XVI. Other diagnostic, screening, preventive and rehabilitative services.

Other diagnostic, screening, preventive and rehabilitative services provided by licensed community mental health centers, and other mental health and substance use providers shall be reimbursed as outlined below:

1. Community Mental Health Centers (CMHCs) are paid CMHC-specific cost-based rates per service based on the type of practitioner rendering the service. For the period beginning January 1, 2014, the rates are those in existence for the practitioners in CY 2013. Separate rates are set for the following practitioners:

    - Licensed Psychologist (LP)
    - Licensed Psychological Practitioner (LPP)
    - Licensed Clinical Social Worker (LCSW)
    - A psychiatric social worker with a master's degree from an accredited school
    - Licensed Professional Clinical Counselor (LPCC)
    - Licensed Professional Art Therapist (LPAT)
    - Licensed Marriage and Family Therapist (LMFT)
    - Licensed Behavior Analyst (LBA)
    - Psychiatrist
    - Physician
    - A psychiatric nurse licensed in the state of Kentucky with one of the following combination of education and experience:
        i. Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.
        ii. Bachelor of Science in Nursing and one (1) year of experience in a mental health setting.
        iii. A graduate of a three-year educational program with two (2) years of experience in a mental health setting.
        iv. A graduate of a two-year educational program (Associate degree) with three (3) years of experience in a mental health setting.
    - Licensed Alcohol and Drug Counselor (LADC)
    - Licensed Alcohol and Drug Counselor Associate*(LADCA)
    - A professional equivalent, through education in a behavioral health field and experience in a behavioral health setting, qualified to provide behavioral health services.
    - The following professionals under the appropriate supervision:
        i. A mental health associate with a minimum of a Bachelor's degree in psychology, sociology, social work, or human services under supervision of one of the above professionals;
        ii. A licensed psychological associate;
        iii. A licensed professional counselor associate;
        iv. A licensed professional art therapist associate;

XVI. Other diagnostic, screening, preventive and rehabilitative services.

ix. Peer Support Specialist working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, or a LPATA ;

x. A certified alcohol and drug counselor (CADC) working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a LPAT, or a LPATA; and

xi. A community support associate who is working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, a LPATA, a LBA, or a LABA.

The current reimbursement methodology, as outlined above, for services provided in CMHCs will end on June 30, 2016.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. All other mental health and substance use providers

The reimbursement described below is applicable to the following mental health and substance use disorder services.

- Screening
- Assessment
- Psychological Testing
- Crisis Intervention
- Residential Crisis Stabilization
- Day Treatment
- Peer Support
- Parent/Family Peer Support
- Individual Outpatient Therapy
- Group Outpatient Therapy
- Family Outpatient Therapy
- Collateral Outpatient Therapy
- Partial Hospitalization
- Service Planning
- SBIRT – Screening, Brief Intervention and Referral to Treatment (Substance use only)
- Medication Assisted Treatment (Substance use only)
- Comprehensive Community Support Services (Mental health & Co-occurring only)
- Therapeutic Rehabilitation Program (TRP) (Mental health only)

Reimbursement for the services listed above are based on the Kentucky specific Medicaid fee schedule, which can be found at http://chfs.ky.gov/dms/fee.htm and is effective beginning on January 1, 2014. The Medicaid fee schedule is based on the following methodology:

1. Physician Base Fee is calculated based on the following (in descending order of applicability):

(a) If a current Kentucky-specific Medicare rate exists for the service, physicians will be reimbursed at 75% of the current Kentucky-specific Medicare rate, as published by CMS on an annual basis, using 15 minute increments. This is calculated using the following methodology:

i The Mental Health and Substance Abuse rates start with the current standard Kentucky specific Non-Facility Medicare rate for a 60 minute service.

ii The 60 minute elapsed time rate is converted to a 15 minute rate to correspond to the Kentucky Medicaid reimbursement methodology of 15 minute units for traditional Medicaid and Mental Health providers.

iii The Kentucky Medicaid rate for physicians/psychiatrists is 75% of the current Kentucky-specific Medicare rate.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. All other mental health and substance use providers

(b) If a current Kentucky-specific Medicare rate does not exist, physicians will be reimbursed for the service based on the state's payment rates for similar services in other Kentucky Medicaid reimbursement programs (with similar degrees of complexity). Kentucky has developed, based on Resource Based Relative Value Scale weighting where possible, and absent RBRVS metrics, a weighted average based comparison of charges, so that a service that Medicare has not priced generates a Medicaid rate to a physician that is "similar" to a rate for either a similar RVRBS metric or a similar percent of charges metric.

(c) If a current Kentucky-specific Medicare rate does not exist and the service is not similar to other Kentucky Medicaid reimbursed services, physicians will be reimbursed for the service based on the state's payment rates for similar services in other Kentucky programs that are not Medicaid reimbursed (i.e., funded only through State General Funds).

XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. Other practitioners providing the service (listed in 1, 2, 3, 4, and 5 below) will be reimbursed based on a step down methodology calculated as a percentage of the physician rate (75% of the current Kentucky-specific Medicare rate, or the established Medicaid rate if a current Kentucky-specific Medicare rate does not exist). The step down includes:

(1) 85% - Advanced Practice Registered Nurse (APRN), Licensed Psychologist (LP)

(2) 80% - Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Psychological Practitioner (LPP), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Art Therapist (LPAT), Licensed Behavior Analyst (LBA), Licensed Alcohol and Drug Counselor (LADC), Certified Alcohol and Drug Counselor (CADC).

(3) 70% - Licensed Psychological Associate (LPA), Licensed Marriage and Family Therapist Associate (LMFTA), Licensed Professional Counselor Associate (LPCA), Certified Social Worker, Masters Level (CSW), Physician Assistant (PA) working under the supervision of a physician, Licensed Professional Art Therapist Associate (LPATA), Licensed Assistant Behavior Analyst (LABA), Licensed Alcohol and Drug Counselor Associate (LADCA). The billing provider is either the supervisor, a provider group, or licensed organization.

(4) 50% - Bachelors-level providers

(5) 40% - Other non-bachelors-level providers

Partial hospitalization will be reimbursed a rate of $194.10 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate is posted at http://chfs.ky.gov/dms/fee.htm.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.

2. The partial hospitalization rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

A. The partial hospitalization daily rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, as this is an outpatient service, these rates do not include costs related to room and board or any other unallowable facility costs.

B. Any provider delivering Partial Hospitalization services will be paid through the daily payment rate and cannot bill the department separately. Any Medicaid providers delivering separate services outside of the Partial Hospitalization services rate may bill for those separate services in accordance with the state's Medicaid billing procedures.

C. The state will periodically monitor the actual provisions of partial hospitalization services paid at this daily rate to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs. Post payment audits will inform and ensure that this rate remains economic and efficient based on the services that are actually provided for the service.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Medication Assisted Treatment for Methadone Only

Methadone Medication Assisted Treatment (MAT) must be provided by a licensed organization meeting all qualifications to be approved as a Narcotic Treatment Program. Methadone MAT will be reimbursed a rate of $105.00 weekly and will this will be the set rate for all governmental as well as private Medicaid providers. Methadone MAT must include at least one of the services (individual, group, and/or family therapies, medication dispensing, and limited laboratory services for drug screening) in order to be reimbursed this rate. The services included in the bundled rate for Methadone MAT for substance use disorder must be administered by a physician, psychiatrist, advanced nurse practitioner registered nurse or a physician assistant and will be paid from the Kentucky Behavioral Health and Substance Abuse Services Outpatient (non-Facility) Fee Schedule. The Fee Schedule can be located at https://chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/BHOutpatientFFS2021.pdf.

A. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.

B. Methadone MAT weekly rate is based on rates currently set for state plan services. The rates for each service are multiplied and averaged by the anticipated service frequency per week. Additionally, as this is an outpatient service, these rates do not include costs related to room and board or any other unallowable facility costs.

C. Any provider delivering Methadone MAT services will be paid through the weekly payment rate and cannot bill the department separately. Any Medicaid providers delivering separate services outside of the Methadone MAT services rate may bill for those separate services in accordance with the state's Medicaid billing procedures.

For dates of services from October 1, 2020, through September 30, 2025, please reference Att. 4.19-B, Page 20.15(1)(d)(i) for all MAT counseling services and behavioral health therapies.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

3. Per 42 CFR 431.107, each provider or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

Residential Services for Substance Use Disorders will be reimbursed a rate of $230 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year. This per diem was calculated by using Kentucky's EPSDT rate for similar facility services.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.

2. The residential services for substance use disorders rate is based on rates currently set for state plan services - Kentucky's EPSDT rate for similar service.s The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Residential Services for Substance Use Disorders will be reimbursed a rate of $230 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year. This per diem was calculated by using Kentucky's EPSDT rate for similar facility services.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.

2. The residential services for substance use disorders rate is based on rates currently set for state plan services - Kentucky's EPSDT rate for similar facility services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Intensive outpatient program will be reimbursed on a per diem basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Intensive Outpatient Therapy. The agency's fee schedule rate was set as of December 2, 2015 and is effective for services provided on or after that date. All rates are published http://chfs.ky.gov/dms/fee.htm. This per diem was calculated by using Kentucky's existing rate for rehabilitative children in the custody of or at risk of being in the custody of the state or for children under the supervision of the state and converting it to a per diem for the same service.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.

2. The intensive outpatient program rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Assertive Community Treatment will be reimbursed a rate of $750 per month for a four (4) person team, and $1,000 per month for a ten (10) person team. In order to be reimbursed this rate, at least one service must be provided during the period. These rates will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.

2. The ACT rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

B. Effective for services provided on and after July 2, 2001, primary care centers will be reimbursed in accordance with the prospective payment system described in Attachment 4.19-B, page 20.16 for FQHCs and RHCs.

For drugs for specified immunizations provided free from the Health Department to primary care centers for immunizations for Medicaid recipients, the cost of the drugs are paid to the Health Department. The specified immunizations are: diphtheria and tetanus toxoids and pertuisis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any type)) (OPV); and hemophilus B conjugate vaccine (HBCV).

Effective January 1, 1989, the cost for these immunizations will not be allowed as a part of the primary care center cost base so long as these drugs are available free from the Health Department.

For the period 10/01/02 through 6/30/04, adjusted payments will be made to Community Mental Health Centers to recognize and support their continued commitment to the provision of mental health services. These payments will be made on a quarterly basis and will reflect the difference in the costs used to determine current rates and Medicaid Costs determined as follows:

1. Using audited cost reports ending June 30, 2000, costs for the covered mental health rehabilitation services described in Attachment 3.1- A, page 7.6.1(a) and Attachment 3.1-B, page 31.5(a) will be allocated to the following cost centers: therapeutic rehabilitation, outpatient individual, outpatient group, outpatient psychiatry, outpatient/personal care home, outpatient/in-home setting, and hospital psychiatric (professional services provided in an inpatient setting).
2. The Medicaid percentage for each cost center will be determined by dividing Medicaid units of service by total units of service by cost center.
3. Medicaid costs per cost center will be determined by multiplying costs by the Medicaid percentage per cost center.
4. Medicaid costs per cost center will be inflated to the mid-point of the rate year using the Home Health Market Basket Index.
5. The increased Medicaid capital will be determined by multiplying any capital increase from the base year to the rate year by the aggregate Medicaid percentage. The aggregate Medicaid percentage is determined by dividing total Medicaid costs by total costs.
6. The difference between the base year Medicaid costs and the inflated Medicaid costs will be added to the increased Medicaid capital.
7. Costs shall be determined in accordance with cost principles outlined in the Provider Manual. Only Medicaid recognized costs will be included in the calculation.
8. These adjusted payments will expire on July 1, 2004.

Payment methodology for rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and that are provided through an agreement with the State Health or Title V agency.

A. Rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rates for rehabilitative services are negotiated rates between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of each service.

The payment rate for rehabilitative services that are authorized after June 30, 2002, are uniform rates, determined by 98% of the weighted median of claims for each service for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

B. Rehabilitative services for children under the supervision of the state and that are provided through an agreement with the State Health or Title V agency.

Payments for rehabilitative services covered in Attachment 3.1-A, page 7.6.1 and Attachment 3.1B, page 31.5 for the target populations are per service. They are based upon one or more documented rehabilitative services provided to each client. The rates for the rehabilitative services are based upon the actual direct and indirect costs to the providers. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing rehabilitative services based on financial information submitted by the provider.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: identification, by recipient and worker, of each individual service provided, a showing of all direct costs for rehabilitative services; and a showing of all indirect costs for rehabilitative services appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principle if necessary.

Rehabilitative service providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.