

907 KAR 1:677. Medicaid Recipient Lock-in Program.

RELATES TO: KRS 205.8453, 21 C.F.R. 1308.12, 1308.13, 1308.14, 42 C.F.R. 431.54, 433.111(b), 42 U.S.C. 1396(a), 1396 (a)(2)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6318, 205.6310, 205.8453, 42 C.F.R. 431.54, 2010 Extra. Sess. Ky. Acts ch. 1, Part I.G.3.b.(26)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) empowers the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.8453(4) and 205.6318(6) direct the cabinet to promulgate administrative regulations to identify misutilization of Medicaid services, to institute other measures necessary or useful in controlling fraud and abuse. This administrative regulation establishes the Medicaid lock-in provisions relating to recipient overutilization of the Medicaid Services.

Section 1. Definitions.

- (1) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).
- (2) "Cabinet" is defined by KRS 205.010(1).
- (3) "Controlled substance" means a drug or substance identified in 21 C.F.R. 1308.12, 1308.13, or 1308.14.
- (4) "Department" means the Department for Medicaid Services or its designee.
- (5) "Emergency medical condition" is defined by 42 U.S.C. 1395dd(e)(1).
- (6) "Emergency service" is defined by 42 C.F.R. 447.53.
- (7) "Fraud" is defined by KRS 205.8451(2).
- (8) "Kentucky All Schedule Prescription Electronic Reporting report" or "KASPER report" means a report displaying information regarding:
 - (a) All the scheduled prescriptions that an individual has had for the time period specified in the report;
 - (b) The prescriber for each prescription written for the individual during the time period specified in the report; and
 - (c) The dispenser who dispensed each prescription written for the individual during the time period specified in the report.
- (9) "Lock-in program" means a department program which restricts a recipient to receiving Medicaid services from a designated provider.
- (10) "Lock-in recipient" means a recipient enrolled in the lock-in program.
- (11) "Medicaid Management Information System" means the department's mechanized claims processing and information retrieval system as defined by, and in accordance with, 42 C.F.R. 433.111(b).
- (12) "Nonemergency care" means a service for a nonemergency condition.
- (13) "Overutilization" means the receipt of a treatment, drug, medical supply, or other Medicaid service from one (1) or more providers in an amount, duration, or scope that exceeds the amount that would reasonably be expected to result in a medical or health benefit to the recipient.
- (14) "Physician" is defined by KRS 311.550(12).
- (15) "Physician assistant" or "PA" is defined by KRS 311.840(3).
- (16) "Prescriber" means a health care professional who:
 - (a) Within the scope of practice under Kentucky licensing laws, has the legal authority to write or order a prescription for the drug that is ordered;
 - (b) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672; and

(c) Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671.

(d) Prescribes in accordance with his or her current registration with the U.S. Department of Justice's Drug Enforcement Administration.

(17) "Primary care provider" means an advanced practice registered nurse, a physician, or physician assistant.

(18) "Provider" is defined by KRS 205.8451(7).

(19) "Provider abuse" is defined by KRS 205.8451(8).

(20) "Recipient" is defined by KRS 205.8451(9).

(21) "Recipient abuse" is defined by KRS 205.8451(10)

(22) "Utilization review" means a department review and analysis:

(a) Of Medicaid claims for a twelve (12) consecutive month period including:

1. A recipient's medical conditions; and

2. Medicaid services received by the recipient; and

(b) To determine if recipient overutilization has occurred.

Section 2. Review of Complaints. (1)(a) A complaint relating to potential fraud, recipient abuse, provider abuse, or overutilization shall be reported to the department or Cabinet for Health and Family Services, Office of Inspector General via the Medicaid and Welfare Fraud and Abuse hotline at 1-800-372-2970.

(b) The department may also review data available to it to determine if potential fraud, recipient abuse, provider abuse, or overutilization has occurred regardless of whether or not a complaint was made regarding a given individual or provider.

(2) The department shall respond to a complaint or data review referenced in subsection (1) of this section by conducting a utilization review of the recipient.

(3) A utilization review of a recipient referenced in subsection (2) of this section shall include a review of claims using data collected from the Medicaid Management Information System or a KASPER report to identify if the recipient:

(a) Utilized Medicaid services at a frequency or amount which meets utilization criteria established in Section 4 of this administrative regulation; and

(b)1. Shall be restricted to receiving Medicaid services from designated providers under the lock-in program.

2. Shall be excluded from the lock-in program if the recipient:

a. Resides in a facility reimbursed pursuant to 907 KAR 1:025 or 1:065 or in a personal care home.

b. Is under the age of eighteen (18) years;

c. Receives:

(i) Services through a home and community based waiver program in accordance with 907 KAR 1:145, 1:160, 1:595, 1:835, 3:090, or 3:210; or

(ii) Hospice services in accordance with 907 KAR 1:330.

d. Utilized Medicaid services at a frequency or amount which was medically necessary to treat a complex, life threatening medical condition as determined by the department.

Section 3. General Exemption. If the department determines that not enrolling a recipient in the lock-in program is in the best interest of the recipient, the department shall not enroll the recipient in the lock-in program.

Section 4. Lock-in Criteria. (1) Except as established in Section 2(3)(b)2 and Section 3 of this administrative regulation, the department shall initiate the lock-in process, as established in Section 5 of this administrative regulation, for a recipient if in two (2) consecutive 180 calendar day

periods, the recipient:

- (a)1. Received services from at least five (5) different providers;
 2. Received at least ten (10) different prescription drugs; and
 3. Received prescriptions from at least three (3) or more different pharmacies; or
 - (b)1. Had at least four (4) hospital emergency department visits for a condition that was not an emergency medical condition; or
 2. Received services from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition.
- (2) A recipient shall be locked in to:
- (a) One (1) primary care provider, one (1) controlled substance prescriber, and one (1) pharmacy if the recipient meets the criteria established in subsection (1)(a) of this section; or
 - (b) One (1) designated hospital for nonemergency care, except for a screening to determine if an emergency medical condition exists pursuant to 907 KAR 10:014, if the recipient meets the criteria established in subsection (1)(b) of this section.

Section 5. Lock-in Process. (1) Upon identification of a recipient who shall be enrolled in the lock-in program in accordance with Section 2(3) of this administrative regulation, the department shall:

- (a) Send a written notification in accordance with subsection (2) of this section; and
 - (b) Enroll the recipient in accordance with subsection (3) of this section.
- (2) The written notification sent to the recipient shall include:
- (a) The reason for enrolling the recipient in the lock-in program;
 - (b) A description of the lock-in program;
 - (c) The effective date of lock-in program enrollment;
 - (d) Identification of the recipient's designated providers as established in subsection (2)(a) of this section;
 - (e) Information relating to the recipient's right to a hearing as established in Section 9 of this administrative regulation; and
 - (f) Contact information of an individual who may be contacted in writing or by telephone for information relating to the lock-in program.
- (3) Except for a recipient who requests a hearing relating to a department lock-in determination, the department shall enroll the recipient in the lock-in program within thirty (30) days of sending the written notification referenced in subsection (2) of this section.
- (a) Once enrolled, the lock-in recipient shall be restricted to receiving Medicaid services from designated providers including:
1. One (1) primary care provider who:
 - a. Shall be accessible to the recipient within normal time and distance standards for the community in which the recipient resides;
 - b. If the lock-in recipient has a designated hospital, has admitting privileges to the designated hospital;
 - c. Shall provide services and manage the lock-in recipient's necessary health care services;
 - d. If the lock-in recipient needs a Medicaid-covered service other than the service of the designated primary care provider, shall complete and forward a Lock-in Recipient Referral to a referred provider;
 - e. Shall participate in the recipient's periodic utilization review as identified in paragraph (c) of this subsection; and
 - f. If the designated primary care provider is a physician, may serve as the lock-in recipient's designated controlled substance prescriber;
 2. One (1) controlled substance prescriber who shall serve as the sole prescriber and manager

of controlled substances for the lock-in recipient;

3. One (1) pharmacy; and

4. If the recipient meets the criteria established in Section 4(2)(b) of this administrative regulation, one (1) hospital.

(b) The restrictions identified in paragraph (a) of this subsection shall be maintained for at least twenty-four (24) months.

(c) Following the initial twenty-four (24) month period of lock-in enrollment as established in paragraph (b) of this subsection, the department shall conduct a utilization review at twelve (12) month intervals to:

1. Measure the effectiveness of the recipient's enrollment in the lock-in program; and

2. Determine if the recipient shall:

a. Continue enrollment in the lock-in program if the recipient continues to meet the criteria established in Section 4(1) of this administrative regulation; or

b. Be discharged from the lock-in program if the recipient does not meet the criteria established in Section 4(1) of this administrative regulation.

(d) The department shall provide the lock-in recipient with a written notification, which shall include:

1. Findings of a utilization review as identified in paragraph (c) of this subsection; and

2. A decision to maintain enrollment in or discharge the recipient from the lock-in program.

Section 6. Designated Providers. (1) A designated provider as identified in Section 5(2)(a) of this administrative regulation shall be the designated provider of a lock-in recipient for at least twenty-four (24) months except if:

(a) the designated provider submits to the department a written request for a release from serving as the recipient's designated provider. The provider shall continue to serve as the recipient's designated provider until a comparable designated provider is selected;

(b) The recipient relocates outside of the designated provider's geographic area;

(c) The recipient submits a written request to the department which:

1. Requests a designated provider change; and

2. Includes information to support cause or a necessary reason for the change, including the recipient:

a. Was denied access to a needed medical service;

b. Received poor quality of care; or

c. Does not have access to a provider qualified to treat the recipient's health care needs;

(d) The designated provider withdraws or is terminated from participation in the Medicaid Program; or

(e) The department determines that it is in the best interest of the lock-in recipient to change the designated provider.

(2) A designated provider for a recipient shall:

(a) Be chosen by the department; and

(b) Not be chosen by the recipient.

(3) A recipient shall not have more than one (1) change in a designated primary care provider within a twenty-four (24) month period except as allowed in subsection (1) of this section.

Section 7. Fees, Payments, and Nonpayments. (1) On behalf of a lock-in recipient, the department shall pay:

(a) At the beginning of each month:

1. A fee of ten (10) dollars to a designated primary care provider for the management of a lock-in recipient's necessary health care; or

2. A fee of five (5) dollars to a designated controlled substance prescriber, unless the designated controlled substance prescriber is also the recipient's designated primary care provider. If a designated controlled substance prescriber is also the recipient's designated primary care provider, the department shall pay a fee of ten (10) dollars in aggregate for being the recipient's designated primary care provider; and

(b) For:

1. A medical screening examination performed in the emergency department of a hospital to determine if an emergency medical condition exists in accordance with 907 KAR 10:014; and

2. An emergency service.

(2) In addition to the fee established in subsection (1)(a)1. of this section, the department shall pay for necessary services provided to the recipient by the recipient's designated primary care provider.

(3) Except for a service as established in subsection (1)(b) of this section, the department shall not pay for a service rendered by a provider other than the recipient's designated primary care provider unless the designated primary care provider:

(a) Refers the recipient to the referred provider for a necessary service; and

(b) Completes and forwards a copy of the Lock-in Recipient Referral to the referred provider of the service.

Section 8. Lock-in Recipient Requirements. A lock-in recipient:

(1) Shall be restricted to receiving necessary nonemergency services from a designated provider as identified in Section 5(3)(a) of this administrative regulation except for services rendered by a referred provider in accordance with Section 7(3) of this administrative regulation;

(2) Shall be responsible for the payment of the charges for a service rendered by a provider who:

(a) Is not the recipient's designated primary care provider;

(b) Does not have a Lock-in Recipient Referral from the recipient's designated primary care provider; and

(c) Informs the lock-in recipient that the recipient shall be responsible for the costs of the provider's services before the service is rendered; and

(3) May request a change of a designated provider in accordance with Section 6(1)(c) of this administrative regulation:

(a) Within ninety (90) days of the date of the recipient notification letter as identified in Section 5(1) of this administrative regulation; or

(b) At least once in a twenty-four (24) month period following initial enrollment in the lock-in program.

Section 9. Appeal Rights. (1) A recipient who is notified of a department decision to enroll or maintain enrollment of the recipient in the lock-in program shall have the right to request a hearing in accordance with this section.

(2) The subject of the hearing shall be limited to whether or not the department had sufficient evidence to support the department's decision.

(3) A request for a hearing shall be:

(a) In writing;

(b) Mailed to the department, to the attention of the commissioner; and

(c) Received by the department within thirty (30) calendar days from the date that the notice referenced in subsection (1) of this section was received by the recipient.

(4) A copy of the request for a hearing shall be mailed to and received by the department's Division of Program Integrity within thirty (30) calendar days from the date that the notice referenced

in subsection (1) of this section was received by the recipient.

(5) If a request for a hearing which meets the criteria established in subsection (3) of this section is:

(a) Received by the department within ten (10) calendar days from the date that the recipient received a notice referenced in subsection (1) of this section, the lock-in action shall be delayed until a fair hearing has occurred; or

(b) Not received by the department within ten (10) calendar days from the date that the recipient received a notice referenced in subsection (1) of this section, the lock-in action shall not be delayed.

(6) A fair hearing shall be held in accordance with 907 KAR 1:563, Sections 6 through 15.

Section 10. Fraud and Abuse Referral. If fraud, provider abuse, or recipient abuse is identified in the course of a department utilization review for lock-in purposes, the department shall comply with KRS 205.8453(3).

Section 11. Incorporation by Reference. (1) The "Lock-in Recipient Referral", November 2010 edition, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, 6C-C, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. (22 Ky.R. 1920; 2307; eff. 7-5-1996; 37 Ky.R. 571; 1295; 1460; eff. 12-1-2010; TAm eff. 5-3-2011; Crt eff. 12-6-2019.)