

**907 KAR 17:020. Managed care organization service and service coverage requirements and policies.**

RELATES TO: KRS 194A.025(3), Chapters 202A, 645, 42 U.S.C. 1396n(c), 42 C.F.R. 422.113(c), 431.51(a)(4), 431.52, Part 438, 447.500-447.522, 42 U.S.C. 1396b(m)(2)(A)(xiii), 1396d(r), 1396u-2(b)(2)(A)(i), (ii)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.025(3), 194A.030(2), 194A.050(1), 205.520(3), 205.560, 42 U.S.C. 1396n(b), 42 C.F.R. Part 438

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 establish requirements relating to managed care. This administrative regulation establishes the Medicaid managed care organization service and service coverage requirements and policies.

Section 1. Covered Services. (1) Except as established in subsection (2) of this section, an MCO shall be responsible for the provision of a covered health service:

- (a) That is established in Title 907 of the Kentucky Administrative Regulations;
- (b) That shall be in the amount, duration, and scope that the services are covered for recipients pursuant to the department's administrative regulations located in Title 907 of the Kentucky Administrative Regulations; and

(c) Beginning on the date of enrollment of a recipient into the MCO.

(2) Other than a nursing facility cost referenced in subsection (3)(i) of this section, an MCO shall be responsible for the cost of a non-nursing facility covered service provided to an enrollee during the first thirty (30) days of a nursing facility admission in accordance with this administrative regulation.

(3) An MCO shall not be responsible for the provision or costs of the following:

(a) A service provided to a recipient in an intermediate care facility for individuals with an intellectual disability;

(b) A service provided to a recipient in a 1915(c) home and community based waiver program;

(c) A hospice service provided to a recipient in an institution;

(d) A nonemergency medical transportation service provided in accordance with 907 KAR 3:066;

(e) Except as established in Section 5 of this administration regulation, a school-based health service;

(f) A service not covered by the Kentucky Medicaid Program;

(g) A health access nurturing development service pursuant to 907 KAR 3:140;

(h) An early intervention program service pursuant to 907 KAR 1:720; or

(i) A nursing facility service for an enrollee during the first thirty (30) days of a nursing facility admission.

(4) The following covered services provided by an MCO shall be accessible to an enrollee without a referral from the enrollee's primary care provider:

(a) A primary care vision service;

(b) A primary dental or oral surgery service;

(c) An evaluation by an orthodontist or a prosthodontist;

(d) A service provided by a women's health specialist;

(e) A family planning service;

- (f) An emergency service;
- (g) Maternity care for an enrollee under age eighteen (18);
- (h) An immunization for an enrollee under twenty-one (21);
- (i) A screening, evaluation, or treatment service for a sexually transmitted disease or tuberculosis;
- (j) Testing for HIV, HIV-related condition, or other communicable disease;
- (k) A chiropractic service;
- (l) A behavioral health service; and
- (m) A substance use disorder service.

(5) An MCO shall:

- (a) Not require the use of a network provider for a family planning service;
- (b) In accordance with 42 C.F.R. 431.51(a)(4), reimburse for a family planning service provided within or outside of the MCO's provider network;
- (c) Cover an emergency service:
  1. In accordance with 42 U.S.C. 1396u-2(b)(2)(A)(i);
  2. Provided within or outside of the MCO's provider network; and
  3. If provided out-of-state, in accordance with 42 C.F.R. 431.52;
- (d) Comply with 42 U.S.C. 1396u-2(b)(2)(A)(ii); and
- (e) Be responsible for the provision and reimbursement of a covered service as described in this section beginning on or after the beginning date of enrollment of a recipient with an MCO as established in 907 KAR 17:010.

(6)(a) If an enrollee is receiving a medically necessary covered service the day before enrollment with an MCO, the MCO shall be responsible for the reimbursement of continuation of the medically necessary covered service without prior approval and without regard to whether services are provided within or outside the MCO's network until the MCO can reasonably transfer the enrollee to a network provider.

(b) An MCO shall comply with paragraph (a) of this subsection without impeding service delivery or jeopardizing the enrollee's health.

(7) To determine if a service is medically necessary and clinically appropriate, the MCO shall:

- (a) Comply with 907 KAR 3:130; and
- (b) Make utilization decisions as follows:
  1. Until the commissioner of the Department of Insurance issues a final order pursuant to KRS 304.240(1)(b)2., in accordance with nationally recognized criteria as approved by the department; and
  2. Once the commissioner of the Department of Insurance issues a final order pursuant to KRS 304.240(1)(b)2., by complying with KRS 205.536.

Section 2. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services. (1) An MCO shall provide an enrollee under the age of twenty-one (21) years with EPSDT services in compliance with:

- (a) 907 KAR 11:034; and
- (b) 42 U.S.C. 1396d(r).

(2) A provider of an EPSDT service shall meet the requirements established in 907 KAR 11:034.

Section 3. Emergency Care, Urgent Care, and Post-stabilization Care. (1) An MCO shall provide to an enrollee:

- (a) Emergency care twenty-four (24) hours a day, seven (7) days a week; and

- (b) Urgent care within forty-eight (48) hours.
- (2) Post-stabilization services shall be provided and reimbursed in accordance with 42 C.F.R. 422.113(c) and 438.114(e).
- (3)(a) Prior authorization shall not be required for a physical emergency service or a behavioral health emergency service.
- (b) In order to be covered, an emergency service shall be:
  - 1. Medically necessary; and
  - 2. Covered in accordance with Section 1(5)(c) of this administrative regulation.

Section 4. Maternity Care. An MCO shall:

- (1) Have procedures to assure:
  - (a) Prompt initiation of prenatal care; or
  - (b) Continuation of prenatal care without interruption for a woman who is pregnant at the time of enrollment;
- (2) Provide maternity care that includes:
  - (a) Prenatal;
  - (b) Delivery;
  - (c) Postpartum care; and
  - (d) Care for a condition that complicates a pregnancy; and
- (3) Perform all the newborn screenings referenced in 902 KAR 4:030.

Section 5. Pediatric Interface. (1) An MCO shall:

- (a) Have procedures to coordinate care for a child receiving a school-based health service or an early intervention service; and
- (b) Monitor the continuity and coordination of care for the child receiving a service referenced in paragraph (a) of this subsection as part of its quality assessment and performance improvement (QAPI) program.
- (2) Except when a child's course of treatment is interrupted by a school break, after-school hours, or summer break, an MCO shall not be responsible for a service referenced in subsection (1)(a) of this section.
- (3) A school-based health service provided by a school district shall not be covered by an MCO.
- (4) A school-based health service provided by a local health department shall be covered by an MCO.

Section 6. Lock-in Program. (1) An MCO shall have a program to control utilization of:

- (a) Drugs and other pharmacy benefits; and
- (b) Non-emergency care provided in an emergency setting.
- (2)(a) The program referenced in subsection (1) of this section shall be approved by the department.
- (b) An MCO shall not be required to use the criteria established in 907 KAR 1:677 for placing an enrollee in the MCO's lock-in program if:
  - 1. The MCO provides notice to the enrollee, in accordance with the adverse action notice requirements established in 907 KAR 17:010, of being placed in the MCO's lock-in program; and
  - 2. The enrollee is granted the opportunity to appeal being placed in a lock-in program in accordance with the:
    - a. MCO internal appeal process requirements established in 907 KAR 17:010; and
    - b. The department's state fair hearing requirements established in 907 KAR 17:010.

Section 7. Pharmacy Benefit Program. (1) The pharmacy benefit program shall be in compliance with the applicable federal and state law, including 42 U.S.C. 1396b(m)(2)(A)(xiii) and 42 C.F.R. 447.500 through 447.522.

(2) If a prescription for an enrollee is for a non-preferred drug and the pharmacist cannot reach the enrollee's primary care provider or the MCO for approval and the pharmacist determines it necessary to provide the prescribed drug, the pharmacist shall:

(a) Provide a seventy-two (72) hour supply of the prescribed drug; or

(b) Provide less than a seventy-two (72) hour supply of the prescribed drug, if the request is for less than a seventy-two (72) hour supply.

(3) Cost sharing imposed by an MCO shall not exceed the cost sharing limits established in 907 KAR 1:604.

Section 8. Behavioral Health Services. (1) An MCO shall:

(a) Provide a medically necessary behavioral health service to an enrollee in accordance with the access standards established in 907 KAR 17:015, Section 2;

(b) Use the DSM-IV multi-axial classification system to assess an enrollee for a behavioral service;

(c) Have an emergency or crisis behavioral health toll-free hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week;

(d) Not operate one (1) hotline to handle both an emergency or crisis call and a routine enrollee call; and

(e) Not impose a maximum call duration limit.

(2) Staff of a hotline referenced in subsection (1)(c) of this section shall:

(a) Communicate in a culturally competent and linguistically accessible manner to an enrollee; and

(b) Include or have access to a qualified behavioral health professional to assess and triage a behavioral health emergency.

(3) A face-to-face emergency service shall be available:

(a) Twenty-four (24) hours a day; and

(b) Seven (7) days a week.

Section 9. Court-Ordered Psychiatric Services. (1) An MCO shall:

(a) Provide an inpatient psychiatric service to an enrollee under the age of twenty-one (21) or over the age of sixty-five (65) who has been ordered to receive the service by a court of competent jurisdiction under the provisions of KRS Chapters 202A or 645;

(b) Not deny, reduce, or negate the medical necessity of an inpatient psychiatric service provided pursuant to a court-ordered commitment for an enrollee under the age of twenty-one (21) or over the age of sixty-five (65);

(c) Coordinate with a provider of a behavioral health service the treatment objectives and projected length of stay for an enrollee committed by a court of law to a state psychiatric hospital; and

(d) Enter into a collaborative agreement with the state-operated or state-contracted psychiatric hospital assigned to the enrollee's district in accordance with 908 KAR 2:040 and in accordance with the Olmstead decision.

(2) An MCO shall present a modification or termination of a service referenced in subsection (1)(b) of this section to the court with jurisdiction over the matter for determination.

(3)(a) An MCO behavioral health service provider shall:

1. Participate in a quarterly continuity of care meeting with a state-operated or state- con-

tracted psychiatric hospital;

2. Assign a case manager prior to or on the date of discharge of an enrollee from a state-operated or state-contracted psychiatric hospital; and

3. Provide case management services to an enrollee with a severe mental illness and co-occurring developmental disability who is discharged from a:

a. State-operated or state-contracted psychiatric hospital; or

b. State-operated nursing facility for individuals with severe mental illness.

(b) A case manager and a behavioral health service provider shall participate in discharge planning to ensure compliance with the Olmstead decision.

Section 10. Centers for Medicare and Medicaid Services Approval and Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies or does not provide federal financial participation for the policy; or

(2) Disapproves the policy. (39 Ky.R. 1836; 2353; eff. 6-27-2013; TAm eff. 7-16-2013; 44 Ky.R. 1406, 2081, 2329; eff. 6-1-2018; TAm eff. 6-5-2018; TAm eff. 1-25-2021.)