

## **Table of Contents**

**State/Territory Name: Kentucky**

**State Plan Amendment (SPA) #: 14-004**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

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



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

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November 7, 2014

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

Re: Kentucky State Plan Amendment 14-004

Dear Mr. Kissner:

We have reviewed the proposed Kentucky state plan amendment (SPA) 14-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on May 14, 2014. Kentucky SPA 14-004 was submitted in response to a companion letter that was issued with the approval of Kentucky SPA 13-014 in which CMS identified comprehensiveness issues. Kentucky SPA 14-004 also provides technical changes needed for immunization reimbursement.

Based on the information provided, the Medicaid State Plan Amendment KY 14-004 was approved on November 7, 2014. The effective date of this amendment is April 1, 2014. Enclosed are the approved HCFA-179 and a copy of the new state plan pages.

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

Sincerely,

//s//

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

Enclosures

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

1. TRANSMITTAL NUMBER: 14-004	2. STATE Kentucky
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**FOR: HEALTH CARE FINANCING ADMINISTRATION**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
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TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE April 1, 2014
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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:
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7. FEDERAL BUDGET IMPACT:
a. FFY 2014                      Budget Neutral
b. FFY 2015                      Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Att. 4.19-B, Page 20.3 – 20.5 Att. 4.19-B Page 20.13E Att. 4.19-B Page 20.1 Att. 4.19-B Page 20.24
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9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ): Same
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10. SUBJECT OF AMENDMENT:  
This SPA is being submitted pursuant to your Companion Letter released with Kentucky State Plan Amendment (SPA) 13-014, Also Kentucky is changing our reimbursement for immunizations and because some of the changes impact the same pages as the Companion letter impacted, we have combined both changes into this SPA. .

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

<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT	X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services
<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	
<input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//
13. TYPED NAME: Lawrence Kissner
14. TITLE: Commissioner, Department for Medicaid Services
15. DATE SUBMITTED: 5/12/14

16. RETURN TO:  Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
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**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 05/14/14
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18. DATE APPROVED: 11/07/14
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**PLAN APPROVED – ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL: 04/01/14
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20. SIGNATURE OF REGIONAL OFFICIAL: //s//
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21. TYPED NAME: Jackie Glaze
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22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns
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23. REMARKS: Approved with following changes to block # 8 and 9 as authorized by the state agency on email dated 09/15/14:

Block # 8 changed to read: Att. 4.19-B page 20.1(b), Att. 4.19-B, Page 20.3 – 20.5, Att. 4.19-B Page 20.13E, Att. 4.19-B Page 20.1 and Att. 4.19-B Page 20.24.

Block # 9 same as Block #8.

XI. Laboratory Services

Eff. The state agency will reimburse participating independent laboratories, outpatient surgical clinics, renal dialysis centers, and outpatient hospital clinics 62% of the current Medicare Clinical Laboratory Fee Schedule.

XII For services provided on or after July 1, 1990, physician (clinical diagnostic) laboratory services shall be reimbursed 60% of the current Medicare Clinical Laboratory Fee Schedule. For laboratory services with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges.

XIII Family Planning Clinics

Effective 7/1/87, the State Agency will reimburse participating family planning agencies for covered services in accordance with 42 CFR 447.32. Payments to physicians and Advanced Registered Nurse Practitioners (ARNP) for individual services shall be reimbursed the lesser of the actual billed amount or the below listed amounts:

	Physicians	ARNP
Initial Clinic Visit	\$50.00	\$37.75
Annual Clinic Visit	\$60.00	\$45.00
Follow-up Visit with Pelvic Examination	\$25.00	\$18.75
Follow-up Visit without Pelvic Examination	\$20.00	\$15.00
Counseling Visit	\$13.00	\$13.00
Counseling Visit w/3 months contraceptive supply	\$17.00	\$17.00
Counseling Visit w/6 months contraceptive supply	\$20.00	\$20.00
Supply Only Visit – Actual acquisition cost of contraceptive supplies dispensed		

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Methods and Standards for Establishing Payment Rates — Other Types of Care

I. Drugs

A. Reimbursement

1. Participating pharmacies are reimbursed for the cost of the drug plus a dispensing fee. Payments shall not exceed the federal upper limits specified in 42 CFR 447.331 through 447.334.
2. Participating dispensing physicians are reimbursed for the cost of the drug only.
3. Providers will be reimbursed only for drugs supplied from pharmaceutical manufacturers who have signed a rebate agreement with CMS.

B. Payment Limits — Payment for the cost of drugs shall be the lesser of:

1. The Federal Upper Limit (FUL) means the maximum federal financial participation available toward reimbursement for a given drug dispensed to a Medicaid recipient.
2. The State Maximum Allowable Cost (SMAC). A SMAC may be established for any drug for which two or more A-rated therapeutically equivalent, multi- source, non-innovator drugs with a significant cost difference exist. The SMAC will be determined taking into account drug price status (non-rebatable, rebatable), marketplace status (obsolete, regional availability), equivalency rating (A-rated), and relative comparable pricing. Other factors considered are clinical indications of generic substitution, utilization and availability in the marketplace. The source of comparable drug prices will be nationally recognized comprehensive data files maintained by a vendor under contract with the Department for Medicaid Services. Resources accessed to determine SMAC include Wholesale Acquisition Cost (WAC), and Direct Price (to retail pharmacies) with weights applied based on the distribution of the volume purchased.
  - a. Multiple drug pricing resources are utilized to determine the estimated acquisition cost for the generic drugs. These resources include pharmacy providers, wholesalers, drug file vendors, and pharmaceutical manufacturers;

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Methods and Standards for Establishing Payment Rates — Other Types of Care

I. Drugs

B. Payment Limits — Payment for the cost of drugs shall be the lesser of:

6. The department shall reimburse for drugs at the lesser of:

- Branded Drugs: WAC + 2% (plus dispensing fee) OR
- Generic Drugs: WAC + 3.2 % (plus dispensing fee) OR
- FUL + dispense fee OR
- MAC + dispense fee OR
- Usual & Customary (U & C)

7. For nursing facility residents meeting Medicaid patient status, an incentive of two (2) cents per unit dose shall be paid to long term care, personal care, and supports for community living pharmacists for repackaging a non-unit dose drug in unit dose form.

8. Injectable Drugs administered in a physician's office

A physician injectable drug product that is administered by a physician or their authorized agent during an in office procedure, and is federally rebateable pursuant to manufacturer agreement, and is identified on the Kentucky Physician Injectable Drug List (posted on the Kentucky Medicaid website and periodically updated) shall be reimbursed at the lesser of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent.

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**II. Physician Services****A. Definitions**

- (1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.
- (2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.
- (3) "Medical School Faculty Physician" is a physician who is employed by a state-supported school of medicine (for teaching and clinical responsibilities), receives their earnings statement (W-2) from the state-supported school of medicine for their teaching and clinical responsibilities, and they are part of a university health care system that includes:
  - (a) a teaching hospital; and
  - (b) a state-owned pediatric teaching hospital; or
  - (c) an affiliation agreement with a pediatric teaching hospital.
- (4) Reimbursement for an anesthesia service shall include:
  - (a) Preoperative and postoperative visits;
  - (b) Administration of the anesthetic;
  - (c) Administration of fluids and blood incidental to the anesthesia or surgery;
  - (d) Postoperative pain management;
  - (e) Preoperative, intraoperative, and postoperative monitoring services; and
  - (f) Insertion of arterial and venous catheters.

**B. Reimbursement**

- (1) Payment for covered physician services shall be based on the lesser of the physicians' usual and customary actual billed charges or the Medicaid Physician Fee Schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physician Services. The agency's fee schedule rate was set as of January 1, 2014 and is effective for services provided on or after that date and are updated annually on January 1<sup>st</sup> or thirty (30) days following the release of the revised CPT Codes from the American Medical Association, whichever is earlier. All rates are published on the agency's website at <http://www.chfs.ky.gov/dms/fee.htm>.
- (2) If there is not an established fee in the Medicaid Physician Fee Schedule, the reimbursement shall be forty-five (45) percent of the billed charge. After the first quarter, Medicaid will establish a reimbursement rate based on the average payments for each procedure code during that quarter. The rate for that code will then be added to our Medicaid Physician Fee Schedule. If Medicare develops RBRVS Units for a procedure code, Kentucky will revise our Fee Schedule using the Medicare RBRVS Units

- (3) The flat rate for a service shall be established by multiplying the dollar conversion factor by the sum of the RVU units plus the number of units spent on that specified procedure. RBRVS units shall be multiplied by a dollar conversion factor to arrive at the fixed upper limit. The dollar conversion factors are as follows:

<u>Types of Service</u>	<u>Kentucky Conversion Factor</u>
Deliveries	Not applicable
Non-delivery Related Anesthesia	\$15.20
Non-anesthesia Related Services	\$29.67

C. Reimbursement Exceptions

- (1) Physicians, who are enrolled in the Vaccines for Children (VFC) Program, will only be reimbursed for the administration of specified immunizations obtained free from the Department for Public Health through the VFC Program to provide immunizations for Medicaid recipients under the age of nineteen (19). Vaccine costs for any VFC specified immunization will not be reimbursed for the physicians who are enrolled in the VFC Program. For additional information on vaccine administration, please see Att. 4.19-B, Page 20.5(4).

- (2) Payments for obstetrical delivery services provided on or after September 15, 1995 shall be reimbursed the lesser of the actual billed charge or at the standard fixed fee paid by type of procedure. The obstetrical services and fixed fees are:

Delivery only	\$870.00
Vaginal delivery including postpartum care	\$900.00
Cesarean delivery only	\$870.00
Cesarean delivery including postpartum care	\$900.00

- (3) For delivery-related anesthesia services provided on or after July 1, 2006, a physician shall be reimbursed the lesser of the actual billed charge or a standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

Vaginal delivery	\$215.00
Cesarean section	\$335.00
Neuroxial labor anesthesia for a vaginal delivery or cesarean section	\$350.00
Additional anesthesia for cesarean delivery following neuroxial labor anesthesia for Vaginal delivery	\$25.00
Additional anesthesia for cesarean hysterectomy following neuroxial labor Anesthesia	\$25.00

- (4) Payment for individuals eligible for coverage under Medicare part B is made, in accordance with Sections A and B and items (1) through



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- (5) Procedures which are specified by Medicare and published annually in the Federal Register, which are commonly performed in the physician's office, will be reimbursed adjusted rates to take into account the change in usual site of service (facility vs. non-facility based on Medicare Site of Service designation) and are subject to the outpatient upper payment limit.
  - (6) Payments for the injection procedure for chemonucleolysis of intervertebral disk(s), lumbar, shall be paid the lesser of the actual billed charge or \$793.50.
  - (7) Specified family planning procedures in the physician office setting shall be reimbursed at the lesser of the actual billed charges or the Medicaid Physician Fee Schedule plus actual cost of the supply minus ten percent.
  - (8) For information relating to physician injectable drug products that are administered by a physician or their authorized agent during an in office procedure see Attachment 4.19-B, Page 20.1(b).
  - (9) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).
  - (10) For practice related services provided by a physician assistant, the participating physician shall be reimbursed at the lesser of the usual and customary charges actual billed charges or 75 percent of the Medicaid Physician Fee Schedule per procedure
  - (11) Any physician participating in the lock-in program will be paid a \$10.00 per month lock-in fee for provision of patient management services for each recipient locked in to that physician.
  - (12) Supplemental payments will be made for services provided by medical school faculty physicians either directly or as supervisors of residents. These payments are in addition to payments otherwise provided under the state plan to physicians that qualify for such payments under the criteria outlined below in Part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in Parts (b) and (c) of this section.
    - a. To qualify for a supplemental payment under this section, physicians must meet the following criteria:
      1. Be Kentucky licensed physicians;
      2. Be enrolled as Kentucky Medicaid providers; and
      3. Be Medical School Faculty Physicians as defined in Att 4.19-B, page 20.3, with an agreement to assign their payments to the state-owned academic medical center in accordance with 42 CFR 447.10.

- b. For physicians qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between payments otherwise made to these physicians and the average rate paid for the services by commercial insurers. The payment amounts are determined by:
1. Annually calculating an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the providers' contracted rates with commercial insurers for each procedure code from an actual year's data, beginning with CY 2006;
  2. Multiplying the total number of Medicaid claims paid per procedure code by the average commercial payment rate for each procedure code to establish the estimated commercial payments to be made for these services; and
  3. Subtracting the initial fee-for-service Medicaid payments, all Medicare payments, and all Third Party Liability payments already made for these services to establish the supplemental payment amount. Effective January 1, 2007 all claims, where Medicare is the primary provider, will be excluded from the supplemental payment methodology.
  4. The supplemental payments will be calculated annually after the end of each CY using actual data from the most recent completed CY. Claims data will only be used for physicians meeting the criteria in Part (a) above. If a physician did not meet the criteria for the whole calendar year, then only the claims data that coincides with their dates of eligibility will be used in the calculation. The supplemental payments will not be increased with any trending or inflationary indexes.
- c. Initial fee-for-service payments under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made as four (4) equal quarterly payments.
- (13) A second anesthesia service provided by a provider to a recipient on the same date of service shall be reimbursed at the Medicaid Physician Fee Schedule amount
- (14) If more than one procedure is performed at the same time, the provider shall be reimbursed one hundred (100) percent of the Medicaid Physician Fee Schedule for the first procedure and fifty (50) percent of the Medicaid Physician Fee Schedule for each additional procedure.
- (15) A fixed rate of twenty-five (25) dollars for anesthesia add-on services provided to a recipient under age one (1) or over age seventy (70).

- (16) Physicians, who are not enrolled in the VFC Program, will be reimbursed for the administration of immunizations, to include the influenza vaccine, as well as the vaccine cost, as defined in the Center for Disease Control (CDC) Vaccine Price List published as of January 1, 2014 to a Medicaid recipient of any age.
- (17) The department shall reimburse a flat rate of seventy-two (72) dollars per office visit for an office visit beginning after 5:00pm Monday through Friday or beginning after 12:00pm on Saturday through the remainder of the weekend.
- (18) Deep sedation of general anesthesia relating to oral surgery performed by an oral surgeon shall have a fixed rate of \$150.
- (19) For an evaluation and management service with a corresponding CPT of 99214 or 99215 exceeding the limit outlined in Att. 3.1-A p. 7.2.1 & Att. 3.1-B p. 21, DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.
- (20) The evaluation and management services with a corresponding CPT of 99201-99205 and 99211-99215 will be reimbursed at eighty-seven and one half (87.5) percent of Medicare Fee Schedule in effect as of January 1, 2006.

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XXV. Advanced Registered Nurse Practitioner Services

(1) Reimbursement

- a. Participating licensed advanced registered nurse practitioners (ARNP) shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of a licensed ARNP.
- b. Except as specified in subsection c of this section or Section 2 below, reimbursement for a procedure provided by an ARNP shall be at the lesser of the following:
  1. The ARNP's actual billed charge for the service; or
  2. Seventy-five (75) percent of the amount reimbursable to a Medicaid participating physician for the same service.
- c. An ARNP employed by a primary care center, federally qualified health center, hospital, or comprehensive care center shall not be reimbursed directly for services provide in that setting while operating as an employee.

(2) Reimbursement Limitations.

- a. The fee for administration of a vaccine to a Medicaid recipient under the age of twenty-one (21) by an ARNP shall be three (3) dollars and thirty (30) cents up to three (3) administrations per ARNP, per recipient, per date of service.
- b. The cost of a vaccine provided to a physician or other provider enrolled in the Vaccines for Children (VFC) Program and available free through the Vaccines for Children Program shall not be reimbursed.
- c. For information relating to physician injectable drug products that are administered by a physician or their authorized agent during an in office procedure see Attachment 4.19-B, Page 20.1(b).