

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**

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February 1, 2016

Veronica J. Cecil, Acting Commissioner  
Department for Medicaid Services  
275 East Main Street, 6WA  
Frankfort, KY 40621-0001

Re: Kentucky State Plan Amendment 15-0008

Dear Ms. Cecil:

We have reviewed the proposed Kentucky state plan amendment, KY 15-0008, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on November 17, 2015. This amendment revises the current reimbursement methodology for Intensive Outpatient Therapy by removing the actual per diem amount from the state plan and including the fee schedule language.

Based on the information provided, the Medicaid State Plan Amendment KY 15-0008 was approved on February 1, 2016. The effective date of this amendment is December 2, 2015. We are enclosing the approved HCFA-179 and a copy of the new state plan page.

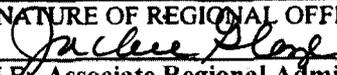
If you have any additional questions or need further assistance, please contact Darlene Noonan at (404) 562-2707 or [Darlene.Noonan@cms.hhs.gov](mailto:Darlene.Noonan@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze". The signature is written in a cursive, flowing style.

Jackie Glaze  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations

Enclosures

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|---|--|---|----------------------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  |  | 1. TRANSMITTAL NUMBER:<br>15-008  | 2. STATE<br>Kentucky |
| <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>  |  | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)  |                      |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES   |  | 4. PROPOSED EFFECTIVE DATE<br>December 1, 2015  |                      |
| 5. TYPE OF PLAN MATERIAL (Check One):<br><input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT<br>COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)   |  |   |                      |
| 6. FEDERAL STATUTE/REGULATION CITATION:   |  | 7. FEDERAL BUDGET IMPACT:<br>a. FFY 2016      Budget Neutral<br>b. FFY 2017      Budget Neutral                             |                      |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>Att. 4.19-B, Page 20.15(1)(g) – Att. 4.19-B, Page 20.15(1)(h)  |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):<br>Same  |                      |
| 10. SUBJECT OF AMENDMENT:<br>The purpose of this SPA is to make change Medicaid reimbursement for Intensive Outpatient Therapy.   |  |   |                      |
| 11. GOVERNOR'S REVIEW (Check One):<br><input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL |  |   |                      |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br>  |  | 16. RETURN TO:<br>Department for Medicaid Services<br>275 East Main Street 6W-A<br>Frankfort, Kentucky 40621                |                      |
| 13. TYPED NAME: Lisa D. Lee   |  |   |                      |
| 14. TITLE: Commissioner, Department for Medicaid Services   |  |   |                      |
| 15. DATE SUBMITTED: 10/30/15/15   |  |   |                      |
| <b>FOR REGIONAL OFFICE USE ONLY</b>   |  |   |                      |
| 17. DATE RECEIVED: 11-17-15   |  | 18. DATE APPROVED: 02-01-16   |                      |
| <b>PLAN APPROVED – ONE COPY ATTACHED</b>  |  |   |                      |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br>12-02-15  |  | 20. SIGNATURE OF REGIONAL OFFICIAL:<br> |                      |
| 21. TYPED NAME: Jackie Glaze  |  | 22. TITLE: Associate Regional Administrator<br>Division of Medicaid & Children Health Opns                                  |                      |
| 23. REMARKS: Approved with the following changes as authorized by state on email date 2-1-16:<br>Block # 4 changed to read: December 2, 2015.<br><br>Block # 8 changed to read: Attachment 4.19-B, page 2015.(1)(g).  |  |   |                      |

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**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.

- 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. 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.
- C. 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.