

MAC Binder Section 2 – Letters to CMS

Table of Contents with Document Summary - Jan. 2016

Located online at <http://chfs.ky.gov/dms/mac.htm>

1 – CMS-SPA Ltr to JG from LL re SPA Amendment 15-003_dte111015:

Information sent regarding RAI on SPA Amendment 15-003. CHFS request that the SPA be put back on-the-clock for approval.

2 – CMS-MMIS-Ltr to JG from LL re MMIS / ANAPD #15 Review Request_dte113015:

DMS is submitting an ANAPD at this time to align forthcoming annual updates with actual FFY as related to staff and contractor resources. Also to request additional funding to account for anticipated incremental project expenditures related to enhancements to KY MMIS.

3 – CMS-SPA 15-009-Ltr to JG from LL Request for Extension in Methodology_dte120415:

SPA 15-009 is a request to extend the current reimbursement methodology for the CMHCs. New procedures require system and processing changes, therefore it has been determined that July 1, 2016 implementation date is the most feasible.

4 – CMS-AAPDU#2-Ltr to JG from LL re KY MEMS Review Request _dte120715:

DMS is requesting through AAPDU#2 to realign the current approved budget and adjust approved funding for the MEMS project. This AAPDU#2 does not request new funding.

5 – CMS-HIT/UKRF-Ltr to JG from LL re Environmental Scan Contract w UK_dte121015:

CHFS requests a no-cost extension for the HIT Environmental Scan contract with the UK's Research Foundation. Requested approval of contract on October 6, 2015 but have not received a response, requesting to add additional 3 months extending contract to March 31, 2016.

6 – CMS- AAPDU#2-Ltr to JG from LL re KY MEMS Review Request _dte121115:

CHFS requests your expedited review and approval of the AAPDU#2. This update does not request new funding.

7 – CMS-E&E Project -Ltr to JK from LL re Integrated State Verification Services _dte121115:

CHFS is requesting an expedited review and approval of the Master Agreement for Integrated State Verification Services awarded to TALX Corp through competitive bidding processes. .

8 – CMS- CMS-2328-FC-Ltr to VW from LL re CMS Final Rule_dte010416:

DMS provide additional comments for reconsideration of rule regarding methods for assuring access to covered Medicaid services.

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9 – CMS- BIP-Ltr to BH from LL re Unspent Funds_dte010616:

DMS will continue to apply unspent BIP funds to the balance across waivers for the remainder of the extended period of spending.



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

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November 10, 2015

Jackie Glaze
Associate Regional Director
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Re: Kentucky State Plan Amendment 15-003

Dear Ms. Glaze:

In response to your Request for Additional Information (RAI), Kentucky Department for Medicaid Services has responded to each of your questions, made the necessary changes to any impacted State Plan pages (attached) and is ready to put this SPA back on-the-clock. Our responses are below:

General

1. The state estimates a federal budget impact of (\$0) for FY 2015 and (\$0) FY 2016. Since you are increasing access to service provided by PRTFs in the community, please explain why you do not expect utilization and cost of serves to increase?

DMS Response - The services that will be provided by the PRTFs can be delivered by other providers. This purpose of this SPA is to increase access points for outpatient behavioral health services. Increasing access points within a member's community will decrease the need for transportation and will also decrease the likelihood of costly inpatient services. We do expect utilization to increase but believe the increased access to lower-level outpatient services will lead to stabilization of behavioral health conditions which will negate the need for costlier treatments, such as inpatient care.

2. Please provide information demonstrating that the changes proposed in this SPA comport with public process requirements at section 1902(a)(13)(A) of the Social Security Act and guidance identified in the state Medicaid Director letter issued on December 10, 1997.

DMS Response - Please see the attached Administrative Register that includes the posting of the Kentucky Administrative Regulations that included these changes.

3. Coverage pages need to reflect that the state complies with the PRTF requirements found at 42 CFR 440.160; 42 CFR 483.352 (a separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis under the direction of a physician; at 42 C.F.R. Part 441, Subpart D - Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs (the PRTF resident population must meet all identified certification of need requirements); and at Part 483, subpart G - Condition of Participation for the Use of Restraint or Seclusion of Psychiatric Residential Treatment Facilities (a PRTF is subject to survey and certification of the entire facility and must meet all requirements under Part 483, subpart G.) Therefore, we would like the state to add an assurance in the plan that the state complies with these PRTF requirements (See the 2007 Survey and Certification Guidance to the State Survey Agencies)

DMS Response - Assurances have been added to the attached State Plan pages.

4. We would like the state to clarify whether the PRTF will be furnishing the “Outpatient PRTF Services” to children who are not residents of the PRTF, but who live in the community and would be going to the PRTF for receipt of these mental health/substance use disorder treatment services.

DMS Response - The state confirms the PRTF will be furnishing the “Outpatient PRTF Services” to children who are not residents of the PRTF, but who live in the community and would be going to the PRTF for receipt of these mental health/substance use disorder treatment services on an outpatient basis only.

Plan Pages

Attachment 3.1-A

5. Attachment 3.1-A, Page 7.8.3: Please remove the references in the state plan to age ranges within the EPSDT population that will receive Level I or Level II services. Comparability requires that all children in the EPSDT population must have access to the same amount, duration and scope of services.

DMS Response - Age ranges have been removed.

6. Attachment 3.1-A, Page 7.8.3, items A.2.d, e and f: Please remove all medical necessity criteria that appear in the state plan as they are within the state's purview and CMS does not wish to be in a position of approving the state's criteria. For example, the information on this page appears to be medical necessity criteria and should be deleted from the plan page. It is allowable to note that all children will be evaluated based on their individual needs according to the state's medical necessity criteria and placed into one or two levels of PRTFs based on the intensity of their needs.

DMS Response - Requested changes have been made.

7. Attachment 3.1-A, Page 7.8.3: Please add an introduction that reflects the state's assurance that it complies with the PRTF requirement noted above.

DMS Response - Requested introduction has been added

8. Attachment 3.1-A, Page 7.8.3: After the introduction, the state can add language about the services that are available to children in the PRTF. For example, "Subject to an individual's plan of care, the following services are furnished to children in a PRTF pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, under the direction of a physician...etc. Then list all of the inpatient and outpatient services.

DMS Response - Please see attached revised State Plan pages.

9. Attachment 3.1-A, Page 7.8.4.1 - Item D, "Reserved Bed and Therapeutic Pass Days": We suggest that the state broadly summarize the coverage for reserved beds and therapeutic pass days, perhaps including language that they are covered, defining them (using the definitions found in items 7, 8 and 9 on page 7.8.4.2), including the limits and explaining that the limits can be exceeded based on medical necessity. Some of the details may be more appropriate for the reimbursement pages. We can discuss this further with the state. NOTE: The state indicates that the limits can be exceeded based on a determination of "the best interest of the recipient" but we think this should read "based on medical necessity."

DMS Response -Please see attached revised State Plan pages.

10. Attachment 3.1-A, page 7.8.4.3: Is the state willing to consider omitting items 3 and 4 on this page. We think it goes without saying that only those children who qualify for the PRTF will be eligible to receive the services furnished by the PRTF.

DMS Response - Please see attached revised State Plan pages.

10. Attachment 3.1-A, page 7.8.4.4: We think these PRTF services can be moved to appear after the "inpatient" PRTF services. The title of the services should be

something such as “Community-Based PRTF Services in order to avoid confusion with Outpatient Hospital services.

DMS Response - See attached revised State Plan pages.

Attachment 4.19-A

12. Page 35 (9) B 2. This section included the following language. “An amount not to exceed the prevailing charges, in the locality where the Level I PRTF is located, for comparable services provided under comparable circumstances”. This language is not comprehensive enough for the read to determine what charges the state is referencing. Also the language in B.1 limits the payment to the lesser of the per diem rate or the usual and customary charges. Please revise the language to make it clear what prevailing charges are being referenced or remove this language.

DMS Response - Language has been removed on the attached State Plan pages.

13. Page 35 (9) B 2. This is a duplicate number 2 and should be revised to number 3. This section provides for a 2.22 percent increase each biennium. Have the rates been increased by this amount? If not, please remove this language and include the effective date and amount of the next increase if one will be given. If not please remove this language.

DMS Response - Previous language was removed which corrected the duplication. The rates have been adjusted according to this language.

14. Page 35 (9) B. 3 (e) 1. This section includes language that references the KAR 1:018 and KAR 1:109 regarding the reimbursement and coverage of drugs. Please include this language in the state plan or an effective date of the KAR. Please provide a copy of these regulations for our review if you leave the references in the plan.

DMS Response - We have removed reference to the Administrative Regulation and instead referenced the pharmacy section of the State Plan.

15. The PRTF per diem rates for Level 1 and 2 included on Page 35 (9) B must be updated if they have been increased.

DMS Response - Rates for Level 1 have been revised on the attached State Plan pages. Level II PRTFs do not receive the increase.

16. Page 35.2 F (1) (a) (b) and 2 (a). The reference to CMS 2552-96 should be revised to CMS 2552-10. Also please include language in these sections that the providers will be required to follow the Medicare reimbursement principles at 42 CFR 413 and the Provider Reimbursement Manual 15-I and 15-II to determine allowable cost allocated and appropriated to the program.

DMS Response - We have changed the reference to CMS 2552-96 and added the requested language.

17. Please provide a copy of a completed CMS 2552-10 cost report for one provider. Also include any instruction issued to providers to be used in completing the annual cost report. Please note any cost for staff that provide inpatient services that will also provide services to patients outside the facility must be removed through the cost report allocation and apportionment process.

DMS Response - The State has removed reference to the CMS cost report because we pay based on an established rate, rather than reimbursing the PRTF at cost.

18. Page 35.2 G(1) and (2). These sections provide for payment of bed reserve day and therapeutic pass days. Please include language that indicates how many days will be paid for each of these categories annually. Also, include the language from the KAR referenced or the effective date of the regulations. If you leave the reference to the KAR in the plan provide a copy of the regulation for our review.

DMS Response - DMS has removed the reference to KAR as the reimbursement is outlined in the State Plan. Also the revised pages reflect additional language regarding how many days will be paid for each.

19. Page 35.2 G (3) (a). Please include the occupancy percentages for the bed reserve days and therapeutic pass days.

DMS Response - The occupancy percentages were in the original submission - Page 35.2 G (1) (a) and (b) for bed reserve days and Page 35.2 G (2) (a) and (b) for Therapeutic pass days.

20. Page 35.2 G (3) (b) (c). This section discusses when the bed reserve and therapeutic days will be included or excluded from the mid-night census? Please explain these sections. Also, the MMIS should track and account for these days separate from the paid days for services provided in the facility.

DMS Response - The state has added additional information to explain the bed reserve and therapeutic days. Also, bed reserve and therapeutic days are filed using the revenue code 183, which allows for these days to be tracked.

Attachment 4.19-B

21. Although the practitioners at the PRTF can furnish services to children who are not residing at the PRTF and live at home in the community, these services must be covered in the state plan under an appropriate benefit category (i.e., Rehab) and be

claimed as that service, not as a PRTF service. Based on that please withdraw the proposed Attachment 4.19-B, pages 20.12(i) through 20.12(m). If the payment methodology for these practitioners is the same as the currently payment methodology for rehab services, no additional information is required. If not, the state must submit the updated payment methodology for CMS' review and approval.

DMS Response - DMS has removed the Attachment 4.19-B pages as the PRTFs will be paid based on the reimbursement in the Rehab section of the state plan. Upon receipt of this information, DMS gives CMS permission to make this change to the 179 Form.

Funding

The following question are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State Plan.

22. 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 claims by the State (including 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 organizations? 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 returned of any of the payment, a complete listing of providers that return a ports 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.)

DMS Response - The providers retain all funds paid.

23. 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 government

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).

DMS Response - Not applicable

- 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.

DMS Response - Not applicable

25. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

DMS Response - Not applicable

26. 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, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

DMS Response - Not applicable

Affordable Care Act Impact

27. Maintenance of Effort (MOE): Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.

DMS Response - The state complies.

MOE period begins on March 10, 2010 and ends on the date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a state under the provisions of section 1311 of the Affordable Care Act is fully operational. Does the State comply with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

DMS Response - The state complies.

28. Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivision to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage that would have been required on December 31, 2009. Would any existing approved plan provisions or State law violate these provisions, if they remain in effect on or after January 1, 2014?

DMS Response - No existing approved plan provisions or State law violate these provisions.

29. Please indicate whether the state is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

DMS Response - CMS confirms we are in conformance with the requirements of section 1902(a)(37) of the Act.

Again, upon receipt of this response to the RAI Kentucky requests that this SPA be put back on-the-clock for approval. Any questions or correspondence to this SPA should be sent to Sharley Hughes.

Sincerely,



Lisa D. Lee
Commissioner

LDL/sjh

Enclosure

to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(9) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

- A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A
- B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

Level I PRTF

To be reimbursable under the Medicaid Program, Level I PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level I PRTF services in accordance with Attachment 3.1-A, Section 16 – Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse for Level I PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of \$280.09; or the usual and customary charge
- 2 The per diem rate shall be increased each biennium by 2.22 percent.
- 3 The per diem or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:
 - (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be covered and reimbursed under Kentucky's pharmacy program in accordance with Attachment 3.1-A and Attachment 4.19-A.

Level II PRTF

To be reimbursable under the Medicaid program, Level II PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level II PRTF services in accordance with Attachment 3.1-A, Section 16 – Inpatient Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse a per diem rate as follows for Level II PRTF services and costs for a recipient not enrolled in a managed care organization:
 - (a) \$345 for Level II PRTF services to a recipient who meets the rate group one (1) criteria described below;
 - (b) \$365 for Level II PRTF services to a recipient who meets the rate group two (2) criteria described below;
 - (c) \$385 for Level II PRTF services to a recipient who meets the rate group three (3) criteria described below; or
 - (d) \$405 for Level II PRTF services to a recipient who meets the rate group four (4) criteria described below.

2 Rate Groups

(a) Rate group one (1) criteria shall be for a recipient who:

1. Is twelve (12) years of age or younger;
2. Is male or female; and
3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).

(b) Rate group two (2) criteria shall be for a recipient who:

1. Is twelve (12) years of age or younger;
2. Is male or female; and
3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).

(c) Rate group three (3) criteria shall be for a recipient who:

1. Is thirteen (13) years of age or older;
2. Is male or female; and
3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).

(d) Rate group four (4) criteria shall be for a recipient who:

1. Is thirteen (13) years of age or older;
2. Is male or female; and
3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).

(e) Rate group four (4) criteria also includes the following for a recipient who:

1. Is under twenty-two (22) years of age;
2. Is male or female; and
3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Has an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient lower than seventy (70).

C. The per diem rates referenced above, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:

- (a) Including all care and treatment costs;
- (b) Including costs for all ancillary services;
- (c) Including capital costs;
- (d) Including room and board costs; and
- (e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program

- D. The department shall annually evaluate each per diem rate for Level II PRTF services and costs by reviewing the most recent, reliable claims data and cost report data to analyze treatment patterns, technology, and other factors that may alter the cost of efficiently providing Level II PRTF services.
- E. The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.
- F. (1) The department's reimbursement for a bed reserve day which qualifies as a bed reserve day for a recipient not enrolled in a managed care organization shall be:
- (a) Seventy-five (75) percent of the rate established if the Level I or II PRTF's occupancy percent is at least eighty-five (85) percent; or
 - (b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is less than eighty-five (85) percent.
 - (c) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - i. Is in Medicaid payment status in a Level I or II PRTF;
 - ii. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - iii. Is reasonably expected to return requiring Level I or II PRTF care; and
 - iv. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital
- (2) The department's reimbursement for a therapeutic pass day which qualifies as a therapeutic pass day for a recipient not enrolled in a managed care organization shall be:
- (a) 100 percent of the rate established if the Level I or II PRTF's occupancy percent is at least fifty (50) percent; or
 - (b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is below fifty (50) percent.
 - (c) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - i. Is in Medicaid payment status in a Level I or II PRTF;
 - ii. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - iii. Is reasonably expected to return requiring Level I or II PRTF care; and
 - iv. Has not exceeded the therapeutic pass day limit established; or
 - v. Received an exception to the limit.
 - vi. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - vii. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.
- (3) (a) A Level I or II PRTF's occupancy percent shall be based on a midnight census.
- (b) An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.
- (c) An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.

(10) Reimbursement for Out-of-state Hospitals.

- A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.
1. The all-inclusive DRG payment amount:
 - a. Shall be based on the patients diagnostic category; and
 - b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
 2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:

to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(9) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

- A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A
- B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

Level I PRTF

To be reimbursable under the Medicaid Program, Level I PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level I PRTF services in accordance with Attachment 3.1-A, Section 16 – Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse for Level I PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of ~~\$274.01~~280.09; or the usual and customary charge
- ~~2. An amount not to exceed the prevailing charges, in the locality where the Level I PRTF is located, for comparable services provided under comparable circumstances.~~
- 2 The per diem rate shall be increased each biennium by 2.22 percent.
- 3 The per diem or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:
 - (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be covered and reimbursed under Kentucky's pharmacy program in accordance with Attachment 3.1-A and Attachment 4.19-A.:
 - ~~1. Reimbursed via the department's pharmacy program in accordance with 907 KAR 1:018 and;~~
 - ~~2. Covered in accordance with 907 KAR 1:019/~~

Level 2 PRTF

To be reimbursable under the Medicaid program, Level II PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level II PRTF services in accordance with Attachment 3.1-A, Section 16 – Inpatient Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse a per diem rate as follows for Level II PRTF services and costs for a recipient not enrolled in a managed care organization:
 - (a) \$345 for Level II PRTF services to a recipient who meets the rate group one (1) criteria described below;
 - (b) \$365 for Level II PRTF services to a recipient who meets the rate group two (2) criteria described below;

- (c) \$385 for Level II PRTF services to a recipient who meets the rate group three (3) criteria described below; or
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2 Rate Groups

- (a) Rate group one (1) criteria shall be for a recipient who:
 - 1. Is twelve (12) years of age or younger;
 - 2. Is male or female; and
 - 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
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- (b) Rate group two (2) criteria shall be for a recipient who:
 - 1. Is twelve (12) years of age or younger;
 - 2. Is male or female; and
 - 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (c) Rate group three (3) criteria shall be for a recipient who:
 - 1. Is thirteen (13) years of age or older;
 - 2. Is male or female; and
 - 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (d) Rate group four (4) criteria shall be for a recipient who:
 - 1. Is thirteen (13) years of age or older;
 - 2. Is male or female; and
 - 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (e) Rate group four (4) criteria also includes the following for a recipient who:
 - 1. Is under twenty-two (22) years of age;
 - 2. Is male or female; and
 - 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Has an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient lower than seventy (70).

- C. The per diem rates referenced above, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:
- (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program and.
2. Covered in accordance with 907 KAR 1:019/
- D. The department shall annually evaluate each per diem rate for Level II PRTF services and costs by reviewing the most recent, reliable claims data and cost report data to analyze treatment patterns, technology, and other factors that may alter the cost of efficiently providing Level II PRTF services.
- E. The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.
- ~~F. Cost Reports and Audits:~~
- ~~(1) (a) A Level I or II PRTF shall annually submit to the department, within ninety (90) days of the closing date of the facility's fiscal year end, a legible and completed Form CMS 2552-96.~~
 - ~~(b) The department shall grant a thirty (30) day extension for submitting a legible and completed Form CMS-2552-96 to the department if an extension is requested by a Level I or II PRTF.~~
 - ~~(2) (a) A Form CMS 2552-96 shall be subject to review and audit by the department.~~
 - ~~(b) The review and audit referenced in paragraph (a) of this subsection shall be to determine if the information provided is accurate.~~
- GF. (1) The department's reimbursement for a bed reserve day which qualifies as a bed reserve day pursuant to 907 KAR 9:005 for a recipient not enrolled in a managed care organization shall be:
- (a) Seventy-five (75) percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is at least eighty-five (85) percent; or
 - (b) Fifty (50) percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is less than eighty-five (85) percent.
 - ~~(c) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:~~
 - ~~a. Is in Medicaid payment status in a Level I or II PRTF;~~
 - ~~b. Has been in the Level I or II PRTF overnight for at least one (1) night;~~
 - ~~c. Is reasonably expected to return requiring Level I or II PRTF care; and~~
 - ~~c. Has not exceeded the bed reserve day limit of 5-days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital~~
- (2) The department's reimbursement for a therapeutic pass day which qualifies as a therapeutic pass day pursuant to 907 KAR 9:005 for a recipient not enrolled in a managed care organization shall be:
- (a) 100 percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is at least fifty (50) percent; or
 - (b) Fifty (50) percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is below fifty (50) percent.
 - ~~(c) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:~~
 - ~~a. Is in Medicaid payment status in a Level I or II PRTF;~~
 - ~~b. Has been in the Level I or II PRTF overnight for at least one (1) night;~~

- c. Is reasonably expected to return requiring Level I or II PRTF care; and
- d. Has not exceeded the therapeutic pass day limit established; or
- e. Received an exception to the limit.
- f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
- g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

- (3) (a) A Level I or II PRTF's occupancy percent shall be based on a midnight census.
- (b) An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.
- (c) An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.

TN# 15-003
Supersedes
TN# 12-005

Approval Date: _____

Effective Date: October 1, 2015

(10) Reimbursement for Out-of-state Hospitals.

- A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.
1. The all-inclusive DRG payment amount:
 - a. Shall be based on the patients diagnostic category; and
 - b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
 2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

A. Covered Inpatient Admissions

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's treatment plan shall specify the amount and frequency of services needed;

- 1) A covered admission for a Level I PRTF shall be prior authorized by a review agency.
- 2) A covered admission for a Level II PRTF shall be prior authorized;

B. PRTF Covered Inpatient Services.

- 1) The following services shall be available to all eligible recipients:
 - a. Diagnostic and assessment services;
 - b. Treatment plan development, review, or revision;
 - c. Psychiatric services;
 - d. Nursing services which shall be provided in compliance with 902 KAR 20:320;
 - e. Medication which shall be provided in compliance with 907 KAR 1:019;
 - f. Evidence-based treatment interventions;
 - g. Individual therapy which shall comply with 902 KAR 20:320;
 - h. Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - i. Group therapy which shall comply with 902 KAR 20:320;
 - j. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - k. Substance abuse education;
 - l. Activities that:
 - (1) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - (2) Support and encourage the parent's ability to re-integrate the child into the home;
 - m. Crisis intervention which shall comply with:
 - (1) 42 C.F.R. 483.350 through 376; and
 - (2) 902 KAR 20:320;
 - n. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - o. Educational activities; or
 - p. Non-medical transportation services as needed to accomplish objectives;

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 2) A Level I PRTF service listed in a above shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Medically necessary; and
 - d. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
 - 3) A Level I PRTF service listed in g, h, I, k, or m. above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
 - 4) A Level II PRTF service listed shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Provided at least once a week:
 - (1) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - (2) Except for diagnostic and assessment services which shall have no weekly minimum requirement;
 - d. Medically necessary; and
 - e. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
 - 5) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.
- C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.
- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
 - 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
 - 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
 - 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
 - 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.
- 1) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital.
 - 2) Based on medical necessity, with a prior authorization, the five (5) day limit may be extended.
 - 3) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

F. Community-Based PRTF Services

Except as specified in the requirements stated for a given service, the services covered may be provided for a mental health disorder, substance use disorder or a co-occurring mental health and substance use disorders. A description of each of the following services and approved providers of services, may be found in Attachment 3.1-A and Attachment 3.1-B, Section 13d (Rehabilitative Services)

- 1) A screening, crisis intervention, or intensive outpatient program service
- 2) An assessment
- 3) Psychological testing
- 4) Day treatment or mobile crisis services
- 5) Peer support
- 6) Individual outpatient therapy, group outpatient therapy, or collateral outpatient
- 7) Family outpatient therapy provided by:
- 8) Service planning provided by:
- 9) A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:
- 10) Assertive community treatment provided by:
- 11) Comprehensive community support services provided by:
- 12) Therapeutic rehabilitation program services provided by:

G. Limits and Non-covered Services or Activities

- 1) Except as established in below, unless a diagnosis is made and documented in the recipient's health record within three (3) visits, the service shall not be covered.
 - a. The requirement established in above paragraph shall not apply to:
 - (1) Mobile crisis services;
 - (2) Crisis intervention;
 - (3) A screening; or
 - (4) An assessment.
- 2) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same date of service for the recipient:
 - a. An assessment;
 - b. Case management;
 - c. Individual outpatient therapy;
 - d. Group outpatient therapy;
 - e. Peer support services; or
 - f. Mobile crisis services.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 3) The department shall not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service.
 - 4) The following services or activities shall not be covered under:
 - a. A service provided to:
 - (1) A resident of:
 - a) A nursing facility; or
 - b) An intermediate care facility for individuals with an intellectual disability;
 - (2) An inmate of a federal, local, or state:
 - a) Jail;
 - b) Detention center; or
 - c) Prison; or
 - (3) An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - b. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the psychiatric residential treatment facility;
 - c. A consultation or educational service provided to a recipient or to others;
 - d. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements of "face-to-face";
 - e. Travel time;
 - f. A field trip;
 - g. A recreational activity;
 - h. A social activity; or
 - i. A physical exercise activity group.
 - 5)
 - a. A consultation by one (1) provider or professional with another shall not be covered for Collateral Outpatient Therapy.
 - b. A third party contract shall not be covered under this administrative regulation.
 - 6) A billing supervisor arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not:
 - a. Violate the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision; or
 - b. Substitute for the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

A. Covered Inpatient Admissions

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's treatment plan shall specify the amount and frequency of services needed;

- 1) A covered admission for a Level I PRTF shall be prior authorized by a review agency.
- 2) A covered admission for a Level II PRTF shall be prior authorized;

B. PRTF Covered Inpatient Services.

- 1) The following services shall be available to all eligible recipients:
 - a. Diagnostic and assessment services;
 - b. Treatment plan development, review, or revision;
 - c. Psychiatric services;
 - d. Nursing services which shall be provided in compliance with 902 KAR 20:320;
 - e. Medication which shall be provided in compliance with 907 KAR 1:019;
 - f. Evidence-based treatment interventions;
 - g. Individual therapy which shall comply with 902 KAR 20:320;
 - h. Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - i. Group therapy which shall comply with 902 KAR 20:320;
 - j. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - k. Substance abuse education;
 - l. Activities that:
 - (1) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - (2) Support and encourage the parent's ability to re-integrate the child into the home;
 - m. Crisis intervention which shall comply with:
 - (1) 42 C.F.R. 483.350 through 376; and
 - (2) 902 KAR 20:320;
 - n. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - o. Educational activities; or
 - p. Non-medical transportation services as needed to accomplish objectives;

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 2) A Level I PRTF service listed in a above shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Medically necessary; and
 - d. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
 - 3) A Level I PRTF service listed in g, h, I, k, or m. above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
 - 4) A Level II PRTF service listed shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Provided at least once a week:
 - (1) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - (2) Except for diagnostic and assessment services which shall have no weekly minimum requirement;
 - d. Medically necessary; and
 - e. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
 - 5) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.

C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.

- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
- 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
- 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
- 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
- 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.
- 1) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
- a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital.
- 2) Based on medical necessity, with a prior authorization, the five (5) day limit may be extended.
- 3) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
- a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

F. Community-Based PRTF Services

Except as specified in the requirements stated for a given service, the services covered may be provided for a mental health disorder, substance use disorder or a co-occurring mental health and substance use disorders. A description of each of the following services and approved providers of services, may be found in Attachment 3.1-A and Attachment 3.1-B, Section 13d (Rehabilitative Services)

- 1) A screening, crisis intervention, or intensive outpatient program service
- 2) An assessment
- 3) Psychological testing
- 4) Day treatment or mobile crisis services
- 5) Peer support
- 6) Individual outpatient therapy, group outpatient therapy, or collateral outpatient
- 7) Family outpatient therapy provided by:
- 8) Service planning provided by:
- 9) A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:
- 10) Assertive community treatment provided by:
- 11) Comprehensive community support services provided by:
- 12) Therapeutic rehabilitation program services provided by:

G. Limits and Non-covered Services or Activities

- 1) Except as established in below, unless a diagnosis is made and documented in the recipient's health record within three (3) visits, the service shall not be covered.
 - a. The requirement established in above paragraph shall not apply to:
 - (1) Mobile crisis services;
 - (2) Crisis intervention;
 - (3) A screening; or
 - (4) An assessment.
- 2) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same date of service for the recipient:
 - a. An assessment;
 - b. Case management;
 - c. Individual outpatient therapy;
 - d. Group outpatient therapy;
 - e. Peer support services; or
 - f. Mobile crisis services.

16. **Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age**
- 3) The department shall not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service.
 - 4) The following services or activities shall not be covered under:
 - a. A service provided to:
 - (1) A resident of:
 - a) A nursing facility; or
 - b) An intermediate care facility for individuals with an intellectual disability;
 - (2) An inmate of a federal, local, or state:
 - a) Jail;
 - b) Detention center; or
 - c) Prison; or
 - (3) An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - b. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the psychiatric residential treatment facility;
 - c. A consultation or educational service provided to a recipient or to others;
 - d. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements of "face-to-face";
 - e. Travel time;
 - f. A field trip;
 - g. A recreational activity;
 - h. A social activity; or
 - i. A physical exercise activity group.
 - 5) a. A consultation by one (1) provider or professional with another shall not be covered for Collateral Outpatient Therapy.
b. A third party contract shall not be covered under this administrative regulation.
 - 6) A billing supervisor arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not:
 - a. Violate the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision; or
 - b. Substitute for the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

A. Covered Inpatient Admissions

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's ~~must a treatment plan developed that shall specify the amount and frequency of services needed;~~

- 1) A covered admission for a Level I PRTF: ~~a. S shall be prior authorized by a review agency; and;~~
 - ~~b. Shall be limited to those for a child age six (6) through twenty (20) years of age who meets Medicaid payment status criteria; or~~
 - ~~c. May continue based on medical necessity, for a recipient who is receiving active treatment in a Level I PRTF on the recipient's twenty-first (21st) birthday if the recipient has not reached his or her twenty-second (22nd) birthday.~~
- 2) A covered admission for a Level II PRTF shall be:
 - ~~a. Prior authorized;~~
 - ~~b. Limited to those for a child age four (4) through twenty-one (21) years who meets Medicaid payment status criteria; and~~
 - ~~c. Whose coverage may continue, based on medical necessity, if the recipient is receiving active treatment in a Level II PRTF on the recipient's twenty-first (21st) birthday and the recipient has not reached his or her twenty-second (22nd) birthday;~~
 - ~~db. With a severe emotional disability in addition to severe and persistent aggressive behaviors, an intellectual disability, sexually acting out behaviors, or a developmental disability; and~~
 - ~~e. Who does not meet the medical necessity criteria for an acute care hospital, private psychiatric hospital, or state mental hospital; and~~
 - ~~f. Whose treatment needs cannot be met in an ambulatory care setting, Level I PRTF, or in any other less restrictive environment; and~~

B. PRTF Covered Inpatient Services.

- 1) ~~Each patient must a treatment plan developed that shall specify:~~
 - ~~a. The amount and frequency of services needed; and~~
 - ~~b. The number of therapeutic pass days for a recipient, if the treatment plan includes any therapeutic pass days.~~
- 2) ~~To be covered by the department:~~
 - a. The following services shall be available to all eligible recipients:

- (1) Diagnostic and assessment services;
- (2) Treatment plan development, review, or revision;
- (3) Psychiatric services;
- (4) Nursing services which shall be provided in compliance with 902 KAR 20:320;
- (5) Medication which shall be provided in compliance with 907 KAR 1:019;

TN No. 15-003

Supersedes

TN No. 90-32

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- (6) Evidence-based treatment interventions;
 - (7) Individual therapy which shall comply with 902 KAR 20:320;
 - (8) Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - (9) Group therapy which shall comply with 902 KAR 20:320;
 - (10) Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - (11) Substance abuse education;
 - (12) Activities that:
 - a) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - b) Support and encourage the parent's ability to re-integrate the child into the home;
 - (13) Crisis intervention which shall comply with:
 - a) 42 C.F.R. 483.350 through 376; and
 - b) 902 KAR 20:320;
 - (14) Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - (15) Educational activities; or
 - (16) Non-medical transportation services as needed to accomplish objectives;
- b. A Level I PRTF service listed in a above shall be:
- (1) Provided under the direction of a physician;
 - (2) If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - (3) Medically necessary; and
 - (4) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
- c. A Level I PRTF service listed in (7), (8), (9), (11), or (13) above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
- d. A Level II PRTF service listed shall be:
- (1) Provided under the direction of a physician;
 - (2) If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - (3) Provided at least once a week:
 - a) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - b) Except for diagnostic and assessment services which shall have no weekly minimum requirement;

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

- (4) Medically necessary; and
 - (5) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
- 3) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.

C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.

- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
- 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
- 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
- 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
- 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
- b. Approved by the recipient's treatment team.

- 1) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit ~~established below of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital;~~ ~~or~~
 - e. ~~Received an exception to the limit below.~~
- 2) ~~The annual bed reserve day limit per recipient shall be five (5) days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital.~~

- 3) ~~Based on medical necessity, with a prior authorization, (The department shall allow a recipient to exceed the limit established five (5) day limit may be extended, if the department determines that an additional bed reserve day is in the best interest of the recipient.~~

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16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 4) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.
 - 5) ~~The bed reserve day and therapeutic pass day count for each recipient shall be zero (0) upon the effective date of this SPA.~~
 - ~~a. For subsequent calendar years, the bed reserve day and therapeutic pass day count for each recipient shall begin at zero (0) on January 1 of the calendar year.~~
 - 6) ~~An authorization decision regarding a bed reserve day or therapeutic pass day in excess of the limits shall be performed by a review agency.~~
 - 7) ~~An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital.~~
 - 8) ~~A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively.~~
 - 9) ~~A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:
 - a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.~~
 - 10) ~~A Level I or II PRTF's occupancy percent shall be based on a midnight census.~~
 - 11) ~~An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.~~
 - 12) ~~An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.
- 3) ~~The department shall not reimburse for Level I or II PRTF services for a recipient if appropriate alternative services are available for the recipient in the community.~~
- 4) ~~The following shall not qualify as reimbursable in a PRTF setting:~~
 - a. ~~An admission that is not medically necessary;~~
 - b. ~~Services for an individual:~~
 - (1) ~~With a major medical problem or minor symptoms;~~
 - (2) ~~Who might only require a psychiatric consultation rather than an admission to a PRTF; or~~
 - (3) ~~Who might need only adequate living accommodations, economic aid, or social support services.~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

F. ~~Outpatient PRTF Services~~ Community-Based PRTF Services

Except as specified in the requirements stated for a given service, the services covered may be provided for a mental health disorder, substance use disorder or a co-occurring mental health and substance use disorders. A description of each of the following services and approved providers of services, may be found in Attachment 3.1-A and Attachment 3.1-B, Section 13d (Rehabilitative Services)

- 1) A screening, crisis intervention, or intensive outpatient program service provided by:
 - a. ~~A licensed psychologist;~~
 - b. ~~A licensed psychological practitioner;~~
 - c. ~~A certified psychologist with autonomous functioning;~~
 - d. ~~A licensed clinical social worker;~~
 - e. ~~A licensed professional clinical counselor;~~
 - f. ~~A licensed professional art therapist;~~
 - g. ~~A licensed marriage and family therapist;~~
 - h. ~~A physician;~~
 - i. ~~A psychiatrist;~~
 - j. ~~An advanced practice registered nurse;~~
 - k. ~~A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
 - l. ~~A certified psychologist working under the supervision of a board approved licensed psychologist;~~
 - m. ~~A licensed clinical alcohol and drug counselor in accordance with; or~~
 - n. ~~A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;~~

- 2) An assessment provided by:
 - a. ~~A licensed psychologist;~~
 - b. ~~A licensed psychological practitioner;~~
 - c. ~~A certified psychologist with autonomous functioning;~~
 - d. ~~A licensed clinical social worker;~~
 - e. ~~A licensed professional clinical counselor;~~
 - f. ~~A licensed professional art therapist;~~
 - g. ~~A licensed marriage and family therapist;~~
 - h. ~~A physician;~~
 - i. ~~A psychiatrist;~~
 - j. ~~An advanced practice registered nurse;~~
 - k. ~~A licensed behavior analyst;~~
 - l. ~~A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
 - m. ~~A certified psychologist working under the supervision of a board approved licensed psychologist;~~
 - n. ~~A licensed clinical alcohol and drug counselor; or~~
 - o. ~~A behavioral health practitioner under supervision;~~

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3) Psychological testing provided by:

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~e. A licensed psychological associate working under the supervision of a board-approved licensed psychologist; or~~
- ~~f. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~

4) Day treatment or mobile crisis services provided by:

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~
- ~~f. A licensed professional art therapist;~~
- ~~g. A licensed marriage and family therapist;~~
- ~~h. A physician;~~
- ~~i. A psychiatrist;~~
- ~~j. An advanced practice registered nurse;~~
- ~~k. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~l. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~m. A licensed clinical alcohol and drug counselor;~~
- ~~n. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst; or~~
- ~~o. A peer support specialist working under the supervision of an approved behavioral health services provider.~~

5) Peer support

~~Provided by a peer support specialist working under the supervision of an approved behavioral health services.~~

6) Individual outpatient therapy, group outpatient therapy, or collateral outpatient therapy provided by:

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

- ~~f. — A licensed professional art therapist;~~
- ~~g. — A licensed marriage and family therapist;~~
- ~~h. — A physician;~~
- ~~i. — A psychiatrist;~~
- ~~j. — An advanced practice registered nurse;~~
- ~~k. — A licensed behavior analyst;~~
- ~~l. — A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
- ~~m. — A certified psychologist working under the supervision of a board approved licensed psychologist;~~
- ~~n. — A licensed clinical alcohol and drug counselor; or~~
- ~~o. — A behavioral health practitioner under supervision;~~

7) Family outpatient therapy provided by:

- ~~a. — A licensed psychologist;~~
- ~~b. — A licensed psychological practitioner;~~
- ~~c. — A certified psychologist with autonomous functioning;~~
- ~~d. — A licensed clinical social worker;~~
- ~~e. — A licensed professional clinical counselor;~~
- ~~f. — A licensed professional art therapist;~~
- ~~g. — A licensed marriage and family therapist;~~
- ~~h. — A physician;~~
- ~~i. — A psychiatrist;~~
- ~~j. — An advanced practice registered nurse;~~
- ~~k. — A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
- ~~l. — A certified psychologist working under the supervision of a board approved licensed psychologist;~~
- ~~m. — A licensed clinical alcohol and drug counselor; or~~
- ~~n. — A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;~~

8) Service planning provided by:

- ~~a. — A licensed psychologist;~~
- ~~b. — A licensed psychological practitioner;~~
- ~~c. — A certified psychologist with autonomous functioning;~~
- ~~d. — A licensed clinical social worker;~~
- ~~e. — A licensed professional clinical counselor;~~
- ~~f. — A licensed professional art therapist;~~
- ~~g. — A licensed marriage and family therapist;~~
- ~~h. — A physician;~~
- ~~i. — A psychiatrist;~~

16. **Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age**

- ~~j. An advanced practice registered nurse;~~
- ~~k. A licensed behavior analyst;~~
- ~~l. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~m. A certified psychologist working under the supervision of a board-approved licensed psychologist; or~~
- ~~n. A behavioral health practitioner under supervision except for:
(1) A certified alcohol and drug counselor; or
(2) A licensed clinical alcohol and drug counselor associate;~~

9. **A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:**

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~
- ~~f. A licensed professional art therapist;~~
- ~~g. A licensed marriage and family therapist;~~
- ~~h. A physician;~~
- ~~i. A psychiatrist;~~
- ~~j. An advanced practice registered nurse;~~
- ~~k. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~m. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~n. A licensed clinical alcohol and drug counselor; or~~
- ~~o. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst; and~~

10) **Assertive community treatment provided by:**

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~
- ~~f. A licensed professional art therapist;~~
- ~~g. A licensed marriage and family therapist;~~
- ~~h. A physician;~~
- ~~i. A psychiatrist;~~
- ~~j. An advanced practice registered nurse;~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

- ~~k. — A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~l. — A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~j. — A behavioral health practitioner under supervision except for a:
 - ~~(1) — Licensed assistant behavior analyst;~~
 - ~~(2) — Certified alcohol and drug counselor; or~~
 - ~~(3) — Licensed clinical alcohol and drug counselor associate;~~~~
- ~~k. — A peer support specialist working under the supervision of an approved behavioral health services provider except for a:
 - ~~(1) — Licensed clinical alcohol and drug counselor;~~
 - ~~(2) — Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(3) — Certified alcohol and drug counselor; or~~~~
- ~~l. — A community support associate;~~

11. Comprehensive community support services provided by:

- ~~a. — A licensed psychologist;~~
- ~~b. — A licensed psychological practitioner;~~
- ~~c. — A certified psychologist with autonomous functioning;~~
- ~~d. — A licensed clinical social worker;~~
- ~~e. — A licensed professional clinical counselor;~~
- ~~f. — A licensed professional art therapist;~~
- ~~g. — A licensed marriage and family therapist;~~
- ~~h. — A physician;~~
- ~~i. — A psychiatrist;~~
- ~~j. — An advanced practice registered nurse;~~
- ~~k. — A licensed behavior analyst;~~
- ~~l. — A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~m. — A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~n. — A behavioral health practitioner under supervision except for a:
 - ~~(1) — Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(2) — Certified alcohol and drug counselor; or~~~~
- ~~o. — A community support associate; or~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

12) Therapeutic rehabilitation program services provided by:

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~
- ~~f. A licensed professional art therapist;~~
- ~~g. A licensed marriage and family therapist;~~
- ~~h. A physician;~~
- ~~i. A psychiatrist;~~
- ~~j. An advanced practice registered nurse;~~
- ~~k. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~l. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~m. A behavioral health practitioner under supervision except for a:
 - ~~(1) Licensed assistant behavior analyst;~~
 - ~~(2) Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(3) Certified alcohol and drug counselor; or~~~~
- ~~n. A peer support specialist working under the supervision of an approved behavioral health services provider except for a:
 - ~~(1) Licensed clinical alcohol and drug counselor;~~
 - ~~(2) Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(3) Certified alcohol and drug counselor.~~~~

G. Limits and Non-covered Services or Activities

- 1) Except as established in below, unless a diagnosis is made and documented in the recipient's health record within three (3) visits, the service shall not be covered.
 - a. The requirement established in above paragraph shall not apply to:
 - (1) Mobile crisis services;
 - (2) Crisis intervention;
 - (3) A screening; or
 - (4) An assessment.
- 2) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same date of service for the recipient:
 - a. An assessment;
 - b. Case management;
 - c. Individual outpatient therapy;
 - d. Group outpatient therapy;
 - e. Peer support services; or
 - f. Mobile crisis services.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 3) The department shall not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service.
 - 4) The following services or activities shall not be covered under:
 - a. A service provided to:
 - (1) A resident of:
 - a) A nursing facility; or
 - b) An intermediate care facility for individuals with an intellectual disability;
 - (2) An inmate of a federal, local, or state:
 - a) Jail;
 - b) Detention center; or
 - c) Prison; or
 - (3) An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - b. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the psychiatric residential treatment facility;
 - c. A consultation or educational service provided to a recipient or to others;
 - d. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements of "face-to-face";
 - e. Travel time;
 - f. A field trip;
 - g. A recreational activity;
 - h. A social activity; or
 - i. A physical exercise activity group.
 - 5) a. A consultation by one (1) provider or professional with another shall not be covered for Collateral Outpatient Therapy.
b. A third party contract shall not be covered under this administrative regulation.
 - 6) A billing supervisor arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not:
 - a. Violate the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision; or
 - b. Substitute for the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

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November 10, 2015

Jackie Glaze
Associate Regional Director
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Re: Kentucky State Plan Amendment 15-003

Dear Ms. Glaze:

In response to your Request for Additional Information (RAI), Kentucky Department for Medicaid Services has responded to each of your questions, made the necessary changes to any impacted State Plan pages (attached) and is ready to put this SPA back on-the-clock. Our responses are below:

General

1. The state estimates a federal budget impact of (\$0) for FY 2015 and (\$0) FY 2016. Since you are increasing access to service provided by PRTFs in the community, please explain why you do not expect utilization and cost of serves to increase?

DMS Response - The services that will be provided by the PRTFs can be delivered by other providers. This purpose of this SPA is to increase access points for outpatient behavioral health services. Increasing access points within a member's community will decrease the need for transportation and will also decrease the likelihood of costly inpatient services. We do expect utilization to increase but believe the increased access to lower-level outpatient services will lead to stabilization of behavioral health conditions which will negate the need for costlier treatments, such as inpatient care.

2. Please provide information demonstrating that the changes proposed in this SPA comport with public process requirements at section 1902(a)(13)(A) of the Social Security Act and guidance identified in the state Medicaid Director letter issued on December 10, 1997.

DMS Response - Please see the attached Administrative Register that includes the posting of the Kentucky Administrative Regulations that included these changes.

3. Coverage pages need to reflect that the state complies with the PRTF requirements found at 42 CFR 440.160; 42 CFR 483.352 (a separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis under the direction of a physician; at 42 C.F.R. Part 441, Subpart D - Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs (the PRTF resident population must meet all identified certification of need requirements); and at Part 483, subpart G - Condition of Participation for the Use of Restraint or Seclusion of Psychiatric Residential Treatment Facilities (a PRTF is subject to survey and certification of the entire facility and must meet all requirements under Part 483, subpart G.) Therefore, we would like the state to add an assurance in the plan that the state complies with these PRTF requirements (See the 2007 Survey and Certification Guidance to the State Survey Agencies)

DMS Response - Assurances have been added to the attached State Plan pages.

4. We would like the state to clarify whether the PRTF will be furnishing the “Outpatient PRTF Services” to children who are not residents of the PRTF, but who live in the community and would be going to the PRTF for receipt of these mental health/substance use disorder treatment services.

DMS Response - The state confirms the PRTF will be furnishing the “Outpatient PRTF Services” to children who are not residents of the PRTF, but who live in the community and would be going to the PRTF for receipt of these mental health/substance use disorder treatment services on an outpatient basis only.

Plan Pages

Attachment 3.1-A

5. Attachment 3.1-A, Page 7.8.3: Please remove the references in the state plan to age ranges within the EPSDT population that will receive Level I or Level II services. Comparability requires that all children in the EPSDT population must have access to the same amount, duration and scope of services.

DMS Response - Age ranges have been removed.

6. Attachment 3.1-A, Page 7.8.3, items A.2.d, e and f: Please remove all medical necessity criteria that appear in the state plan as they are within the state's purview and CMS does not wish to be in a position of approving the state's criteria. For example, the information on this page appears to be medical necessity criteria and should be deleted from the plan page. It is allowable to note that all children will be evaluated based on their individual needs according to the state's medical necessity criteria and placed into one or two levels of PRTFs based on the intensity of their needs.

DMS Response - Requested changes have been made.

7. Attachment 3.1-A, Page 7.8.3: Please add an introduction that reflects the state's assurance that it complies with the PRTF requirement noted above.

DMS Response - Requested introduction has been added

8. Attachment 3.1-A, Page 7.8.3: After the introduction, the state can add language about the services that are available to children in the PRTF. For example, "Subject to an individual's plan of care, the following services are furnished to children in a PRTF pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, under the direction of a physician...etc. Then list all of the inpatient and outpatient services.

DMS Response - Please see attached revised State Plan pages.

9. Attachment 3.1-A, Page 7.8.4.1 - Item D, "Reserved Bed and Therapeutic Pass Days": We suggest that the state broadly summarize the coverage for reserved beds and therapeutic pass days, perhaps including language that they are covered, defining them (using the definitions found in items 7, 8 and 9 on page 7.8.4.2), including the limits and explaining that the limits can be exceeded based on medical necessity. Some of the details may be more appropriate for the reimbursement pages. We can discuss this further with the state. NOTE: The state indicates that the limits can be exceeded based on a determination of "the best interest of the recipient" but we think this should read "based on medical necessity."

DMS Response -Please see attached revised State Plan pages.

10. Attachment 3.1-A, page 7.8.4.3: Is the state willing to consider omitting items 3 and 4 on this page. We think it goes without saying that only those children who qualify for the PRTF will be eligible to receive the services furnished by the PRTF.

DMS Response - Please see attached revised State Plan pages.

10. Attachment 3.1-A, page 7.8.4.4: We think these PRTF services can be moved to appear after the "inpatient" PRTF services. The title of the services should be

something such as “Community-Based PRTF Services in order to avoid confusion with Outpatient Hospital services.

DMS Response - See attached revised State Plan pages.

Attachment 4.19-A

12. Page 35 (9) B 2. This section included the following language. “An amount not to exceed the prevailing charges, in the locality where the Level I PRTF is located, for comparable services provided under comparable circumstances”. This language is not comprehensive enough for the read to determine what charges the state is referencing. Also the language in B.1 limits the payment to the lesser of the per diem rate or the usual and customary charges. Please revise the language to make it clear what prevailing charges are being referenced or remove this language.

DMS Response - Language has been removed on the attached State Plan pages.

13. Page 35 (9) B 2. This is a duplicate number 2 and should be revised to number 3. This section provides for a 2.22 percent increase each biennium. Have the rates been increased by this amount? If not, please remove this language and include the effective date and amount of the next increase if one will be given. If not please remove this language.

DMS Response - Previous language was removed which corrected the duplication. The rates have been adjusted according to this language.

14. Page 35 (9) B. 3 (e) 1. This section includes language that references the KAR 1:018 and KAR 1:109 regarding the reimbursement and coverage of drugs. Please include this language in the state plan or an effective date of the KAR. Please provide a copy of these regulations for our review if you leave the references in the plan.

DMS Response - We have removed reference to the Administrative Regulation and instead referenced the pharmacy section of the State Plan.

15. The PRTF per diem rates for Level 1 and 2 included on Page 35 (9) B must be updated if they have been increased.

DMS Response - Rates for Level 1 have been revised on the attached State Plan pages. Level II PRTFs do not receive the increase.

16. Page 35.2 F (1) (a) (b) and 2 (a). The reference to CMS 2552-96 should be revised to CMS 2552-10. Also please include language in these sections that the providers will be required to follow the Medicare reimbursement principles at 42 CFR 413 and the Provider Reimbursement Manual 15-I and 15-II to determine allowable cost allocated and appropriated to the program.

DMS Response - We have changed the reference to CMS 2552-96 and added the requested language.

17. Please provide a copy of a completed CMS 2552-10 cost report for one provider. Also include any instruction issued to providers to be used in completing the annual cost report. Please note any cost for staff that provide inpatient services that will also provide services to patients outside the facility must be removed through the cost report allocation and apportionment process.

DMS Response - The State has removed reference to the CMS cost report because we pay based on an established rate, rather than reimbursing the PRTF at cost.

18. Page 35.2 G(1) and (2). These sections provide for payment of bed reserve day and therapeutic pass days. Please include language that indicates how many days will be paid for each of these categories annually. Also, include the language from the KAR referenced or the effective date of the regulations. If you leave the reference to the KAR in the plan provide a copy of the regulation for our review.

DMS Response - DMS has removed the reference to KAR as the reimbursement is outlined in the State Plan. Also the revised pages reflect additional language regarding how many days will be paid for each.

19. Page 35.2 G (3) (a). Please include the occupancy percentages for the bed reserve days and therapeutic pass days.

DMS Response - The occupancy percentages were in the original submission - Page 35.2 G (1) (a) and (b) for bed reserve days and Page 35.2 G (2) (a) and (b) for Therapeutic pass days.

20. Page 35.2 G (3) (b) (c). This section discusses when the bed reserve and therapeutic days will be included or excluded from the mid-night census? Please explain these sections. Also, the MMIS should track and account for these days separate from the paid days for services provided in the facility.

DMS Response - The state has added additional information to explain the bed reserve and therapeutic days. Also, bed reserve and therapeutic days are filed using the revenue code 183, which allows for these days to be tracked.

Attachment 4.19-B

21. Although the practitioners at the PRTF can furnish services to children who are not residing at the PRTF and live at home in the community, these services must be covered in the state plan under an appropriate benefit category (i.e., Rehab) and be

claimed as that service, not as a PRTF service. Based on that please withdraw the proposed Attachment 4.19-B, pages 20.12(i) through 20.12(m). If the payment methodology for these practitioners is the same as the currently payment methodology for rehab services, no additional information is required. If not, the state must submit the updated payment methodology for CMS' review and approval.

DMS Response - DMS has removed the Attachment 4.19-B pages as the PRTFs will be paid based on the reimbursement in the Rehab section of the state plan. Upon receipt of this information, DMS gives CMS permission to make this change to the 179 Form.

Funding

The following question are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State Plan.

22. 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 claims by the State (including 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 organizations? 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 returned of any of the payment, a complete listing of providers that return a ports 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.)

DMS Response - The providers retain all funds paid.

23. 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 government

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).

DMS Response - Not applicable

- 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.

DMS Response - Not applicable

25. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

DMS Response - Not applicable

26. 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, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

DMS Response - Not applicable

Affordable Care Act Impact

27. Maintenance of Effort (MOE): Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.

DMS Response - The state complies.

MOE period begins on March 10, 2010 and ends on the date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a state under the provisions of section 1311 of the Affordable Care Act is fully operational. Does the State comply with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

DMS Response - The state complies.

28. Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivision to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage that would have been required on December 31, 2009. Would any existing approved plan provisions or State law violate these provisions, if they remain in effect on or after January 1, 2014?

DMS Response - No existing approved plan provisions or State law violate these provisions.

29. Please indicate whether the state is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

DMS Response - CMS confirms we are in conformance with the requirements of section 1902(a)(37) of the Act.

Again, upon receipt of this response to the RAI Kentucky requests that this SPA be put back on-the-clock for approval. Any questions or correspondence to this SPA should be sent to Sharley Hughes.

Sincerely,



Lisa D. Lee
Commissioner

LDL/sjh

Enclosure

to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(9) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

- A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A
- B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

Level I PRTF

To be reimbursable under the Medicaid Program, Level I PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level I PRTF services in accordance with Attachment 3.1-A, Section 16 – Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse for Level I PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of \$280.09; or the usual and customary charge
- 2 The per diem rate shall be increased each biennium by 2.22 percent.
- 3 The per diem or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:
 - (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be covered and reimbursed under Kentucky's pharmacy program in accordance with Attachment 3.1-A and Attachment 4.19-A.

Level II PRTF

To be reimbursable under the Medicaid program, Level II PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level II PRTF services in accordance with Attachment 3.1-A, Section 16 – Inpatient Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse a per diem rate as follows for Level II PRTF services and costs for a recipient not enrolled in a managed care organization:
 - (a) \$345 for Level II PRTF services to a recipient who meets the rate group one (1) criteria described below;
 - (b) \$365 for Level II PRTF services to a recipient who meets the rate group two (2) criteria described below;
 - (c) \$385 for Level II PRTF services to a recipient who meets the rate group three (3) criteria described below; or
 - (d) \$405 for Level II PRTF services to a recipient who meets the rate group four (4) criteria described below.

2 Rate Groups

(a) Rate group one (1) criteria shall be for a recipient who:

1. Is twelve (12) years of age or younger;
2. Is male or female; and
3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).

(b) Rate group two (2) criteria shall be for a recipient who:

1. Is twelve (12) years of age or younger;
2. Is male or female; and
3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).

(c) Rate group three (3) criteria shall be for a recipient who:

1. Is thirteen (13) years of age or older;
2. Is male or female; and
3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).

(d) Rate group four (4) criteria shall be for a recipient who:

1. Is thirteen (13) years of age or older;
2. Is male or female; and
3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).

(e) Rate group four (4) criteria also includes the following for a recipient who:

1. Is under twenty-two (22) years of age;
2. Is male or female; and
3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Has an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient lower than seventy (70).

C. The per diem rates referenced above, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:

- (a) Including all care and treatment costs;
- (b) Including costs for all ancillary services;
- (c) Including capital costs;
- (d) Including room and board costs; and
- (e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program

- D. The department shall annually evaluate each per diem rate for Level II PRTF services and costs by reviewing the most recent, reliable claims data and cost report data to analyze treatment patterns, technology, and other factors that may alter the cost of efficiently providing Level II PRTF services.
- E. The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.
- F. (1) The department's reimbursement for a bed reserve day which qualifies as a bed reserve day for a recipient not enrolled in a managed care organization shall be:
- (a) Seventy-five (75) percent of the rate established if the Level I or II PRTF's occupancy percent is at least eighty-five (85) percent; or
 - (b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is less than eighty-five (85) percent.
 - (c) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - i. Is in Medicaid payment status in a Level I or II PRTF;
 - ii. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - iii. Is reasonably expected to return requiring Level I or II PRTF care; and
 - iv. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital
- (2) The department's reimbursement for a therapeutic pass day which qualifies as a therapeutic pass day for a recipient not enrolled in a managed care organization shall be:
- (a) 100 percent of the rate established if the Level I or II PRTF's occupancy percent is at least fifty (50) percent; or
 - (b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is below fifty (50) percent.
 - (c) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - i. Is in Medicaid payment status in a Level I or II PRTF;
 - ii. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - iii. Is reasonably expected to return requiring Level I or II PRTF care; and
 - iv. Has not exceeded the therapeutic pass day limit established; or
 - v. Received an exception to the limit.
 - vi. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - vii. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.
- (3) (a) A Level I or II PRTF's occupancy percent shall be based on a midnight census.
- (b) An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.
- (c) An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.

(10) Reimbursement for Out-of-state Hospitals.

- A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.
1. The all-inclusive DRG payment amount:
 - a. Shall be based on the patients diagnostic category; and
 - b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
 2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:

to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(9) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

- A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A
- B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

Level I PRTF

To be reimbursable under the Medicaid Program, Level I PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level I PRTF services in accordance with Attachment 3.1-A, Section 16 – Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse for Level I PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of ~~\$274.01~~ \$280.09; or the usual and customary charge
- ~~2. An amount not to exceed the prevailing charges, in the locality where the Level I PRTF is located, for comparable services provided under comparable circumstances.~~
- 2 The per diem rate shall be increased each biennium by 2.22 percent.
- 3 The per diem or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:
 - (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be covered and reimbursed under Kentucky's pharmacy program in accordance with Attachment 3.1-A and Attachment 4.19-A.:
 - ~~1. Reimbursed via the department's pharmacy program in accordance with 907 KAR 1:018 and;~~
 - ~~2. Covered in accordance with 907 KAR 1:019/~~

Level 2 PRTF

To be reimbursable under the Medicaid program, Level II PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level II PRTF services in accordance with Attachment 3.1-A, Section 16 – Inpatient Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse a per diem rate as follows for Level II PRTF services and costs for a recipient not enrolled in a managed care organization:
 - (a) \$345 for Level II PRTF services to a recipient who meets the rate group one (1) criteria described below;
 - (b) \$365 for Level II PRTF services to a recipient who meets the rate group two (2) criteria described below;

- (c) \$385 for Level II PRTF services to a recipient who meets the rate group three (3) criteria described below; or
- (d) \$405 for Level II PRTF services to a recipient who meets the rate group four (4) criteria described below.

2 Rate Groups

- (a) Rate group one (1) criteria shall be for a recipient who:
 - 1. Is twelve (12) years of age or younger;
 - 2. Is male or female; and
 - 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (b) Rate group two (2) criteria shall be for a recipient who:
 - 1. Is twelve (12) years of age or younger;
 - 2. Is male or female; and
 - 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (c) Rate group three (3) criteria shall be for a recipient who:
 - 1. Is thirteen (13) years of age or older;
 - 2. Is male or female; and
 - 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (d) Rate group four (4) criteria shall be for a recipient who:
 - 1. Is thirteen (13) years of age or older;
 - 2. Is male or female; and
 - 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (e) Rate group four (4) criteria also includes the following for a recipient who:
 - 1. Is under twenty-two (22) years of age;
 - 2. Is male or female; and
 - 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Has an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient lower than seventy (70).

- C. The per diem rates referenced above, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:
- (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program and.
2. Covered in accordance with 907 KAR 1:019/
- D. The department shall annually evaluate each per diem rate for Level II PRTF services and costs by reviewing the most recent, reliable claims data and cost report data to analyze treatment patterns, technology, and other factors that may alter the cost of efficiently providing Level II PRTF services.
- E. The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.
- ~~F. Cost Reports and Audits:~~
- ~~(1) (a) A Level I or II PRTF shall annually submit to the department, within ninety (90) days of the closing date of the facility's fiscal year end, a legible and completed Form CMS 2552-96.~~
 - ~~(b) The department shall grant a thirty (30) day extension for submitting a legible and completed Form CMS-2552-96 to the department if an extension is requested by a Level I or II PRTF.~~
 - ~~(2) (a) A Form CMS 2552-96 shall be subject to review and audit by the department.~~
 - ~~(b) The review and audit referenced in paragraph (a) of this subsection shall be to determine if the information provided is accurate.~~
- GF. (1) The department's reimbursement for a bed reserve day which qualifies as a bed reserve day pursuant to 907 KAR 9:005 for a recipient not enrolled in a managed care organization shall be:
- (a) Seventy-five (75) percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is at least eighty-five (85) percent; or
 - (b) Fifty (50) percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is less than eighty-five (85) percent.
 - ~~(c) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:~~
 - ~~a. Is in Medicaid payment status in a Level I or II PRTF;~~
 - ~~b. Has been in the Level I or II PRTF overnight for at least one (1) night;~~
 - ~~c. Is reasonably expected to return requiring Level I or II PRTF care; and~~
 - ~~c. Has not exceeded the bed reserve day limit of 5-days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital~~
- (2) The department's reimbursement for a therapeutic pass day which qualifies as a therapeutic pass day pursuant to 907 KAR 9:005 for a recipient not enrolled in a managed care organization shall be:
- (a) 100 percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is at least fifty (50) percent; or
 - (b) Fifty (50) percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is below fifty (50) percent.
 - ~~(c) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:~~
 - ~~a. Is in Medicaid payment status in a Level I or II PRTF;~~
 - ~~b. Has been in the Level I or II PRTF overnight for at least one (1) night;~~

- c. Is reasonably expected to return requiring Level I or II PRTF care; and
- d. Has not exceeded the therapeutic pass day limit established; or
- e. Received an exception to the limit.
- f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
- g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

- (3) (a) A Level I or II PRTF's occupancy percent shall be based on a midnight census.
- (b) An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.
- (c) An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.

TN# 15-003
Supersedes
TN# 12-005

Approval Date: _____

Effective Date: October 1, 2015

(10) Reimbursement for Out-of-state Hospitals.

- A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.
1. The all-inclusive DRG payment amount:
 - a. Shall be based on the patients diagnostic category; and
 - b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
 2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

A. Covered Inpatient Admissions

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's treatment plan shall specify the amount and frequency of services needed;

- 1) A covered admission for a Level I PRTF shall be prior authorized by a review agency.
- 2) A covered admission for a Level II PRTF shall be prior authorized;

B. PRTF Covered Inpatient Services.

- 1) The following services shall be available to all eligible recipients:
 - a. Diagnostic and assessment services;
 - b. Treatment plan development, review, or revision;
 - c. Psychiatric services;
 - d. Nursing services which shall be provided in compliance with 902 KAR 20:320;
 - e. Medication which shall be provided in compliance with 907 KAR 1:019;
 - f. Evidence-based treatment interventions;
 - g. Individual therapy which shall comply with 902 KAR 20:320;
 - h. Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - i. Group therapy which shall comply with 902 KAR 20:320;
 - j. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - k. Substance abuse education;
 - l. Activities that:
 - (1) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - (2) Support and encourage the parent's ability to re-integrate the child into the home;
 - m. Crisis intervention which shall comply with:
 - (1) 42 C.F.R. 483.350 through 376; and
 - (2) 902 KAR 20:320;
 - n. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - o. Educational activities; or
 - p. Non-medical transportation services as needed to accomplish objectives;

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 2) A Level I PRTF service listed in a above shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Medically necessary; and
 - d. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
 - 3) A Level I PRTF service listed in g, h, I, k, or m. above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
 - 4) A Level II PRTF service listed shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Provided at least once a week:
 - (1) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - (2) Except for diagnostic and assessment services which shall have no weekly minimum requirement;
 - d. Medically necessary; and
 - e. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
 - 5) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.
- C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.
- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
 - 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
 - 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
 - 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
 - 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.
- 1) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital.
 - 2) Based on medical necessity, with a prior authorization, the five (5) day limit may be extended.
 - 3) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

F. Community-Based PRTF Services

Except as specified in the requirements stated for a given service, the services covered may be provided for a mental health disorder, substance use disorder or a co-occurring mental health and substance use disorders. A description of each of the following services and approved providers of services, may be found in Attachment 3.1-A and Attachment 3.1-B, Section 13d (Rehabilitative Services)

- 1) A screening, crisis intervention, or intensive outpatient program service
- 2) An assessment
- 3) Psychological testing
- 4) Day treatment or mobile crisis services
- 5) Peer support
- 6) Individual outpatient therapy, group outpatient therapy, or collateral outpatient
- 7) Family outpatient therapy provided by:
- 8) Service planning provided by:
- 9) A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:
- 10) Assertive community treatment provided by:
- 11) Comprehensive community support services provided by:
- 12) Therapeutic rehabilitation program services provided by:

G. Limits and Non-covered Services or Activities

- 1) Except as established in below, unless a diagnosis is made and documented in the recipient's health record within three (3) visits, the service shall not be covered.
 - a. The requirement established in above paragraph shall not apply to:
 - (1) Mobile crisis services;
 - (2) Crisis intervention;
 - (3) A screening; or
 - (4) An assessment.
- 2) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same date of service for the recipient:
 - a. An assessment;
 - b. Case management;
 - c. Individual outpatient therapy;
 - d. Group outpatient therapy;
 - e. Peer support services; or
 - f. Mobile crisis services.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 3) The department shall not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service.
 - 4) The following services or activities shall not be covered under:
 - a. A service provided to:
 - (1) A resident of:
 - a) A nursing facility; or
 - b) An intermediate care facility for individuals with an intellectual disability;
 - (2) An inmate of a federal, local, or state:
 - a) Jail;
 - b) Detention center; or
 - c) Prison; or
 - (3) An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - b. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the psychiatric residential treatment facility;
 - c. A consultation or educational service provided to a recipient or to others;
 - d. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements of "face-to-face";
 - e. Travel time;
 - f. A field trip;
 - g. A recreational activity;
 - h. A social activity; or
 - i. A physical exercise activity group.
 - 5)
 - a. A consultation by one (1) provider or professional with another shall not be covered for Collateral Outpatient Therapy.
 - b. A third party contract shall not be covered under this administrative regulation.
 - 6) A billing supervisor arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not:
 - a. Violate the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision; or
 - b. Substitute for the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

A. Covered Inpatient Admissions

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's treatment plan shall specify the amount and frequency of services needed;

- 1) A covered admission for a Level I PRTF shall be prior authorized by a review agency.
- 2) A covered admission for a Level II PRTF shall be prior authorized;

B. PRTF Covered Inpatient Services.

- 1) The following services shall be available to all eligible recipients:
 - a. Diagnostic and assessment services;
 - b. Treatment plan development, review, or revision;
 - c. Psychiatric services;
 - d. Nursing services which shall be provided in compliance with 902 KAR 20:320;
 - e. Medication which shall be provided in compliance with 907 KAR 1:019;
 - f. Evidence-based treatment interventions;
 - g. Individual therapy which shall comply with 902 KAR 20:320;
 - h. Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - i. Group therapy which shall comply with 902 KAR 20:320;
 - j. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - k. Substance abuse education;
 - l. Activities that:
 - (1) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - (2) Support and encourage the parent's ability to re-integrate the child into the home;
 - m. Crisis intervention which shall comply with:
 - (1) 42 C.F.R. 483.350 through 376; and
 - (2) 902 KAR 20:320;
 - n. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - o. Educational activities; or
 - p. Non-medical transportation services as needed to accomplish objectives;

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 2) A Level I PRTF service listed in a above shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Medically necessary; and
 - d. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
 - 3) A Level I PRTF service listed in g, h, I, k, or m. above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
 - 4) A Level II PRTF service listed shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Provided at least once a week:
 - (1) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - (2) Except for diagnostic and assessment services which shall have no weekly minimum requirement;
 - d. Medically necessary; and
 - e. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
 - 5) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.

C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.

- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
- 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
- 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
- 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
- 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.
- 1) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
- a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital.
- 2) Based on medical necessity, with a prior authorization, the five (5) day limit may be extended.
- 3) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
- a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

F. Community-Based PRTF Services

Except as specified in the requirements stated for a given service, the services covered may be provided for a mental health disorder, substance use disorder or a co-occurring mental health and substance use disorders. A description of each of the following services and approved providers of services, may be found in Attachment 3.1-A and Attachment 3.1-B, Section 13d (Rehabilitative Services)

- 1) A screening, crisis intervention, or intensive outpatient program service
- 2) An assessment
- 3) Psychological testing
- 4) Day treatment or mobile crisis services
- 5) Peer support
- 6) Individual outpatient therapy, group outpatient therapy, or collateral outpatient
- 7) Family outpatient therapy provided by:
- 8) Service planning provided by:
- 9) A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:
- 10) Assertive community treatment provided by:
- 11) Comprehensive community support services provided by:
- 12) Therapeutic rehabilitation program services provided by:

G. Limits and Non-covered Services or Activities

- 1) Except as established in below, unless a diagnosis is made and documented in the recipient's health record within three (3) visits, the service shall not be covered.
 - a. The requirement established in above paragraph shall not apply to:
 - (1) Mobile crisis services;
 - (2) Crisis intervention;
 - (3) A screening; or
 - (4) An assessment.
- 2) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same date of service for the recipient:
 - a. An assessment;
 - b. Case management;
 - c. Individual outpatient therapy;
 - d. Group outpatient therapy;
 - e. Peer support services; or
 - f. Mobile crisis services.

16. **Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age**
- 3) The department shall not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service.
 - 4) The following services or activities shall not be covered under:
 - a. A service provided to:
 - (1) A resident of:
 - a) A nursing facility; or
 - b) An intermediate care facility for individuals with an intellectual disability;
 - (2) An inmate of a federal, local, or state:
 - a) Jail;
 - b) Detention center; or
 - c) Prison; or
 - (3) An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - b. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the psychiatric residential treatment facility;
 - c. A consultation or educational service provided to a recipient or to others;
 - d. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements of "face-to-face";
 - e. Travel time;
 - f. A field trip;
 - g. A recreational activity;
 - h. A social activity; or
 - i. A physical exercise activity group.
 - 5) a. A consultation by one (1) provider or professional with another shall not be covered for Collateral Outpatient Therapy.
b. A third party contract shall not be covered under this administrative regulation.
 - 6) A billing supervisor arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not:
 - a. Violate the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision; or
 - b. Substitute for the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

A. Covered Inpatient Admissions

~~The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):~~

~~Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G~~

~~Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's ~~must a treatment plan developed that shall specify the amount and frequency of services needed;~~~~

- 1) ~~A covered admission for a Level I PRTF:~~
 - ~~a. S shall be prior authorized by a review agency; and;~~
 - ~~b. Shall be limited to those for a child age six (6) through twenty (20) years of age who meets Medicaid payment status criteria; or~~
 - ~~c. May continue based on medical necessity, for a recipient who is receiving active treatment in a Level I PRTF on the recipient's twenty-first (21st) birthday if the recipient has not reached his or her twenty-second (22nd) birthday.~~
- 2) ~~A covered admission for a Level II PRTF shall be:~~
 - ~~a. Prior authorized;~~
 - ~~b. Limited to those for a child age four (4) through twenty-one (21) years who meets Medicaid payment status criteria; and~~
 - ~~c. Whose coverage may continue, based on medical necessity, if the recipient is receiving active treatment in a Level II PRTF on the recipient's twenty-first (21st) birthday and the recipient has not reached his or her twenty-second (22nd) birthday;~~
 - ~~db. With a severe emotional disability in addition to severe and persistent aggressive behaviors, an intellectual disability, sexually acting out behaviors, or a developmental disability; and~~
 - ~~e. Who does not meet the medical necessity criteria for an acute care hospital, private psychiatric hospital, or state mental hospital; and~~
 - ~~f. Whose treatment needs cannot be met in an ambulatory care setting, Level I PRTF, or in any other less restrictive environment; and~~

B. PRTF Covered Inpatient Services.

- 1) ~~Each patient must a treatment plan developed that shall specify:~~
 - ~~a. The amount and frequency of services needed; and~~
 - ~~b. The number of therapeutic pass days for a recipient, if the treatment plan includes any therapeutic pass days.~~
- 2) ~~To be covered by the department:~~
 - a. The following services shall be available to all eligible recipients:

- (1) Diagnostic and assessment services;
- (2) Treatment plan development, review, or revision;
- (3) Psychiatric services;
- (4) Nursing services which shall be provided in compliance with 902 KAR 20:320;
- (5) Medication which shall be provided in compliance with 907 KAR 1:019;

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- (6) Evidence-based treatment interventions;
 - (7) Individual therapy which shall comply with 902 KAR 20:320;
 - (8) Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - (9) Group therapy which shall comply with 902 KAR 20:320;
 - (10) Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - (11) Substance abuse education;
 - (12) Activities that:
 - a) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - b) Support and encourage the parent's ability to re-integrate the child into the home;
 - (13) Crisis intervention which shall comply with:
 - a) 42 C.F.R. 483.350 through 376; and
 - b) 902 KAR 20:320;
 - (14) Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - (15) Educational activities; or
 - (16) Non-medical transportation services as needed to accomplish objectives;
- b. A Level I PRTF service listed in a above shall be:
- (1) Provided under the direction of a physician;
 - (2) If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - (3) Medically necessary; and
 - (4) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
- c. A Level I PRTF service listed in (7), (8), (9), (11), or (13) above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
- d. A Level II PRTF service listed shall be:
- (1) Provided under the direction of a physician;
 - (2) If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - (3) Provided at least once a week:
 - a) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - b) Except for diagnostic and assessment services which shall have no weekly minimum requirement;

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- (4) Medically necessary; and
 - (5) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
- 3) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.

C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.

- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
- 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
- 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
- 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
- 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
- b. Approved by the recipient's treatment team.

- 1) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit ~~established below of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital;~~ ~~or~~
 - e. ~~Received an exception to the limit below.~~
- 2) ~~The annual bed reserve day limit per recipient shall be five (5) days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital.~~

- 3) ~~Based on medical necessity, with a prior authorization, (The department shall allow a recipient to exceed the limit established five (5) day limit may be extended, if the department determines that an additional bed reserve day is in the best interest of the recipient.~~

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Supersedes

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16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 4) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.
 - 5) ~~The bed reserve day and therapeutic pass day count for each recipient shall be zero (0) upon the effective date of this SPA.~~
 - ~~a. For subsequent calendar years, the bed reserve day and therapeutic pass day count for each recipient shall begin at zero (0) on January 1 of the calendar year.~~
 - 6) ~~An authorization decision regarding a bed reserve day or therapeutic pass day in excess of the limits shall be performed by a review agency.~~
 - 7) ~~An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital.~~
 - 8) ~~A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively.~~
 - 9) ~~A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:
 - a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.~~
 - 10) ~~A Level I or II PRTF's occupancy percent shall be based on a midnight census.~~
 - 11) ~~An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.~~
 - 12) ~~An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.
- 3) ~~The department shall not reimburse for Level I or II PRTF services for a recipient if appropriate alternative services are available for the recipient in the community.~~
- 4) ~~The following shall not qualify as reimbursable in a PRTF setting:~~
 - a. ~~An admission that is not medically necessary;~~
 - b. ~~Services for an individual:~~
 - (1) ~~With a major medical problem or minor symptoms;~~
 - (2) ~~Who might only require a psychiatric consultation rather than an admission to a PRTF; or~~
 - (3) ~~Who might need only adequate living accommodations, economic aid, or social support services.~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

F. ~~Outpatient PRTF Services~~ Community-Based PRTF Services

Except as specified in the requirements stated for a given service, the services covered may be provided for a mental health disorder, substance use disorder or a co-occurring mental health and substance use disorders. A description of each of the following services and approved providers of services, may be found in Attachment 3.1-A and Attachment 3.1-B, Section 13d (Rehabilitative Services)

- 1) A screening, crisis intervention, or intensive outpatient program service provided by:
 - a. ~~A licensed psychologist;~~
 - b. ~~A licensed psychological practitioner;~~
 - c. ~~A certified psychologist with autonomous functioning;~~
 - d. ~~A licensed clinical social worker;~~
 - e. ~~A licensed professional clinical counselor;~~
 - f. ~~A licensed professional art therapist;~~
 - g. ~~A licensed marriage and family therapist;~~
 - h. ~~A physician;~~
 - i. ~~A psychiatrist;~~
 - j. ~~An advanced practice registered nurse;~~
 - k. ~~A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
 - l. ~~A certified psychologist working under the supervision of a board approved licensed psychologist;~~
 - m. ~~A licensed clinical alcohol and drug counselor in accordance with; or~~
 - n. ~~A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;~~

- 2) An assessment provided by:
 - a. ~~A licensed psychologist;~~
 - b. ~~A licensed psychological practitioner;~~
 - c. ~~A certified psychologist with autonomous functioning;~~
 - d. ~~A licensed clinical social worker;~~
 - e. ~~A licensed professional clinical counselor;~~
 - f. ~~A licensed professional art therapist;~~
 - g. ~~A licensed marriage and family therapist;~~
 - h. ~~A physician;~~
 - i. ~~A psychiatrist;~~
 - j. ~~An advanced practice registered nurse;~~
 - k. ~~A licensed behavior analyst;~~
 - l. ~~A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
 - m. ~~A certified psychologist working under the supervision of a board approved licensed psychologist;~~
 - n. ~~A licensed clinical alcohol and drug counselor; or~~
 - o. ~~A behavioral health practitioner under supervision;~~

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- 3) Psychological testing provided by:
- ~~a. A licensed psychologist;~~
 - ~~b. A licensed psychological practitioner;~~
 - ~~c. A certified psychologist with autonomous functioning;~~
 - ~~e. A licensed psychological associate working under the supervision of a board-approved licensed psychologist; or~~
 - ~~f. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- 4) Day treatment or mobile crisis services provided by:
- ~~a. A licensed psychologist;~~
 - ~~b. A licensed psychological practitioner;~~
 - ~~c. A certified psychologist with autonomous functioning;~~
 - ~~d. A licensed clinical social worker;~~
 - ~~e. A licensed professional clinical counselor;~~
 - ~~f. A licensed professional art therapist;~~
 - ~~g. A licensed marriage and family therapist;~~
 - ~~h. A physician;~~
 - ~~i. A psychiatrist;~~
 - ~~j. An advanced practice registered nurse;~~
 - ~~k. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
 - ~~l. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
 - ~~m. A licensed clinical alcohol and drug counselor;~~
 - ~~n. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst; or~~
 - ~~o. A peer support specialist working under the supervision of an approved behavioral health services provider.~~
- 5) Peer support
- ~~Provided by a peer support specialist working under the supervision of an approved behavioral health services.~~
- 6) Individual outpatient therapy, group outpatient therapy, or collateral outpatient therapy provided by:
- ~~a. A licensed psychologist;~~
 - ~~b. A licensed psychological practitioner;~~
 - ~~c. A certified psychologist with autonomous functioning;~~
 - ~~d. A licensed clinical social worker;~~
 - ~~e. A licensed professional clinical counselor;~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

- ~~f. — A licensed professional art therapist;~~
- ~~g. — A licensed marriage and family therapist;~~
- ~~h. — A physician;~~
- ~~i. — A psychiatrist;~~
- ~~j. — An advanced practice registered nurse;~~
- ~~k. — A licensed behavior analyst;~~
- ~~l. — A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
- ~~m. — A certified psychologist working under the supervision of a board approved licensed psychologist;~~
- ~~n. — A licensed clinical alcohol and drug counselor; or~~
- ~~o. — A behavioral health practitioner under supervision;~~

7) Family outpatient therapy provided by:

- ~~a. — A licensed psychologist;~~
- ~~b. — A licensed psychological practitioner;~~
- ~~c. — A certified psychologist with autonomous functioning;~~
- ~~d. — A licensed clinical social worker;~~
- ~~e. — A licensed professional clinical counselor;~~
- ~~f. — A licensed professional art therapist;~~
- ~~g. — A licensed marriage and family therapist;~~
- ~~h. — A physician;~~
- ~~i. — A psychiatrist;~~
- ~~j. — An advanced practice registered nurse;~~
- ~~k. — A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
- ~~l. — A certified psychologist working under the supervision of a board approved licensed psychologist;~~
- ~~m. — A licensed clinical alcohol and drug counselor; or~~
- ~~n. — A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;~~

8) Service planning provided by:

- ~~a. — A licensed psychologist;~~
- ~~b. — A licensed psychological practitioner;~~
- ~~c. — A certified psychologist with autonomous functioning;~~
- ~~d. — A licensed clinical social worker;~~
- ~~e. — A licensed professional clinical counselor;~~
- ~~f. — A licensed professional art therapist;~~
- ~~g. — A licensed marriage and family therapist;~~
- ~~h. — A physician;~~
- ~~i. — A psychiatrist;~~

16. **Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age**

- ~~j. An advanced practice registered nurse;~~
- ~~k. A licensed behavior analyst;~~
- ~~l. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~m. A certified psychologist working under the supervision of a board-approved licensed psychologist; or~~
- ~~n. A behavioral health practitioner under supervision except for:
 - ~~(1) A certified alcohol and drug counselor; or~~
 - ~~(2) A licensed clinical alcohol and drug counselor associate;~~~~

9. **A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:**

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~
- ~~f. A licensed professional art therapist;~~
- ~~g. A licensed marriage and family therapist;~~
- ~~h. A physician;~~
- ~~i. A psychiatrist;~~
- ~~j. An advanced practice registered nurse;~~
- ~~k. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~m. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~n. A licensed clinical alcohol and drug counselor; or~~
- ~~o. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst; and~~

10) **Assertive community treatment provided by:**

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~
- ~~f. A licensed professional art therapist;~~
- ~~g. A licensed marriage and family therapist;~~
- ~~h. A physician;~~
- ~~i. A psychiatrist;~~
- ~~j. An advanced practice registered nurse;~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

- ~~k. — A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~l. — A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~j. — A behavioral health practitioner under supervision except for a:
 - ~~(1) — Licensed assistant behavior analyst;~~
 - ~~(2) — Certified alcohol and drug counselor; or~~
 - ~~(3) — Licensed clinical alcohol and drug counselor associate;~~~~
- ~~k. — A peer support specialist working under the supervision of an approved behavioral health services provider except for a:
 - ~~(1) — Licensed clinical alcohol and drug counselor;~~
 - ~~(2) — Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(3) — Certified alcohol and drug counselor; or~~~~
- ~~l. — A community support associate;~~

11. Comprehensive community support services provided by:

- ~~a. — A licensed psychologist;~~
- ~~b. — A licensed psychological practitioner;~~
- ~~c. — A certified psychologist with autonomous functioning;~~
- ~~d. — A licensed clinical social worker;~~
- ~~e. — A licensed professional clinical counselor;~~
- ~~f. — A licensed professional art therapist;~~
- ~~g. — A licensed marriage and family therapist;~~
- ~~h. — A physician;~~
- ~~i. — A psychiatrist;~~
- ~~j. — An advanced practice registered nurse;~~
- ~~k. — A licensed behavior analyst;~~
- ~~l. — A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~m. — A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~n. — A behavioral health practitioner under supervision except for a:
 - ~~(1) — Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(2) — Certified alcohol and drug counselor; or~~~~
- ~~o. — A community support associate; or~~

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12) Therapeutic rehabilitation program services provided by:

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~
- ~~f. A licensed professional art therapist;~~
- ~~g. A licensed marriage and family therapist;~~
- ~~h. A physician;~~
- ~~i. A psychiatrist;~~
- ~~j. An advanced practice registered nurse;~~
- ~~k. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~l. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~m. A behavioral health practitioner under supervision except for a:
 - ~~(1) Licensed assistant behavior analyst;~~
 - ~~(2) Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(3) Certified alcohol and drug counselor; or~~~~
- ~~n. A peer support specialist working under the supervision of an approved behavioral health services provider except for a:
 - ~~(1) Licensed clinical alcohol and drug counselor;~~
 - ~~(2) Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(3) Certified alcohol and drug counselor.~~~~

G. Limits and Non-covered Services or Activities

- 1) Except as established in below, unless a diagnosis is made and documented in the recipient's health record within three (3) visits, the service shall not be covered.
 - a. The requirement established in above paragraph shall not apply to:
 - (1) Mobile crisis services;
 - (2) Crisis intervention;
 - (3) A screening; or
 - (4) An assessment.
- 2) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same date of service for the recipient:
 - a. An assessment;
 - b. Case management;
 - c. Individual outpatient therapy;
 - d. Group outpatient therapy;
 - e. Peer support services; or
 - f. Mobile crisis services.

16. **Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age**
- 3) The department shall not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service.
 - 4) The following services or activities shall not be covered under:
 - a. A service provided to:
 - (1) A resident of:
 - a) A nursing facility; or
 - b) An intermediate care facility for individuals with an intellectual disability;
 - (2) An inmate of a federal, local, or state:
 - a) Jail;
 - b) Detention center; or
 - c) Prison; or
 - (3) An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - b. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the psychiatric residential treatment facility;
 - c. A consultation or educational service provided to a recipient or to others;
 - d. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements of "face-to-face";
 - e. Travel time;
 - f. A field trip;
 - g. A recreational activity;
 - h. A social activity; or
 - i. A physical exercise activity group.
 - 5)
 - a. A consultation by one (1) provider or professional with another shall not be covered for Collateral Outpatient Therapy.
 - b. A third party contract shall not be covered under this administrative regulation.
 - 6) A billing supervisor arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not:
 - a. Violate the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision; or
 - b. Substitute for the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

A. Covered Inpatient Admissions

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's ~~must a treatment plan developed that shall specify the amount and frequency of services needed;~~

- 1) A covered admission for a Level I PRTF: ~~a. S shall be prior authorized by a review agency; and;~~
 - ~~b. Shall be limited to those for a child age six (6) through twenty (20) years of age who meets Medicaid payment status criteria; or~~
 - ~~c. May continue based on medical necessity, for a recipient who is receiving active treatment in a Level I PRTF on the recipient's twenty-first (21st) birthday if the recipient has not reached his or her twenty-second (22nd) birthday.~~
- 2) A covered admission for a Level II PRTF shall be:
 - ~~a. Prior authorized;~~
 - ~~b. Limited to those for a child age four (4) through twenty-one (21) years who meets Medicaid payment status criteria; and~~
 - ~~c. Whose coverage may continue, based on medical necessity, if the recipient is receiving active treatment in a Level II PRTF on the recipient's twenty-first (21st) birthday and the recipient has not reached his or her twenty-second (22nd) birthday;~~
 - ~~db. With a severe emotional disability in addition to severe and persistent aggressive behaviors, an intellectual disability, sexually acting out behaviors, or a developmental disability; and~~
 - ~~e. Who does not meet the medical necessity criteria for an acute care hospital, private psychiatric hospital, or state mental hospital; and~~
 - ~~f. Whose treatment needs cannot be met in an ambulatory care setting, Level I PRTF, or in any other less restrictive environment; and~~

B. PRTF Covered Inpatient Services.

- 1) ~~Each patient must a treatment plan developed that shall specify:~~
 - ~~a. The amount and frequency of services needed; and~~
 - ~~b. The number of therapeutic pass days for a recipient, if the treatment plan includes any therapeutic pass days.~~
- 2) ~~To be covered by the department:~~
 - a. The following services shall be available to all eligible recipients:

- (1) Diagnostic and assessment services;
- (2) Treatment plan development, review, or revision;
- (3) Psychiatric services;
- (4) Nursing services which shall be provided in compliance with 902 KAR 20:320;
- (5) Medication which shall be provided in compliance with 907 KAR 1:019;

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- (6) Evidence-based treatment interventions;
 - (7) Individual therapy which shall comply with 902 KAR 20:320;
 - (8) Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - (9) Group therapy which shall comply with 902 KAR 20:320;
 - (10) Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - (11) Substance abuse education;
 - (12) Activities that:
 - a) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - b) Support and encourage the parent's ability to re-integrate the child into the home;
 - (13) Crisis intervention which shall comply with:
 - a) 42 C.F.R. 483.350 through 376; and
 - b) 902 KAR 20:320;
 - (14) Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - (15) Educational activities; or
 - (16) Non-medical transportation services as needed to accomplish objectives;
- b. A Level I PRTF service listed in a above shall be:
- (1) Provided under the direction of a physician;
 - (2) If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - (3) Medically necessary; and
 - (4) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
- c. A Level I PRTF service listed in (7), (8), (9), (11), or (13) above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
- d. A Level II PRTF service listed shall be:
- (1) Provided under the direction of a physician;
 - (2) If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - (3) Provided at least once a week:
 - a) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - b) Except for diagnostic and assessment services which shall have no weekly minimum requirement;

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

- (4) Medically necessary; and
 - (5) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
- 3) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.

C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.

- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
- 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
- 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
- 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
- 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
- b. Approved by the recipient's treatment team.

- 1) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit ~~established below of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital;~~ ~~or~~
 - e. ~~Received an exception to the limit below.~~
- 2) ~~The annual bed reserve day limit per recipient shall be five (5) days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital.~~

- 3) ~~Based on medical necessity, with a prior authorization, (The department shall allow a recipient to exceed the limit established five (5) day limit may be extended, if the department determines that an additional bed reserve day is in the best interest of the recipient.~~

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- 4) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.
 - 5) ~~The bed reserve day and therapeutic pass day count for each recipient shall be zero (0) upon the effective date of this SPA.~~
 - ~~a. For subsequent calendar years, the bed reserve day and therapeutic pass day count for each recipient shall begin at zero (0) on January 1 of the calendar year.~~
 - 6) ~~An authorization decision regarding a bed reserve day or therapeutic pass day in excess of the limits shall be performed by a review agency.~~
 - 7) ~~An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital.~~
 - 8) ~~A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively.~~
 - 9) ~~A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:
 - a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.~~
 - 10) ~~A Level I or II PRTF's occupancy percent shall be based on a midnight census.~~
 - 11) ~~An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.~~
 - 12) ~~An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.
- 3) ~~The department shall not reimburse for Level I or II PRTF services for a recipient if appropriate alternative services are available for the recipient in the community.~~
- 4) ~~The following shall not qualify as reimbursable in a PRTF setting:~~
 - a. ~~An admission that is not medically necessary;~~
 - b. ~~Services for an individual:~~
 - (1) ~~With a major medical problem or minor symptoms;~~
 - (2) ~~Who might only require a psychiatric consultation rather than an admission to a PRTF; or~~
 - (3) ~~Who might need only adequate living accommodations, economic aid, or social support services.~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

F. ~~Outpatient PRTF Services~~ Community-Based PRTF Services

Except as specified in the requirements stated for a given service, the services covered may be provided for a mental health disorder, substance use disorder or a co-occurring mental health and substance use disorders. A description of each of the following services and approved providers of services, may be found in Attachment 3.1-A and Attachment 3.1-B, Section 13d (Rehabilitative Services)

- 1) A screening, crisis intervention, or intensive outpatient program service provided by:
 - a. ~~A licensed psychologist;~~
 - b. ~~A licensed psychological practitioner;~~
 - c. ~~A certified psychologist with autonomous functioning;~~
 - d. ~~A licensed clinical social worker;~~
 - e. ~~A licensed professional clinical counselor;~~
 - f. ~~A licensed professional art therapist;~~
 - g. ~~A licensed marriage and family therapist;~~
 - h. ~~A physician;~~
 - i. ~~A psychiatrist;~~
 - j. ~~An advanced practice registered nurse;~~
 - k. ~~A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
 - l. ~~A certified psychologist working under the supervision of a board approved licensed psychologist;~~
 - m. ~~A licensed clinical alcohol and drug counselor in accordance with; or~~
 - n. ~~A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;~~

- 2) An assessment provided by:
 - a. ~~A licensed psychologist;~~
 - b. ~~A licensed psychological practitioner;~~
 - c. ~~A certified psychologist with autonomous functioning;~~
 - d. ~~A licensed clinical social worker;~~
 - e. ~~A licensed professional clinical counselor;~~
 - f. ~~A licensed professional art therapist;~~
 - g. ~~A licensed marriage and family therapist;~~
 - h. ~~A physician;~~
 - i. ~~A psychiatrist;~~
 - j. ~~An advanced practice registered nurse;~~
 - k. ~~A licensed behavior analyst;~~
 - l. ~~A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
 - m. ~~A certified psychologist working under the supervision of a board approved licensed psychologist;~~
 - n. ~~A licensed clinical alcohol and drug counselor; or~~
 - o. ~~A behavioral health practitioner under supervision;~~

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- 3) Psychological testing provided by:
- ~~a. A licensed psychologist;~~
 - ~~b. A licensed psychological practitioner;~~
 - ~~c. A certified psychologist with autonomous functioning;~~
 - ~~e. A licensed psychological associate working under the supervision of a board-approved licensed psychologist; or~~
 - ~~f. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- 4) Day treatment or mobile crisis services provided by:
- ~~a. A licensed psychologist;~~
 - ~~b. A licensed psychological practitioner;~~
 - ~~c. A certified psychologist with autonomous functioning;~~
 - ~~d. A licensed clinical social worker;~~
 - ~~e. A licensed professional clinical counselor;~~
 - ~~f. A licensed professional art therapist;~~
 - ~~g. A licensed marriage and family therapist;~~
 - ~~h. A physician;~~
 - ~~i. A psychiatrist;~~
 - ~~j. An advanced practice registered nurse;~~
 - ~~k. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
 - ~~l. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
 - ~~m. A licensed clinical alcohol and drug counselor;~~
 - ~~n. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst; or~~
 - ~~o. A peer support specialist working under the supervision of an approved behavioral health services provider.~~
- 5) Peer support
- ~~Provided by a peer support specialist working under the supervision of an approved behavioral health services.~~
- 6) Individual outpatient therapy, group outpatient therapy, or collateral outpatient therapy provided by:
- ~~a. A licensed psychologist;~~
 - ~~b. A licensed psychological practitioner;~~
 - ~~c. A certified psychologist with autonomous functioning;~~
 - ~~d. A licensed clinical social worker;~~
 - ~~e. A licensed professional clinical counselor;~~

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- ~~f. — A licensed professional art therapist;~~
- ~~g. — A licensed marriage and family therapist;~~
- ~~h. — A physician;~~
- ~~i. — A psychiatrist;~~
- ~~j. — An advanced practice registered nurse;~~
- ~~k. — A licensed behavior analyst;~~
- ~~l. — A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
- ~~m. — A certified psychologist working under the supervision of a board approved licensed psychologist;~~
- ~~n. — A licensed clinical alcohol and drug counselor; or~~
- ~~o. — A behavioral health practitioner under supervision;~~

7) Family outpatient therapy provided by:

- ~~a. — A licensed psychologist;~~
- ~~b. — A licensed psychological practitioner;~~
- ~~c. — A certified psychologist with autonomous functioning;~~
- ~~d. — A licensed clinical social worker;~~
- ~~e. — A licensed professional clinical counselor;~~
- ~~f. — A licensed professional art therapist;~~
- ~~g. — A licensed marriage and family therapist;~~
- ~~h. — A physician;~~
- ~~i. — A psychiatrist;~~
- ~~j. — An advanced practice registered nurse;~~
- ~~k. — A licensed psychological associate working under the supervision of a board approved licensed psychologist;~~
- ~~l. — A certified psychologist working under the supervision of a board approved licensed psychologist;~~
- ~~m. — A licensed clinical alcohol and drug counselor; or~~
- ~~n. — A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;~~

8) Service planning provided by:

- ~~a. — A licensed psychologist;~~
- ~~b. — A licensed psychological practitioner;~~
- ~~c. — A certified psychologist with autonomous functioning;~~
- ~~d. — A licensed clinical social worker;~~
- ~~e. — A licensed professional clinical counselor;~~
- ~~f. — A licensed professional art therapist;~~
- ~~g. — A licensed marriage and family therapist;~~
- ~~h. — A physician;~~
- ~~i. — A psychiatrist;~~

16. **Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age**

- ~~j. An advanced practice registered nurse;~~
- ~~k. A licensed behavior analyst;~~
- ~~l. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~m. A certified psychologist working under the supervision of a board-approved licensed psychologist; or~~
- ~~n. A behavioral health practitioner under supervision except for:
(1) A certified alcohol and drug counselor; or
(2) A licensed clinical alcohol and drug counselor associate;~~

9. **A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:**

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~
- ~~f. A licensed professional art therapist;~~
- ~~g. A licensed marriage and family therapist;~~
- ~~h. A physician;~~
- ~~i. A psychiatrist;~~
- ~~j. An advanced practice registered nurse;~~
- ~~k. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~m. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~n. A licensed clinical alcohol and drug counselor; or~~
- ~~o. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst; and~~

10) **Assertive community treatment provided by:**

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~
- ~~f. A licensed professional art therapist;~~
- ~~g. A licensed marriage and family therapist;~~
- ~~h. A physician;~~
- ~~i. A psychiatrist;~~
- ~~j. An advanced practice registered nurse;~~

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- ~~k. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~l. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~j. A behavioral health practitioner under supervision except for a:
 - ~~(1) Licensed assistant behavior analyst;~~
 - ~~(2) Certified alcohol and drug counselor; or~~
 - ~~(3) Licensed clinical alcohol and drug counselor associate;~~~~
- ~~k. A peer support specialist working under the supervision of an approved behavioral health services provider except for a:
 - ~~(1) Licensed clinical alcohol and drug counselor;~~
 - ~~(2) Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(3) Certified alcohol and drug counselor; or~~~~
- ~~l. A community support associate;~~

11. Comprehensive community support services provided by:

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~
- ~~f. A licensed professional art therapist;~~
- ~~g. A licensed marriage and family therapist;~~
- ~~h. A physician;~~
- ~~i. A psychiatrist;~~
- ~~j. An advanced practice registered nurse;~~
- ~~k. A licensed behavior analyst;~~
- ~~l. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~m. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~n. A behavioral health practitioner under supervision except for a:
 - ~~(1) Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(2) Certified alcohol and drug counselor; or~~~~
- ~~o. A community support associate; or~~

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

12) Therapeutic rehabilitation program services provided by:

- ~~a. A licensed psychologist;~~
- ~~b. A licensed psychological practitioner;~~
- ~~c. A certified psychologist with autonomous functioning;~~
- ~~d. A licensed clinical social worker;~~
- ~~e. A licensed professional clinical counselor;~~
- ~~f. A licensed professional art therapist;~~
- ~~g. A licensed marriage and family therapist;~~
- ~~h. A physician;~~
- ~~i. A psychiatrist;~~
- ~~j. An advanced practice registered nurse;~~
- ~~k. A licensed psychological associate working under the supervision of a board-approved licensed psychologist;~~
- ~~l. A certified psychologist working under the supervision of a board-approved licensed psychologist;~~
- ~~m. A behavioral health practitioner under supervision except for a:
 - ~~(1) Licensed assistant behavior analyst;~~
 - ~~(2) Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(3) Certified alcohol and drug counselor; or~~~~
- ~~n. A peer support specialist working under the supervision of an approved behavioral health services provider except for a:
 - ~~(1) Licensed clinical alcohol and drug counselor;~~
 - ~~(2) Licensed clinical alcohol and drug counselor associate; or~~
 - ~~(3) Certified alcohol and drug counselor.~~~~

G. Limits and Non-covered Services or Activities

- 1) Except as established in below, unless a diagnosis is made and documented in the recipient's health record within three (3) visits, the service shall not be covered.
 - a. The requirement established in above paragraph shall not apply to:
 - (1) Mobile crisis services;
 - (2) Crisis intervention;
 - (3) A screening; or
 - (4) An assessment.
- 2) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same date of service for the recipient:
 - a. An assessment;
 - b. Case management;
 - c. Individual outpatient therapy;
 - d. Group outpatient therapy;
 - e. Peer support services; or
 - f. Mobile crisis services.

16. **Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age**
- 3) The department shall not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service.
 - 4) The following services or activities shall not be covered under:
 - a. A service provided to:
 - (1) A resident of:
 - a) A nursing facility; or
 - b) An intermediate care facility for individuals with an intellectual disability;
 - (2) An inmate of a federal, local, or state:
 - a) Jail;
 - b) Detention center; or
 - c) Prison; or
 - (3) An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - b. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the psychiatric residential treatment facility;
 - c. A consultation or educational service provided to a recipient or to others;
 - d. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements of "face-to-face";
 - e. Travel time;
 - f. A field trip;
 - g. A recreational activity;
 - h. A social activity; or
 - i. A physical exercise activity group.
 - 5) a. A consultation by one (1) provider or professional with another shall not be covered for Collateral Outpatient Therapy.
b. A third party contract shall not be covered under this administrative regulation.
 - 6) A billing supervisor arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not:
 - a. Violate the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision; or
 - b. Substitute for the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

A. Covered Inpatient Admissions

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's treatment plan shall specify the amount and frequency of services needed;

- 1) A covered admission for a Level I PRTF shall be prior authorized by a review agency.
- 2) A covered admission for a Level II PRTF shall be prior authorized;

B. PRTF Covered Inpatient Services.

- 1) The following services shall be available to all eligible recipients:
 - a. Diagnostic and assessment services;
 - b. Treatment plan development, review, or revision;
 - c. Psychiatric services;
 - d. Nursing services which shall be provided in compliance with 902 KAR 20:320;
 - e. Medication which shall be provided in compliance with 907 KAR 1:019;
 - f. Evidence-based treatment interventions;
 - g. Individual therapy which shall comply with 902 KAR 20:320;
 - h. Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - i. Group therapy which shall comply with 902 KAR 20:320;
 - j. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - k. Substance abuse education;
 - l. Activities that:
 - (1) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - (2) Support and encourage the parent's ability to re-integrate the child into the home;
 - m. Crisis intervention which shall comply with:
 - (1) 42 C.F.R. 483.350 through 376; and
 - (2) 902 KAR 20:320;
 - n. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - o. Educational activities; or
 - p. Non-medical transportation services as needed to accomplish objectives;

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 2) A Level I PRTF service listed in a above shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Medically necessary; and
 - d. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
 - 3) A Level I PRTF service listed in g, h, I, k, or m. above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
 - 4) A Level II PRTF service listed shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Provided at least once a week:
 - (1) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - (2) Except for diagnostic and assessment services which shall have no weekly minimum requirement;
 - d. Medically necessary; and
 - e. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
 - 5) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.

C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.

- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
- 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
- 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
- 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
- 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.
- 1) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
- a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital.
- 2) Based on medical necessity, with a prior authorization, the five (5) day limit may be extended.
- 3) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
- a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

F. Community-Based PRTF Services

Except as specified in the requirements stated for a given service, the services covered may be provided for a mental health disorder, substance use disorder or a co-occurring mental health and substance use disorders. A description of each of the following services and approved providers of services, may be found in Attachment 3.1-A and Attachment 3.1-B, Section 13d (Rehabilitative Services)

- 1) A screening, crisis intervention, or intensive outpatient program service
- 2) An assessment
- 3) Psychological testing
- 4) Day treatment or mobile crisis services
- 5) Peer support
- 6) Individual outpatient therapy, group outpatient therapy, or collateral outpatient
- 7) Family outpatient therapy provided by:
- 8) Service planning provided by:
- 9) A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:
- 10) Assertive community treatment provided by:
- 11) Comprehensive community support services provided by:
- 12) Therapeutic rehabilitation program services provided by:

G. Limits and Non-covered Services or Activities

- 1) Except as established in below, unless a diagnosis is made and documented in the recipient's health record within three (3) visits, the service shall not be covered.
 - a. The requirement established in above paragraph shall not apply to:
 - (1) Mobile crisis services;
 - (2) Crisis intervention;
 - (3) A screening; or
 - (4) An assessment.
- 2) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same date of service for the recipient:
 - a. An assessment;
 - b. Case management;
 - c. Individual outpatient therapy;
 - d. Group outpatient therapy;
 - e. Peer support services; or
 - f. Mobile crisis services.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 3) The department shall not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service.
 - 4) The following services or activities shall not be covered under:
 - a. A service provided to:
 - (1) A resident of:
 - a) A nursing facility; or
 - b) An intermediate care facility for individuals with an intellectual disability;
 - (2) An inmate of a federal, local, or state:
 - a) Jail;
 - b) Detention center; or
 - c) Prison; or
 - (3) An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - b. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the psychiatric residential treatment facility;
 - c. A consultation or educational service provided to a recipient or to others;
 - d. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements of "face-to-face";
 - e. Travel time;
 - f. A field trip;
 - g. A recreational activity;
 - h. A social activity; or
 - i. A physical exercise activity group.
 - 5) a. A consultation by one (1) provider or professional with another shall not be covered for Collateral Outpatient Therapy.
b. A third party contract shall not be covered under this administrative regulation.
 - 6) A billing supervisor arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not:
 - a. Violate the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision; or
 - b. Substitute for the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

A. Covered Inpatient Admissions

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's treatment plan shall specify the amount and frequency of services needed;

- 1) A covered admission for a Level I PRTF shall be prior authorized by a review agency.
- 2) A covered admission for a Level II PRTF shall be prior authorized;

B. PRTF Covered Inpatient Services.

- 1) The following services shall be available to all eligible recipients:
 - a. Diagnostic and assessment services;
 - b. Treatment plan development, review, or revision;
 - c. Psychiatric services;
 - d. Nursing services which shall be provided in compliance with 902 KAR 20:320;
 - e. Medication which shall be provided in compliance with 907 KAR 1:019;
 - f. Evidence-based treatment interventions;
 - g. Individual therapy which shall comply with 902 KAR 20:320;
 - h. Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - i. Group therapy which shall comply with 902 KAR 20:320;
 - j. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - k. Substance abuse education;
 - l. Activities that:
 - (1) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - (2) Support and encourage the parent's ability to re-integrate the child into the home;
 - m. Crisis intervention which shall comply with:
 - (1) 42 C.F.R. 483.350 through 376; and
 - (2) 902 KAR 20:320;
 - n. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - o. Educational activities; or
 - p. Non-medical transportation services as needed to accomplish objectives;

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 2) A Level I PRTF service listed in a above shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Medically necessary; and
 - d. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
 - 3) A Level I PRTF service listed in g, h, I, k, or m. above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
 - 4) A Level II PRTF service listed shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Provided at least once a week:
 - (1) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - (2) Except for diagnostic and assessment services which shall have no weekly minimum requirement;
 - d. Medically necessary; and
 - e. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
 - 5) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.
- C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.
- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
 - 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
 - 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
 - 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
 - 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state mental hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state mental hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.
- 1) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital.
 - 2) Based on medical necessity, with a prior authorization, the five (5) day limit may be extended.
 - 3) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age

F. Community-Based PRTF Services

Except as specified in the requirements stated for a given service, the services covered may be provided for a mental health disorder, substance use disorder or a co-occurring mental health and substance use disorders. A description of each of the following services and approved providers of services, may be found in Attachment 3.1-A and Attachment 3.1-B, Section 13d (Rehabilitative Services)

- 1) A screening, crisis intervention, or intensive outpatient program service
- 2) An assessment
- 3) Psychological testing
- 4) Day treatment or mobile crisis services
- 5) Peer support
- 6) Individual outpatient therapy, group outpatient therapy, or collateral outpatient
- 7) Family outpatient therapy provided by:
- 8) Service planning provided by:
- 9) A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:
- 10) Assertive community treatment provided by:
- 11) Comprehensive community support services provided by:
- 12) Therapeutic rehabilitation program services provided by:

G. Limits and Non-covered Services or Activities

- 1) Except as established in below, unless a diagnosis is made and documented in the recipient's health record within three (3) visits, the service shall not be covered.
 - a. The requirement established in above paragraph shall not apply to:
 - (1) Mobile crisis services;
 - (2) Crisis intervention;
 - (3) A screening; or
 - (4) An assessment.
- 2) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same date of service for the recipient:
 - a. An assessment;
 - b. Case management;
 - c. Individual outpatient therapy;
 - d. Group outpatient therapy;
 - e. Peer support services; or
 - f. Mobile crisis services.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 22 Years of Age
- 3) The department shall not reimburse for both a screening and an SBIRT provided to a recipient on the same date of service.
 - 4) The following services or activities shall not be covered under:
 - a. A service provided to:
 - (1) A resident of:
 - a) A nursing facility; or
 - b) An intermediate care facility for individuals with an intellectual disability;
 - (2) An inmate of a federal, local, or state:
 - a) Jail;
 - b) Detention center; or
 - c) Prison; or
 - (3) An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - b. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the psychiatric residential treatment facility;
 - c. A consultation or educational service provided to a recipient or to others;
 - d. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements of "face-to-face";
 - e. Travel time;
 - f. A field trip;
 - g. A recreational activity;
 - h. A social activity; or
 - i. A physical exercise activity group.
 - 5)
 - a. A consultation by one (1) provider or professional with another shall not be covered for Collateral Outpatient Therapy.
 - b. A third party contract shall not be covered under this administrative regulation.
 - 6) A billing supervisor arrangement between a billing supervisor and a behavioral health practitioner under supervision shall not:
 - a. Violate the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision; or
 - b. Substitute for the clinical supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the behavioral health practitioner under supervision.

to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(9) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

- A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A
- B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

Level I PRTF

To be reimbursable under the Medicaid Program, Level I PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level I PRTF services in accordance with Attachment 3.1-A, Section 16 – Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse for Level I PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of ~~\$274.01~~ \$280.09; or the usual and customary charge
- ~~2. An amount not to exceed the prevailing charges, in the locality where the Level I PRTF is located, for comparable services provided under comparable circumstances.~~
- 2 The per diem rate shall be increased each biennium by 2.22 percent.
- 3 The per diem or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:
 - (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be covered and reimbursed under Kentucky's pharmacy program in accordance with Attachment 3.1-A and Attachment 4.19-A.:
 - ~~1. Reimbursed via the department's pharmacy program in accordance with 907 KAR 1:018 and;~~
 - ~~2. Covered in accordance with 907 KAR 1:019/~~

Level 2 PRTF

To be reimbursable under the Medicaid program, Level II PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level II PRTF services in accordance with Attachment 3.1-A, Section 16 – Inpatient Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse a per diem rate as follows for Level II PRTF services and costs for a recipient not enrolled in a managed care organization:
 - (a) \$345 for Level II PRTF services to a recipient who meets the rate group one (1) criteria described below;
 - (b) \$365 for Level II PRTF services to a recipient who meets the rate group two (2) criteria described below;

- (c) \$385 for Level II PRTF services to a recipient who meets the rate group three (3) criteria described below; or
- (d) \$405 for Level II PRTF services to a recipient who meets the rate group four (4) criteria described below.

2 Rate Groups

- (a) Rate group one (1) criteria shall be for a recipient who:
 - 1. Is twelve (12) years of age or younger;
 - 2. Is male or female; and
 - 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (b) Rate group two (2) criteria shall be for a recipient who:
 - 1. Is twelve (12) years of age or younger;
 - 2. Is male or female; and
 - 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (c) Rate group three (3) criteria shall be for a recipient who:
 - 1. Is thirteen (13) years of age or older;
 - 2. Is male or female; and
 - 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (d) Rate group four (4) criteria shall be for a recipient who:
 - 1. Is thirteen (13) years of age or older;
 - 2. Is male or female; and
 - 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (e) Rate group four (4) criteria also includes the following for a recipient who:
 - 1. Is under twenty-two (22) years of age;
 - 2. Is male or female; and
 - 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Has an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient lower than seventy (70).

- C. The per diem rates referenced above, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:
- (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program and.
2. Covered in accordance with 907 KAR 1:019/
- D. The department shall annually evaluate each per diem rate for Level II PRTF services and costs by reviewing the most recent, reliable claims data and cost report data to analyze treatment patterns, technology, and other factors that may alter the cost of efficiently providing Level II PRTF services.
- E. The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.
- ~~F. Cost Reports and Audits:~~
- ~~(1) (a) A Level I or II PRTF shall annually submit to the department, within ninety (90) days of the closing date of the facility's fiscal year end, a legible and completed Form CMS 2552-96.~~
 - ~~(b) The department shall grant a thirty (30) day extension for submitting a legible and completed Form CMS-2552-96 to the department if an extension is requested by a Level I or II PRTF.~~
 - ~~(2) (a) A Form CMS 2552-96 shall be subject to review and audit by the department.~~
 - ~~(b) The review and audit referenced in paragraph (a) of this subsection shall be to determine if the information provided is accurate.~~
- GF. (1) The department's reimbursement for a bed reserve day which qualifies as a bed reserve day pursuant to 907 KAR 9:005 for a recipient not enrolled in a managed care organization shall be:
- (a) Seventy-five (75) percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is at least eighty-five (85) percent; or
 - (b) Fifty (50) percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is less than eighty-five (85) percent.
 - ~~(c) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:~~
 - ~~a. Is in Medicaid payment status in a Level I or II PRTF;~~
 - ~~b. Has been in the Level I or II PRTF overnight for at least one (1) night;~~
 - ~~c. Is reasonably expected to return requiring Level I or II PRTF care; and~~
 - ~~c. Has not exceeded the bed reserve day limit of 5-days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital~~
- (2) The department's reimbursement for a therapeutic pass day which qualifies as a therapeutic pass day pursuant to 907 KAR 9:005 for a recipient not enrolled in a managed care organization shall be:
- (a) 100 percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is at least fifty (50) percent; or
 - (b) Fifty (50) percent of the rate established in Section 2 or 3 of this administrative regulation if the Level I or II PRTF's occupancy percent is below fifty (50) percent.
 - ~~(c) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:~~
 - ~~a. Is in Medicaid payment status in a Level I or II PRTF;~~
 - ~~b. Has been in the Level I or II PRTF overnight for at least one (1) night;~~

- c. Is reasonably expected to return requiring Level I or II PRTF care; and
- d. Has not exceeded the therapeutic pass day limit established; or
- e. Received an exception to the limit.
- f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
- g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

- (3) (a) A Level I or II PRTF's occupancy percent shall be based on a midnight census.
- (b) An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.
- (c) An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.

TN# 15-003
Supersedes
TN# 12-005

Approval Date: _____

Effective Date: October 1, 2015

(10) Reimbursement for Out-of-state Hospitals.

- A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.
1. The all-inclusive DRG payment amount:
 - a. Shall be based on the patients diagnostic category; and
 - b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
 2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:

to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(9) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

- A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A
- B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

Level I PRTF

To be reimbursable under the Medicaid Program, Level I PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level I PRTF services in accordance with Attachment 3.1-A, Section 16 – Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

- 1 The department shall reimburse for Level I PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of \$280.09; or the usual and customary charge
- 2 The per diem rate shall be increased each biennium by 2.22 percent.
- 3 The per diem or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:
 - (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be covered and reimbursed under Kentucky's pharmacy program in accordance with Attachment 3.1-A and Attachment 4.19-A.

Level II PRTF

To be reimbursable under the Medicaid program, Level II PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level II PRTF services in accordance with Attachment 3.1-A, Section 16 – Inpatient Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

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2 Rate Groups

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2. Is male or female; and
3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).

(b) Rate group two (2) criteria shall be for a recipient who:

1. Is twelve (12) years of age or younger;
2. Is male or female; and
3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).

(c) Rate group three (3) criteria shall be for a recipient who:

1. Is thirteen (13) years of age or older;
2. Is male or female; and
3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
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 - (iii) Has an intelligence quotient higher than seventy (70).

(d) Rate group four (4) criteria shall be for a recipient who:

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(e) Rate group four (4) criteria also includes the following for a recipient who:

1. Is under twenty-two (22) years of age;
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3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Has an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient lower than seventy (70).

C. The per diem rates referenced above, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:

- (a) Including all care and treatment costs;
- (b) Including costs for all ancillary services;
- (c) Including capital costs;
- (d) Including room and board costs; and
- (e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program

- D. The department shall annually evaluate each per diem rate for Level II PRTF services and costs by reviewing the most recent, reliable claims data and cost report data to analyze treatment patterns, technology, and other factors that may alter the cost of efficiently providing Level II PRTF services.
- E. The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.
- F. (1) The department's reimbursement for a bed reserve day which qualifies as a bed reserve day for a recipient not enrolled in a managed care organization shall be:
- (a) Seventy-five (75) percent of the rate established if the Level I or II PRTF's occupancy percent is at least eighty-five (85) percent; or
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 - i. Is in Medicaid payment status in a Level I or II PRTF;
 - ii. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - iii. Is reasonably expected to return requiring Level I or II PRTF care; and
 - iv. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital
- (2) The department's reimbursement for a therapeutic pass day which qualifies as a therapeutic pass day for a recipient not enrolled in a managed care organization shall be:
- (a) 100 percent of the rate established if the Level I or II PRTF's occupancy percent is at least fifty (50) percent; or
 - (b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is below fifty (50) percent.
 - (c) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - i. Is in Medicaid payment status in a Level I or II PRTF;
 - ii. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - iii. Is reasonably expected to return requiring Level I or II PRTF care; and
 - iv. Has not exceeded the therapeutic pass day limit established; or
 - v. Received an exception to the limit.
 - vi. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - vii. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.
- (3) (a) A Level I or II PRTF's occupancy percent shall be based on a midnight census.
- (b) An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.
- (c) An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.

(10) Reimbursement for Out-of-state Hospitals.

- A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.
1. The all-inclusive DRG payment amount:
 - a. Shall be based on the patients diagnostic category; and
 - b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
 2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Steven L. Beshear
Governor

275 East Main Street, 6W-A
Frankfort, KY 40621
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

Lisa Lee
Commissioner

November 30, 2015

DHHS/CMS
Atlanta Regional Office
Attn: Jackie Glaze, Associate Regional Administrator
Division of Medicaid & Children's Health Operations
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303 8909

RE: Kentucky's Medicaid Management Information System (MMIS) As-Needed Advance Planning Document (ANAPD) #15—Review Request

Dear Ms. Glaze,

The Kentucky Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS), requests review and approval of the attached As-Needed Advance Planning Document (ANAPD) regarding the department's Medicaid Management Information System (MMIS).

DMS is submitting an ANAPD at this time for two strategic reasons:

- To align forthcoming annual updates with actual Federal Fiscal Years (FFY) as related to staff and contractor resources.
- To request additional funding to account for anticipated incremental project expenditures related to enhancements to KY MMIS.

DMS is requesting approval for the following:

- Extend CMS approval for state and contractor resources from May 30, 2016 to the end of FFY 2016, September 30, 2016. A no cost solution, the extension aligns the expiration of Federal Financial Participation (FFP) with the close of each FFY.
- New funding from CMS in the amount of \$2,200,000 for data quality enhancement projects on KY MMIS.

- New funding from CMS in the amount of \$572,932, representing 5,653 project hours for an interface enhancement project between KY MMIS, KY Health Benefits Exchange (HBE), and the State Data Hub (SDH).
- New funding from CMS in the amount of \$1,597,580, representing 15,763 additional modification hours needed to implement change orders on KY MMIS resulting from Medicaid expansion.

The total cost of this ANAPD is \$4,370,512 (\$3,693,824 Federal share and \$676,688 Commonwealth share). The FFP summary for this request is segmented below:

- Request \$2,772,932 for KY MMIS at 90% FFP (\$2,495,639 Federal share and \$277,293 in Commonwealth share).
- Request \$1,597,580 for KY MMIS at 75% FFP (\$1,198,185 Federal share and \$399,395 in Commonwealth share).

Please contact Stacy Fish at **(502) 564-0105, ext. 2925**, if you have any questions.

Sincerely,



Lisa Lee,
Commissioner

Enclosure: KY MMIS ANAPD #15



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Steven L. Beshear
Governor

275 East Main Street, 6W-A
Frankfort, KY 40621
P: 502-564-4321
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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

December 4, 2015

Jackie Glaze
Associate Regional Director
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Re: Kentucky State Plan Amendment 15-009

Dear Ms. Glaze:

Attached, please find Kentucky State Plan Amendment (SPA) 15-009. The purpose of this SPA is to request an extension of the current reimbursement methodology for the Community Mental Health Centers (CMHCs). As you are aware, the Department has been working with CMS officials in the development of a cost report that will be used by CMHCs for future rate setting purposes.

The current sunset date for the reimbursement methodology in use today is December 31, 2015. We are requesting a new sunset date of June 30, 2016. We believe that the cost report is near completion and, as only one CMHC has been involved in the development, it must be vetted through the remaining CMHCs to have a complete picture of the impact. In addition, the new procedures require system and processing changes. Therefore, we have determined that a July 1, 2016 implementation date is the most feasible at this time.

Your favorable consideration of this request is greatly appreciated. If you have additional questions, please do not hesitate to contact me.

Sincerely,

A handwritten signature in blue ink, appearing to read "Lisa D. Lee".

Lisa D. Lee, Commissioner

LDL/sjh

Enclosure



**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
15-009

2. STATE
Kentucky

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2016

5. TYPE OF PLAN MATERIAL (*Check One*):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 Budget Neutral
b. FFY 2016 Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-B, Page 20.15(1)(a)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):
Same

10. SUBJECT OF AMENDMENT:

The purpose of this SPA is to continue the current reimbursement that was to sunset on December 31, 2015 until July 1, 2016 for the Community Mental Health Centers.

11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED: Review delegated
to Commissioner, Department for Medicaid
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: Lisa D. Lee

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 12/2/15

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

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.



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Steven L. Beshear
Governor

275 East Main Street, 6W-A
P: (502) 564-4321
F: (502) 564-0509
Frankfort, KY 40621
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

Lisa Lee
Commissioner

December 7, 2015

DHHS/CMS
Atlanta Regional Office
Attn: Jackie Glaze, Associate Regional Administrator
Division of Medicaid & Children's Health Operations
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303 8909

RE: Kentucky's MEMS Annual Advance Planning Document Update #2 (AAPDU#2) – Review Request

Dear Ms. Glaze:

The Kentucky Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS), is submitting this request through the attached AAPDU#2 to realign the currently approved budget and adjust approved funding for the Commonwealth's Medicaid Enterprise Management System (MEMS) project. This AAPDU#2 does not request new funding. The activities for AAPDU#2 are as follows:

1. Propose line item shifts from the MEMS Design, Development and Implementation (DDI) Replacement budget of \$13,649,719 (Federal share \$12,284,747 and Commonwealth share \$1,364,972) for the following list of items:
 - Call Center for \$702,146 (Federal share \$631,931 and Commonwealth share \$70,215) to be shared equally by Partner Portal (\$351,073) and MWMA (\$351,073). The original estimate was for \$351,073; the following year is estimated for the same amount
 - Customer Relationship Management (CRM) and Interactive Voice Response (IVR) modifications added to the Call Center for \$51,699 (Federal share \$46,529 and Commonwealth share \$5,170). The Statement of Work (SOW) was approved by CMS on April 15, 2015
 - Enhancements to MWMA for compliance with federal and state regulations for \$2,225,000 (Federal share \$2,002,500 and Commonwealth share \$222,500). The SOW was submitted to CMS the week of October 12, 2015
 - Host the SERCH function for \$319,800 (Federal share \$287,820 and Commonwealth share \$31,980). The first year was approved by CMS on August 10, 2015
 - Enhancements required for compliance with state and federal regulations for \$10,000,000 (Federal share \$9,000,000 and Commonwealth share \$1,000,000)
2. Request the carry forward of \$26,119,301 (Federal share \$23,316,632 and Commonwealth share \$2,802,669) DDI funds from Federal Fiscal Year (FFY) 2015 funds to FFY 2016.
 - \$25,642,452 at 90% Federal Financial Participation (FFP) (Federal share \$23,078,207 and Commonwealth share \$2,564,245)
 - \$476,849 at 50% FFP (Federal share \$238,425 and Commonwealth share \$238,424)

Please contact Stacy Fish at (502) 564-0105, ext. 2925, if you have any questions.

Sincerely,

Lisa Lee
Commissioner

APD COVER SHEET

Title: Kentucky Medicaid Enterprise Management System (MEMS)
Replacement Project Annual Advance Planning Document Update #2
(AAPDU#2)

Description: Funding requested is necessary for the following projects: Call Center, Customer Relationship Management (CRM) and Interactive Voice Response (IVR) modifications added to the Call Center, enhancements to Medicaid Waiver Management Application (MWMA), hosting Southeast Regional Collaborative for Health (SERCH) information Exchange/Health Information Technology, and Enhancements required for state and federal regulations.

APD Cost: No new funding is being requested. 1-Propose line item shifts from the MEMS Design, Development and Implementation (DDI) Replacement budget of \$13,649,719 (Federal share \$12,284,747 and Commonwealth share \$1,364,972). 2- Request the carry forward of \$26,119,301 (Federal share \$23,316,632 and Commonwealth share \$2,802,669) DDI funds from Federal Fiscal Year (FFY) 2015 funds to FFY 2016.

Funding: Amount Source

State:	\$41,466,671.00	Medicaid General Funds
Federal:	\$177,593,240.00	
Other:		

Senior Sponsorship:

Name	Dept
Jennifer Harp	OATS
Lisa Lee	DMS



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

275 E Main St, 6W-A
Frankfort, KY 40621
www.chfs.ky.gov

Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

December 10, 2015

DHHS/CMS
Atlanta Regional Office
Attn: Jackie Glaze, Associate Regional Administrator
61 Forsyth Street, Suite 4T20
Atlanta, GA 30303 8909

RE: Kentucky Health Information Technology (HIT) Environmental Scan Contract with University of Kentucky Research Foundation (UKRF)

Dear Ms. Garner:

The Kentucky Cabinet for Health and Family Services (CHFS) respectfully requests a no-cost extension for the attached HIT Environmental Scan contract with the University of Kentucky Research Foundation. CHFS submitted a request for review and approval of this contract on October 6, 2015, but has not received approval from CMS at this time. As a result of the desire to add additional provider groups to the scan, CHFS is seeking to amend this request. The original dates for the contract were from July 1, 2015 through December 31, 2015. This new request for review and approval of the contract is to add an additional three month onto the contract for a new end date of March 31, 2016.

Granting approval of this no-cost extension through March 31, 2016 would be beneficial to the Kentucky Medicaid program and CMS for the following reasons:

1. The additional time would enable more for providers to respond to the scan.
2. The no-cost extension would enable the inclusion of additional new eligible provider types from the practice areas of behavioral health
3. Additionally, many providers working to electronically document Transition of Care with Medicaid members would be left out of the scan if the results are submitted in December. It is important to note that data from providers such as dentist and public health have not been captured in previous environmental scans and including them would help Kentucky to better define the HIT landscape and the technology needs of providers across the Commonwealth.
4. The revised environmental scan surveys that include these new provider types are almost through the Institutional Review Board and should therefore soon be released.

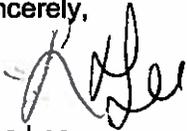
5. The additional time will provide UKRF the ability to perform more in-depth analysis of the data collected thus far from eligible providers participating in the Medicaid EHR Incentive Program. This deeper analysis entails recoding data from multiple surveys into a common data set and also adding a GIS layer to the data for a more robust presentation.

Ultimately stronger data and analysis will allow for more actionable health policy decisions and enable the Kentucky Medicaid program to support the HIT needs of participating providers, both of which assist with improving the care of our Medicaid members.

Given there is no major change in scope other than to add the additional provider types and to extend the agreement with UKRF from December 31, 2015 to March 31, 2016, CHFS will forward a copy of the agreement to CMS upon receipt of approval from CMS.

Please contact me at (502) 564-4321, ext. 2009 if you have any questions.

Sincerely,



Lisa Lee
Commissioner
Kentucky Department for Kentucky Medicaid Services



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

275 E Main St, 6W-A
Frankfort, KY 40621
www.chfs.ky.gov

Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

December 11, 2015

DHHS/CMS
Atlanta Regional Office
Attn: Jackie Glaze, Associate Regional Administrator
Division of Medicaid & Children's Health Operations
61 Forsyth Street SW, Suite 4T20
Atlanta, GA 30303 8909

RE: Kentucky's MEMS Annual Advance Planning Document Update #2 – Review Request

Dear Ms. Glaze:

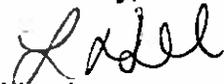
The Kentucky Cabinet for Health and Family Services, Department for Medicaid Services, requests your expedited review and approval of the attached Annual Advance Planning Document Update (AAPDU#2). This update does not request new funding. This update requests line item shifts and carry forward of approved Federal Financial Participation (FFP) in the amounts listed below:

Request the carry forward of \$23,316,632 of FFP in DDI funds to be divided as follows:

- \$23,078,207 at 90% FFP
- \$238,425 at 50% FFP

Please contact Stacy Fish at (502) 564-0105, ext. 2925, if you have any questions.

Sincerely,


Lisa Lee
Commissioner





**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

275 East Main Street, 6W-A
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Frankfort, KY 40621
www.chfs.ky.gov

Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

December 11, 2015

Jessica Kahn, Acting Director
CMS Division of State Systems
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**RE: Kentucky Medicaid Eligibility and Enrollment (E&E) Project – Integrated State Verification Services
Master Agreement**

Dear Ms. Kahn:

The Kentucky Cabinet for Health and Family Services (CHFS) respectfully request expedited review and approval of the attached Master Agreement 758 1600000469 for Integrated State Verification Services. This contract has been awarded to TALX Corporation through a competitive bidding process utilizing RFP 758 1500000273. The projected costs are identified within the E&E Implementation and Advanced Planning Document Update approved by CMS under KY-2015-09-01-EE-APD on September 15, 2015.

This Master Agreement will provide CHFS an integrated VSH in real time and batch. The support will streamline the application and verification process for Kentucky citizens among multiple State programs resulting in increased customer service by providing benefits to clients more quickly, increasing the efficiency of workers, reducing errors, improving quality control and assisting in fraud identification and prevention.

Please contact Shannon MacDonald at (502)564-0105 ext. 2880 or Steve Bechtel at (502)564-8217 ext. 2032 if you have any questions.

Sincerely,

Lisa Lee
Commissioner
Kentucky Department for Kentucky Medicaid Services





BUDGET CATEGORY	FTE - Support									
	KORRIE	Medicaid	Waiver	CHIP	SNAP	JAMI	Child Care	State	Fair	Total
Technology Staffing	\$ 1,827,871	\$ 4,702,224	\$ 656	\$ 188,707	\$ 210,521	\$ 59,227	\$ 2,644	\$ 1,525,570	\$ 8,517,419	
Contracts and MOUs	\$ -	\$ 33,012,980	\$ -	\$ 1,365,623	\$ -	\$ -	\$ -	\$ 15,721,397	\$ 50,100,000	
DCBS Walk In Support Staff - Pre Eligibility	\$ -	\$ 25,963,080	\$ -	\$ 965,423	\$ -	\$ -	\$ -	\$ 8,671,497	\$ 35,600,000	
DCBS Walk In Support Staff Post Eligibility	\$ -	\$ 7,049,900	\$ -	\$ 400,200	\$ -	\$ -	\$ -	\$ 7,049,900	\$ 14,500,000	
Vendor Services	\$ 17,207,799	\$ 46,926,085	\$ 4,049	\$ 8,139,999	\$ 2,477,587	\$ 1,159,993	\$ 16,924	\$ 13,106,679	\$ 89,039,055	
Existing System Changes	\$ 63,330	\$ 388,024	\$ -	\$ 14,805	\$ -	\$ -	\$ -	\$ 133,841	\$ 600,000	
Branding and Marketing	\$ 135,225	\$ 618,328	\$ -	\$ 29,400	\$ -	\$ -	\$ -	\$ 342,047	\$ 1,125,000	
Development Vendor (Design, Build, Test)	\$ 13,068,671	\$ 27,129,582	\$ -	\$ 1,392,293	\$ 1,513,095	\$ 1,045,468	\$ -	\$ 4,907,121	\$ 49,056,231	
IV&V	\$ 525,998	\$ 430,405	\$ -	\$ 26,780	\$ 18,267	\$ 12,621	\$ -	\$ 66,089	\$ 1,080,160	
Fulfillment Execution	\$ 651,271	\$ 5,145,872	\$ 3,348	\$ 121,157	\$ 788,501	\$ 84,868	\$ 14,103	\$ 2,681,551	\$ 9,490,672	
Verification Services	\$ 40,090	\$ 1,147,642	\$ 700	\$ 3,152	\$ 157,725	\$ 16,976	\$ 2,821	\$ 540,495	\$ 1,909,602	
Contact Center System	\$ 1,981,642	\$ 11,973,258	\$ -	\$ 463,259	\$ -	\$ -	\$ -	\$ 4,356,282	\$ 18,774,442	
Contact Center Pre Eligibility	\$ 1,807,590	\$ 11,075,130	\$ -	\$ 422,570	\$ -	\$ -	\$ -	\$ 3,820,151	\$ 17,125,442	
Contact Center Post Eligibility	\$ 174,052	\$ 898,128	\$ -	\$ 40,689	\$ -	\$ -	\$ -	\$ 536,131	\$ 1,649,000	
SMS Service	\$ 3,800	\$ 23,281	\$ -	\$ 888	\$ -	\$ -	\$ -	\$ 8,030	\$ 36,000	
Policy and Procedure Training	\$ 19,780	\$ 69,691	\$ -	\$ 3,866	\$ -	\$ -	\$ -	\$ 71,222	\$ 164,560	
Navigators/IPA	\$ 717,992	\$ -	\$ -	\$ 6,094,307	\$ -	\$ -	\$ -	\$ -	\$ 6,802,389	
Hardware	\$ 16,737	\$ 38,324	\$ -	\$ 2,665	\$ -	\$ -	\$ -	\$ 12,775	\$ 70,500	
Software	\$ 642,246	\$ 1,715,844	\$ 1,470	\$ 54,613	\$ 662,142	\$ 35,634	\$ 5,921	\$ 553,877	\$ 3,671,747	
Facility (rent, utilities)	\$ 38,658	\$ 236,861	\$ -	\$ 9,037	\$ -	\$ -	\$ -	\$ 81,700	\$ 366,257	
Janitorial, etc.	\$ 20,834	\$ 85,101	\$ -	\$ 4,871	\$ -	\$ -	\$ -	\$ 86,582	\$ 197,388	
Miscellaneous	\$ 55,816	\$ 286,309	\$ 50	\$ 11,809	\$ 12,779	\$ 2,267	\$ 201	\$ 104,866	\$ 474,097	
Exchange Leadership Organization	\$ 7,122	\$ 16,308	\$ -	\$ 1,134	\$ -	\$ -	\$ -	\$ 5,436	\$ 30,000	
Travel	\$ 4,996	\$ 27,452	\$ -	\$ 1,107	\$ -	\$ -	\$ -	\$ 9,447	\$ 43,002	
Equipment	\$ 39,708	\$ 218,104	\$ 50	\$ 8,635	\$ 12,779	\$ 2,267	\$ 201	\$ 81,550	\$ 363,295	
Supplies	\$ 3,990	\$ 24,445	\$ -	\$ 933	\$ -	\$ -	\$ -	\$ 8,432	\$ 37,800	
Other Overhead (COI rate, data center, etc.)	\$ 120,392	\$ 1,013,840	\$ 1,794	\$ 17,479	\$ 293,296	\$ 31,564	\$ 5,312	\$ 526,451	\$ 2,161,469	
Total	\$ 19,930,360	\$ 88,017,568	\$ 7,518	\$ 9,789,402	\$ 3,655,315	\$ 1,289,024	\$ 30,903	\$ 31,820,276	\$ 154,540,367	



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

Vickie Yates Brown Glisson
Secretary

275 E Main St, 6W-A
Frankfort, KY 40621
www.chfs.ky.gov

Lisa D. Lee
Commissioner

January 4, 2016

Ms. Vikki Wachino
Director
Center for Medicaid and CHIP Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS Final Rule *Methods for Assuring Access to Covered Medicaid Services* (CMS-2328-FC)

Dear Ms. Wachino:

Kentucky Medicaid appreciates the opportunity to provide additional comments on aspects of the final rule regarding methods for assuring access to covered Medicaid services. We agree that states must have sufficient systems in place to monitor and review access to services. We also agree that such processes necessarily include some level of engagement with consumers and providers.

I would like to emphasize some critical issues concerning the complexity of this rule and its impact on Kentucky Medicaid resources. First, Kentucky has over 90% of its members enrolled with Managed Care Organizations (MCOs). Second, Kentucky's fee for service population consists of waiver and long term care members who receive many of their services in their home. Third, Kentucky Medicaid does not currently possess the necessary expertise required to develop, implement, and monitor such a complex system. Therefore, we would need to contract with outside vendors or increase our current personnel cap that is set by our legislative body. In addition, Kentucky Medicaid depends upon its legislative body for budget allocations. Increases in personnel or budget are dependent upon the legislative body and are on a fixed schedule. Finally, Kentucky believes it unlikely we will be able to identify an acceptable source or commercial proprietary data regarding provider compensation.

Kentucky's Medicaid population totals approximately 1.3 million with 1.2 million enrolled with an MCO. The fee for service (FFS) members consist of approximately 80,000 Medicare Savings only and the balance either Long Term Care (LTC) eligible or Waiver members. Each MCO is contractually required to provide adequate access for its members and provide reports documenting the same. On a monthly basis, Kentucky Medicaid monitors each

MCO's compliance with access standards established in contract. We view any additional access monitoring as burdensome to the state.

As stated above, FFS members consist of approximately 80,000 Medicare Savings only and the remaining 40,000 members are either in a Long Term Care (LTC) facility or enrolled in one of Kentucky's six (6) 1915(c) waiver programs. The majority of our LTC members are institutionalized and by definition have no access to care issues. Each and every one of our Waiver members has case managers to monitor their access and quality of care. We believe the substantial resource investment needed to develop AMPs for FFS populations would not produce a significant return on this effort. For this reason, Kentucky supports an exception threshold (90 percent of individuals enrolled with an MCO) or an exception process for states with similar populations and also requests direction on how to apply for said exception to this rule.

From our initial reading of the rule, Medicaid has determined we do not currently possess the expertise sets to develop the necessary access monitoring system. As a result, Medicaid will be required to engage in Kentucky's procurement process. This process normally takes from 3 to 6 months. Even under the best of circumstances, a vendor could only have three months to develop and then implement this system. We do not believe this leaves adequate time to develop and implement a complex monitoring system on which so much will depend. For this reason Kentucky Medicaid requests reconsideration of the implementation time line.

As noted above this is a complex monitoring system which will be costly to develop and implement. Since these costs were not budgeted in the previous biennium and Kentucky's General Assembly is convening in January 2016 to enact the next biennium budget, we do not believe the additional funding will be available. Another critical issue to note is that while all Medicaid program funding is in the hands of Kentucky's legislature DMS can in no way predict what the legislature will ultimately allocate in the budget as the budget won't be passed until April 2016. Additionally, in the past decade the legislature has failed to enact a budget during the regular budget session multiple times.

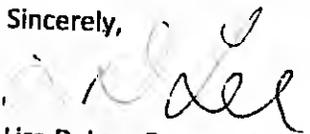
Finally, the requirement for provider reimbursement comparison places Kentucky Medicaid in a difficult position. Most of our claims data is not received from MCO's. Per our contract, MCO provider reimbursement is proprietary and thus not available to us for publication. Without further guidance from CMS, Medicaid is not certain this data can be acquired. This uncertainly places an onerous burden on Medicaid.

In conclusion, Kentucky Medicaid makes the following requests:

- Exemption from the rule as more than 90% of our population is enrolled with an MCO; and
- Extension of implementation time line; and
- Recognition of our budgeting restrictions with a process in place for a time line extension if needed; and
- Further guidance concerning an acceptable source of commercial proprietary provider rates.

In light of these barriers to implementing an AMP, we urge CMS to delay the initial submission date. Thank you for your time and attention to this matter. Please contact me if you have further questions.

Sincerely,



Lisa D. Lee, Commissioner





**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

275 E Main St, 6W-A
Phone (502) 564-4321
Fax: (502) 564-0509
Frankfort, KY 40621
www.chfs.ky.gov

Vickie Yates Brown Glisson
Secretary

Lisa D. Lee
Commissioner

January 6, 2016

Barbara Holt, Ph.D.
Centers for Medicare & Medicaid Services
Project Officer
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, MD 21244-1850

Dear Dr. Holt:

According to Kentucky's most recent quarterly report, there is a total of unspent funds associated with the Balancing Incentive Program (BIP) of \$6,127,618. To date, the enhanced match rate has been spent towards the expansion of waivers, both "slots" and services. The Department for Medicaid Services (DMS) will continue to apply the balance across waivers for the remainder of the extended period of spending, projected as follows:

Federal Fiscal Year	Projected Expenditure
Quarter 1	\$2,500,000
Quarter 2	\$2,500,000
Quarter 3	\$1,127,618
Total	\$6,127,618

In late fall of 2015, continuous reconciliation of the waiting list and non-active waiver members resulted in the discovery of available slots. As a result, 250 were released in December, 2015 and 251 will be released in February. This staggered release approach is a safety measure for timely assessments and service implementation. The reconciliation was specific to the Michelle P. waiver, a program developed as an alternative to institutional care for persons with intellectual or developmental disabilities.

Kentucky remains committed to stimulating greater access to non-institutionally based long-term services and supports (LTSS). As such, DMS has requested authorization from the Centers for Medicare and Medicaid Services (CMS) to add a total of 1,600 additional slots equally across the following waivers: Acquired Brain Injury (ABI), ABI-Long Term Care, Supports for Community Living (SCL), and Michele P. during state fiscal years 2017-2018. Individuals with intellectual and developmental disabilities are served within the SCL waiver.

Thank you for the opportunity to participate in the BIP further supporting our commitment to improve LTSS that is so vital to the lives of our citizens.

Sincerely,

Lisa D. Lee, Commissioner
Department for Medicaid Services

LL/lh/kl

MAC Binder Section 2 – Letters to CMS

Table of Contents with Document Summary

Located online at <http://chfs.ky.gov/dms/mac.htm>

1 – CMS-State plan Ltr to JG from VC re State Plan Amendment 16-001_dt011216:

Information sent for review and approval that Veronica Cecil as Acting Commissioner is authorized to submit state plan amendments for DMS.

2 – CMS- Div. of Error Rate -Ltr to JG from LL re Federal Health Official_dte020216:

DMS in response to the CMS Review Summary Analysis received on December 17, 2015. The subject of this analysis was the Kentucky Medicaid and CHIP Round 2 Eligibility Review Pilot results.



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

275 E Main St, 6W-A
Frankfort, KY 40621
www.chfs.ky.gov

Vickie Yates Brown Glisson
Secretary

Veronica J. Cecil
Acting Commissioner

January 12, 2016

Jackie Glaze
Associate Regional Director
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

RE: State Plan Amendment 16-001
State Governor's Review

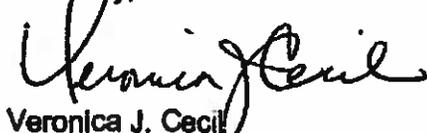
Dear Ms. Glaze:

Enclosed for your review and approval is Kentucky Title XIX State Plan Amendment No. 16-001. This amendment shows that I, as Commissioner, Department for Medicaid Services, have been authorized to submit state plan amendments for the Department for Medicaid Services, the designated single state agency. A copy of the letter from Secretary Vickie Yates Brown Glisson providing this authority is enclosed.

All correspondence relating to the Medicaid Program should be sent to my office.

Please let me know if you have any questions relating to this matter.

Sincerely,


Veronica J. Cecil
Acting Commissioner

VJC/sjh

Enclosure

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
16-001

2. STATE
Kentucky

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 11, 2016

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430.12(b)

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 \$0
b. FFY 2013 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 89

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Same

10. SUBJECT OF AMENDMENT:

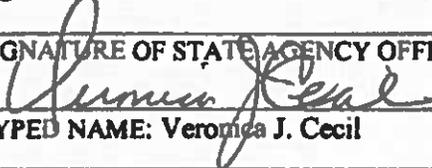
State Governor's Review appoint Veronica J. Cecil

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED: Review delegated
to Commissioner, Department for Medicaid
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: Veronica J. Cecil

14. TITLE: Acting Commissioner, Department for Medicaid
Services

15. DATE SUBMITTED: 1/12/16

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Matthew G. Bevin
Governor

275 E Main St, 6W-A
Frankfort, KY 40621
www.chfs.ky.gov

Vickie Yates Brown Glisson
Secretary

Veronica L. Judy-Cecil
Acting Commissioner

February 02, 2016

Department for Health and Human Services
Centers for Medicare & Medicaid Services
Office of Financial Management
Provider Compliance Group
Division of Error Rate Measurement
7500 Security Boulevard, Mail Stop C3-09-27
Baltimore, Maryland 21244-1850

Dear Federal Health Official:

This correspondence is in response to the CMS Review Summary Analysis received on December 17, 2015. The subject of this analysis was the Kentucky Medicaid and CHIP Round 2 Eligibility Review Pilot results. We would like to address the CMS findings in order.

1. The state acknowledged a processing error in determining the Medicaid household size and Medicaid household income relative to FPL. The errors included unborn children and a same sex married couple.

Response: The system change to accommodate same sex married couples went into production on 10/02/2015. The household size error related to the unborn child was not per design, but was a temporary system issue. A bug was created and the system error was corrected.

2. The state did not follow the Medicaid hierarchy of coverage guidelines. The state determined the applicant eligible for Medicaid Pregnant Women Group, but the applicant should have been determined eligible for the Medicaid Child Group. The Medicaid Child Group offers a more comprehensive benefit package. This error is a repeat finding from Round 1.

Response: Kentucky Medicaid provides the same Alternate Benefit Plan coverage for both pregnant women and children, as explained in our response to the findings in Round 1. We will keep this recommendation in mind if benefit packages are changed. We prefer to retain our current hierarchy until that time.

3. The state failed to take into account data regarding disability found on the verified tab in the application data. The state denied the MAGI Medicaid application, referred the applicant to the FFM for a QHP, but did not refer the application for determination on a non-MAGI basis.

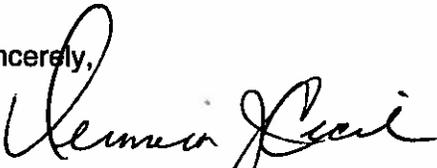
Response: A change request has been entered to populate the disability indicator based on data from the SSA Composite Service, in addition to allowing the applicant to attest to disability. If we may make a correctional note: as a State Based Marketplace, Kentucky approved the applicant for a QHP. Kentucky wrote a change order to address this finding and it is currently being analyzed. No production date has been assigned at this time. We will continue to refer individuals who self-attest to disability for potential Non-MAGI eligibility until the change allowing the system to consume the disability indicator from SSA is in place.

4. The state had errors calculating the Medicaid household size and FPL because it is failing to exclude dependent income that falls below the filing threshold. This error is a repeat finding from Round 1. The state acknowledged the error. It has a system change order in place and expects the system to be corrected by October 2015.

Response: The system change to correctly exclude nontaxable income of children and tax dependents went into production on 10/02/2015. A mass update was run at that time, recalculating the income of all financial assistance cases. This included Medicaid, KCHP and Advance Premium Tax Credit (APTC) recipients. Eligibility category changes resulting from the updated countable income were applied automatically.

We appreciate the opportunity to participate in this Pilot Review. We further look forward to working with you to achieve a satisfactory resolution to these issues.

Sincerely,



Veronica J. Cecil, Acting Commissioner
The Department for Medicaid Services

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