

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 5, 2014

Lawrence Kissner, Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001



RE: Title XIX State Plan Amendment, KY 14-006

Dear Mr. Kissner:

Kentucky submitted State Plan Amendment (SPA) 14-006 that was received by the Centers for Medicare & Medicaid Services (CMS) on May 19, 2014. Effective July 1, 2014, this amendment proposes to add Licensed Professional Art Therapists, Licensed Professional Art Therapist Associates, Certified Alcohol and Drug Counselors, Licensed Behavior Analysts, and Licensed Behavior Analyst Assistants as providers of substance use disorders and mental health disorder services under Rehabilitative Services. This SPA also provides for other technical corrections.

As previously discussed with the state, we have completed our review of KY SPA 14-006. Before we can continue processing this amendment, we need additional or clarifying information. We are requesting the below additional information pursuant to Section 1915(f)(2) of the Act.

Plan Pages – Attachment 3.1-A (all below questions are applicable to the Attachment 3.1-B pages):

1. The state has added a Licensed Professional Art Therapist and a Licensed Professional Art Therapist Associate to most of the mental health and substance use disorders services. Please explain how their scope of practice qualifies them to furnish State plan services such as “crisis intervention,” “mobile crisis,” “collateral outpatient therapy,” etc.
2. Page 7.6.1(g) (and all applicable pages): “Screening” for the Certified Alcohol and Drug Counselor (CADC) is unclear. Please provide clarity for the following items:
 - a. Please explain the meaning of, “rendering as part of a licensed organization.”

- b. Please add clarifying language to the State plan explaining whether the addition of the language implies that the other listed practitioners do not work as “part of a licensed organization.”
 - c. Please explain how the state ensures free choice of providers as required by Section 1902(a)(23) of the Social Security Act (the Act) if the CADC must be a part of a licensed organization.
3. Page 7.6.1(n): Under “Residential Crisis Stabilization” in the middle of the page, the State plan indicates: “KY Medicaid will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds for individuals between the ages of 22 and 64.” The additional language is not technically accurate. Please revise the plan language as follows: “KY Medicaid will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds, except for services furnished pursuant to the State plan benefit, ‘inpatient psychiatric services for individuals under 21,’ (Section 1905(a)(16) of the Act; 42 CFR 440.160) or pursuant to an exclusion for individuals age 65 or older who reside in institutions that are IMDs (Section 1905(a) of the Act; 42 CFR 440.140).”
4. Page 7.6.1(q): The role of the Peer Support Specialist (PSS) under “Day Treatment” is unclear:
 - a. Please explain the meaning of, “rendering as part of a provider group or licensed organization.” Page 7.6.1(s) indicates that the PSS “must either be employed by a provider group or licensed organization...” If this is what the state intended, please add a cross reference to Page 7.6.1(s) in the plan for the explanation or insert the language from Page 7.6.1(s) into Page 7.6.1(q).
 - b. Please add clarifying language to the State plan explaining whether the addition of the “rendering” language implies that the other listed practitioners do not work as “part of a provider group or licensed organization.”
 - c. Please explain how the state ensures free choice of providers as required by Section 1902(a)(23) of the Act if the PSS must be a part of a provider group or a licensed organization.
5. Pages 7.6.1(t) and Page 7.6.1(u): In order to distinguish the Peer Support Specialists, please consider calling the peers that furnish Parent/Family Peer Support Services, “Parent/Family Peer Support Specialists.”
6. Page 7.6.1(ii) and Page 7.6.1(jj): Under “Residential Services for Substance Use Disorders” the State plan indicates, “Services should have less than or equal to 16 patient beds, if provided to individuals between the ages of 22 and 64...” The additional language is not technically accurate. Either the currently approved language should stand, or the state should add the language as in Question 3 above, “Services must not have more than 16 patient beds, unless services are furnished pursuant to the State plan benefit ‘inpatient psychiatric services for individuals under 21,’ (Section 1905(a)(16) of the Act; 42 CFR 440.160) or pursuant to an exclusion for individuals age 65 or older who reside in institutions that are IMDs (Section 1905(a) of the Act; 42 CFR 440.140).”

7. Page 7.6.1(kk): Under “Residential Services for Substance Use Disorders,” please add to the State plan how beneficiaries exercise freedom of choice of providers as required by Section 1902(a)(23) of the Act. Please also add an assurance that all willing and qualified providers may furnish “Residential Services for Substance Use Disorders.”
8. Page 7.6.1(pp): Under “Assertive Community Treatment,” the State plan indicates, “Basic living skills are rehabilitative services focused on teaching activities of daily living...” The “teaching of activities of daily living” appears to be a “habilitative” service that helps individuals “acquire” or “maintain” skills/functions and not “rehabilitative” services that reduce disability and restore function. Please revise the service description to reflect the purposes of the rehabilitative services benefit pursuant to 42 CFR 440.130(d).

Plan Pages – Attachment 4.19-B:

1. Page 20.15(1)(a)(x and xi): Qualifications of providers should be included in the coverage section of the State plan. Please remove the qualifications from these two paragraphs.
2. Page 20.15(1)(a): Please change the sunset language to read, “The payment methodology for services provided in CMHCs will end on December 31, 2014.”

Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA.

1. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.).
2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through

intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and state share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
 - (ii) the operational nature of the entity (state, county, city, other);
 - (iii) the total amounts transferred or certified by each entity;
 - (iv) clarify whether the certifying or transferring entity has general taxing authority and,
 - (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).
3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for federal financial participation to states for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.
4. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, does the state recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

We are requesting this additional/clarifying information under provisions of Section 1915(f)(2) of the Act. This has the effect of stopping the 90-day clock for CMS to take action on the material, which would have expired on 8/17/14. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to all state Medicaid directors dated January 2, 2001, if we have not received the state's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment.

Mr. Lawrence Kissner

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We ask that you respond to this request for additional information via the Atlanta Regional Office SPA/Waiver mailbox at CMS SPA_Waivers_Atlanta_R04. In addition, please send hard copies to the Atlanta Regional Office and to me at the above address.

If you have any questions, please contact Melanie Benning at 404-562-7414.

Sincerely,

A handwritten signature in cursive script that reads "Jackie Glaze".

Jackie Glaze

Associate Regional Administrator

Division of Medicaid and Children's Health Operations