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CABINET FOR HEALTH AND FAMILY SERVICES

Kentucky Health and Human Services Delivery Task Force
Medicaid Fee Schedules and Rates

Lisa D. Lee, Commissioner
Department for Medicaid Services

August 22, 2023

Kentucky Medicaid at a Glance

Approximately 1,660,700 members
(as of July 31, 2023)

Over 600,000 children – more than half of the children in Kentucky

614,000 expansion members
(as of July 31, 2023)

Over 69,000 enrolled providers

$16.8 billion in total SFY 2023 expenditures (administrative and benefits combined)

DIRECTED PAYMENTS

- Approximately 18% of Medicaid's benefit expenditures in SFY 2023 were related to directed payments. The following are the directed payments paid by each fiscal year:

	SFY 2020	SFY 2021	SFY 2022	SFY2023	Total
Hospital Rate Improvement Program (HRIP)	$98,359,000	$781,227,100	$1,145,677,000	$1,362,928,400	$3,388,191,500
Ambulance Provider Assessment Program (APAP)	$0	$26,248,700	$41,463,500	$46,704,700	$114,416,900
University Directed Payment	$831,091,500	$1,162,908,100	$1,490,850,400	$1,548,118,300	$5,032,968,300
Total Directed Payments	$929,450,500	$1,970,383,900	$2,677,990,900	$2,957,751,400	$8,535,576,700
% of Expenditures	7.8%	13.7%	18.0%	17.8%	

MEDICAID FEE SCHEDULES

Fee Schedules Published on DMS Website			
Fee Schedule Type	**Update Occurrence**	**Comparison to Medicare**	**Regulation**
Ambulatory Surgical Center (ASC)	Annually on 1/1	Based on Medicare Fee Schedule, with Cincinnati wage index adjustment	907 KAR 1:008
Audiology	Updated when new codes are added	Rates are based on Medicare or surrounding states	907 KAR 1:0039
Behavioral Health and Substance Abuse	Annually on 1/1	The rates are based on Medicare and are tiered with the highest getting 75% and then 63.75%, 60%, 52.5% and 37.5% of Kentucky Specific Medicare Physician Fee Schedule	907 KAR 15:015
Chiropractor	Updated when new codes are added	Rates are based on Medicare or surrounding states	907 KAR 3:125
Clinical Laboratory	Annually on 1/1	Reimbursed at 100% of Medicare	907 KAR 1:028
Dental	Updated when new codes are added	Rates are based on Medicare or surrounding states	907 KAR 1:626
Durable Medical Equipment (DME)	Updated when new codes are added annually on 1/1	Compares rate to Cures Codes and must reimburse at or below Medicare's lowest rate (Rural, Urban, Owensboro and Louisville)	907 KAR 1:479
Hospice	Updated every federal fiscal year on 10/1	Rates are calculated based on Medicare's hospice rates	907 KAR 1:340
Occupational, Physical, and Speech Therapy	Annually on 1/1	Rates are based on Medicare and are tiered with the Therapist getting 63.75% and Assistants getting 37.5% of Kentucky Specific Medicare Physician Fee Schedule	907 KAR 8:015 (OT) 907 KAR 8:025 (PT) 907 KAR 8:035 (ST)

MEDICAID FEE SCHEDULES

Fee Schedules Published on DMS Website			
Fee Schedule Type	**Update Occurrence**	**Comparison to Medicare**	**Regulation**
Physician	Updated when new codes are added annually on 1/1	Rates are based on Relative Value Units (RVU) values released from CMS. The RVU is multiplied by the dollar conversion ($29.67 for non-anesthesia $15.20 for non-delivery related anesthesia services) to obtain the Resource-Based Relative Value Scale (RBRVS)	907 KAR 3:010
Physician Administered Drug (PAD)	Updated Annually	Rates not listed	907 KAR 23:020
Private Duty Nursing	Updated when new codes are added	Not Regularly	907 KAR 13:015
Preventive Health	Updated when new codes are added	Not Regularly	907 KAR 1:360
Renal Dialysis Medicare Part B Drugs	Updated when new codes are added	Rates not listed	907 KAR 1:400
Transportation	Updated when new codes are added	Not Regularly	907 KAR 1:061
Vision	Updated when new codes are added	Rates are based on Medicare or surrounding states	907 KAR 1:632E

OTHER RATES (Non-Fee Schedule)

Other Medicaid Rates			
Fee Schedule Type	**Update Occurrence**	**Rate Methodology**	**Regulation**
Home and Community Based Waiver	A rate study is currently in processed	A rate study is currently in processed	907 KAR 7:015
Nursing Facilities	Quarterly with case mix index (CMI) updates and annually for inflation.	There are two base rates (urban and rural) based on a cost/market rate. Rates are scheduled to be rebased on 7/1/2024	907 KAR 1:065
Ventilator Nursing Facilities	Annually on 7/1	Initially cost based, which appears to have been set prior to SFY 2006.	907 KAR 1:025
Long-Term Care Cost-Based	Annually on 7/1 for all with some provider types receiving another update once desk reviews are finished.	All are cost based rates. State-owned Intermediate Care Facilities (ICFs) and Veterans Affairs Nursing Facilities (VANFs) are updated annually on 7/1, then receive cost settlement when desk reviews are finished. The Private ICFs, Institutions for Mental Disease (IMD), and Dually-Licensed Pediatric Facility (PED) rates are updated annually on 7/1 and again once desk reviews are finished	907 KAR 1:025; 907 KAR 18:005
Rural Health Clinic (RHC) & Federally-Qualified Health Center (FQHC)	Rates are established with new provider, change of ownership (CHOW), or change in scope, then updated annually for inflation	Prospective Payment System (PPS) rates based on cost reports, updated annually for inflation	907 KAR 1:055

OTHER RATES (Non-Fee Schedule)

Other Medicaid Rates			
Fee Schedule Type	**Update Occurrence**	**Rate Methodology**	**Regulation**
Community Mental Health Centers (CMHCs)	Fee-for-service (FFS) rate are updated annually on 7/1.	FFS rates are cost based and updated annually based on costs and inflation. Additionally, providers are cost settled annually when desk reviews are finished	907 KAR 1:045
Certified Community Behavioral Health Centers (CCBHCs)	Annually on 1/1 and recalculated rates at least every three years	PPS rates based on cost reports, updated annually for inflation	N/A - Federal Demonstration
Psychiatric Residential Treatment Facilities (PRTF) Level I	Every two years on 11/1 (next update 11/1/23)	Not Regularly	907 KAR 9:010
Psychiatric Residential Treatment Facilities (PRTF) Level II	None	Not Regularly	907 KAR 9:010

PROVIDER TAX SUMMARY

- States may generate their non-federal share (aka state share) of Medicaid expenditures through multiple sources, including health care-related taxes, sometimes referred to as provider taxes, fees, or assessments.
- These taxes are imposed on healthcare providers as:
  - A percentage of revenue (i.e. 5% of revenues)
  - Flat taxes (i.e. amount per facility bed or inpatient stay)
- State Medicaid programs utilize health care-related taxes to help accomplish various things:
  - To support Medicaid payment rates (most common)
  - To fund supplemental and/or directed payments

PROVIDER TAX - FEDERAL & STATE LEGISLATION

- Federal Legislation:
  - 42 CFR 433.55 Health care-related taxes defined
  - 42 CFR 433.56 Classes of health care services and providers defined
  - 42 CFR 433.68 Permissible health care-related taxes
  - 42 CFR 433.70 Limitation on level of FFP for revenues from health care-related taxes
  - 42 CFR 433.72 Waiver provisions applicable to health care-related taxes

- State Legislation:
  - KRS Chapter 142.301 thru 142.363

PROVIDER TAX – FEDERAL REQUIREMENTS

- Under 42 CFR 433.68, states may use health care-related taxes as a source of non-federal share of Medicaid if they meet all three of the following requirements:

  - **Broad based** – tax is imposed on all the non-governmental health care entities, items, and services within a class and throughout the jurisdiction of the applicable unit of government. (i.e. the tax cannot be exclusive to providers that treat a high proportion of Medicaid patients)

  - **Uniformly imposed** – A uniform tax applies consistently in amount and scope to the entities, items, and services to which it applies. (i.e. the tax rate cannot be higher on a provider's Medicaid revenue than on its non-Medicaid revenue)

  - **Does not hold taxpayers harmless** - Taxpayers cannot be given a direct or indirect guarantee that they will be repaid for all or a portion of the amount of taxes that they contribute.

PROVIDER TAX – FEDERAL REQUIREMENTS

- Under 42 CFR 433.56, there are 19 classes of services that are allowed to be utilized for a healthcare provider tax, as listed below:
    - Inpatient hospital services
    - Outpatient hospital services
    - Nursing facility services (other than services of intermediate care facilities for individuals with intellectual disabilities)
    - Intermediate care facility services for individuals with intellectual disabilities, and similar services furnished by community-based residences for individuals with intellectual disabilities, under a waiver under section 1915(c) of the Act, in a state in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/IIDs prior to the grant of the waiver
    - Physician services
    - Home health care services
    - Outpatient prescription drugs
    - Services of managed care organizations

PROVIDER TAX – FEDERAL REQUIREMENTS

- Continued service classes:
  - Ambulatory surgical center services (as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures)
  - Dental services
  - Podiatric services
  - Chiropractic services
  - Optometric/optician services
  - Psychological services
  - Therapist services (defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services)
  - Nursing services (defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses)

PROVIDER TAX – FEDERAL REQUIREMENTS

- Continued service classes:
  - Laboratory and x-ray services (defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department)
  - Emergency ambulance services
  - Other health care items or services not listed above on which the state has enacted a licensing or certification fee, subject to the following:
    - The fee must be broad based and uniform or the state must receive a waiver of these requirements
    - The payer of the fee cannot be held harmless; and
    - The aggregate amount of the fee cannot exceed the state's estimated cost of operating the licensing or certification program.

QUESTIONS?