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

A. Community Mental Health Centers (CMHC) Reimbursement

Services provided by a CMHC provider may be provided both in the CMHC and within the community. Reimbursement will be the same regardless of where the services are performed.

Community Mental Health Centers (CMHCs) are paid CMHC-specific cost-based rates per service rendered. For services incurred on or after October 1, 2016, Medicaid will reimburse for the following providers of service. Providers will only be paid for services provided within the scope of their licensure.

1. Licensed Psychologist (LP)
2. Licensed Psychological Practitioner (LPP)
3. Licensed Clinical Social Worker (LCSW)
4. A psychiatric social worker with a master's degree from an accredited school
5. Licensed Professional Clinical Counselor (LPCC)
6. Licensed Professional Art Therapist (LPAT)
7. Licensed Marriage and Family Therapist (LMFT)
8. Licensed Behavior Analyst (LBA)
9. Psychiatrist
10. A psychiatric nurse licensed in the state of Kentucky with one of the following combination of education and experience:
    a. Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.
    b. Bachelor of Science in Nursing and one (1) year of experience in a mental health setting.
    c. A graduate of a three-year educational program with two (2) years of experience in a mental health setting.
    d. A graduate of a two-year educational program (Associate degree) with three (3) years of experience in a mental health setting.
11. Licensed Certified Alcohol and Drug Counselor (LCADC)
12. A professional equivalent, through education in a behavioral health field and experience in a behavioral health setting, qualified to provide behavioral health services. Professional equivalents may include practitioners obtaining experience to qualify for licensure in their behavioral health profession or individuals with a bachelor's degree or greater, with experience in behavioral health. Education and experience are as follows:
    (1) Bachelor's degree and three (3) years of full-time supervised experience. (2) Master's degree and six (6) months of full-time supervised experience.
    (3) Doctoral degree. No experience.
13. Physician
14. Advanced Practice Registered Nurse (APRN)
15. Physical Therapist - must meet requirements defined in 42 C.F.R. 484.4
16. Occupational Therapist - must meet requirements defined in 42 C.F.R. 484.4
17. Speech Therapist - must meet requirements defined in 42 C.F.R. 484.4

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

A. Community Mental Health Centers (CMHC) Reimbursement

18. The following professionals under the appropriate supervision:

a. 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;
b. A licensed psychological associate;
c. A licensed professional counselor associate;
d. A licensed professional art therapist associate;
e. A certified social worker, Master Level;
f. A marriage and family therapy associate;
g. A licensed assistant behavior analyst;
h. i. 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 MFTA, a LPCA, a LCADC, a LCADCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, or a LPATA ;
j. 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, a LCSW, a LMFT, a LPCC, a CSW, a MFTA, a LPCA, a LPAT, or a; and
k. 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, a LPCA, a LCADC, a LCADCA a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, a LPATA, or a LBA.
l.. A physician assistant working under the supervision of a physician;
m. Physical Therapist Assistant - must meet requirements defined in 42 C.F.R. 484.4
n. Occupational Therapist Assistant- must meet requirements defined in 42 C.F.R. 484.4
o. Speech Therapist Assistant - must meet requirements defined in 42 C.F.R. 484.4
p. Prevention Specialist
q. Substance Use Peer Support Specialist
r. Licensed Certified Alcohol and Drug Counselor Associate (LCADCA)

B. Community Mental Health Centers In-state Reimbursement

1. The department shall reimburse a participating in-state community mental health center:

a. If the services are:
(1) Covered services outlined in the State Plan;
(2) Services are not provided by the CMHC acting as a 1915(c) home and community based waiver services provider, as those services are reimbursed based on the home and community based waiver;
(3) Provided to recipients who are not enrolled with a managed care organization; and
(4) Medically necessary; and

b. Based on the community mental health center's Medicaid allowable costs.

2 The department's reimbursement shall include reimbursing:

a. On an interim basis during the course of a state fiscal year; and

b A final reimbursement for the state fiscal year that results from a reconciliation of the interim reimbursement amount paid to the CMHC compared to the CMHC's Medicaid allowable cost by Cost Center for the state fiscal year.

C. Interim Reimbursement for Services Other Than Behavioral Health.

1 The department's interim reimbursement to a CMHC for primary care services shall depend on the type of primary care service provided.

2. The department's interim reimbursement for:

a. Physician services shall be the reimbursement established for the service on the current Kentucky-specific Medicare Physician Fee Schedule.

b If no reimbursement for a given physician service exists on the current Kentucky-specific Medicare Physician Fee Schedule, the department shall reimburse on an interim basis for the service as it reimburses for services outlined in Attachment 4.19-B, II Physician Services, Page 20.3 – 20.5(6).

3. a. Laboratory services shall be the reimbursement established for the service on the current Kentucky-specific Medicare Laboratory Fee Schedule unless no reimbursement for the service exists on the current Kentucky-specific Medicare Laboratory Fee Schedule for the given service.

. b. If no reimbursement for a given laboratory service exists on the current Kentucky-specific Medicare Laboratory Fee Schedule, the department shall reimburse on an interim basis for the service as it reimburses for services as described in Attachment 4.19-B, Page 20.13E;

C. Interim Reimbursement for Services Other Than Behavioral Health (continued)

4. a. Radiological services shall be the reimbursement established for the service on the current Kentucky-specific Medicare Physician Fee Schedule unless no reimbursement for the service exists on the current Kentucky-specific Medicare Physician Fee Schedule for the given service.

b. If no reimbursement for a given radiological service exists on the current Kentucky-specific Medicare Physician Fee Schedule, the department shall reimburse on an interim basis for the service as it reimburses for services as described in Attachment 4.19-B, Page 20.38;

5. a. Occupational therapy service shall be the reimbursement established for the service on the current Kentucky-specific Medicare Physician Fee Schedule unless no reimbursement for the given service exists on the current Kentucky-specific Medicare Physician Fee Schedule.

b. If no reimbursement for a given occupational therapy service exists on the current Kentucky-specific Medicare Physician Fee Schedule, the department shall reimburse on an interim basis for the service as it reimburses for the service as outlined in Attachment 4.19-B, Page 27;

C. Interim Reimbursement for Services Other Than Behavioral Health (continued)

6. a. Physical therapy service shall be the reimbursement established for the service on the current Kentucky-specific Medicare Physician Fee Schedule unless no reimbursement for the given service exists on the current Kentucky-specific Medicare Physician Fee Schedule.

b. If no reimbursement for a given physical therapy service exists on the current Kentucky-specific Medicare Physician Fee Schedule, the department shall reimburse on an interim basis for the service as it reimburses for the service as outlined in Attachment 4.19-B, Page 27; or

7. a. Speech-language pathology service shall be the reimbursement established for the service on the current Kentucky-specific Medicare Physician Fee Schedule unless no reimbursement for the given service exists on the current Kentucky-specific Medicare Physician Fee Schedule.

b. If no reimbursement for a given speech-language pathology service exists on the current Kentucky-specific Medicare Physician Fee Schedule, the department shall reimburse on an interim basis for the service as it reimburses for the service as outlined in Attachment 4.19-B, Page 27.

8. The department's interim reimbursement for the cost of injectable drugs administered in a CMHC shall be the reimbursement methodology established in Attachment 4.19-B, Page 20.1(b).

D. Interim Reimbursement for Behavioral Health Services through June 30, 2018.

(1) (a) To establish interim rates for behavioral health services effective for dates of service through June 30, 2018 , the department shall use the CMHC rates paid effective July 1, 2015.

(b) To establish interim rates for behavioral health services effective for dates of service July 1 2018, and each subsequent July 1, the department shall use a CMHC's most recently submitted cost report that meets the requirements established in paragraph (c) of this subsection.

(c) The cost report shall comply with all requirements established in F.(1) below.

(2) The department shall:

(a) Review the cost report referenced in subsection (1) of this section; and

(b) Establish interim rates for Medicaid-covered behavioral health services:

1. To be effective July 1, 2018;
2. Based on Medicaid allowable costs as determined by the department through its review; and
3. Intended to result in a reimbursement for Medicaid-covered behavioral health services:
   a. Provided to recipients who are not enrollees in managed care;
   b. That equals the department's estimate of behavioral health services' costs for the CMHC for the period.
4. That shall be updated effective July 1, 2019, and each July 1 thereafter based on the most recently received cost report referenced in subsection (1) of this section.

D. Interim Reimbursement for Behavioral Health Services (continued)

(3) Interim rates for behavioral health services effective July 1 each year shall have been trended and indexed from the midpoint of the cost report period to the midpoint of the rate year using the Medicare Economic Index.

(4) To illustrate the timeline referenced in paragraph (2)(b) of this section, a cost report submitted by a CMHC to the department on December 31, 2017, shall be used by the department to establish behavioral health services' interim rates effective July 1, 2018.

(5) (a) A behavioral health services interim rate shall not be subject to retroactive adjustment except as specified in this section.

(b) The department shall adjust a behavioral health services interim rate during the state fiscal year if the rate that was established appears likely to result in a substantial cost settlement that could be avoided by adjusting the rate.

(c) 1. If the cost report from a CMHC has not been audited or desk-reviewed by the department prior to establishing interim rates for the next state fiscal year, the department shall use the cost report under the condition that interim rates shall be subject to adjustment as established in subparagraph 2 of this paragraph.

2. A behavioral health services interim rate based on a cost report which has not been audited or desk-reviewed shall be subject to adjustment when the audit or desk review is completed.

3. An unaudited cost report shall be subject to an adjustment to the audited amount after the auditing has occurred.

(d) Upon receipt of the cost report filed December 31, 2017, the Department shall review the cost report to determine if the interim rates established in accordance with subsection 1(a) of this section need to be revised to more closely reflect the costs of services for the interim period.

E. Final Reimbursement

(1) (a) Beginning October 1, 2016, and ending June 30, 2017, by December 31 following the end of the state fiscal year, a CMHC shall submit a cost report to the department:

1. In a format that has been approved by the Centers for Medicare and Medicaid Services;
2. That has been audited by an independent auditing entity; and
3. That states all of the:
   a. CMHC's Medicaid allowable direct costs:
      (i) For Medicaid-covered services rendered to eligible recipients during the cost report period; and
      (ii) For Medicaid-covered injectable drugs rendered to eligible recipients during the cost report period;

K. Reimbursement of Out-of-state Providers.

Reimbursement to a participating out-of-state community mental health center shall be the lesser of the:
(1) Charges for the service;
(2) Facility's rate as set by the state Medicaid Program in the other state; or
(3) The state-wide average of payments for in-state community mental health centers.

L. Provider Appeals.

A CMHC may appeal department decisions as to the application of this state plan section as it impacts the CMHC's cost-based reimbursement in accordance with 907 KAR 1:671, Sections 8 through 10 (effective December 19, 2001).

E. Final Reimbursement (continued)

b. CMHC's costs associated with:
(i) Medicaid-covered services rendered to enrollees during the cost report period and
(ii) Medicaid-covered injectable drugs rendered to enrollees during the cost report period;

c. Costs of the community board for mental health or individuals with an intellectual disability under which the CMHC operates for the cost report period; and

d. CMHC's costs associated with services rendered to individuals:
(i) That were reimbursed by an insurer or party other than the department or a managed care organization; and
(ii) During the cost report period.

(b) To illustrate the timeline referenced in paragraph (a) of this subsection, an independently audited cost report stating costs associated with services and injectable drugs provided from October 1, 2016, through June 30, 2017 shall be submitted to the department by December 31, 2017.

(2) By October 1 following the department's receipt of a CMHC's completed cost report submitted to the department by the prior December 31, the department shall:

(a) Review the cost report referenced in subsection (1) of this section; and

(b) Compare the Medicaid allowable costs to the department's interim reimbursement for Medicaid-covered services and injectable drugs rendered during the same state fiscal year.

(3) (a) After the department compares a CMHC's interim reimbursement with the CMHC's Medicaid allowable costs for the period, if the department determines that the interim reimbursement:

1. Was less than the CMHC's Medicaid allowable costs for the period, the department shall send a payment to the CMHC equal to the difference between the CMHC's total interim reimbursement and the CMHC's Medicaid allowable costs; or

2. Exceeded the CMHC's Medicaid allowable costs for the period, the:

a. Department shall send written notification to the CMHC requesting the amount of the overpayment; and

b. CMHC shall, within thirty (30) days of receiving the department's written notice, send a:
(i) Payment to the department equal to the excessive amount; or
(ii) Payment plan request to the department.

(b) A CMHC shall not implement a payment plan unless the department has approved the payment plan in writing.

E. Final Reimbursement (continued)

(c) If a CMHC fails to comply with the requirements established in paragraph (a)2 of this subsection, the department shall:

1. Suspend payment to the CMHC; and
2. Recoup the amount owed by the CMHC to the department.

F. New Services.

(1) Reimbursement regarding a projection of the cost of a new Medicaid-covered service or expansion shall be made on a prospective basis in that the costs of the new service or expansion shall be considered when actually incurred as an allowable cost.

(2) (a) A CMHC may request an adjustment to an interim rate after reaching the mid-year point of the new service or expansion.

(b) An adjustment shall be based on actual costs incurred.

G. Auditing and Accounting Records.

(1) (a) The department shall perform a desk review of each cost report to determine whether an audit is necessary and, if so, the scope of the audit.

(b) If the department determines that an audit is not necessary, the cost report shall be settled without an audit.

(c) A desk review or audit shall be used to verify costs to be used in setting the interim behavioral health services rate, to adjust interim behavioral health services rates which have been set based on unaudited data, or final settlement to cost.

(2) (a) A CMHC shall maintain and make available any records and data necessary to justify and document:

1. Costs to the CMHC;
2. Services provided by the CMHC;
3. The cost of injectable drugs provided, if any, by the CMHC;
4. Cost allocations utilized including overhead statistics and supportive documentation; and
5. Any amount reported on the cost report.
6. Chart of accounts

(b) The department shall have unlimited on-site access to all of a CMHC's fiscal and service records for the purpose of:

1. Accounting;
2. Auditing;
3. Medical review;
4. Utilization control; or
5. Program planning.

(3) A CMHC shall maintain an acceptable accounting system to account for the:

(a) Cost of total services provided;

(b) Charges for total services rendered; and

(c) Charges for covered services rendered to eligible recipients.

(4) An overpayment discovered as a result of an audit or desk review shall be settled through recoupment or withholding.

H. Allowable and Non-allowable Costs.

(1) The following shall be allowable costs:

(a) Services' or drugs' costs associated with the services or drugs;

(b) Depreciation as follows:

1. A straight line method shall be used;
2. The edition of the American Hospital Association's useful life guidelines currently used by the Centers for Medicare and Medicaid Services' Medicare program shall be used;
3. The maximum amount for expensing an item in a single cost report shall be $5000; and
4. Only the depreciation of assets actually being used to provide services shall be recognized;

(c) Interest costs;

(d) Costs incurred for research purposes are allowable to the extent that they are related to usual patient services and are not covered by separate research funding;

(e) Costs of motor vehicles used by management personnel up to $25,000;

(f) Costs for training or educational purposes for licensed professional staff outside of Kentucky excluding transportation costs to travel to the training or education;

(g) Costs associated with any necessary legal expense incurred in the normal administration of the CMHC;

(h) The cost of administrative staff and practitioner salaries will be reviewed for reasonableness; and

(i) 1. Indirect costs calculated utilizing the approved Federal indirect rate, if the provider has an approved federal indirect rate. Providers shall include in indirect costs on line 1 of the cost report the same category of costs identified as indirect within the approved federal indirect rate supporting documentation. Similarly, direct costs shall be those costs identified as direct within the approved federal indirect rate. The Federal indirect rate will be applied to the same category of expenses identified as direct during the Federal rate determination. or

2. For providers that do not have a federal indirect rate, indirect costs are defined as those costs of an organization which are not specifically identified with a particular project, service, program, or activity but nevertheless are necessary to the general operation of the organization and the conduct of the activities it performs. The actual allowable cost of indirect services as reported on the cost report shall be allocated to direct cost centers based on accumulated cost if no Federal indirect rate is available.

(j) Services provided in leased or donated space outside the walls of the facility shall be allowable costs.

(k) To be allowable, all costs must comply with reasonable cost principles established in 42 C.F.R. 413.

(2) (a) The allowable cost for a service or good purchased by a facility from a related organization shall be in accordance with 42 C.F.R. 413.17 and Provider Reimbursement Manual 15-1, Chapter 10 – Cost to Related Organizations.

I. Allowable and Non-allowable Costs.

(3) The following shall not be allowable costs:
- (a) Bad debt;
- (b) Charity;
- (c) Courtesy allowances;
- (d) Political contributions;
- (e) Costs associated with an unsuccessful lawsuit against the department or the Cabinet for Health and Family Services;
- (f) Costs associated with any legal expense incurred related to a judgment granted as a result of an unlawful activity or pursuit;
- (g) The value of services provided by non-paid workers;
- (h) Travel or related costs or expenses associated with non-licensed staff attending:
  1. A convention;
  2. A meeting;
  3. An assembly; or
  4. A conference; or
- (i) Costs related to lobbying; or
- (j) Costs related to outreach services. Outreach services' cost will either be directly assigned or allocated to a cost report line that is not cost-settled by the department; or
- (k) Costs incurred for transporting recipients to services.

(4) A discount or other allowance received regarding the purchase of a good or service shall be deducted from the cost of the good or service for cost reporting purposes, including in-kind donations.

(5) (a) Maximum allowable costs shall be the maximum amount which may be allowed as reasonable cost for the provision of a service or drug.

(b) To be considered allowable, any cost shall:
1. Be necessary and appropriate for providing services; and
2. Not exceed usual and customary charges.

(6) For direct and indirect personnel costs, 100% time reporting methods shall be utilized to group/report expenses to each cost category. Detailed documentation shall be available upon request.

J. Units of Service.

(1) (a) Interim payments for behavioral health services, physician services, physical therapy services, occupational therapy services, speech-language pathology services, laboratory services or radiological services shall be based on units of service.

(b) A unit for a physician service, a physical therapy service, a speech-language pathology service, an occupational therapy service, a laboratory service or a behavioral health service shall be the amount indicated for the corresponding:
1. CPT code; or
2. Healthcare Common Procedure Coding System code.

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 Physician 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), Physician Assistant (PA)
(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 Clinical Alcohol and Drug Counselor (LCADC), or Certified Psychologist with autonomous functioning.
(3) 70% - Licensed Psychological Associate (LPA), Licensed Marriage and Family Therapist Associate (LMFTA), Licensed Professional Counselor Associate (LPCA), Certified Social Worker, Masters Level (CSW), Licensed Professional Art Therapist Associate (LPATA), Licensed Assistant Behavior Analyst (LABA), Licensed Clinical Alcohol and Drug Counselor Associate (LCADCA), Licensed Alcohol and Drug Counselor, or Certified psychologist without autonomous functioning. The billing provider is either the supervisor, a provider group, or licensed organization.
(4) 50% - Certified alcohol and drug counselor (CADC) and Behavioral Health Associate.
(5) 40% - Other non-bachelors-level providers

C. Reimbursement for the following services shall be as established on the Behavioral Health and Substance Abuse Services Outpatient (Non-Facility) fee Schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the following services. The agency's fee schedule rate was set as of 7/1/2019 and is effective for services provided on or after that date. All rates are published on the agency's website at https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx

(1) Screening, brief intervention and referral to treatment (SBIRT)
(2) Service planning
(3) Day treatment
(4) Comprehensive community support services
(5) Peer support services
(6) Intensive outpatient program services
(7) Partial hospitalization services

Reimbursement for these services will be reviewed and may be adjusted annually according to the Medicare Economic Index.

D. Reimbursement for mobile crisis intervention (MCI) services, crisis observation and stabilization services (COSS) and residential crisis stabilization services shall be as established on the Behavioral Health Fee Schedule 2023. This fee schedule will be posted at http://chfs.ky.gov/dms/fee.htm and is effective beginning on October 1, 2023. The fee schedule rates are calculated based on the following methodology:

(1) The mobile crisis intervention rate is a per hour or per diem rate based on calculated market costs which includes salaries/wages, travel and administrative expense.
   i. Salaries/wages include practitioner and paraprofessional providers utilizing the Bureau of Labor Statistics information
   ii. Travel expense is calculated based on the federal reimbursement rate per mile.
   iii. Administrative expense is based on 15% of salaries/wages and travel expense.

(2) COSS is an hourly rate and residential crisis stabilization is a per diem rate based on calculated market costs which includes salaries/wages, facility, supplies, equipment, and administrative expenses.
   i. Salaries/wages include practitioner and paraprofessional providers utilizing the Bureau of Labor Statistics information.
   ii. Facility, supplies, equipment expense is based on 13% salaries/wages.
   iii. Administrative expense is based on 20% of salaries/wages.

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.