AN ACT relating to behavioral health services benefits in the Medicaid program.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

(1) Notwithstanding any other state law, the Department for Medicaid Services shall directly administer all behavioral health service benefits for Medicaid recipients.

(2) (a) A contract to provide benefits under this chapter shall not be entered into or renewed if it provides for the administration of behavioral health services benefits for Medicaid recipients by an entity other than the Department for Medicaid Services.

(b) Unless otherwise authorized by the General Assembly, all Medicaid managed care contracts with Medicaid managed care organizations that are entered into or renewed on or after the effective date of this Act shall be reduced in amount by at least the cost of all behavioral health service benefits within the contract or master agreement to administer the Medicaid program that was in operation as of January 1, 2019.

(3) The cabinet, or any of its departments, shall take any steps necessary to implement the requirements of this section, including but not limited to:

(a) Requesting an amendment to the State Medicaid Plan;

(b) Applying for a waiver or waiver amendment; or

(c) Making any other submission necessary to obtain authorization to implement this section.

➔Section 2. KRS 205.527 is amended to read as follows:

(1) As used in this section, "IMPACT Plus" program means the program of community-based behavioral health services provided to an eligible IMPACT Plus recipient through an agreement between the Department for Medicaid Services and the Department for Public Health as the state agency for the federal Title V

Maternal and Child Health Block Grant, 42 U.S.C. secs. 701 to 710 or as authorized under subsection (3) of this section.

(2) ~~[Any Medicaid managed care organization that contracts with]~~The Department for Medicaid Services shall, to the extent possible under the Title V agreement, manage aspects of the IMPACT Plus program for ***Medicaid recipients*** ~~[its members]~~, including but not limited to the determination of a child's eligibility for IMPACT Plus services, processing and direct payment of claims, and audits.~~[No state agency shall duplicate any function performed by the Medicaid managed care organizations for the IMPACT Plus program.]~~ Appeals of payments shall be submitted for review to the Department for Behavioral Health, Developmental and Intellectual Disabilities.

(3) Children eligible for the IMPACT Plus program may continue to receive services, if the family and provider agree, from:

(a) An individual IMPACT Plus therapist if the child is relocated outside of the provider's service area; and

(b) The same provider if a child is eligible for those services, but no longer eligible for IMPACT Plus services, and the provider meets the participation standards to provide services under the acquired brain injury, the Michelle P. waiver, the supports for community living, or the home and community based waiver programs.

(4) IMPACT Plus providers shall bill for all IMPACT Plus services, including case management, under their IMPACT Plus provider identification. IMPACT Plus providers shall not be required to obtain a Medical Assistance Identification Number (MAID). Nothing in this section shall preclude an IMPACT Plus provider from applying for a MAID number, providing they meet all necessary criteria.

(5) ***The Department for Medicaid Services*** ~~[Medicaid managed care organizations]~~may report documented gaps in IMPACT Plus services or lack of access to

IMPACT Plus services to the Department for Behavioral Health, Developmental and Intellectual Disabilities. The Department for Behavioral Health, Developmental and Intellectual Disabilities shall verify or not verify the reported gaps.

(6) If the Department for Behavioral Health, Developmental and Intellectual Disabilities verifies gaps in IMPACT Plus services or lack of access to IMPACT Plus services, IMPACT Plus providers may be utilized for additional IMPACT Plus services and additional IMPACT Plus providers may be utilized.

➔Section 3. KRS 205.560 is amended to read as follows:

(1) The scope of medical care for which the Cabinet for Health and Family Services undertakes to pay shall be designated and limited by regulations promulgated by the cabinet, pursuant to the provisions in this section. Within the limitations of any appropriation therefor, the provision of complete upper and lower dentures to recipients of Medical Assistance Program benefits who have their teeth removed by a dentist resulting in the total absence of teeth shall be a mandatory class in the scope of medical care. Payment to a dentist of any Medical Assistance Program benefits for complete upper and lower dentures shall only be provided on the condition of a preauthorized agreement between an authorized representative of the Medical Assistance Program and the dentist prior to the removal of the teeth. The selection of another class or other classes of medical care shall be recommended by the council to the secretary for health and family services after taking into consideration, among other things, the amount of federal and state funds available, the most essential needs of recipients, and the meeting of such need on a basis insuring the greatest amount of medical care as defined in KRS 205.510 consonant with the funds available, including but not limited to the following categories, except where the aid is for the purpose of obtaining an abortion:

(a) Hospital care, including drugs, and medical supplies and services during any period of actual hospitalization;

(b) Nursing-home care, including medical supplies and services, and drugs during confinement therein on prescription of a physician, dentist, or podiatrist;

(c) Drugs, nursing care, medical supplies, and services during the time when a recipient is not in a hospital but is under treatment and on the prescription of a physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall include products for the treatment of inborn errors of metabolism or genetic, gastrointestinal, and food allergic conditions, consisting of therapeutic food, formulas, supplements, amino acid-based elemental formula, or low-protein modified food products that are medically indicated for therapeutic treatment and are administered under the direction of a physician, and include but are not limited to the following conditions:

1. Phenylketonuria;
2. Hyperphenylalaninemia;
3. Tyrosinemia (types I, II, and III);
4. Maple syrup urine disease;
5. A-ketoacid dehydrogenase deficiency;
6. Isovaleryl-CoA dehydrogenase deficiency;
7. 3-methylcrotonyl-CoA carboxylase deficiency;
8. 3-methylglutaconyl-CoA hydratase deficiency;
9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency);
10. B-ketothiolase deficiency;
11. Homocystinuria;
12. Glutaric aciduria (types I and II);
13. Lysinuric protein intolerance;
14. Non-ketotic hyperglycinemia;
15. Propionic acidemia;

16. Gyrate atrophy;
17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
18. Carbamoyl phosphate synthetase deficiency;
19. Ornithine carbamoyl transferase deficiency;
20. Citrullinemia;
21. Arginosuccinic aciduria;
22. Methylmalonic acidemia;
23. Argininemia;
24. Food protein allergies;
25. Food protein-induced enterocolitis syndrome;
26. Eosinophilic disorders; and
27. Short bowel syndrome;

(d) Physician, podiatric, and dental services;

(e) Optometric services for all age groups shall be limited to prescription services, services to frames and lenses, and diagnostic services provided by an optometrist, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses shall be provided only to children under age twenty-one (21);

(f) Drugs on the prescription of a physician used to prevent the rejection of transplanted organs if the patient is indigent; and

(g) Nonprofit neighborhood health organizations or clinics where some or all of the medical services are provided by licensed registered nurses or by advanced medical students presently enrolled in a medical school accredited by the Association of American Medical Colleges and where the students or licensed registered nurses are under the direct supervision of a licensed physician who rotates his services in this supervisory capacity between two (2) or more of the

nonprofit neighborhood health organizations or clinics specified in this paragraph.

(2) Payments for hospital care, nursing-home care, and drugs or other medical, ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount of the payment to the cost of providing the services or supplies. It shall be one (1) of the functions of the council to make recommendations to the Cabinet for Health and Family Services with respect to the bases for payment. In determining the rates of reimbursement for long-term-care facilities participating in the Medical Assistance Program, the Cabinet for Health and Family Services shall, to the extent permitted by federal law, not allow the following items to be considered as a cost to the facility for purposes of reimbursement:

(a) Motor vehicles that are not owned by the facility, including motor vehicles that are registered or owned by the facility but used primarily by the owner or family members thereof;

(b) The cost of motor vehicles, including vans or trucks, used for facility business shall be allowed up to fifteen thousand dollars ($15,000) per facility, adjusted annually for inflation according to the increase in the consumer price index-u for the most recent twelve (12) month period, as determined by the United States Department of Labor. Medically equipped motor vehicles, vans, or trucks shall be exempt from the fifteen thousand dollar ($15,000) limitation. Costs exceeding this limit shall not be reimbursable and shall be borne by the facility. Costs for additional motor vehicles, not to exceed a total of three (3) per facility, may be approved by the Cabinet for Health and Family Services if the facility demonstrates that each additional vehicle is necessary for the operation of the facility as required by regulations of the cabinet;

(c) Salaries paid to immediate family members of the owner or administrator, or both, of a facility, to the extent that services are not actually performed and are

not a necessary function as required by regulation of the cabinet for the operation of the facility. The facility shall keep a record of all work actually performed by family members;

(d) The cost of contracts, loans, or other payments made by the facility to owners, administrators, or both, unless the payments are for services which would otherwise be necessary to the operation of the facility and the services are required by regulations of the Cabinet for Health and Family Services. Any other payments shall be deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health and Family Services. Interest paid to the facility for loans made to a third party may be used to offset allowable interest claimed by the facility;

(e) Private club memberships for owners or administrators, travel expenses for trips outside the state for owners or administrators, and other indirect payments made to the owner, unless the payments are deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health and Family Services; and

(f) Payments made to related organizations supplying the facility with goods or services shall be limited to the actual cost of the goods or services to the related organization, unless it can be demonstrated that no relationship between the facility and the supplier exists. A relationship shall be considered to exist when an individual, including brothers, sisters, father, mother, aunts, uncles, and in-laws, possesses a total of five percent (5%) or more of ownership equity in the facility and the supplying business. An exception to the relationship shall exist if fifty-one percent (51%) or more of the supplier's business activity of the type carried on with the facility is transacted with persons and organizations other than the facility and its related organizations.

(3) No vendor payment shall be made unless the class and type of medical care

rendered and the cost basis therefor has first been designated by regulation.

(4) The rules and regulations of the Cabinet for Health and Family Services shall require that a written statement, including the required opinion of a physician, shall accompany any claim for reimbursement for induced premature births. This statement shall indicate the procedures used in providing the medical services.

(5) The range of medical care benefit standards provided and the quality and quantity standards and the methods for determining cost formulae for vendor payments within each category of public assistance and other recipients shall be uniform for the entire state, and shall be designated by regulation promulgated within the limitations established by the Social Security Act and federal regulations. It shall not be necessary that the amount of payments for units of services be uniform for the entire state but amounts may vary from county to county and from city to city, as well as among hospitals, based on the prevailing cost of medical care in each locale and other local economic and geographic conditions, except that insofar as allowed by applicable federal law and regulation, the maximum amounts reimbursable for similar services rendered by physicians within the same specialty of medical practice shall not vary according to the physician's place of residence or place of practice, as long as the place of practice is within the boundaries of the state.

(6) Nothing in this section shall be deemed to deprive a woman of all appropriate medical care necessary to prevent her physical death.

(7) To the extent permitted by federal law, no medical assistance recipient shall be recertified as qualifying for a level of long-term care below the recipient's current level, unless the recertification includes a physical examination conducted by a physician licensed pursuant to KRS Chapter 311 or by an advanced practice registered nurse licensed pursuant to KRS Chapter 314 and acting under the physician's supervision.

(8) If payments made to community mental health centers, established pursuant to KRS

Chapter 210, for services provided to the intellectually disabled exceed the actual cost of providing the service, the balance of the payments shall be used solely for the provision of other services to the intellectually disabled through community mental health centers.

(9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to recipients of medical assistance under Title XIX of the Social Security Act on July 15, 1986, shall deny admission of a person to a bed certified for reimbursement under the provisions of the Medical Assistance Program solely on the basis of the person's paying status as a Medicaid recipient. No person shall be removed or discharged from any facility solely because they became eligible for participation in the Medical Assistance Program, unless the facility can demonstrate the resident or the resident's responsible party was fully notified in writing that the resident was being admitted to a bed not certified for Medicaid reimbursement. No facility may decertify a bed occupied by a Medicaid recipient or may decertify a bed that is occupied by a resident who has made application for medical assistance.

(10) Family-practice physicians practicing in geographic areas with no more than one (1) primary-care physician per five thousand (5,000) population, as reported by the United States Department of Health and Human Services, shall be reimbursed one hundred twenty-five percent (125%) of the standard reimbursement rate for physician services.

(11) The Cabinet for Health and Family Services shall make payments under the Medical Assistance program for services which are within the lawful scope of practice of a chiropractor licensed pursuant to KRS Chapter 312, to the extent the Medical Assistance Program pays for the same services provided by a physician.

(12) (a) The Medical Assistance Program shall use the appropriate form and guidelines for enrolling those providers applying for participation in the Medical Assistance Program, including those licensed and regulated under

KRS Chapters 311, 312, 314, 315, and 320, any facility required to be licensed pursuant to KRS Chapter 216B, and any other health care practitioner or facility as determined by the Department for Medicaid Services through an administrative regulation promulgated under KRS Chapter 13A. A Medicaid managed care organization shall use the forms and guidelines established under KRS 304.17A-545(5) to credential a provider. For any provider who contracts with and is credentialed by a Medicaid managed care organization prior to enrollment, the cabinet shall complete the enrollment process and deny, or approve and issue a Provider Identification Number (PID) within fifteen (15) business days from the time all necessary completed enrollment forms have been submitted and all outstanding accounts receivable have been satisfied.

(b) Within forty-five (45) days of receiving a correct and complete provider application, the Department for Medicaid Services shall complete the enrollment process by either denying or approving and issuing a Provider Identification Number (PID) for a behavioral health provider who provides substance use disorder services, unless the department notifies the provider that additional time is needed to render a decision for resolution of an issue or dispute.

(c)~~[Within forty-five (45) days of receipt of a correct and complete application for credentialing by a behavioral health provider providing substance use disorder services, a Medicaid managed care organization shall complete its contracting and credentialing process, unless the Medicaid managed care organization notifies the provider that additional time is needed to render a decision. If additional time is needed, the Medicaid managed care organization shall not take any longer than ninety (90) days from receipt of the credentialing application to deny or approve and contract with the provider.~~

~~(d) A Medicaid managed care organization shall adjudicate any clean claims submitted for a substance use disorder service from an enrolled and credentialed behavioral health provider who provides substance use disorder services in accordance with KRS 304.17A-700 to 304.17A-730.~~]

[~~(e)~~] The Department of Insurance may impose a civil penalty of one hundred dollars ($100) per violation when a Medicaid managed care organization fails to comply with ***paragraph (a) of this subsection***[~~this section. Each day that a Medicaid managed care organization fails to pay a claim may count as a separate violation~~].

(13) Dentists licensed under KRS Chapter 313 shall be excluded from the requirements of subsection (12) of this section. The Department for Medicaid Services shall develop a specific form and establish guidelines for assessing the credentials of dentists applying for participation in the Medical Assistance Program.

➔Section 4. KRS 205.6311 is amended to read as follows:

(1) The Department for Medicaid Services shall provide a substance use disorder benefit consistent with federal laws and regulations which shall include a broad array of treatment options for those with heroin and other substance use disorders.

(2) The department shall promulgate administrative regulations to implement this section and to expand the behavioral health network to allow providers to provide services within their licensure category.

(3) Providers of peer-mediated, recovery-oriented, therapeutic community models of care shall have the opportunity to [~~contract with managed care organizations to~~]be reimbursed for any portion of those services that are provided by licensed or certified providers in accordance with approved billing codes.

(4) ***The Department for Medicaid Services***[~~A Medicaid managed care organization~~] shall:

(a) Authorize treatment for each diagnosis related to substance use disorder and

co-occurring mental health and substance use disorder covered by Medicaid that is identified within the most updated edition of the Diagnostic and Statistical Manual of Mental Disorders issued by the American Psychiatric Association that meets the criteria for medical necessity and level of care; and

(b) Approve coverage and payment for continuing care at the appropriate level of care.

(5) Beginning January 1, 2016, the Department for Medicaid Services shall provide an annual report to the Legislative Research Commission detailing the number of providers of substance use disorder treatment, the type of services offered by each provider, the geographic distribution of providers, and a summary of expenditures on substance use disorder treatment services provided by Medicaid.

➔Section 5. KRS 304.38-240 is amended to read as follows:

(1) (a) The commissioner shall promulgate an administrative regulation to establish procedures for conducting a competitive process to solicit proposals from publishers of medical necessity criteria to designate for each category of services which medical necessity criteria Medicaid managed care organizations, as defined in KRS 205.532, shall use to determine the medical necessity and clinical appropriateness of proposed services pursuant to the utilization review plan required by KRS 205.536.

(b) The procedures shall require:

1. The department to provide adequate public notice of the deadline for publishers of medical necessity criteria to submit proposals; and

2. a. The commissioner to issue a final order at the conclusion of the competitive process.

b. The order shall designate, for each category of services, one (1) set of medical necessity criteria determined by the commissioner to be the most advantageous to the Commonwealth.

c. Nothing in this section shall preclude the commissioner from designating the same set of medical necessity criteria for two (2) or more categories of service if the commissioner determines, in accordance with the procedures required by this subsection, that the designation would be the most advantageous to the Commonwealth.

(c) The procedures shall permit any person who is aggrieved in connection with the solicitation of proposals or the commissioner's final order to request a hearing pursuant to KRS 304.2-310.

(2) (a) For purposes of this subsection, "objective and evidence-based" includes:

1. Methods or systems where:

a. The publisher evaluates and grades the sufficiency of medical evidence incorporated into the criteria;

b. The publisher reviews and updates the criteria periodically as appropriate, but no less frequently than annually; and

c. The criteria are evaluated annually by a panel of one (1) or more physicians not directly employed by the publisher of the criteria; and

2. Sufficient unique citations to published medical research and other peer-reviewed literature to substantiate the criteria's evidentiary basis.

(b) In conducting the competitive process required by subsection (1) of this section, the commissioner shall only accept proposals from publishers of medical necessity criteria if the criteria:

1. Are nationally recognized;

2. Are objective and evidence-based; and

3. Are not proprietary property of a Medicaid managed care organization or a subsidiary of a Medicaid managed care organization, or a corporation

which a Medicaid managed care organization controls or owns more than five percent (5%) of the stock.

(3) The categories of service shall be limited to:

(a) Physical health services; ***and***

(b) ~~[Behavioral health services; and~~

~~(c)]~~Any other categories of service required under federal law for Medicaid managed care.

(4) (a) Notwithstanding KRS 13A.3102, any administrative regulation promulgated under this section shall expire two (2) years from the last effective date, as defined in KRS 13A.010, unless the department follows the certification or amendment process established in KRS 13A.3104.

(b) If the department files a certification letter pursuant to KRS 13A.3104, and does not intend to amend an administrative regulation promulgated under this section, it shall allow for a public comment period and public hearing on the certification letter meeting the requirements of KRS 13A.270.

(5) In promulgating any administrative regulation under this section, the commissioner shall:

(a) Collaborate with the Department for Medicaid Services to ensure that the regulation is consistent with:

1. Federal requirements relating to Medicaid managed care medical necessity review criteria; and

2. Any administrative regulation promulgated by the Department for Medicaid Services that is not inconsistent with this section, relating to the processes Medicaid managed care organizations are required to follow when using the medical necessity criteria designated pursuant to this section;

(b) Set forth in any federal mandate analysis comparison for an administrative

regulation promulgated under this section:

1. A description of any federal requirements relating to Medicaid managed care medical necessity review criteria; and
2. A summary of all input provided by the Department for Medicaid Services to the commissioner relating to the form and content of the regulation; and

(c) Receive from the Department for Medicaid Services the input of healthcare professionals, which shall include members of the Advisory Council for Medical Assistance established pursuant to KRS 205.540, in each category of care in accordance with subsection (3) of this section.