2. Mandatory State Supplementation. (1) A recipient for mandatory state
11 supplementation shall include a former Aid to the Aged, Blind and Disabled Program
12 recipient who became ineligible for SSI due to income but whose special needs entitled
13 the recipient to an Aid to the Aged, Blind and Disabled Program payment as of
14 December 1973.

15 (2) A mandatory state supplementation recipient shall be subject to the same
16 payment requirements as specified in Section 4 of this administrative regulation.

17 (3) A mandatory state supplementation payment shall be equal to the difference
18 between:

19 (a) The Aid to the Aged, Blind and Disabled Program payment for the month of
20 December 1973; and

21 (b) 1. The total of the SSI payment; or

22 2. The total of the SSI payment and other income for the current month.

23 (4) A mandatory payment shall discontinue if:

1 (a) The needs of the recipient as recognized in December 1973 have decreased; or

2 (b) Income has increased to the December 1973 level.

3 (5) The mandatory payment shall not be increased unless:

4 (a) Income as recognized in December 1973 decreases;

5 (b) The SSI payment is reduced, but the recipient's circumstances are unchanged; or

6 (c) The standard of need as specified in Section 9 of this administrative regulation for
7 a class of recipients is increased.

8 (6) If a husband and wife are living together, an income change after September
9 1974 shall not result in an increased mandatory payment unless total income of the
10 couple is less than December 1973 total income.

11 Section 3. Optional State Supplementation Program. (1) Except as established in
12 Sections 7, 8, and 9 of this administrative regulation, optional state supplementation
13 shall be available to a person who meets technical requirements and resource
14 limitations of the medically needy program for a person who is aged, blind, or has a
15 disability in accordance with:

16 (a) 907 KAR 20:001;

17 (b) 907 KAR 20:005, Sections 5(2), (3), (4), (7), 10, and 12~~[11]~~;

18 (c) 907 KAR 20:020, Section 2(4)(a);

19 (d) 907 KAR 20:025; or

20 (e) 907 KAR 20:040, Section 1.

21 (2) A person shall apply or reapply for the state supplementation program in
22 accordance with 921 KAR 2:035 and shall be required to:

23 (a) Furnish a Social Security number; or

(b) Apply for a Social Security number, if a Social Security number has not been issued.

(3) If potential eligibility exists for SSI, an application for SSI shall be mandatory.

(4) The effective date for state supplementation program approval shall be in accordance with 921 KAR 2:050.

Section 4. Optional State Supplementation Payment. (1) An optional supplementation payment shall be issued in accordance with 921 KAR 2:050 for an eligible individual who:

(a) Requires a full-time living arrangement;

(b) Has insufficient income to meet the payment standards specified in Section 9 of this administrative regulation; and

(c)1. Resides in a personal care home and is eighteen (18) years of age or older in accordance with KRS 216.765(2);

2. Resides in a family care home and is at least eighteen (18) years of age in accordance with 902 KAR 20:041, Section 3(14);

3. Receives caretaker services and is at least eighteen (18) years of age; or

4.a. Resides in a private residence;

b. Is at least eighteen (18) years of age; and

c. Has SMI.

(2) A full-time living arrangement shall include:

(a) Residence in a personal care home that:

1. Meets the requirements and provides services established in 902 KAR 20:036; and

2. Is licensed under KRS 216B.010 to 216B.131;

1 (b) Residence in a family care home that:

2 1. Meets the requirements and provides services established in 902 KAR 20:041; and

3 2. Is licensed under KRS 216B.010 to 216B.131;

4 (c) A situation in which a caretaker is required to be hired to provide care other than
5 room and board; or

6 (d) A private residence, which shall:

7 1. Be permanent housing with:

8 a. Tenancy rights; and

9 b. Preference given to single occupancy; and

10 2. Afford an individual with SMI choice in activities of daily living, social interaction,
11 and access to the community.

12 (3) A guardian or other payee who receives a state supplementation check for a state
13 supplementation recipient shall:

14 (a) Return the check to the Kentucky State Treasurer, the month after the month of:

15 1. Discharge to a:

16 a. Nursing facility, unless the admission is for temporary medical care as specified in
17 Section 10 of this administrative regulation; or

18 b. Residence other than a private residence pursuant to subsection (2)(d) of this
19 section; or

20 2. Death of the state supplementation recipient; and

21 (b) Notify a local county department office within five (5) working days of the death or
22 discharge of the state supplementation recipient.

23 (4) Failure to comply with subsection (3)(a) of this section may result in prosecution in

1 accordance with KRS Chapter 514.

2 (5) If there is no guardian or other payee, a personal care or family care home that
3 receives a state supplementation check for a state supplementation recipient shall:

4 (a) Return the check to the Kentucky State Treasurer, the month after the month of:

5 1. Discharge to a:

6 a. Nursing facility, unless the admission is for temporary medical care as specified in
7 Section 10 of this administrative regulation;

8 b. Another personal care or family care home; or

9 c. Residence other than a private residence pursuant to subsection (2)(d) of this
10 section; or

11 2. Death of the state supplementation recipient; and

12 (b) Notify a local county department within five (5) working days of the:

13 1. Death or discharge of the state supplementation recipient; or

14 2. Voluntary relinquishment of a license to the Office of Inspector General.

15 (6) If a personal care or family care home receives a state supplementation check
16 after voluntary relinquishment of a license, as specified in subsection (5)(b)2 of this
17 section, the personal care or family care home shall return the check to the Kentucky
18 State Treasurer.

19 (7) Failure to comply with subsections (5)(a) or (6) of this section may result in
20 prosecution in accordance with KRS Chapter 514.

21 Section 5. Eligibility for Caretaker Services. (1) Service by a caretaker shall be
22 provided to enable an adult to:

23 (a) Remain safely and adequately:

1 1. At home;

2 2. In another family setting; or

3 3. In a room and board situation; and

4 (b) Prevent institutionalization.

5 (2) Service by a caretaker shall be provided at regular intervals by:

6 (a) A live-in attendant; or

7 (b) One (1) or more persons hired to come to the home.

8 (3) Eligibility for caretaker supplementation shall be verified annually by the cabinet
9 with the caretaker to establish how:

10 (a) Often the service is provided;

11 (b) The service prevents institutionalization; and

12 (c) Payment is made for the service.

13 (4) A supplemental payment shall not be made to or on behalf of an otherwise
14 eligible individual if the:

15 (a) Client is taken daily or periodically to the home of the caretaker; or

16 (b) Caretaker service is provided by the following persons living with the applicant:

17 1. The spouse;

18 2. Parent of an adult or minor child who has a disability; or

19 3. Adult child of a parent who is aged, blind, or has a disability.

20 Section 6. Eligibility for Community Integration Supplementation. (1) Eligibility for the
21 community integration supplementation shall be based upon a diagnosis of SMI by a
22 qualified mental health professional. SMI shall:

23 (a) Not include a primary diagnosis of Alzheimer's disease or dementia;

(b) Be described in the Diagnostic and Statistical Manual of Mental Disorders (DSM), fourth (4th) edition or edition currently in use;

(c) Impair or impede the individual's functioning in at least one (1) major area of living such as inability to care for or support self, communicate, or make and maintain interpersonal relationships; and

(d) Be unlikely to improve without treatment, services, or supports.

(2) Eligibility for the community integration supplementation shall be verified annually by the cabinet with the applicant, recipient, or care coordinator to establish how:

(a) Often services are provided;

(b) The services prevent institutionalization and support private residence in accordance with Section 4(2)(d) of this administrative regulation; and

(c) Payment is made for the services.

(3) Unless criteria in Section 10 of this administrative regulation are met by the applicant or recipient, SMI supplementation shall not be available to a resident of a home, facility, institution, lodging, or other establishment:

(a) Licensed or registered in accordance with KRS Chapter 216B; or

(b) Certified in accordance with KRS Chapter 194A.

Section 7. Resource Consideration. (1) Except as stated in subsection (2) of this section, countable resources shall be determined according to policies for the medically needy in accordance with:

(a) 907 KAR 20:001;

(b) 907 KAR 20:020, Section 2(4)(a);

(c) 907 KAR 20:025; and

(d) 907 KAR 20:040, Section 1.

(2) An individual or couple shall not be eligible if countable resources exceed the limit of:

(a) \$2,000 for an individual; or

(b) \$3,000 for a couple.

Section 8. Income Considerations. (1) Except as noted in subsections (2) through (8) of this section, income and earned income deductions shall be considered according to the policy for the medically needy in accordance with:

(a) 907 KAR 20:001;

(b) 907 KAR 20:020, Section 2(4)(a);

(c) 907 KAR 20:025; and

(d) 907 KAR 20:040, Section 1.

(2) The optional supplementation payment shall be determined by:

(a) Adding:

1. Total countable income of the applicant or recipient, or applicant or recipient and spouse; and

2. A payment made to a third party on behalf of an applicant or recipient; and

(b) Subtracting the total of paragraph (a)1 and 2 of this subsection from the standard of need in Section 9 of this administrative regulation.

(3) Income of an ineligible spouse shall be:

(a) Adjusted by deducting sixty-five (65) dollars and one-half (1/2) of the remainder from the monthly earnings; and

(b) Conserved in the amount of one-half (1/2) of the SSI standard for an individual

1 for:

2 1. The applicant or recipient; and

3 2. Each minor dependent child.

4 (4) Income of an eligible individual shall not be conserved for the needs of the
5 ineligible spouse or minor dependent child.

6 (5) Income of a child shall be considered if conserving for the needs of the minor
7 dependent child so the amount conserved does not exceed the allowable amount.

8 (6) The earnings of the eligible individual and ineligible spouse shall be combined
9 prior to the application of the earnings disregard of sixty-five (65) dollars and one-half
10 (1/2) of the remainder.

11 (7) If treating a husband and wife who reside in the same personal care or family care
12 home as living apart prevents them from receiving state supplementation, the husband
13 and wife may be considered to be living with each other.

14 (8) The SSI twenty (20) dollar general exclusion shall not be an allowable deduction
15 from income.

16 Section 9. Standard of Need. (1) To the extent funds are available, the standard of
17 need is as follows:

18 (a) For a resident of a personal care home on or after January 1, 2019, \$1,291~~[2018,~~
19 ~~\$1,270]~~;

20 (b) For a resident of a family care home on or after January 1, 2019, \$943~~[2018,~~
21 ~~\$922]~~;

22 (c) For individuals who receive caretaker services:

23 1. A single individual, or an eligible individual with an ineligible spouse who is not

1 aged, blind, or has a disability on or after January 1, 2019, \$833~~[2018, \$812]~~;

2 2. An eligible couple, both aged, blind, or having~~[have]~~ a disability and one (1)
3 requiring care on or after January 1, 2019, \$1,218~~[2018, \$1,186]~~; or

4 3. An eligible couple, both aged, blind, or having ~~[have]~~ a disability and both requiring
5 care on or after January 1, 2019, \$1,272~~[2018, \$1,240]~~; or

6 (d) For an individual who resides in a private residence and has SMI on or after
7 January 1, 2019, \$1,291~~[2018, \$1,270]~~.

8 (2)(a) In a couple case, if both are eligible, the couple's income shall be combined
9 prior to comparison with the standard of need.

10 (b) One-half (1/2) of the deficit shall be payable to each.

11 (3) A personal care home shall accept as full payment for cost of care the amount of
12 the standard, based on the living arrangement, minus a sixty (60) dollar personal needs
13 allowance that shall be retained by the client.

14 (4) A family care home shall accept as full payment for cost of care the amount of the
15 standard, based on the living arrangement, minus a forty (40) dollar personal needs
16 allowance that shall be retained by the client.

17 Section 10. Temporary Stay in a Medical Facility. (1) An SSI recipient who receives
18 optional or mandatory state supplementation shall have continuation of state
19 supplementation benefits without interruption for the first three (3) full months of medical
20 care in a health care facility if the:

21 (a) SSI recipient meets eligibility for medical confinement established by 20 C.F.R.
22 416.212;

23 (b) Social Security Administration notifies the department that the admission shall be

temporary; and

(c) Purpose shall be to maintain the recipient's home or other living arrangement during a temporary admission to a health care facility.

(2) A non-SSI recipient who receives mandatory or optional state supplementation shall have continuation of state supplementation benefits without interruption for the first three (3) full months of medical care in a health care facility if:

(a) The non-SSI recipient meets the requirements of subsection (1)(c) of this section;

(b) A physician certifies, in writing, that the non-SSI recipient is not likely to be confined for longer than ninety (90) full consecutive days; and

(c) A guardian or other payee, personal care home, or family care home, receiving a state supplementation check for the state supplementation recipient, provides a local county department office with:

1. Notification of the temporary admission; and

2. The physician statement specified in paragraph (b) of this subsection.

(3) A temporary admission shall be limited to the following health care facilities:

(a) Hospital;

(b) Psychiatric hospital; or

(c) Nursing facility.

(4) If a state supplementation recipient is discharged in the month following the last month of continued benefits, the temporary absence shall continue through the date of discharge.

Section 11. Citizenship requirements. An applicant or recipient shall be a:

(1) Citizen of the United States; or

1 (2) Qualified alien.

2 Section 12. Requirement for Residency. An applicant or recipient shall reside in
3 Kentucky.

4 Section 13. Mental Illness or Intellectual Disability (MI/ID) Supplement Program. (1) A
5 personal care home:

6 (a) May qualify, to the extent funds are available, for a quarterly supplement payment
7 of fifty (50) cents per diem for a state supplementation recipient in the personal care
8 home's care as of the first calendar day of a qualifying month;

9 (b) Shall not be eligible for a payment for a Type A Citation that is not abated; and

10 (c) Shall meet the following certification criteria for eligibility to participate in the MI/ID
11 Supplement Program:

12 1. Be licensed in accordance with KRS 216B.010 to 216B.131;

13 2. Care for a population that is thirty-five (35) percent mental illness or intellectual
14 disability clients in all of its occupied licensed personal care home beds and who have
15 a:

16 a. Primary or secondary diagnosis of intellectual disability including mild or moderate,
17 or other ranges of intellectual disability whose needs can be met in a personal care
18 home;

19 b. Primary or secondary diagnosis of mental illness excluding organic brain
20 syndrome, senility, chronic brain syndrome, Alzheimer's, and similar diagnoses; or

21 c. Medical history that includes a previous hospitalization in a psychiatric facility,
22 regardless of present diagnosis;

23 3. Have a licensed nurse or an individual who has received and successfully

1 completed certified medication technician or Kentucky medication aide training on duty
2 for at least four (4) hours during the first or second shift each day;

3 4. Not decrease staffing hours of the licensed nurse or individual who has
4 successfully completed certified medication technician training in effect prior to July
5 1990, as a result of this minimum requirement;

6 5. Be verified by the Office of Inspector General in accordance with Section 15(2)
7 through (4) of this administrative regulation; and

8 6. File an STS-1, Mental Illness or Intellectual Disability (MI/ID) Supplement Program
9 Application for Benefits, with the department by the tenth working day of the first month
10 of the calendar quarter to be eligible for payment in that quarter.

11 a. Quarters shall begin in January, April, July, and October.

12 b. Unless mental illness or intellectual disability supplement eligibility is discontinued,
13 a new application for the purpose of program certification shall not be required.

14 (2) A personal care home shall provide the department with its tax identification
15 number and address as part of the application process.

16 (3) The department shall provide an STS-2, Mental Illness or Intellectual Disability
17 (MI/ID) Supplement Program Notice of Decision to Personal Care Home, to a personal
18 care home following:

19 (a) Receipt of verification from the Office of Inspector General as specified in Section
20 15(6) of this administrative regulation; and

21 (b) Approval or denial of an application.

22 (4) A personal care home shall:

23 (a) Provide the department with an STS-3, Mental Illness or Intellectual Disability

(MI/ID) Supplement Program Monthly Report Form, that:

1. Lists every resident of the personal care home who was a resident on the first day of the month;

2. Lists the last four (4) digits only of the resident's Social Security Number; [and]

3. Lists the resident's date of birth; and

4. Is marked appropriately for each resident to indicate the resident~~[Annotates the form, in order to maintain confidentiality, as follows with a]:~~

a. ~~[Star indicating a resident]~~ Has a mental illness ~~[or intellectual disability]~~ diagnosis;

b. Has an intellectual disability diagnosis~~[Check mark indicating a resident receives state supplementation]; or [and]~~

c. Receives state supplementation ~~[Star and a check mark indicating the resident has a mental illness or intellectual disability diagnosis and is a recipient of state supplementation]; and~~

(b) Submit the STS-3 to the department on or postmarked by the fifth working day of the month by:

1. Mail;

2. Fax; or

3. Electronically.

(5) The monthly report shall be used by the department for:

(a) Verification as specified in subsection (4)(a) of this section;

(b) Payment; and

(c) Audit purposes.

(6)(a) A personal care home shall notify the department within ten (10) working days

1 if its mental illness or intellectual disability percentage goes below thirty-five (35)
2 percent for all personal care residents.

3 (b) A personal care home may be randomly audited by the department to verify
4 percentages and payment accuracy.

5 Section 14. Mental Illness or Intellectual Disability (MI/ID) Training. (1)(a) To the
6 extent cabinet funds are available to support the training, a personal care home's
7 licensed nurse or individual who has successfully completed certified medication
8 technician or Kentucky medication aide training shall complete [attend] the personal
9 care home mental illness or intellectual disability training workshop provided through
10 the Department for Behavioral Health, Developmental and Intellectual Disabilities, once
11 every two (2) years.

12 (b) Other staff may complete [attend] the training workshop in order to assure the
13 personal care home always has at least one (1) certified staff employed for certification
14 purposes.

15 (2) The personal care home mental illness or intellectual disability training shall be
16 provided through a one (1) day workshop. The following topics shall be covered:

17 (a) Importance of proper medication administration;

18 (b) Side effects and adverse medication reactions with special attention to
19 psychotropics;

20 (c) Signs and symptoms of an acute onset of a psychiatric episode;

21 (d) SMI;

22 (e) SMI recovery;

23 (f) Characteristics of each major diagnosis, for example, paranoia, schizophrenia,

bipolar disorder, or intellectual disability;

~~(g)[(e)]~~ Guidance in the area of supervision versus patient rights for the population with a diagnosis of mental illness or intellectual disability; ~~[and]~~

~~(h)[(f)]~~ Instruction in providing a necessary activity to meet the needs of a resident who has a diagnosis of mental illness or intellectual disability;

(i) Activities of daily living and instrumental activities of daily living; and

(j) Adult learning principles.

(3) Initial training shall:

(a) Include the licensed nurse or the individual who has successfully completed certified medication technician or Kentucky medication aide training and may include the owner or operator; and

(b) Be in the quarter during which the STS-1 is filed with the department.

~~(4)(a) A personal care home shall have at least one (1) direct care [To assure that a] staff member who has received training [is always employed at the personal care home, a maximum of five (5) may be trained during a year].~~

~~[(a) If staff turnover results in the loss of the licensed nurse or individual who has successfully completed certified medication technician or Kentucky medication aide training and four (4) other staff have been trained, the personal care home shall request in writing to the department an exemption of the five (5) staff maximum, in order to train another staff member.]~~

(b) A personal care home shall have on staff a licensed nurse or individual who:

1. Has successfully completed certified medication technician training; and

2.a. Has received mental illness or intellectual disability training; or

b. Is enrolled in the next scheduled mental illness or intellectual disability training workshop [at the closest location].

(5) The Department for Behavioral Health, Developmental and Intellectual Disabilities shall provide within five (5) working days a:

(a) Certificate to direct care staff who complete the training workshop; and

(b) Listing to the department of staff who completed the training workshop.

~~(6) [Unless staff turnover occurs as specified in subsection (4)(a) of this section,~~ The department shall pay twenty-five (25) dollars, to the extent funds are available, to a personal care home:

(a) That has applied for the MI/ID Supplement Program; and

(b) For each staff member receiving training up to a [the] maximum of five (5) staff per year.

~~[(7) Attendance of the training workshop shall be optional for a specialized personal care home.]~~

Section 15. MI/ID Supplement Program Certification. (1) The Office of the Inspector General shall visit a personal care home to certify eligibility to participate in the MI/ID Supplement Program.

(a) The personal care home's initial MI/ID Supplement Program Certification Survey:

1. May be separate from an inspection conducted in accordance with KRS 216.530; and

2. Shall be in effect until the next licensure survey.

(b) After a personal care home's initial MI/ID Supplement Program Certification Survey is completed, the personal care home may complete any subsequent

1 certification survey during the licensure survey as specified in paragraph (a)2 of this
2 subsection.

3 (c) The department shall notify the Office of Inspector General that the personal care
4 home is ready for an inspection for eligibility.

5 (2) During the eligibility inspection, the Office of Inspector General shall:

6 (a) Observe and interview residents and staff; and

7 (b) Review records to assure the following criteria are met:

8 1. ~~[Except for a specialized personal care home,]~~ Certification is on file at the
9 personal care home to verify staff's completion ~~[attendance]~~ of training, as specified in
10 Section 14(1) through (4) of this administrative regulation;

11 2. The personal care home:

12 a. Has certified staff training all other direct care staff through in-service training or
13 orientation regarding the information obtained at the mental illness or intellectual
14 disability training workshop; and

15 b. Maintains documentation of completion ~~[attendance]~~ at the in-service training for
16 all direct care staff;

17 3. Medication administration meets licensure requirements and a licensed nurse or
18 individual who has successfully completed certified medication technician training:

19 a. Demonstrates a knowledge of psychotropic drug side effects; and

20 b. Is on duty as specified in Section 13(1)(c)3 of this administrative regulation; and

21 4. An activity is being regularly provided that meets the needs of a resident.

22 a. If a resident does not attend a group activity, an activity shall be designed to meet
23 the needs of the individual resident, for example, reading or other activity that may be

1 provided on an individual basis.

2 b. An individualized care plan shall not be required for the criteria in clause a. of this
3 subparagraph.

4 (3) The Office of Inspector General shall review the personal care home copy of the
5 training certification prior to performing a record review during the MI/ID Supplement
6 Program Certification Survey process.

7 (4) If thirty-five (35) percent of the population is mental illness or intellectual disability
8 clients, as specified in Section 13(1)(c)2 of this administrative regulation, on the day of
9 the visit, a personal care home shall be deemed to have an ongoing qualifying
10 percentage effective with month of request for certification as specified in subsection
11 (1)(c) of this section.

12 (5) If the mental illness or intellectual disability population goes below thirty-five (35)
13 percent of all occupied personal care beds in the facility, the personal care home shall
14 notify the department as specified in Section 13(6)(a) of this administrative regulation.

15 (6) The Office of Inspector General shall provide the department with a completed
16 STS-4, Mental Illness or Intellectual Disability (MI/ID) Supplement Certification Survey,
17 within fifteen (15) working days of an:

18 (a) Initial survey; or

19 (b) Inspection in accordance with KRS 216.530.

20 (7) The Office of Inspector General shall provide a copy of a Type A Citation issued
21 to a personal care home to the department by the fifth working day of each month for
22 the prior month.

23 (8) The personal care home shall receive a reduced payment for the number of days

the Type A Citation occurred on the first administratively feasible quarter following notification by the Office of Inspector General, in accordance with 921 KAR 2:050.

(9) If a criterion for certification is not met, the department shall issue an STS-2 to a personal care home following receipt of the survey by the Office of Inspector General as specified in subsection (6) of this section.

(10) The personal care home shall provide the department with the information requested on the STS-2:

(a) Relevant to unmet certification criteria specified on the STS-4; and

(b) Within ten (10) working days after the STS-2 is issued.

(11) If a personal care home fails to provide the department with the requested information specified in subsection (10) of this section, assistance shall be discontinued or decreased, pursuant to 921 KAR 2:046.

(12) If a personal care home is discontinued from the MI/ID Supplement Program, the personal care home may reapply for certification, by filing an STS-1 in accordance with Section 13(1)(c)6 of this administrative regulation, for the next following quarter.

Section 16. Hearings and Appeals. An applicant or recipient of benefits under a program described in this administrative regulation who is dissatisfied with an action or inaction on the part of the cabinet shall have the right to a hearing under 921 KAR 2:055.

Section 17. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "STS-1, Mental Illness or Intellectual Disability (MI/ID) Supplement Program Application for Benefits", 01/15;

1 (b) "STS-2, Mental Illness or Intellectual Disability (MI/ID) Supplement Program
2 Notice of Decision to Personal Care Home", 01/15;

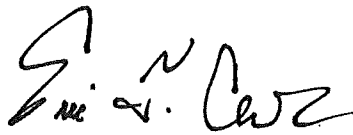
3 (c) "STS-3, Mental Illness or Intellectual Disability (MI/ID) Supplement Program
4 Monthly Report Form", 01/19 [01/13/14]; and

5 (d) "STS-4, Mental Illness or Intellectual Disability (MI/ID) Supplement Certification
6 Survey", 01/19 [01/17].

7 (2) This material may be inspected, copied, or obtained, subject to applicable
8 copyright law, at the Cabinet for Health and Family Services, 275 East Main Street,
9 Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

921 KAR 2:015

REVIEWED:



12/10/2018

Eric T. Clark, Commissioner Date
Department for Community Based Services

APPROVED:



12.18.18

Adam M. Meier, Secretary Date
Cabinet for Health and Family Services

PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall, if requested, be held February 25, 2019, at 9:00 a.m. in Suites A & B, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 18, 2019, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until February 28, 2019. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Chase Coffey, Executive Administrative Assistant, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, KY 40621; Phone: 502-564-6746; Fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 921 KAR 2:015

Agency Contact: Laura Begin

Phone Number: (502) 564-3798

Email: Laura.Begin@ky.gov

Contact Person: Chase Coffey

Phone Number: (502) 564-6746

Email: CHFSregs@ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes a program for supplemental payments to persons who are aged, blind, or have a disability in accordance with KRS 205.245 and the Mental Illness or Intellectual Disability (MI/ID) Supplement Program.

(b) The necessity of this administrative regulation: The administrative regulation is needed to establish conditions and requirements regarding the State Supplementation Program and the MI/ID Program.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the authorizing statutes through its establishment of a supplemental program of persons who are aged, blind, or have a disability and its compliance with the agreement with the Social Security Administration, formerly a part of the U. S. Department of Health, Education, and Welfare, to maintain the state's eligibility for federal Medicaid funding.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the eligibility requirements and standards of need for the State Supplemental Program for persons who are aged, blind, or have a disability.

(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 will increase the standard of need in the State Supplemental Program to reflect the cost of living adjustment (COLA) to be implemented in calendar year 2019 by the Social Security Administration for Supplemental Security Income (SSI) recipients. The Social Security Administration deemed the COLA to be an increase of 2.8%. In addition, the training requirement is being amended to add serious mental illness, activities of daily living, and adult learning

principles to the topics included in the training and to require attendance once every two years rather than every year. The term "specialized personal care home" and references to it are being deleted because they are no longer necessary. The STS-3 and STS-4 forms are being amended for consistency with the regulatory amendment.

(b) The necessity of the amendment to this administrative regulation: The amendment to this administrative regulation will increase the standard of need in the State Supplemental Program to reflect the COLA to be implemented in calendar year 2019 by the Social Security Administration for SSI recipients.

(c) How the amendment conforms to the content of the authorizing statutes: 42 U.S.C. 1382 authorizes the cabinet to administer a state funded program of supplementation to all former recipients of the Aid to the Aged, Blind, and Disabled Program as of December 13, 1973, and who were disadvantaged by the implementation of the Supplemental Security Income Program. KRS 205.245 establishes the mandatory supplementation program and the supplementation to other needy persons who are aged, blind, or have a disability. This administrative regulation establishes the provisions of the supplementation program. The amendment to this administrative regulation will increase the standard of need in the State Supplemental Program to reflect the COLA to be implemented in calendar year 2019 by the Social Security Administration for SSI recipients.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the statutes by passing along the 2019 2.8% COLA for the Supplemental Security Income benefit by modifying the standard of need for all levels of care for the State Supplementation Program.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: In SFY 18, there were 3,085 individuals who received State Supplementation Program benefits. As of fall 2018, there are 23 personal care homes participating in the MI/ID Supplement Program.

(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: There is no new action required of regulated entities.

(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: There is no new action required of regulated entities.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There is no new or additional cost to the regulated entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): A 2.8% increase in the COLA for SSI recipients.

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

(a) Initially: There will be negligible fiscal impact to the Cabinet for Health and Family Services to implement the mandated COLA pass-through money.

(b) On a continuing basis: There will be negligible fiscal impact to the Cabinet for Health and Family Services to implement the mandated pass-through of the 2019 SSI COLA. Not complying with the federal pass-through mandate would jeopardize the state's federal Medicaid funding.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: General funds and agency funds are used to implement and enforce the State Supplementation Program.

(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: No increase in fees or funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish any fees.

(9) TIERING: Is tiering applied? (Explain why or why not) Tiering is not applied because this administrative regulation will be applied in a like manner statewide.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 921 KAR 2:015

Agency Contact: Laura Begin

Phone Number: (502) 564-3798

Email: Laura.Begin@ky.gov

1. Federal statute or regulation constituting the federal mandate.
42 U.S.C. 1382 e-g, 20 C.F.R. Part 416
2. State compliance standards.
KRS 194A.050(1), 205.245
3. Minimum or uniform standards contained in the federal mandate.
42 U.S.C. 1382 e-g, 20 C.F.R. Part 416
4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This administrative regulation does not impose stricter requirements or additional or different responsibilities or requirements than those required by federal mandate.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This administrative regulation does not impose stricter requirements or additional or different responsibilities or requirements than those required by federal mandate.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 921 KAR 2:015

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- (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 Cabinet for Health and Family Services, Department for Community Based Services, will be impacted by 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.050(1), 205.245, 42 U.S.C.1328e-g, 20 C.F.R. Part 416
- (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? This administrative regulation will not generate additional revenue in the first year.
 - (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 administrative regulation will not generate any additional revenue in the subsequent year.
 - (c) How much will it cost to administer this program for the first year? No additional costs are projected to administer this program for the first year
 - (d) How much will it cost to administer this program for subsequent years? No additional costs are projected to administer this program for 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:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR COMMUNITY BASED SERVICES

921 KAR 2:015

Supplemental programs for persons who are aged, blind, or have a disability.
Summary of Material Incorporated by Reference

1. The form, "STS-3, Mental Illness or Intellectual Disability (MI/ID) Supplement Program Monthly Report Form", 01/19, is used by personal care homes to report attendance. This form is being revised to increase confidentiality by requesting only the last four digits of the social security number. It is also being revised to include three (3) columns for MI, ID, and State Supplementation. This form contains four (4) pages.
2. The form, "STS-4, Mental Illness or Intellectual Disability (MI/ID) Supplement Certification Survey", 01/19, is used as a tool to survey personal care homes participating in the MI/ID program by the Office of Inspector General. This form is being revised to add reference to technical changes in training. This form contains three (3) pages.

The total number of pages incorporated by reference for this administrative regulation is seven (7) pages.

FILED WITH LRC TIME: <i>NOON</i>
DEC 28 2018
<i>Emily B Caudill</i> REGULATIONS COMPILER

STATEMENT OF EMERGENCY
921 KAR 2:015E.

- (1) This emergency administrative regulation is necessary to increase the standards of need for all levels of care in the State Supplementation Program for persons who are aged, blind, or have a disability due to the federal and state agreement to pass through the Supplemental Security Income 2019 cost of living adjustment. Failure to comply with this agreement jeopardizes the state's Medicaid funds pursuant to 20 CFR 416.2099. The Social Security Administration notified the Department for Community Based Services of the Supplemental Security Income cost of living adjustment in October of 2018.
- (2) An ordinary administrative regulation would not allow the agency sufficient time to have an administrative regulation in place in order to revise the payment standards effective January 1, 2019.
- (3) This emergency administrative regulation will be replaced by an ordinary administrative regulation.
- (4) The ordinary administrative regulation is identical to the emergency administrative regulation.


Matthew G. Bevin, Governor


Adam M. Meier, Secretary
Cabinet for Health and Family Services