

1 AN ACT relating to certified waiver providers.

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

3 ➔Section 1. KRS 205.560 is amended to read as follows:

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

- 21 (a) Hospital care, including drugs, and medical supplies and services during any
22 period of actual hospitalization;
- 23 (b) Nursing-home care, including medical supplies and services, and drugs during
24 confinement therein on prescription of a physician, dentist, or podiatrist;
- 25 (c) Drugs, nursing care, medical supplies, and services during the time when a
26 recipient is not in a hospital but is under treatment and on the prescription of a
27 physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall

1 include products for the treatment of inborn errors of metabolism or genetic,
2 gastrointestinal, and food allergic conditions, consisting of therapeutic food,
3 formulas, supplements, amino acid-based elemental formula, or low-protein
4 modified food products that are medically indicated for therapeutic treatment
5 and are administered under the direction of a physician, and include but are
6 not limited to the following conditions:

- 7 1. Phenylketonuria;
- 8 2. Hyperphenylalaninemia;
- 9 3. Tyrosinemia (types I, II, and III);
- 10 4. Maple syrup urine disease;
- 11 5. A-ketoacid dehydrogenase deficiency;
- 12 6. Isovaleryl-CoA dehydrogenase deficiency;
- 13 7. 3-methylcrotonyl-CoA carboxylase deficiency;
- 14 8. 3-methylglutaconyl-CoA hydratase deficiency;
- 15 9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase
16 deficiency);
- 17 10. B-ketothiolase deficiency;
- 18 11. Homocystinuria;
- 19 12. Glutaric aciduria (types I and II);
- 20 13. Lysinuric protein intolerance;
- 21 14. Non-ketotic hyperglycinemia;
- 22 15. Propionic acidemia;
- 23 16. Gyrate atrophy;
- 24 17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
- 25 18. Carbamoyl phosphate synthetase deficiency;
- 26 19. Ornithine carbamoyl transferase deficiency;
- 27 20. Citrullinemia;

- 1 21. Arginosuccinic aciduria;
- 2 22. Methylmalonic acidemia;
- 3 23. Argininemia;
- 4 24. Food protein allergies;
- 5 25. Food protein-induced enterocolitis syndrome;
- 6 26. Eosinophilic disorders; and
- 7 27. Short bowel syndrome;
- 8 (d) Physician, podiatric, and dental services;
- 9 (e) Optometric services for all age groups shall be limited to prescription
- 10 services, services to frames and lenses, and diagnostic services provided by an
- 11 optometrist, to the extent the optometrist is licensed to perform the services
- 12 and to the extent the services are covered in the ophthalmologist portion of the
- 13 physician's program. Eyeglasses shall be provided only to children under age
- 14 twenty-one (21);
- 15 (f) Drugs on the prescription of a physician used to prevent the rejection of
- 16 transplanted organs if the patient is indigent; and
- 17 (g) Nonprofit neighborhood health organizations or clinics where some or all of
- 18 the medical services are provided by licensed registered nurses or by
- 19 advanced medical students presently enrolled in a medical school accredited
- 20 by the Association of American Medical Colleges and where the students or
- 21 licensed registered nurses are under the direct supervision of a licensed
- 22 physician who rotates his services in this supervisory capacity between two
- 23 (2) or more of the nonprofit neighborhood health organizations or clinics
- 24 specified in this paragraph.
- 25 (2) Payments for hospital care, nursing-home care, and drugs or other medical,
- 26 ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount
- 27 of the payment to the cost of providing the services or supplies. It shall be one (1)

1 of the functions of the council to make recommendations to the Cabinet for Health
2 and Family Services with respect to the bases for payment. In determining the rates
3 of reimbursement for long-term-care facilities participating in the Medical
4 Assistance Program, the Cabinet for Health and Family Services shall, to the extent
5 permitted by federal law, not allow the following items to be considered as a cost to
6 the facility for purposes of reimbursement:

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

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

21 (c) Salaries paid to immediate family members of the owner or administrator, or
22 both, of a facility, to the extent that services are not actually performed and
23 are not a necessary function as required by regulation of the cabinet for the
24 operation of the facility. The facility shall keep a record of all work actually
25 performed by family members;

26 (d) The cost of contracts, loans, or other payments made by the facility to owners,
27 administrators, or both, unless the payments are for services which would

- 1 otherwise be necessary to the operation of the facility and the services are
2 required by regulations of the Cabinet for Health and Family Services. Any
3 other payments shall be deemed part of the owner's compensation in
4 accordance with maximum limits established by regulations of the Cabinet for
5 Health and Family Services. Interest paid to the facility for loans made to a
6 third party may be used to offset allowable interest claimed by the facility;
- 7 (e) Private club memberships for owners or administrators, travel expenses for
8 trips outside the state for owners or administrators, and other indirect
9 payments made to the owner, unless the payments are deemed part of the
10 owner's compensation in accordance with maximum limits established by
11 regulations of the Cabinet for Health and Family Services; and
- 12 (f) Payments made to related organizations supplying the facility with goods or
13 services shall be limited to the actual cost of the goods or services to the
14 related organization, unless it can be demonstrated that no relationship
15 between the facility and the supplier exists. A relationship shall be considered
16 to exist when an individual, including brothers, sisters, father, mother, aunts,
17 uncles, and in-laws, possesses a total of five percent (5%) or more of
18 ownership equity in the facility and the supplying business. An exception to
19 the relationship shall exist if fifty-one percent (51%) or more of the supplier's
20 business activity of the type carried on with the facility is transacted with
21 persons and organizations other than the facility and its related organizations.
- 22 (3) No vendor payment shall be made unless the class and type of medical care
23 rendered and the cost basis therefor has first been designated by regulation.
- 24 (4) The rules and regulations of the Cabinet for Health and Family Services shall
25 require that a written statement, including the required opinion of a physician, shall
26 accompany any claim for reimbursement for induced premature births. This
27 statement shall indicate the procedures used in providing the medical services.

- 1 (5) The range of medical care benefit standards provided and the quality and quantity
2 standards and the methods for determining cost formulae for vendor payments
3 within each category of public assistance and other recipients shall be uniform for
4 the entire state, and shall be designated by regulation promulgated within the
5 limitations established by the Social Security Act and federal regulations. It shall
6 not be necessary that the amount of payments for units of services be uniform for
7 the entire state but amounts may vary from county to county and from city to city,
8 as well as among hospitals, based on the prevailing cost of medical care in each
9 locale and other local economic and geographic conditions, except that insofar as
10 allowed by applicable federal law and regulation, the maximum amounts
11 reimbursable for similar services rendered by physicians within the same specialty
12 of medical practice shall not vary according to the physician's place of residence or
13 place of practice, as long as the place of practice is within the boundaries of the
14 state.
- 15 (6) Nothing in this section shall be deemed to deprive a woman of all appropriate
16 medical care necessary to prevent her physical death.
- 17 (7) To the extent permitted by federal law, no medical assistance recipient shall be
18 recertified as qualifying for a level of long-term care below the recipient's current
19 level, unless the recertification includes a physical examination conducted by a
20 physician licensed pursuant to KRS Chapter 311 or by an advanced practice
21 registered nurse licensed pursuant to KRS Chapter 314 and acting under the
22 physician's supervision.
- 23 (8) (a) If payments made to community mental health centers, established pursuant to
24 KRS Chapter 210, for services provided to the intellectually disabled exceed
25 the actual cost of providing the service, the balance of the payments shall be
26 used solely for the provision of other services to the intellectually disabled
27 through community mental health centers.

- 1 (b) Except as provided in KRS 210.370(4) and (5)(c), if a community mental
2 health center, established pursuant to KRS Chapter 210, provides services to a
3 recipient of Medical Assistance Program benefits outside of the community
4 mental health center's regional service area, as established in KRS 210.370,
5 the community mental health center shall not be reimbursed for such services
6 in accordance with the department's fee schedule for community mental
7 health centers but shall instead be reimbursed in accordance with the
8 department's fee schedule for behavioral health service organizations.
- 9 (c) As used in this subsection, "community mental health center" means a
10 regional community services program as defined in KRS 210.005.
- 11 (9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to
12 recipients of medical assistance under Title XIX of the Social Security Act on July
13 15, 1986, shall deny admission of a person to a bed certified for reimbursement
14 under the provisions of the Medical Assistance Program solely on the basis of the
15 person's paying status as a Medicaid recipient. No person shall be removed or
16 discharged from any facility solely because they became eligible for participation in
17 the Medical Assistance Program, unless the facility can demonstrate the resident or
18 the resident's responsible party was fully notified in writing that the resident was
19 being admitted to a bed not certified for Medicaid reimbursement. No facility may
20 decertify a bed occupied by a Medicaid recipient or may decertify a bed that is
21 occupied by a resident who has made application for medical assistance.
- 22 (10) Family-practice physicians practicing in geographic areas with no more than one
23 (1) primary-care physician per five thousand (5,000) population, as reported by the
24 United States Department of Health and Human Services, shall be reimbursed one
25 hundred twenty-five percent (125%) of the standard reimbursement rate for
26 physician services.
- 27 (11) The Cabinet for Health and Family Services shall make payments under the

1 Medical Assistance Program for services which are within the lawful scope of
2 practice of a chiropractor licensed pursuant to KRS Chapter 312, to the extent the
3 Medical Assistance Program pays for the same services provided by a physician.

4 (12) (a) The Medical Assistance Program shall use the appropriate form and
5 guidelines for enrolling those providers applying for participation in the
6 Medical Assistance Program, including those licensed and regulated under
7 KRS Chapters 311, 312, 314, 315, and 320, any facility required to be
8 licensed pursuant to KRS Chapter 216B, and any other health care practitioner
9 or facility as determined by the Department for Medicaid Services through an
10 administrative regulation promulgated under KRS Chapter 13A. A Medicaid
11 managed care organization shall use the forms and guidelines established
12 under KRS 304.17A-545(5) to credential a provider. For any provider who
13 contracts with and is credentialed by a Medicaid managed care organization
14 prior to enrollment, the cabinet shall complete the enrollment process and
15 deny, or approve and issue a Provider Identification Number (PID) within
16 fifteen (15) business days from the time all necessary completed enrollment
17 forms have been submitted and all outstanding accounts receivable have been
18 satisfied.

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

26 (c) Within forty-five (45) days of receipt of a correct and complete application for
27 credentialing by a behavioral health provider providing substance use disorder

1 services, a Medicaid managed care organization shall complete its contracting
2 and credentialing process, unless the Medicaid managed care organization
3 notifies the provider that additional time is needed to render a decision. If
4 additional time is needed, the Medicaid managed care organization shall not
5 take any longer than ninety (90) days from receipt of the credentialing
6 application to deny or approve and contract with the provider.

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

11 (e) The Department of Insurance may impose a civil penalty of one hundred
12 dollars (\$100) per violation when a Medicaid managed care organization fails
13 to comply with this section. Each day that a Medicaid managed care
14 organization fails to pay a claim may count as a separate violation.

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

19 **(14) (a) As used in this subsection:**

20 **1. "Certified waiver provider" means a service provider who:**

21 **a. Is currently enrolled in and participating in the state's Medical**
22 **Assistance Program in accordance with administrative**
23 **regulations promulgated by the cabinet;**

24 **b. Provides Medical Assistance Program covered services to a**
25 **recipient in a 1915(c) home and community-based services**
26 **waiver program; and**

27 **c. Has been determined by the cabinet to have met the certified**

- 1 waiver provider requirements establish by the cabinet;
- 2 2. "Corrective action plan" means a document submitted by a certified
- 3 waiver provider to the cabinet that:
- 4 a. States the system changes, processes, or other actions that the
- 5 provider shall take to prevent a future occurrence of a violation
- 6 of relevant state or federal law;
- 7 b. States the timeframe in which the provider shall successfully
- 8 implement or perform a system change, process, or other action
- 9 required by the corrective action plan; and
- 10 c. Is not valid or effective until approved by the cabinet;
- 11 3. "Moratorium" means a prohibition against a certified waiver provider
- 12 providing services to a new 1915(c) home and community-based
- 13 services waiver participant; and
- 14 4. "New 1915(c) home and community-based services waiver
- 15 participant" means an individual who has never received 1915(c)
- 16 home and community-based services from a given provider though the
- 17 individual may have previously received 1915(c) home and
- 18 community-based services from another service provider.
- 19 (b) If the cabinet has reliable evidence that leads it to believe that a certified
- 20 waiver provider has committed a violation of relevant federal or state law,
- 21 including administrative regulations promulgated by the cabinet, that
- 22 threatened the health, safety, or welfare of a recipient, the cabinet shall:
- 23 1. Offer the certified wavier provider an opportunity to undergo a
- 24 voluntary moratorium while the cabinet conducts an investigation into
- 25 the alleged violation. Upon being offered an opportunity to undergo a
- 26 voluntary moratorium, a certified waiver provider shall have five (5)
- 27 business days from the date on which the offer was extended to accept

- 1 or refuse a voluntary moratorium. If the certified waiver provider
2 refuses to undergo a voluntary moratorium while the cabinet conducts
3 an investigation, the cabinet shall terminate the certified waiver
4 provider in accordance with administrative regulations promulgated
5 by the cabinet; and
- 6 2. Conduct and conclude its investigation within fourteen (14) business
7 days from the date on which a voluntary moratorium begins;
- 8 3. Document its findings in an investigation report that contains:
- 9 a. The beginning and end dates of the investigation;
- 10 b. A summary of the alleged violation or violations of relevant
11 federal or state law, including administrative regulations
12 promulgated by the cabinet, that threatened the health, safety, or
13 welfare of a recipient including a summary of the reliable
14 evidence that led the cabinet to believe that a violation had
15 occurred;
- 16 c. A summary of the investigation and how it was conducted by the
17 cabinet; and
- 18 d. A summary of the cabinet's findings and conclusions; and
- 19 4. Transmit a copy of the investigation report via email and certified mail
20 to the certified waiver provider within three (3) business days
21 following the date on which the investigation is completed.
- 22 (c) If the cabinet determines, following the conclusion of an investigation
23 conducted pursuant to this paragraph (b) of this subsection, that the
24 certified waiver provider:
- 25 1. Did not commit a violation of relevant federal or state law, including
26 administrative regulations promulgated by the cabinet, that threatened
27 the health, safety, or welfare of a recipient, the voluntary moratorium

- 1 shall be immediately lifted; or
- 2 2. Did commit a violation of relevant federal or state law, including
- 3 administrative regulations promulgated by the cabinet, that threatened
- 4 the health, safety, or welfare of a recipient, the cabinet shall:
- 5 a. Terminate the certified waiver provider in accordance with
- 6 administrative regulations promulgated by the cabinet; or
- 7 b. Offer the certified waiver provider an opportunity to continue the
- 8 voluntary moratorium during which time the certified waiver
- 9 provider shall be required to create and submit a corrective
- 10 action plan to the cabinet, and the voluntary moratorium shall be
- 11 immediately lifted upon approval of the corrective action plan by
- 12 the cabinet.
- 13 (d) Upon receipt of a corrective action plan submitted pursuant to paragraph
- 14 (c) of this subsection, the cabinet shall review and approve or reject the
- 15 corrective action plan within seven (7) business days. If the cabinet rejects a
- 16 corrective action plan, it shall specify the reasons for rejection in a response
- 17 to the certified waiver provider.
- 18 (e) The cabinet may promulgate administrative regulations in accordance with
- 19 KRS Chapter 13A to implement the provisions of this subsection.