

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-SPA 15-001-Ltr from LL to JG re state designee_dte020315:

DMS request for review and approval of SPA 15-001 which designates Commissioner Lisa Lee authority to submit SPAs for the Department.

2 – CMS-TCM-Ltr from LL to JG re RAI SPA14-002B_dte021215:

DMS request to withdraw response to the RAI for targeted case management SPA 14-002B that was submitted to CMS on January 8, 2015.

3 – CMS-AfterHrs-Ltr from LL to JG re RAI SPA14-008_dte021815:

DMS response to CMS request for additional information dated February 17, 2015, for SPA 14-008 related to after-hours CPT 99050.

4 – CMS-Wellness-Ltr from LL to JG re RAI SPA14-009_dte022515:

DMS response to CMS request for additional information dated February 17, 2015, for SPA 14-009 related to the Wellness Incentive for certain primary care services.



**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
F: 502-564-0509
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

Lisa Lee
Commissioner

February 3, 2015

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 15-001
State Governor's Review

Dear Ms. Glaze:

Enclosed for your review and approval is Kentucky Title XIX State Plan Amendment No. 15-001. 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 Audrey Tayse Haynes 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,

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

Lisa Lee
Commissioner

LL/sjh

Enclosure

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

1. TRANSMITTAL NUMBER:
15-001

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
February 1, 2015

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:

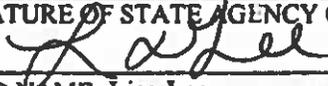
State Governor's Review appoint Lisa Lee

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: Lisa Lee

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 2/3/2015

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:

State: KentuckyCitation 7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid Agency will provide opportunity for the Office of Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

- Not Applicable. The Governor-
 Does not wish to review any plan material.
 Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department for Medicaid Services

(Designated Single State Agency)

Date: February 4, 2015



Lisa Lee, Commissioner
Department for Medicaid Services

TN#: 15-001
 Supersedes
 TN#: 12-004

Approval Date: _____

Effective Date: February 1, 2015



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

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Audrey Tayse Haynes
Secretary

Lisa Lee
Commissioner

February 3, 2015

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

Dear Ms. Lee:

Please be advised that in your capacity as Commissioner, you will serve as the Governor's designee under 42 CFR 430.12(b) for review and approval of the Title XIX State Plan and State Plan Amendments. This appointment shall take effect on February 1, 2015.

I appreciate your acceptance of these duties.

Sincerely,


Audrey Tayse Haynes

ATH/sh



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

Steven L. Beshear
Governor

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Audrey Tayse Haynes
Secretary

Lisa D. Lee
Commissioner

February 12, 2015

Ms. Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

RE: KY SPA 14-002B – Targeted Case Management

Dear Ms. Glaze:

The KY Department for Medicaid Services (DMS) would like to withdraw our response to the RAI that was submitted to CMS on January 8, 2015. This will allow both DMS and CMS to continue to work together to provide the information necessary to move this SPA forward for approval.

If you have any questions, please let me know.

Sincerely,

A handwritten signature in black ink, appearing to read "L. Lee".

Lisa D. Lee, Commissioner
Department for Medicaid Services

LL/sh



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

Steven L. Beshear
Governor

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Audrey Tayse Haynes
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Lisa D. Lee
Commissioner

February 18, 2015

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 14-008

Dear Ms. Glaze:

This letter is in response to your Request for Additional Information dated February 17, 2015 for KY SPA 14-008. We have responded to each question below and have revised the attached State Plan page per your request. Upon receipt of this letter, Kentucky requests that this SPA be put back on the clock and proceed toward approval.

1. **Attachment 4.19-B, Page 20.5, Item (17)**

- A. The 2nd paragraph currently reads, "CPT code 99050 is eligible for separate reimbursement, in addition ..." Please change this to read, "CPT code 99050 is eligible for separate payment, in addition ..."

DMS Response – Changes made on the attached Att. 4.19-B, Page 20.5.

- B. Please change the 2nd bullet to read, "It is rendered after hours; and"

DMS Response – Changes made on the attached Att. 4.19-B, Page 20.5.

- C. The third paragraph currently reads, "CPT code 99050 is not eligible for separate reimbursement when it is reported with a preventive diagnosis and/or a preventive service." Please change "reimbursement" to "payment".

DMS Response – Changes made on the attached Att. 4.19-B, Page 20.5.



- D. The last paragraph currently reads, "Reimbursement for CPT Code 99050 will be \$25.00." Please change this to read, "Effective for services provided on or after January 1, 2015, payment for CPT Code 99050 will be \$25.00."

DMS Response – Changes made on the attached Att. 4.19-B, Page 20.5.

2. Attachment 4.19-B, Page 20.5

Please change the footers to indicate that 14-008 supersedes 14-004, delete the approval date and change the effective date to January 1, 2015 (assuming that public notice was provided prior to January 1, 2015).

DMS Response – Changes made on the attached Att. 4.19-B, Page 20.5.

3. Public Notice- Please provide a copy of the published public notice. Please note that public notice must be published at least one day prior to the effective date of the SPA.

DMS Response – Public Notice is attached. This change was included in the same Public Notice as the Enhanced Wellness SPA 14-009 and listed in the Fee Schedule that was listed in the Public Notice.

4. In the state's cover letter, the state indicated that the proposed payment would result in an average payment of \$72 (which is currently being paid) and, therefore, is budget neutral. Please explain how this was determined.

DMS Response - The Department received a letter from the Office of the Attorney General dated August 29, 2014 (copy enclosed). This letter outlined concerns with the current Medicaid regulation related to providers billing for after-hours services using CPT code 99050. This letter also suggested that the Department may wish to change the state regulation in order to prohibit the use of the code within normal office hours. Please note in the last paragraph, it is suggested that this change in regulation would most likely result in a cost savings to the Department due to a reduction in hospital emergency room use. Immediately upon receiving this letter, the Department conducted additional investigations and we came to the conclusion that reducing the rate of the after-hours code would result in budget neutrality and would also result in appropriate billing as the code should only be billed as an add-on code in conjunction with the normal office visit.

Please note that the Department provided clarification regarding CPT code 99050 in July 2007 that stated the code was to be billed in lieu of the normal office visit codes. Given that the range of rates for normal office hours codes are \$29.66 through \$112.27 and given that some providers may not extend their office hours for the flat rate of \$72, the Department concluded that the reduction in the after-hours code and the use of the code as an add-on the normal office visit, may result in providers extending office hours. As a result, there may be some providers who treat members with high complexity needs that receive more reimbursement, depending on the level of care provided. However, as extending office hours could potentially reduce hospital emergency visits, the Department concluded that the result of this combination of slightly higher office fees and reduced hospitalization costs would result in budget neutrality for the

Department. Please be assured that the Department will continue to monitor both the use of the after-hours code and emergency room use to ensure proper use of both services.

Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physicians or other practitioners, the questions must be answered for all payments made under the State plan for each service.

1. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.)

DMS Response – Providers receive and retain the total Medicaid reimbursement.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived either through IGTs or CPEs. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and state share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);

- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority:
and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

DMS Response – Not applicable.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for FFP 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 – no supplemental or enhanced payments are made.

4. For clinic or outpatient hospital services, 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.

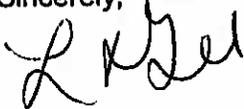
DMS Response – Not applicable.

5. 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.

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

Sincerely,



Lisa D. Lee
Commissioner

LDL/sjh

Enclosure

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- (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) After Hours Services - CPT 99050 is reported when services are provided in the office at times other than regularly scheduled office hours or days when the office is normally closed. DMS refers to this time as "After Hours," and defines "After Hours" as services rendered between 5:00 p.m. and 8:00 a.m. on weekdays, and anytime on weekends and holidays when the office is usually closed. For example – if normal office hours are scheduled from 9:00 – 5:00 and service is provided at 7:00, the provider would bill CPT 99050. However, if normal office hours are scheduled from 9:00 am – 7:00 pm and the service is performed at 6:00, the provider would NOT bill for CPT code 99050.

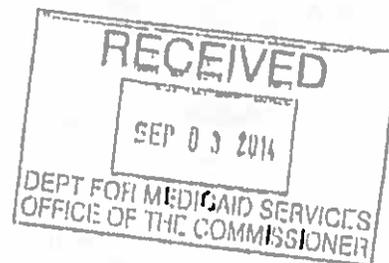
CPT code 99050 is eligible for separate payment, in addition to the basic covered service, if the basic service provided meets all of the criteria described below:

- It is reported with an office setting place of service;
- It is rendered after hours; and
- The basic service time is based on arrival time, not actual time services commence.

CPT code 99050 is not eligible for separate payment when it is reported with a preventive diagnosis and/or a preventive service.

Effective for services provided on or after January 1, 2015, payment for CPT Code 99050 will be \$25.00

- (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.



JACK CONWAY
ATTORNEY GENERAL

COMMONWEALTH OF KENTUCKY
OFFICE OF THE ATTORNEY GENERAL

1024 CAPITAL CENTER DRIVE
SUITE 200
FRANKFORT, KENTUCKY 40601

August 29, 2014

Lawrence Kissner
Commissioner
Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main St.
Frankfort, KY 40621

Re: Ambiguities in the use of after-hours billing code 99050

Dear Commissioner Kissner:

Over the past year the Office of the Attorney General Medicaid Fraud and Abuse Control Division (MFCU) has received several criminal referrals from the Department of Medicaid Services (DMS) Office of the Inspector General (OIG) which involve providers billing for after-hours services using CPT code 99050.

The CPT Code definition for 99050 provides: "Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g. holidays, Saturday or Sunday), in addition to basic service" (emphasis added).

Kentucky Medicaid provided the following in Physicians Provider Letter A-363: "Effective July 1, 2007 extended office hours are defined as an office visit beginning after 5:01 P.M., Monday through Friday and from 12:01 P.M. on Saturday through 7:59 A.M. Monday. The extended office hours reimbursement rate for provider type 64/65 is set at a flat rate of \$72.00. These services should be billed using CPT code 99050 in lieu of the normal office visit codes 99201-99205 and 99211-99215."

The criminal referrals regarding the use of this code fall into one of two categories. The first involves providers who use the after-hours code to bill for services provided during normal business hours of that provider but which are also after 5:00 P.M. weekdays, noon Saturday or anytime on Sunday (e.g. a clinic which is open until 9:00 P.M. on a weekday seeing a patient at 8:00 P.M.). State regulatory guidance contained at the physician reimbursement regulation (907 KAR 3:010) however seems to permit use of the code regardless of the normal office hours of the involved provider. Because of this criminal prosecution is not possible. DMS may wish to consider seeking a change to the state regulation if it wishes to prohibit the use of the code within the normal office hours of a

August 22, 2014
to Lawrence Kissner

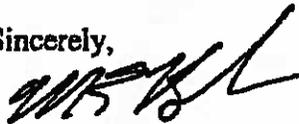
provider.

The second category of referral involves providers who bill both the after-hours code and the E&M code for the service provided to the patient. This is in accordance with AMA guidelines for CPT code 99050 but is not permitted under Kentucky Medicaid Rules and was the subject of provider letters (A-363 above and A-22). The problem with bringing a criminal action under such circumstances is that the wording of the state regulation is ambiguous. While the Provider Letters were clear it is impossible to prove that a particular provider either received or read the letters. In addition DMS provides on its web site that it does not provide billing instructions. The site directs providers to the fiscal agent HP Enterprise Services (HP). The HP billing instructions for the physician manual state that the Kentucky Medicaid program provides reimbursement for covered services according to CPT/HCPCS codes reported on a claims form and only has the descriptors of the codes in the CPT book. As noted above the CPT guidance permits use of both the after-hours code and an E&M code for the same service provided after-hours. Therefore the provider letters are in conflict with DMS's own billing instructions.

Investigation by the MFCU has determined that three states, including Kentucky, account for 77 percent of all Medicaid billings for after-hours care in the whole country (OEI-07-11-00050). The MFCU believes this is the result of Kentucky's rate of reimbursement to provider types 64/65 (physician/physician group) for the use of code 99050 which is \$72.00. Most states reimburse 99050 at a much lower rate with the apparent intent of rewarding a provider who sees a patient after-hours by paying that provider both the rate for the service provided and additional money because it occurred after-hours. This has the effect of lowering overall costs when patients see their primary physician rather than go to a more expensive hospital emergency room. The MFCU believes DMS should consider a similar policy for reimbursement for after-hours treatments.

If you have any questions please do not hesitate to call me at 502 696-5412.

Sincerely,



Michael E. Brooks
Executive Director
Office of Medicaid Fraud and Abuse
Control Division
Office of the Attorney General
1024 Capital Center Dr.
Frankfort, KY 40601



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

Steven L. Beshear
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Audrey Tayse Haynes
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Lisa D. Lee
Commissioner

February 25, 2015

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 14-009

Dear Ms. Glaze:

This letter is in response to your Request for Additional Information dated February 17, 2015 for KY SPA 14-009. We have responded to each question below and have revised the attached State Plan page per your request. Upon receipt of this letter, Kentucky requests that this SPA be put back on the clock and proceed toward approval.

1. Attachment 4.19-B, Page 20.5(2) – Please remove the check boxes and language that are not being used under both sections (Method of Payment and Primary Care Services Affected by this Payment Methodology) as they are not needed.

DMS Response – We have removed the requested language.

2. It appears as if the state will make the higher payment, for the selected codes, to all providers. Please confirm. If not, please explain which provider types will receive the higher payment.

DMS Response – The enhanced payments will go to Provider Type 64 and 65.

3. The state indicates that providers will receive a “bonus” payment. Please explain how the state will determine that a physician will receive the “bonus” payment. Additionally, please describe in the state plan.

DMS Response – This is an enhanced reimbursement for Provider Type 64 and 65 for certain wellness care services. As Kentucky tries to work to improve the health of our recipients, we realize that physicians are a vital part of improving their health. So we are attempting to

encourage providers to perform more wellness services that have the ability to prevent more chronic conditions. This plan is an attempt to continue to provide an enhanced reimbursement for providers similar to what ACA has provided for the last two (2) years. This is not really a bonus payment and the word bonus has been removed from the attached State Plan pages.

4. 1902(a)(30)(A) requires that rates be economic and efficient. Please explain how the state determined the higher rates.

DMS Response – After conducting market research on Wellness Incentive Programs, Kentucky leveraged the framework of a comparable state for incentivizing preventive services provided to Medicaid members. Modifications were made as appropriate to comply with Kentucky's policies and procedures; and in part adopting a flat add-on fee for each group of preventive services. This add-on fee was added to the 2014 KY Medicaid Physician Fee Schedule rate to arrive at the DMS modified rate. This DMS modified rate was then compared to the 2014 Medicare Rate. The Wellness Enhanced Rate is the lesser of the modified rate and the 2014 Medicare Rate.

5. We note that the state has included quantity limits that apply to the number of bonus payments a provider will receive per year for each CPT code listed. Please explain how the state will track these limits.

DMS Response – As part of the system change order, the Department's Fiscal Agent has created system audits to track and enforce quantity limitations. Once a limitation has been met, the service will pay at the standard KY Medicaid Physician Fee Schedule rate, as appropriate. Modifier combinations have been implemented for providers to use when billing for Wellness Preventive Services. These modifier combinations, in conjunction with applicable system edits/audits, will be used to systematically identify and price eligible claim details.

6. Vaccines - It looks like the payment is only for vaccine administration, as the modifier is 33 U5 for these codes. However, based on the rates in the chart, it looks like the chart includes the product cost. Please confirm what the state's intent is for the vaccines. If the state only plans to pay for vaccine administration, CMS would expect the rates to be the same for all of the vaccines lines. HPV is a very expensive vaccine, and the fact that 90649 and 90650 are so much higher than the other codes, it appears as if the product prices are included on the chart. Please explain.

DMS Response –Kentucky's intention is to incentivize the administration of eligible vaccine/toxoid vaccines. For the eligible childhood immunizations, flu vaccines and HPV vaccines, the Wellness Add-on fee is applied to the vaccine administration CPT codes. For administration codes 90460, 90471, and 90473 the add-on fee is \$12.00; for the add-on administration codes 90472 and 90474 the add-on fee is \$10.00. For 90649 and 90650 the price listed is for completion of the three doses of the HPV vaccine not just one.

7. Additionally, under the Vaccines for Children (VFC) program, the vaccines are free to providers as they are purchased by the Federal government. Therefore most of the HPV doses administered will be under the VFC program and the providers will not have purchased the vaccine. Therefore the only payment to providers for vaccines administered to children under

age 20 would be for vaccine administration. Kentucky's vaccine administration payment is capped at \$19.93 under the VFC program; therefore, CMS would only pay the Federal share of \$19.93 regardless of what the State chooses to pay the provider.

DMS Response – Kentucky is incentivizing the administration of eligible vaccines for both adults and children; providers have been instructed to append modifier combination 33/U7 to the appropriate administration code. This modifier combination should be used in addition to any other modifiers outlined in coding guidelines and/or Department policy. For patients under the age of 19, the provider is to bill Kentucky Medicaid using the appropriate administration CPT and the appropriate vaccine CPT. If the vaccine was procured from the VFC program, modifier 'SL' should be appended to the vaccine CPT code. If the vaccine is NOT procured from the VFC program, modifier 'SL' should not be appended.

8. The state indicated, in block 7 of the HCFA-179, that the federal budget impact for KY- 14-009 is \$4,609,000 for both FFY 2015 and FFY 2016. Please explain how the state determined these amounts.

DMS Response - The numbers have been revised since the original submission of this SPA. The State ran data based on the 2013 for each of the codes listed. We looked at both the Fee-For-Service (FFS) and Managed Care Organization members. We multiplied the total number of FFS services by the amount of the enhanced amount and came up with revised numbers. The total federal match for 2015 and 2016 is \$625,000 and \$675,000 respectively. Upon receipt of this RAI response, the State give CMS permission to make these changes to block 7 of the HCFA 179 form.

8. Please provide a copy of the published Public Notice.

DMS Response – See attached

Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physicians or other practitioners, the questions must be answered for all payments made under the State plan for each service.

1. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.)

DMS Response – Providers retain the total Medicaid reimbursement

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived either through IGTs or CPEs. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and state share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

DMS Response – The state's share is from appropriations from the Legislature.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for FFP 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

4. For clinic or outpatient hospital services, 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.

Ms. Jackie Glaze
February 25, 2015
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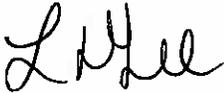
DMS Response – Not applicable

5. 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 – If it is determined that any overpayment is made, DMS will recoup the refund and return the federal share to CMS on the quarterly expenditure report.

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

Sincerely,



Lisa D. Lee
Commissioner

LDL/sjh

Enclosure

Physician Services - Wellness Incentive

Method of Payment

- The state has adjusted its fee schedule to make payment at the higher rate for each CPT Code the State has included in the Enhanced Wellness Fee Schedule.

Primary Care Services Affected by this Payment Methodology

- This payment applies to all billing codes listed below. Multiple services performed on the same day by the same provider will be processed using Modifier 1 and Modifier 2. Multiple enhanced payments may be paid for same day/same provider up to the Medicare Allowed Amount for the CPT Code listed. The State has included quantity limits that apply to the number of enhanced payments a provider will receive per year for each CPT code listed.

Physician Services - Wellness Incentive (cont.)

Primary Care Services Affected by this Payment Methodology

The Wellness Enhanced Rate is the lesser of the modified rate and the 2014 Medicare Rate.

Modifier Descriptions	
33/U5 identifies vaccine administration	33/UA identifies well child visits first 15 months of life
33/U7 identifies screenings	33/UB identifies BMI/Weight Counseling
33/U8 identifies after hours	33/UD identifies controlling BP

Bonus Fee	CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description	Quantity Limits
	83655	33	U7	\$0.00	\$17.13	\$16.00	\$33.13	\$33.13	Modified Rate	Once annually
	99381	33	UA	\$103.36	\$78.58	\$16.00	\$94.58	\$94.58	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
	99382	33	UA	\$107.92	\$89.90	\$16.00	\$105.90	\$105.90	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
	99391	33	UA	\$93.12	\$67.57	\$16.00	\$83.57	\$83.57	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
	99392	33	UA	\$99.61	\$78.58	\$16.00	\$94.58	\$94.58	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months

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Physician Services - Wellness Incentive (cont.)

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99461	33	UA	\$91.40	\$75.36	\$16.00	\$91.36	\$91.36	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99201	33	UA	\$39.86	\$29.66	\$16.00	\$45.66	\$39.86	Medicare Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99202	33	UA	\$68.99	\$53.00	\$16.00	\$69.00	\$68.99	Medicare Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99203	33	UA	\$100.39	\$79.04	\$16.00	\$95.04	\$95.04	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99204	33	UA	\$155.31	\$112.27	\$16.00	\$128.27	\$128.27	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months

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Physician Services - Wellness Incentive (cont.)

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medical P40 P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description	Quantity Limits
99205	33	UA	\$194.18	\$143.29	\$16.00	\$159.29	\$159.29	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99211	33	UA	\$18.28	\$16.98	\$16.00	\$32.98	\$18.28	Medicare Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99214	33	UA	\$100.55	\$67.10	\$16.00	\$83.10	\$83.10	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99215	33	UA	\$135.11	\$98.39	\$16.00	\$114.39	\$114.39	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
77055	33	U7	\$81.75	\$56.43	\$17.00	\$73.43	\$73.43	Modified Rate	Once annually
77056	33	U7	\$104.99	\$70.46	\$17.00	\$87.46	\$87.46	Modified Rate	Once annually
77057	33	U7	\$75.19	\$58.97	\$17.00	\$75.97	\$75.19	Medicare Rate	Once annually
G0202	33	U7	\$120.80	\$91.56	\$17.00	\$108.56	\$108.56	Modified Rate	Once annually
G0204	33	U7	\$147.47	\$99.65	\$17.00	\$116.65	\$116.65	Modified Rate	Once annually
G0206	33	U7	\$116.11	\$80.34	\$17.00	\$97.34	\$97.34	Modified Rate	Once annually
88141	33	U7	\$29.62	\$18.02	\$13.00	\$31.02	\$29.62	Medicare Rate	Once annually
88142	33	U7	\$0.00	\$27.64	\$13.00	\$40.64	\$40.64	Modified Rate	Once annually

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Effective Date: January 1, 2015

Physician Services - Wellness Incentive (cont.)

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
88143	33	U7	\$0.00	\$27.64	\$13.00	\$40.64	\$40.64	Modified Rate	Once annually
88147	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate	Once annually
88148	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate	Once annually
88150	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate	Once annually
88160	33	U7	\$58.45	\$36.56	\$13.00	\$49.56	\$49.56	Modified Rate	Once annually
88161	33	U7	\$53.45	\$36.81	\$13.00	\$49.81	\$49.81	Modified Rate	Once annually
88162	33	U7	\$87.37	\$45.06	\$13.00	\$58.06	\$58.06	Modified Rate	Once annually
G0123	33	U7	\$0.00	\$27.64	\$13.00	\$40.64	\$40.64	Modified Rate	Once annually
G0144	33	U7	\$0.00	\$29.15	\$13.00	\$42.15	\$42.15	Modified Rate	Once annually
G0145	33	U7	\$0.00	\$35.04	\$13.00	\$48.04	\$48.04	Modified Rate	Once annually
P3000	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate	Once annually
Q0091	33	U7	\$40.64	\$33.66	\$13.00	\$46.66	\$40.64	Medicare Rate	Once annually
90655	33	U5	\$0.00	\$17.24	\$10.00	\$27.24	\$27.24	Modified Rate	Once annually
90656	33	U5	\$0.00	\$12.40	\$10.00	\$22.40	\$22.40	Modified Rate	Once annually
90657	33	U5	\$0.00	\$6.02	\$10.00	\$16.02	\$16.02	Modified Rate	Once annually
90658	33	U5	\$0.00	\$14.35	\$10.00	\$24.35	\$24.35	Modified Rate	Once annually
90660	33	U5	\$0.00	\$21.70	\$10.00	\$31.70	\$31.70	Modified Rate	Once annually
90661	33	U5	\$0.00	\$20.66	\$10.00	\$30.66	\$30.66	Modified Rate	Once annually

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Physician Services - Wellness Incentive (cont.)

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description	Quantity Limits
90662	33	U5	\$0.00	\$31.82	\$10.00	\$41.82	\$41.82	Modified Rate	Once annually
90672	33	U5	\$0.00	\$24.60	\$10.00	\$34.60	\$34.60	Modified Rate	Once annually
90649	33	U5	\$0.00	\$141.38	\$10.00	\$151.38	\$151.38	Modified Rate	Up to 3 annually
90650	33	U5	\$0.00	\$128.75	\$10.00	\$138.75	\$138.75	Modified Rate	Up to 3 annually
44388	33	U7	\$322.86	\$191.73	\$15.00	\$206.73	\$206.73	Modified Rate	Once annually
44389	33	U7	\$362.87	\$210.07	\$15.00	\$225.07	\$225.07	Modified Rate	Once annually
44391	33	U7	\$457.41	\$280.73	\$15.00	\$295.73	\$295.73	Modified Rate	Once annually
44392	33	U7	\$404.58	\$267.50	\$15.00	\$282.50	\$282.50	Modified Rate	Once annually
44394	33	U7	\$457.15	\$285.40	\$15.00	\$300.40	\$300.40	Modified Rate	Once annually
45330	33	U7	\$124.52	\$64.08	\$15.00	\$79.08	\$79.08	Modified Rate	Once annually
45331	33	U7	\$148.99	\$83.80	\$15.00	\$98.80	\$98.80	Modified Rate	Once annually
45332	33	U7	\$265.56	\$108.61	\$15.00	\$123.61	\$123.61	Modified Rate	Once annually
45341	33	U7	\$150.29	\$148.42	\$15.00	\$163.42	\$150.29	Medicare Rate	Once annually
45342	33	U7	\$228.98	\$171.39	\$15.00	\$186.39	\$186.39	Modified Rate	Once annually
45345	33	U7	\$167.48	\$142.59	\$15.00	\$157.59	\$157.59	Modified Rate	Once annually
45355	33	U7	\$198.12	\$137.10	\$15.00	\$152.10	\$152.10	Modified Rate	Once annually
45378	33	U7	\$359.50	\$228.82	\$15.00	\$243.82	\$243.82	Modified Rate	Once annually
45379	33	U7	\$461.67	\$292.40	\$15.00	\$307.40	\$307.40	Modified Rate	Once annually

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Physician Services - Wellness Incentive (cont.)

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
45380	33	U7	\$428.21	\$255.86	\$15.00	\$270.86	\$270.86	Modified Rate	Once annually
45381	33	U7	\$428.82	\$284.36	\$15.00	\$299.36	\$299.36	Modified Rate	Once annually
45382	33	U7	\$556.15	\$335.55	\$15.00	\$350.55	\$350.55	Modified Rate	Once annually
45383	33	U7	\$522.37	\$343.18	\$15.00	\$358.18	\$358.18	Modified Rate	Once annually
45386	33	U7	\$607.98	\$530.14	\$15.00	\$545.14	\$545.14	Modified Rate	Once annually
45387	33	U7	\$332.42	\$232.95	\$15.00	\$247.95	\$247.95	Modified Rate	Once annually
45391	33	U7	\$283.59	\$212.17	\$15.00	\$227.17	\$227.17	Modified Rate	Once annually
45392	33	U7	\$364.54	\$268.20	\$15.00	\$283.20	\$283.20	Modified Rate	Once annually
82270	33	U7	\$0.00	\$4.44	\$15.00	\$19.44	\$19.44	Modified Rate	Once annually
82274	33	U7	\$0.00	\$21.70	\$15.00	\$36.70	\$36.70	Modified Rate	Once annually
G0105	33	U7	\$359.50	\$255.86	\$15.00	\$270.86	\$270.86	Modified Rate	Once annually
G0121	33	U7	\$359.50	\$297.76	\$15.00	\$312.76	\$312.76	Modified Rate	Once annually
G0328	33	U7	\$0.00	\$21.70	\$15.00	\$36.70	\$36.70	Modified Rate	Once annually
94010	33	U7	\$32.26	\$24.44	\$12.00	\$36.44	\$32.26	Medicare Rate	Once annually
94014	33	U7	\$47.92	\$12.62	\$12.00	\$24.62	\$24.62	Modified Rate	Once annually
94016	33	U7	\$24.53	\$4.89	\$12.00	\$16.89	\$16.89	Modified Rate	Once annually
94060	33	U7	\$54.27	\$45.35	\$12.00	\$57.35	\$54.27	Medicare Rate	Once annually
94375	33	U7	\$35.71	\$28.04	\$12.00	\$40.04	\$35.71	Medicare Rate	Once annually

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Physician Services - Wellness Incentive (cont.)

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99201	33	UB	\$39.86	\$29.66	\$10.00	\$39.66	\$39.66	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99202	33	UB	\$68.99	\$53.00	\$10.00	\$63.00	\$63.00	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99203	33	UB	\$100.39	\$79.04	\$10.00	\$89.04	\$89.04	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99204	33	UB	\$155.31	\$112.27	\$10.00	\$122.27	\$122.27	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr

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Physician Services - Wellness Incentive (cont.)

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99211	33	UB	\$18.28	\$16.98	\$10.00	\$26.98	\$18.28	Medicare Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99212	33	UB	\$40.17	\$31.08	\$10.00	\$41.08	\$40.17	Medicare Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99214	33	UB	\$100.55	\$67.10	\$10.00	\$77.10	\$77.10	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99215	33	UB	\$135.11	\$98.39	\$10.00	\$108.39	\$108.39	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr

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Physician Services - Wellness Incentive (cont.)

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate/Medicare	Rate Description	Quantity Limits
99382	33	UB	\$107.92	\$89.90	\$10.00	\$99.90	\$99.90	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99383	33	UB	\$112.71	\$89.90	\$10.00	\$99.90	\$99.90	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99384	33	UB	\$127.76	\$101.22	\$10.00	\$111.22	\$111.22	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99385	33	UB	\$123.96	\$95.21	\$10.00	\$105.21	\$105.21	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr

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Physician Services - Wellness Incentive (cont.)

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99386	33	UB	\$143.58	\$116.70	\$10.00	\$126.70	\$126.70	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99387	33	UB	\$155.84	\$127.40	\$10.00	\$137.40	\$137.40	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99392	33	UB	\$99.61	\$78.58	\$10.00	\$88.58	\$88.58	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99393	33	UB	\$99.30	\$78.58	\$10.00	\$88.58	\$88.58	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr

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Physician Services - Wellness Incentive (cont.)

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99394	33	UB	\$108.97	\$89.90	\$10.00	\$99.90	\$99.90	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99395	33	UB	\$111.38	\$84.80	\$10.00	\$94.80	\$94.80	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99396	33	UB	\$118.91	\$100.83	\$10.00	\$110.83	\$110.83	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99397	33	UB	\$127.76	\$106.26	\$10.00	\$116.26	\$116.26	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99201	33	UD	\$39.86	\$29.66	\$16.00	\$45.66	\$39.86	Medicare Rate	Once annually

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Physician Services - Wellness Incentive (cont.)

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99202	33	UD	\$68.99	\$53.00	\$16.00	\$69.00	\$68.99	Medicare Rate	Once annually
99203	33	UD	\$100.39	\$79.04	\$16.00	\$95.04	\$95.04	Modified Rate	Once annually
99204	33	UD	\$155.31	\$112.27	\$16.00	\$128.27	\$128.27	Modified Rate	Once annually
99205	33	UD	\$194.18	\$143.29	\$16.00	\$159.29	\$159.29	Modified Rate	Once annually
99211	33	UD	\$18.28	\$16.98	\$16.00	\$32.98	\$18.28	Medicare Rate	Once annually
99212	33	UD	\$40.17	\$31.08	\$16.00	\$47.08	\$40.17	Medicare Rate	Once annually
99213	33	UD	\$67.93	\$42.63	\$16.00	\$58.63	\$58.63	Modified Rate	Once annually
99214	33	UD	\$100.55	\$67.10	\$16.00	\$83.10	\$83.10	Modified Rate	Once annually
99215	33	UD	\$135.11	\$98.39	\$16.00	\$114.39	\$114.39	Modified Rate	Once annually
99241	33	UD	\$45.48	\$36.55	\$16.00	\$52.55	\$45.48	Medicare Rate	Once annually
99242	33	UD	\$85.97	\$67.83	\$16.00	\$83.83	\$83.83	Modified Rate	Once annually
99243	33	UD	\$117.67	\$90.43	\$16.00	\$106.43	\$106.43	Modified Rate	Once annually
99245	33	UD	\$214.66	\$166.18	\$16.00	\$182.18	\$182.18	Modified Rate	Once annually
99386	33	UD	\$143.58	\$116.70	\$16.00	\$132.70	\$132.70	Modified Rate	Once annually
99387	33	UD	\$155.84	\$127.40	\$16.00	\$143.40	\$143.40	Modified Rate	Once annually
99394	33	UD	\$108.97	\$89.90	\$16.00	\$105.90	\$105.90	Modified Rate	Once annually
99395	33	UD	\$111.38	\$84.80	\$16.00	\$100.80	\$100.80	Modified Rate	Once annually
99396	33	UD	\$118.91	\$100.83	\$16.00	\$116.83	\$116.83	Modified Rate	Once annually
99397	33	UD	\$127.76	\$106.26	\$16.00	\$122.26	\$122.26	Modified Rate	Once annually

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Effective Date: January 1, 2015

Physician Services - Wellness Incentive (cont.)

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2015, ending on June 30, 2016. All rates are published at <http://chfs.ky.gov/dms/fee.htm>.

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Effective Date: January 1, 2015

**CABINET FOR HEALTH AND FAMILY SERVICES
PURCHASE REQUISITION FORM**

- Hardware Other
 Software
 Task Order

Date: 12/30/2014
Requested By: Jonathan MacDonald
Phone/Extension: 502-564-4321
E-Mail: jonathan.macdonald@ky.gov

Cabinet: Medicaid Service
Address: 275 East Main Street
Address: 6W-A
City/Zip: Frankfort/40621

Suggested Vendor Information
Name: Cincinnati Enquirer
Address: Dept 00097
Address:
City/Zip: Cincinnati/45274-0097
Rep: Carla Mahan
Account #: 399889
Website: www.nky.com
Phone: 1-877-283-2420
Fax:
E-Mail: cmahan@cincinnati@gannett.com

Accounting Profile/Template:	Funding Line 1	Funding Line 2
Department Code:	HWWCCA	
Unit Code:	746	
Object Code:	D746	
Activity Code:	E381	
Amount:	2,914.40	0.00
If Federal, CFDA#	93.778	
Enter Percentages for split funding:	0%	0%
COT Billing Code:		

Software Requirements:
Request Type:
Maint. Start Date:
Maint. End Date:
Installed on:

Justification Summary and Special Requirements: (Please hit enter after typing to expand box)
Federal requirement to publish a public notice when making a change in reimbursement.

Customer:
Phone/Extension:
E-Mail:

Customer Address Line 1:
Customer Address Line 2:
City/Zip:

Line	Item Description and Catalog Number	Qty	Unit of Measure	Unit Price (Yearly)	Extended Total
0	Standard Desktop - DT10		\$55.00 Monthly	\$660.00	
0	Standard Laptop - DT10		\$55.00 Monthly + \$83.52 Up Front Passthrough	\$660.00	
0	Standard Laptop with Bundle - DT20 (E-Port Replicator, Keyboard, Mouse w 19" monitor & laptop case)		\$75.00 Monthly	\$900.00	
1	Preventive and Wellness Enhanced Reimb rate				\$1,154.80
2	Cost-based Reimb model for CMHC services				\$1,759.60
3					
4					
5					
6					
7					
8					
9					
10					

Page1 Total:	\$2,914.40
Addl. Page Totals:	\$0.00
Grand Total:	\$2,914.40

Approvals:
Jonathan MacDonald 12-30-14
Requestor Date

Ex. Director/Commissioner Date

Supervisor/Director Date
[Signature] 12/30/14
Department/Office Budget Officer Date

Office of the Secretary Date

Other (if applicable) Date

The Cincinnati Enquirer
The Kentucky Enquirer
Cincinnati.Com

312 ELM STREET
CINCINNATI, OHIO 45202-2739
(513) 721-2700

KY DEPT FOR MEDICAID SERVICES
275 E MAIN ST
FRANKFORT, KY 40601

Monday, December 22, 2014

cct#: 399889

Order #: 1001831980

COMMONWEALTH OF KENTUCKY CABINET FOR HEA

O Number: Legal Notice

DATES	TOTAL AMOUNT		
12/21/14			
			1,749.60
Affidavit of Publication Charge			10.00
TOTAL AMOUNT DUE			1,759.60

Check #: _____

Date: _____

**CONFIRMATION OF PRICE
NOT AN INVOICE**

Affidavit of Publication

Publisher's Fee 1,759.60 Affidavit Charge 10.00

State of Ohio

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SS.

Hamilton County

Janice Colston

Personally appeared

If the The Enquirer, a newspaper printed in Cincinnati, Ohio and published in Cincinnati, in said County and State, and of general circulation in said county, and as to the Kentucky Enquirer published in Ft. Mitchell, Kenton County, Kentucky, who being duly sworn, depose and saith that the advertisement of which the annexed is a true copy, has been published in the said newspaper 1 times, once in each issue as follows:

12/21/14

- Cincinnati Enquirer
- Kentucky Enquirer
- Cincinnati.Com

Janice Colston

AFFIANT
Sworn to before me, this

12/22/14

Crystal Williams
Notary Public of Ohio

**COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
PUBLIC NOTICE**

The Cabinet for Health and Family Services, Department for Medicaid Services (DMS), in accordance with 42 GFR 447.205, hereby provides public notice of its changes to community mental health center (CMHC) services' reimbursement to be effective January 1, 2015.

Effective January 1, 2015, DMS will implement a cost-based reimbursement model for CMHC services. Via the cost-based model DMS will reimburse for all services rendered by a CMHC during a given state fiscal year based on the CMHC's Medicaid allowable costs. Each CMHC will submit a detailed cost report to DMS and DMS will review the report to determine the CMHC's Medicaid allowable costs.

After completing the review and determination of a CMHC's Medicaid allowable costs for a given state fiscal year, DMS will compare its interim reimbursement paid to the CMHC during the course of the year to the CMHC's actual Medicaid allowable costs for the year. If DMS's interim reimbursement to the CMHC exceeded the CMHC's Medicaid allowable costs, the CMHC will send the overpayment amount to DMS. If DMS's interim reimbursement was less than the CMHC's Medicaid allowable costs for the year, DMS will issue a lump sum payment to the CMHC equaling the amount owed.

Initial Interim Reimbursement
As a given CMHC's costs for a year is reported after the year concludes and DMS must review the cost data before determining the CMHC's total Medicaid allowable costs for the year, DMS will reimburse each CMHC on an interim basis during the course of the state fiscal year.

DMS's interim reimbursement for CMHC services initially will be the same reimbursement DMS currently pays each CMHC.

DMS will then adjust interim reimbursement, effective July 1, 2015, based on cost reports submitted to DMS by the CMHCs by April 1, 2015. Each such cost report submitted to DMS by a CMHC must state the CMHC's costs for the period beginning July 1, 2013 and ending June 30, 2014.

Fee-for-Service Only
The reimbursement established in this administrative regulation only applies to services rendered to Medicaid "fee-for-service" recipients. These are Medicaid recipients who are not enrolled with a managed care organization. Managed care organizations are not required to reimburse for CMHC services in the manner described in this public notice.

Necessity
DMS is establishing this new reimbursement model in response to a mandate



Crystal Williams
Notary Public - State of Ohio
My Commission Expires 08-24-2015

The Cincinnati Enquirer
The Kentucky Enquirer
Cincinnati.Com

312 ELM STREET
CINCINNATI, OHIO 45202-2739
(513) 721-2700

KY DEPT FOR MEDICAID SERVICES
275 E MAIN ST
FRANKFORT, KY 40601

Monday, December 22, 2014

acct#: 399889

Order #: 1001831981

COMMONWEALTH OF KENTUCKY CABINET FOR HEA

PO Number: Legal Notice

DATES	TOTAL AMOUNT		
12/21/14			
			1,144.80
Affidavit of Publication Charge			10.00
TOTAL AMOUNT DUE			1,154.80

Check #: _____

Date: _____

**CONFIRMATION OF PRICE
NOT AN INVOICE**

Affidavit of Publication

Publisher's Fee 1,154.80 Affidavit Charge 10.00

State of Ohio

}
}
} **SS.**
}
}

Hamilton County

Personally appeared **Janice Colton**

Of the The Enquirer, a newspaper printed in Cincinnati, Ohio and published in Cincinnati, in said County and State, and of general circulation in said county, and as to the Kentucky Enquirer published in Ft. Mitchell, Kenton County, Kentucky, who being duly sworn, deposeth and saith that the advertisement of which the annexed is a true copy, has been published in the said newspaper 1 times, once in each issue as follows:

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- Kentucky Enquirer
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Janice Colton

AFFIANT
Sworn to before me, this

12/22/14

Crystal Williams

Notary Public of Ohio



Crystal Williams
Notary Public, State of Ohio
My Commission Expires 08-24-2015

**COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
PUBLIC NOTICE**

The Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS), in accordance with 42 CFR 447.205, hereby provides public notice of enhanced reimbursement rates it is implementing for certain preventive and wellness services to be effective for such services provided anytime from January 1, 2015 through June 30, 2016.

The enhanced reimbursement rates will be stated on a fee schedule - the Medicaid Preventive and Wellness Enhanced Fee Schedule - located at <http://www.chfs.ky.gov/dms/fee.htm>.

DMS is enhancing reimbursement for these services to ensure Medicaid recipient access to such services by providing an incentive for more providers of the services to participate in the Medicaid Program. The reimbursement applies to services provided to Medicaid "fee-for-service" recipients and does not apply to services provided to Medicaid recipients who are enrolled with a managed care organization (MCO) as MCOs are not required to reimburse for services in the same manner as DMS reimburses.

Fiscal Impact:
DMS estimates that increasing the preventive and wellness reimbursement rates from January 1, 2015 through June 30, 2015 will cost DMS approximately \$4.39 million (state and federal funds combined.)

DMS estimates that increasing the preventive and wellness reimbursement rates for the period spanning July 1, 2015 through June 30, 2016 will cost DMS approximately \$8.78 million (state and federal funds combined.)

Public Comment
A copy of this notice is available for public review at the Department for Medicaid Services at the address listed below. Comments or inquiries may be submitted in writing within thirty (30) days to:

Commissioner's Office
Department for Medicaid Services, 6W-A
275 E. Main Street
Frankfort, Kentucky 40621

