Table of Contents

State/Territory Name: Kentucky

State Plan Amendment (SPA)#: 22-0006

This file contains the following documents in the order listed

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

June 28, 2023

Ms. Lisa Lee
Commissioner, Department for Medicaid Services
Commonwealth of Kentucky
Cabinet for Health and Human Services
275 East Main Street, 6 West A
Frankfort, KY 40601

Re: Kentucky State Plan Amendment (SPA) Transmittal Number 22-0006

Dear Commissioner Lee:

Enclosed please find a corrected approval package for your Kentucky State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0006. This SPA, implementing changes to hearing, vision and dental. was originally approved on June 23, 2023. The approval package sent to Kentucky included the following errors:

- The SPA package included the incorrect set of approved SPA pages.
- The 179 was updated with the correct listing of SPA pages.

The enclosed corrected package contains the original signed letter, the corrected CMS-179, and the corrected SPA pages.

If you have any questions, please contact Keri Toback at 312-353-1754 or via email at keri.toback@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures
cc: Erin Bickers, KY DMS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
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Medicaid and CHIP Operations Group

June 23, 2023

Ms. Lisa Lee
Commissioner, Department for Medicaid Services
Commonwealth of Kentucky
Cabinet for Health and Human Services
275 East Main Street, 6 West A
Frankfort, KY 40601

Re: Kentucky State Plan Amendment (SPA) Transmittal Number 22-0006

Dear Commissioner Lee:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0006. This amendment proposes to implement changes to the state plan language to extend services for the adult population in hearing, vision and dental.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations in 42 C.F.R 400.203. This letter is to inform you that KY Medicaid SPA 22-0006 was approved on June 13, 2023, with an effective date of January 1, 2023.

If you have any questions, please contact Keri Toback at 312-353-1754 or via email at keri.toback@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures
cc: Erin Bickers, KY DMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0006

2. STATE: KY

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1,2023

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. 400.203

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 23,451,525
b. FFY 2024 $ 31,268,700

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att. 3.1-A Page 3; Att. 3.1-A Page 5; Att. 3.1-A Page 7.4.1; Att. 3.1-A Page 7.5.3; Att. 3.1-B Page 3; Att. 3.1-B Page 4; Att. 3.1-B Page 27; Att. 3.1-B Page 31.2; Att. 4.19-B Page 20.6; Att. 4.19-B Page 20.7

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att. 3.1-A Page 3; Att. 3.1-A Page 5; Att. 3.1-A Page 7.4.1; Att. 3.1-A Page 7.5.3; Att. 3.1-B Page 3; Att. 3.1-B Page 4; Att. 3.1-B Page 27; Att. 3.1-B Page 31.2; Att. 4.19-B Page 20.6; Att. 4.19-B Page 20.7

9. SUBJECT OF AMENDMENT
The Kentucky Department for Medicaid Services is implementing changes to the state plan language to extend services for the adult population in hearing, vision and dental.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Lisa Lee

13. TITLE
Commissioner

14. DATE SUBMITTED
10-15-2022

15. RETURN TO
Lisa Lee
275 E. Main St.
Frankfort, KY 40601

FOR CMS USE ONLY

16. DATE RECEIVED
10/20/2022

17. DATE APPROVED
06/13/2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
01/01/2023

19. SIGNAT[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Commonwealth Global Choices

b. Optometrist services.

☐ Provided: ☐ No limitations ☐ With limitations* ☒ Not Provided.

c. Chiropractor services.

☒ Provided: ☐ No limitations ☒ With limitations* Not provided.

d. Other Practitioners' Services

☒ Provided: ☐ No limitations ☒ With limitations* ☐ Not provided.

7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in area.

☒ Provided: ☐ No limitations ☒ With limitations* ☐ Not provided.

b. Home health aide services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With limitations* ☐ Not provided.

c. Medical supplies, equipment, and appliances suitable for use in the home

☒ Provided: ☐ No limitations ☒ With limitations* ☐ Not provided.

*Description provided on attachment

AMOUNT, DURATION, SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVEDED TO THE CATEGORIACLLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations* ☐ Not Provided.

b. Dentures

☒ Provided: ☐ No limitations ☒ With limitations* ☐ Not provided.

c. prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations* ☐ Not Provided.

d. Eyeglasses

☒ Provided: ☐ No limitations ☒ With limitations* ☐ Not Provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☒ Provided: ☐ No limitations ☒ With limitations* ☐ Not Provided.

*Description provided on attachment.

10. Dental Services

A. Dental Services include the following:

- Preventative services include:
  - Prophylaxis (1 per 6 months per member, per provider), preventive resin restoration, application of caries arresting medicament (two times per tooth within six months).
- Restorations include:
  - Amalgam (once per tooth per 12 months per member), resin-based composite (once per tooth per 12 months per member), resin-based composite crown indirect (1 per 5 years), interim crown (1 per 5 years), re-cement or re-bond crown (1 per 5 years), prefabricated crowns (1 per 5 years), tooth pin retention (permanent molars only. 1 per tooth per date of service and 2 per lifetime per member), resin infiltration of lesion (2 per tooth per lifetime), implants (prior authorization required - once per tooth per lifetime), bridges (1 per 5 years).
- Endodontics
  - Root canal therapy (1 per tooth per lifetime), retreat root canal (1 per tooth per lifetime), apexification/recalcification (1 per tooth per lifetime), apicoectomy (1 per tooth per lifetime), retrograde filling (1 per tooth per lifetime).
- Diagnostic clinical oral examination
  - Periodic oral evaluation (1 per 6 months), comprehensive oral evaluation (1 per 12 months), detailed and extensive oral evaluation, re-evaluations, comprehensive periodontal evaluation.
- Diagnostic Imaging
  - Intraoral complete series (1 per 24 months), intraoral-periapical (14 per 12 months), bitewings (4 films per 12 months, panoramic film (1 per 12 months), cephalometric film (1 per 24 months).
- Emergent Services
  - Limited oral evaluation, palliative treatment of dental pain (1 per date of service)
- Surgical
  - Gingivectomy/gingivoplasty (requires prior authorization), crown lengthen hard tissue (1 per tooth/quadrant per lifetime), bone replacement graft (1 per site per lifetime), guided tissue regeneration (1 per 36 months), pedicle, autogenous, and soft tissue grafts (1 per area per lifetime), extractions including erupted or exposed tooth, impacted tooth, residual tooth roots, and coronal remnants (1 per lifetime per tooth), coronectomy (1 per lifetime per tooth), oroantral fistula closure, exposure of unerupted tooth, tooth re-implantation, alveoplasty, excision of benign soft tissue lesion, removal of lateral exostosis, removal of torus palatinus (1 per lifetime), incision & drainage of abscess, removal of foreign body, suture of recent small wound, buccal/labial frenectomy (2 per date of service), frenectomy (2 per date of service).
- Substance abuse counseling
  - Counseling for high-risk substance use related to oral health (1 per 6 months).
- Non-Surgical periodontal service
  - Periodontal scaling and root planning (requires prior authorization), full mouth debridement, localized delivery antimicrobial agents (prior authorization), periodontal maintenance procedures
- Maxillofacial Prosthetics
  - Nasal prosthesis, auricular prosthesis, facial prosthesis, obturator (temporary and permanent), mandibular resection prosthesis, speech aid prosthesis, palatal augmentation prosthesis, palatal lift prosthesis, oral surgical splint, and other medically necessary maxillofacial prosthetic procedures.
- Temporomandibular Joint Dysfunctions Management
  - Occlusal orthotic device (requires prior authorization, 1 per lifetime)
- Anesthesia and Sedation
  - Deep sedation/general anesthesia (maximum of four times per date of service), analgesia intravenous moderate (conscious) sedation/analgesia, non-intravenous (conscious) sedation
- Dental Visits
  - Dental visits may be provided in extended care facilities when medically necessary.
- Miscellaneous Services
  - Occlusal guard - hard appliance, full and partial arch (1 per 2 years), occlusal guard - soft appliance, full arch (1 per 2 years), unscheduled dressing change, splint intra and extra-coronal

B. Out-of-Hospital Dental Services

Oral and maxillofacial surgeries performed in outpatient hospital, ambulatory surgical centers, qualified oral surgeon office/facility may be covered based on medical necessity, and prior authorizations as required.

C. In-Hospital Care

In-hospital care for oral surgery and maxillofacial surgery for adults is only covered for medical emergencies when medically necessary.

Limits may be exceeded based upon emergencies and medical necessity with prior authorization and DMS review

Commonwealth Global Choices

B. Dentures

(1) Partial and full dentures is limited to 1 per 5 years.
   a. Children under 21 may receive coverage for additional dentures if medically necessary due to growth with prior authorization.
(2) Immediate placement of temporary dentures is covered.
(3) Adjustment and relining of dentures are covered once per 12 months.
(4) Replacement of dentures due to broken base is covered for mandibular and maxillary 1 each per 12 months.
(5) Repair of broken or missing teeth on dentures is covered 1 per tooth per 12 months.
(6) Repair or replace broken retentive clasping material is covered 1 per tooth per 12 months.

C. Prosthetics

Prosthetic devices are covered based on medical necessity with an approved prior authorization.

D. Eyeglasses and contact lenses are covered for adults and children. Recipients may choose either glasses or contacts lens per year, not both

(1) Eyeglasses are provided 1 per year per member.
   a. An additional 1 pair of glasses is covered for lost, stolen, or broken glasses with prior authorization.
   b. Bifocal, multifocal, and progressive lens is covered.
   c. Scratch resistant, UV and anti-reflective coating is covered.
(2) Contact lenses are provided to children and adults. 2 contact lens (1 per eye) per year.
(3) Telephone contacts are not covered.
(4) If medically necessary, prisms shall be added within the cost of the lenses.

If medical necessity is established, these items do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

Denture and eyeglass limits may be exceeded based upon emergencies and medical necessity with prior authorization.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

Commonwealth Global Choices

6. Medical care and any other type of remedial care recognized under State Law, furnished by licensed practitioners within the scope of their practice as defined by State Law.

a. Podiatrist services.

☒	Provided:	☐	No limitations	☒	With Limitations*	☐	Not provided

b. Optometrists' services.

☐	Provided:	☐	No limitations	☐	With Limitations*	☒	Not provided

c. Chiropractic' services.

☒	Provided:	☐	No limitations	☒	With Limitations*	☐	Not provided

d. Other Practitioners' Services

☒	Provided:	☐	No limitations	☒	With Limitations*	☐	Not provided

7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in area.

☒	Provided:	☐	No limitations	☒	With Limitations*	☐	Not provided

b. Home health aide services provided by a home health agency.

☒	Provided:	☐	No limitations	☒	With Limitations*	☐	Not provided

c. Medical supplies, equipment, and appliances suitable for use in the home

☒	Provided:	☐	No limitations	☒	With Limitations*	☐	Not provided

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒	Provided:	☐	No limitations	☒	With Limitations*	☐	Not provided

*Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

8. Private duty nursing services.

☒ Provided: ☐ No limitations ☒ With limitations*

9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations*

10. Dental services.

☒ Provided: ☐ No limitations ☒ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Occupational therapy.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

☒ Provided: ☐ No limitations ☒ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Dentures.

☐ ☒ Provided: ☐ No limitations ☐ ☒ With limitations*

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10. Dental Services

A. Dental Services include the following:

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Commonwealth Global Choices

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(3) Telephone contacts are not covered.
(4) If medically necessary, prisms shall be added within the cost of the lenses.

If medical necessity is established, these items do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

Denture and eyeglass limits may be exceeded based upon emergencies and medical necessity with prior authorization.

III. Dental Services

A. Definitions.

For purposes of determination of payment usual and customary actual billed charge refers to the uniform amount the individual dentist charges in the majority of cases for a specific dental procedure or service.

"Dental School Faculty Dentist" is a dentist who is employed by a state-supported school of dentistry.

B. Reimbursement for Outpatient and Inpatient Services.

(1) The department shall reimburse participating dentists for covered services provided to eligible Medicaid recipients at the dentist's actual billed charge not to exceed the fixed upper limit per procedure established by the department.

(2) With the exceptions specified in section (3), (4), (5), and (8) the upper payment limit per procedure shall be established by increasing the limit in effect on 9/30/00 by 32.78%, rounded to the nearest dollar. This rate of increase is based upon an allocation of funds by the 2000 Kentucky General Assembly and a comparison to rates of other states based upon a survey of Dental Fees by the American Dental Association. The DMS fee schedule rate was set as of October 31, 2008 and is effective for services provided on or after that date. All rates are published on the DMS website http://www.chfs.ky.gov/dms/fee.htm.

(3) If an upper payment limit is not established for a covered dental service in accordance with (2) above, the department shall establish an upper limit by the following:

a. The state will obtain no less than three (3) rates from other sources such as Medicare, Workmen's Compensation, private insurers or three (3) high volume Medicaid providers:
b. An average limit based upon these rates will be calculated; and
c. The calculated limit will be compared to rates for similar procedures to assure consistency with reimbursement for comparable services.

(4) The following reimbursement shall apply:

a. Orthodontic Consultation, $112.00, except that a fixed fee of $56.00 shall be paid if:

1. The provider is referring a recipient to a medical specialist;
2. The prior authorization for orthodontic services is not approved; or
3. A request for prior authorization for orthodontic services is not made.

b. Prior authorized early phase orthodontic services for moderately severe disabling malocclusions, $1,367 for orthodontists and $1,234 for general dentists.

c. Prior authorized orthodontic services for moderately severe disabling malocclusions, *$1,825* for orthodontists and $1,649 for general dentists.

d. Prior authorized orthodontic services for severe disabling malocclusions, $3000 for orthodontists and $2674 for general dentists.
e. Prior authorized services for Temporomandibular Joint (TMJ) therapy, an assessed rate per service not to exceed $424.

(5) This reimbursement methodology does not apply to oral surgeons' services that are included within the scope of their licenses. Those services are reimbursed in accordance with the reimbursement methodology for physician services.

(6) Medicaid reimbursement shall be made for medically necessary dental services provided in an inpatient or outpatient setting if:

a. The recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if provided in a dentist's office; and

b. In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in an inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.

(7) Supplemental payments will be made in addition to payments otherwise provided under the state plan to practice plans whose dentists 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, dentists in the practice plan must meet the following criteria:

i. Be Kentucky licensed dentists;

ii. Be enrolled as Kentucky Medicaid providers; and

iii. Be members of a practice plan under contract to provide professional services at a state-owned academic medical center as determined by the Department.

b. For practice plans qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between Medicaid payments otherwise made to these practice plans and the average rate paid for the services by commercial insurers. The average commercial rates are determined by:

i. Calculating a commercial payment to charge ratio for all services paid to the eligible providers by commercial insurers using the providers' claims-specific data from the most currently available fiscal year;

ii. Multiplying the Medicaid charges by the commercial payment to charge ratio to establish the estimated commercial payments to be made for these services; and

iii. Subtracting the interim Medicaid payments already made for these services to establish the supplemental payment amount.

c. Practice plans eligible 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 on a quarterly basis or as determined by the Department.

(8) The upper payment limit per procedure for a recipient under age twenty-one (21) shall be established by increasing the limit in effect on 9/30/07 by 30%, rounded to the nearest dollar. The 30% limit increase applied to all dental procedure codes, except dental procedure codes D2951, D0150, D0140, D0330, D1520, D1525, shall not be adjusted from the limit in effect on 9/30/07. The DMS fee schedule rate was set as of October 31, 2008 and is effective for services provided on or after that date. All rates are published on the DMS website http://www.chfs.ky.gov/dms/fee.htm