AN ACT relating to regional service areas for regional community services programs.

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

➔Section 1. KRS 210.005 is amended to read as follows:

As used in this chapter, unless the context otherwise requires:

(1) "Individual with an intellectual disability" means a person with significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period**;** ~~[.]~~

(2) "Mental illness" means a diagnostic term that covers many clinical categories, typically including behavioral or psychological symptoms, or both, along with impairment of personal and social function, and specifically defined and clinically interpreted through reference to criteria contained in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition) and any subsequent revision thereto, of the American Psychiatric Association**;** ~~[.]~~

(3) "Chronic" means that clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two (2) years, or that the individual has been hospitalized for mental illness more than once in the last two (2) years, and that the individual is presently significantly impaired in his ability to function socially or occupationally, or both**;** ~~[.]~~

(4) "Cabinet" means the Cabinet for Health and Family Services**;** ~~[.]~~

(5) "Deaf or hard-of-hearing" means having a hearing impairment so that a person cannot hear and understand speech clearly through the ear alone, irrespective of the use of any hearing aid device**;** ~~[.]~~

(6) "Secretary" means the secretary of the Cabinet for Health and Family Services***; and***

(7) "Regional community services program" means a community services program for mental health or individuals with an intellectual disability established in accordance with this chapter, a community mental health center, a certified

community behavioral health clinic, or a certified eligible community behavioral health clinic.

➔Section 2. KRS 210.370 is amended to read as follows:

(1) The following fifteen (15) regional service areas for regional community services programs are hereby created and established:

(a) Regional service area one (1), which shall include the counties of Ballard, Carlisle, Hickman, Fulton, McCracken, Graves, Marshall, Livingston, and Calloway;

(b) Regional service area two (2), which shall include the counties of Crittenden, Lyon, Caldwell, Hopkins, Muhlenberg, Trigg, Christian, and Todd;

(c) Regional service area three (3), which shall include the counties of Union, Henderson, Webster, McLean, Daviess, Ohio, and Hancock;

(d) Regional service area four (4), which shall include the counties of Logan, Simpson, Butler, Warren, Edmonson, Hart, Barren, Allen, Metcalfe, and Monroe;

(e) Regional service area five (5), which shall include the counties of Breckinridge, Meade, Grayson, Hardin, Larue, Nelson, Washington, and Marion;

(f) Regional service area six (6), which shall include the counties of Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, and Trimble;

(g) Regional service area seven (7), which shall include the counties of Boone, Kenton, Campbell, Carroll, Gallatin, Owen, Grant, and Pendleton;

(h) Regional service area eight (8), which shall include the counties of Bracken, Mason, Robertson, Fleming, and Lewis;

(i) Regional service area nine (9), which shall include the counties of Rowan, Bath, Montgomery, Menifee, and Morgan;

(j) Regional service area ten (10), which shall include the counties of Greenup, Boyd, Carter, Elliott, and Lawrence;

(k) Regional service area eleven (11), which shall include the counties of Johnson, Magoffin, Martin, Floyd, and Pike;

(l) Regional service area twelve (12), which shall include the counties of Wolfe, Owsley, Lee, Breathitt, Leslie, Perry, Knott, and Letcher;

(m) Regional service area thirteen (13), which shall include the counties of Jackson, Rockcastle, Laurel, Clay, Knox, Whitley, Bell, and Harlan;

(n) Regional service area fourteen (14), which shall include the counties of Taylor, Adair, Green, Casey, Russell, Pulaski, Clinton, Cumberland, Wayne, and McCreary; and

(o) Regional service area fifteen (15), which shall include the counties of Anderson, Franklin, Woodford, Mercer, Boyle, Lincoln, Garrard, Jessamine, Fayette, Scott, Harrison, Bourbon, Nicholas, Clark, Madison, Powell, and Estill.

(2) Notwithstanding subsection (1) of this section, any combination of cities or counties of over fifty thousand (50,000) population, and upon the consent of the secretary of the ***cabinet***~~[Cabinet for Health and Family Services,]~~ any combination of cities or counties with less than fifty thousand (50,000) population, may establish a regional community services program~~[for mental health or individuals with an intellectual disability]~~ and staff same with persons specially trained in psychiatry and related fields. Such programs and clinics may be administered by a community board for mental health or individuals with an intellectual disability established pursuant to KRS 210.370 to 210.460, or by a nonprofit corporation.

(3) Notwithstanding any provision of law to the contrary and except as provided for in subsection (4) of this section:

(a) A regional community services program may provide services outside of its

regional service area as established in subsection (1) of this section, but when doing so, the regional community services program shall be considered, including by the cabinet, to be operating as a behavioral health services organization and not as a regional community services program.

(b) A regional community services program shall not be required to obtain licensure or any other form of authorization from the cabinet to operate as a behavioral health services organization in order to provide services outside of its regional service area established in subsection (1) of this section.

(c) When a regional community services program chooses to provide services as a behavioral health services organization outside of its regional service area established in subsection (1) of this section, the regional community services program shall:

1. Comply with all administrative regulations related to behavioral health services organization promulgated by the cabinet; and

2. Be reimbursed by the Department for Medicaid Services or a managed care organization with whom the department has contracted for the delivery of Medicaid services in accordance with subsection (8)(b) of Section 4 of this Act.

(4) (a) If a regional community services program notifies the secretary in writing that the regional community services program is unable to provide a service that is included in its respective plan and budget for the current fiscal year:

1. The secretary shall contact the regional community services programs in the regional service areas contiguous to the region that has notified the secretary to assess their interest in and ability to provide the service that the regional community service program indicated it is unable to provide. If a regional community services program in a

contiguous regional service area is interested in an able to provide the service, the secretary shall approve it to provide that service in the regional service area of the regional community services program that made notice to the secretary; and

2. If a regional community services program in a contiguous region is not interested in or is unable to provide the service, the secretary shall contact all other regional community services programs to assess their interest in and ability to provide the service that the regional community services program indicated it is unable to provide. If another regional community services program in a noncontiguous regional service area is interested in and able to provide the service, the secretary shall approve it to provide that service in the regional service area of the regional community services program that made notice to the secretary.

(b) If a regional community services program is approved by the secretary pursuant to this subsection to provide services outside of its regional service area as established in subsection (1) of this section, the regional community services program shall be considered, including by the cabinet, to be operating as a regional community services program and shall be reimbursed by the Department for Medicaid Services or a managed care organization with whom the department has contracted for the delivery of Medicaid services accordingly.

➔Section 3. KRS 210.410 is amended to read as follows:

(1) The secretary of the ***cabinet***~~[Cabinet for Health and Family Services]~~ is hereby authorized to make state grants and other fund allocations from the ***cabinet***~~[Cabinet for Health and Family Services]~~ to assist any ***regional service area established in Section 2 of this Act, any*** combination of cities and counties, or nonprofit

corporations in the establishment and operation of regional community mental health and intellectual disability programs which may provide primary care services and shall provide at least the following services:

(a) Inpatient services;

(b) Outpatient services;

(c) Partial hospitalization or psychosocial rehabilitation services;

(d) Emergency services;

(e) Consultation and education services; and

(f) Services for individuals with an intellectual disability.

(2) The services required in subsection (1)(a), (b), (c), (d), and (e) of this section, in addition to primary care services, if provided, shall be available to the mentally ill, drug abusers and alcohol abusers, and all age groups including children and the elderly. The services required in subsection (1)(a), (b), (c), (d), (e), and (f), in addition to primary care services, if provided, shall be available to individuals with an intellectual disability. The services required in subsection (1)(b) of this section shall be available to any child age sixteen (16) or older upon request of such child without the consent of a parent or legal guardian, if the matter for which the services are sought involves alleged physical or sexual abuse by a parent or guardian whose consent would otherwise be required.

➔Section 4. 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) ***(a)*** 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.

(b) If a community mental health center, established pursuant to KRS Chapter 210, provides services to a recipient of Medical Assistance Program benefits outside of the community mental health center's regional service area, as established in Section 2 of this Act, the community mental health center shall not be reimbursed for such services in accordance with the department's fee schedule for community mental health centers but shall instead be reimbursed in accordance with the department's fee schedule for behavioral health service organizations.

(c) As used in this subsection, "community mental health center" means a regional community services program as defined in Section 1 of this Act.

(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 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.