

**KANSAS MEDICAID STATE PLAN**

Attachment 4.19-B

Page 1

## Methods and Standards for Establishing Payment Rates

The 4% Medicaid reduction implemented on July 1, 2016 is restored with dates of services August 18, 2017. Established fee amounts are the same for governmental and private providers. The payment restoration is applied to the net Medicaid paid amount after reductions for Medicare, other insurance, or any other third party liability payment.

Specific Services Impacted by this SPA:

Outpatient Hospital Services (Attachment 4.19-B, #1, Replacement Page and Page 1a)  
 Physician's Services (Attachment 4.19-B, #5)  
 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Attachment 4.19-B, #4b, and Page 2)  
 Outpatient Services (Attachment 4.19-B, #5, Page 1)  
 Physicians' Services Obstetrical Practitioner Services (Attachment 4.19-B, #5, Page 2)  
 Physicians' Services Pediatric Practitioner Services (Attachment 4.19-B, #5, Page 3)  
 Physicians' Services (Attachment 4.19-B, #5, Page 4)  
 Dental Services (Attachment 4.19-B, #10)  
 Freestanding Birth Centers (Attachment 4.19-B, #8)  
 Nurse-Midwife Services (Attachment 4.19-B, #17)  
 Optometrist's Services (Attachment 4.19-B, #6b)  
 Chiropractor's Services (Attachment 4.19-B, #6c)  
 Other Practitioner's Services (Attachment 4.19-B, #6d)  
 Clinic Services (Attachment 4.19-B, #9)  
 Prosthetic Devices (Attachment 4.19-B, Page #12c.)  
 Eyeglasses (Attachment 4.19-B, Page #12d.)  
 Physical Therapy, Occupational Therapy, Speech, Hearing, and Language Disorders (Attachment 4.19-B, Page #11a, b and c)  
 Dentures (Attachment 4.19-B, #12b)  
 Rehabilitation Services (Attachment 4.19-B, #13d, Page 1)  
 Home Health Services (Attachment 4.19-B, #7)  
 Other Laboratory and X-ray Services (Attachment 4.19-B, #3)  
 Emergency Hospital Services (Attachment 4.19-B, #23e)  
 Pediatric or Family Nurse Practitioner's Services (Attachment 4.19-B, #24)  
 Transportation (Attachment 4.19-B, #24.a.)  
 Targeted Case Management/MH, MR/DD, TBI, PD and FE (Attachment 4.19-B, #6.a.)  
 Inpatient Hospital Care (Attachment 4.19-A, Page 25c (1), Page 29, Page 31, Page 31a and Page 37)

In general, the following should be noted concerning the Kansas Medicaid fee schedules:

**Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's established fee schedule rates are published on the agency's website at <https://www.kmap-state-ks.us>.**

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### Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

### Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

### Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19(A)

       Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

### Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 (B).

  X   Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

       Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physicians services) of the plan:

Effective January 6, 2012 reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

No payment shall be made for services for Other Provider Preventable Conditions (OPPCs). OPPC is one category of Provider Preventable Conditions (PPC), as identified by the Centers for Medicare & Medicaid Services, and applies broadly to any health care setting where an OPPC may occur. OPPCs include the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

TN No. KS #11-16 Approval Date **SEP 18 2012** Effective Date 01/06/12 Supersedes TN# New

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No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

- i. The identified provider-preventable conditions would otherwise result in an increase in payment.
- ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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#1

## Outpatient Hospital Services Methods and Standards for Establishing Payment Rates

Payments to general and special hospitals for outpatient hospital services are based on the reimbursement methodologies for comparable services rendered by non-hospital providers.

Effective January 1, 2021 and thereafter, cardiac catheterization reimbursement rates are set at 80% of non-rural Medicare rates as set on January 1 of each year.

Effective April 1, 2021 and thereafter, Outpatient therapeutic phlebotomy reimbursement rates are set at 85% of non-rural Medicare rates. These rates will also change on January 1 of each year following this date as the non-rural Medicare rates change.

Effective January 1, 2022, additional varicose vein treatment modalities reimbursement rates have been added to the plan.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of August 1, 2024 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp>

When the user is on the landing page of the above link, select the link Download Fee Schedules. This link will take the user to a page titled "Reference Copyright Notice." Scroll to the bottom of the page and click on the word "Accept" to access the fee schedule. The next page that appears is titled "KMAP Fee Schedules."

To access a fee schedule:

- a. Select the program from the drop-down list -TXIX;
- b. Choose the type of rates – Medicaid;
- c. After choosing the rate type, the user will see a list of the current and historical versions of the corresponding schedule;
- d. Click the schedule TXIX.

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## Methods and Standards for Establishing Payment Rates

### Outpatient Services

Effective February 8, 2008, claims for outpatient hospital services provided at a Large Public Kansas Teaching Hospital, as defined in Attachment 4.19-A, will be reimbursed based on a reasonable cost methodology. Reasonable cost is determined using Medicare principles by applying a cost-to-charge ratio derived from the latest audited Medicare cost report to Medicaid claims data.

TN # 08-02 Approval Date SEP 16 2008 Effective Date 02/08/08 Supersedes TN # New

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## Methods & Standards for Establishing Payment Rates

### Rural Health Clinics

Effective January 1, 2001, rural health clinics enrolled in the Kansas Medicaid Program shall be reimbursed for covered services furnished to eligible beneficiaries under a prospective payment system (PPS) in accordance with the requirements of section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. An alternative payment system that assures the amount determined under the Medicaid PPS mandated by BIPA as minimum reimbursement, will also be available to providers at their option. An RHC will be reimbursed at the greater rate between the PPS rate and the alternative methodology rate. Under both options, reimbursement for services covered by Medicare shall be made through an all-inclusive encounter rate determined by the Medicare intermediary for each qualified encounter.

When a rural health clinic furnishes “other ambulatory services”, the Kansas Medicaid Program shall reimburse the provider using the methodologies utilized in paying for same services in other settings, provided all the requirements under the state plan are met. “Other ambulatory services” are those services which do not meet the Medicare definition of rural health clinic services but are covered under the Medicaid state plan.

#### I. ENCOUNTER BILLING

##### A. Billable Visit or Encounter

A rural health clinic “visit” means a face-to-face encounter between a clinic patient and a clinic health care professional including a physician, optometrist, physician assistant (PA), advanced practice registered nurse (APRN), nurse-midwife, clinical psychologist, clinical social worker, Marriage and Family Therapists (MFTs), Mental Health Counselors (MHCs), and for Kan-Be-Healthy nursing assessments only, registered nurse. This may also include a visiting nurse provided all the conditions listed in I(D)(4) are fulfilled. Encounters with more than one certified health care professional or multiple encounters with the same health professional on the same day shall constitute a single visit.

##### B. More Than One Encounter on the Same Day

If the patient suffers illness or injury subsequent to the first visit on the same day, requiring additional diagnosis and treatment which are different from the first visit, the second encounter will qualify as an additional RHC visit.

**Methods & Standards for Establishing Payment Rates****Rural Health Clinics****C. Health Care Professional Requirements**

For services to be covered, the practitioner should either be an employee or an owner of the rural health clinic. A physician under contractual arrangement to receive compensation from the RHC also qualifies. The RN that performs KBH nursing assessments must be an employee of the RHC.

**D. Place of Service Criteria**

1. **Services at the Clinic:** Covered services provided at the clinic facility by practitioners defined in I(A) & I(B), excluding visiting nurse, may be billed as RHC visits. Services performed in the clinic are payable only to the clinic. Practitioners may not bill for these services under any other Medicaid provider number.
2. **Services Away from the Clinic:** Covered services provided at the patient's place of residence or elsewhere (e.g., at the scene of an accident) by an RHC practitioners excluding visiting nurse may be billed as a visit only if the practitioner is employed or compensated under agreement by the clinic for furnishing services to clinic patients in a location other than the clinic facility. These services are payable only to the RHC. The practitioner may not bill Medicaid for these services under any other provider number. If, on the other hand, the practitioner is NOT compensated by the RHC for provision of services in a location away from the clinic facility, services provided away from the clinic shall not constitute RHC services and the practitioner may bill Medicaid under a professional provider number. However, if these services are furnished during a time period for which he/she is compensated by the RHC, the clinic is required to carve out all expenditure associated with those services on the cost report.
3. **Services in a Hospital:** Services provided by a clinic practitioner in outpatient, inpatient, or emergency room of a hospital or swing-bed do not constitute RHC services under the Kansas Medicaid Program. These services may be billed under the practitioner's professional Medicaid provider number. However, if these services are provided by a clinic practitioner during time period for which he/she is compensated by the RHC, the clinic must carve out all expenditure associated with these services on the cost report.
4. **Visiting Nurse Services:** Part time or intermittent nursing care provided in a patient's place of residence may be billed as an encounter only if each of the following requirements is fulfilled:

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**Rural Health Clinics**

- (i) The RHC is located in an area designated by the Secretary of Health and Human Services as an area with a shortage of home health agencies;
- (ii) the services are rendered to a homebound patient who is confined, either temporarily or permanently, to his or her place of residence as a result of a medical or health condition;
- (iii) the “place of residence” may be a private home, a home for the aged, or other type of institution as long as it is NOT a hospital, long term facility, or skilled nursing facility (SNF) which is required to provide nursing care, rehabilitation, and other related services to inpatients as a condition for participation in Medicare & Medicaid SNF programs;
- (iv) the services are furnished by a registered nurse (RN) or a licensed practical nurse (LPN) who is employed by or receives compensation from the RHC for providing these services;
- (v) the services are furnished under a written plan of treatment established by a supervising physician, ARNP, or PA of the clinic. The treatment plan is:
  - reviewed at least every 60 days by a supervising physician, and
  - signed by a supervising physician, ARNP, or PA of the clinic;
- (vi) the services consist of:
  - nursing care that must be performed by an RN or LPN to assure the safety of the patient and to achieve the medically desired results; and
  - personal care services to the extent covered under home health services. This does not include household & housekeeping services.

**E. Content-of-Service**

Content-of-service is a service or supply which does not constitute a billable encounter by itself, but its cost is included in the encounter rate. These should neither be billed as RHC encounter nor as a service under any other Medicaid provider number. Examples of services that are content-of-service:

1. Services furnished by the auxiliary health care staff employed by the clinic that are “incident to” the services provided by the certified health care professionals.
2. Administration of vaccine, immunization, or other injection.
3. Professional component of Radiology or EKG if performed by a clinic health care professional.
4. Drugs and biologicals which cannot be self-administered.

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**Rural Health Clinics**

**F. Exclusions**

Services & supplies, both direct and indirect, not related to patient care and not reasonable & necessary for the efficient delivery of health care services for diagnosis & treatment of clinic patients are not covered. These should neither be billed as RHC visits nor reported on the cost report as allowable RHC expenditure. In addition, the following are not covered as RHC benefit:

1. All services furnished by the auxiliary health care staff who are not employed by the clinic.
2. Services provided by the RHC's auxiliary health care employees without direct supervision of a clinic practitioner.
3. Technical components of Radiology and EKG.
4. Clinic diagnostic laboratory services including the six required lab tests for RHC certification.
5. Health care services performed by outside entities, including those entities which are owned by the clinic's owner or staff. These include but are not limited to Lab, Radiology, EKG, pharmacy, PT, and psychotherapy. The state plan requires that providers of these services bill Medicaid directly.

**II. REIMBURSEMENT METHODS**

Effective January 1, 2001, the Kansas Medicaid Program will implement the prospective payment system (PPS) for rural health clinics to conform with BIPA 2000. There will be no retroactive cost settlements under this system. Effective January 1, 2013 as an alternative to the PPS, providers will be offered the opportunity for reimbursement under a Alternative Prospective Payment System (APPS) that will be calculated based on the two most recent facility final cost reports of 2008, 2009 or 2010. The RHCs will be reimbursed at the higher rate of PPS rate or APPS rate.

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### Methods & Standards for Establishing Payment Rates

#### Rural Health Clinics

##### A. Definitions

1. **Rate** – Payment for each qualified encounter or visit.
2. **Base Years or FY 1 & FY 2 – Current Providers** – Facility fiscal years 1999 and 2000.
3. **Base Years or FY 1 & FY 2 – New Providers** – Two facility fiscal years subsequent to the first year of business as a rural health clinic.
4. **Cost-Based Rate or Payment** – Based on the Medicare cost report.
5. **Baseline Rate** – Average of cost-based rates from the base years.
6. **MEI** – Percentage increase in the Medicare Economic Index for primary care services.
7. **PPS Rate or Payment** – Meets PPS requirements outlined in the BIPA 2000.
8. **Non-PPS Rate or Payment** – Does not meet BIPA requirements.
9. **Preliminary** – Derives from the Medicare cost report for only one base year.
10. **Final or Finalized** – Derived from Medicare cost reports for both base years.
11. **Re-Base Years or RFY1 and RFY2 – Current Providers** – Two latest facility fiscal years of 2008, 2009, or 2010 where final Medicare cost reports were submitted.
12. **Re-Base Years or RFY1 and RFY2 – New Providers** – Two facility fiscal years subsequent to the first year of business as a rural health clinic.

##### B. Cost Reports

RHC providers shall be required to submit cost reports to Medicaid. The providers will submit to the agency finalized cost reports received from Medicare intermediaries.

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### Rural Health Clinics

#### III. PROSPECTIVE PAYMENT SYSTEM (PPS)

Under this methodology, rural health clinics shall be paid prospective rates based on an average of the reasonable costs of providing covered RHC services during the base years, with no retroactive settlement.

##### A. Determination of PPS Baseline Rate

1. **Methodology** - It will depend on the times frames covered by an availability of cost reports as follows:
  - (i) Both Base Years Full Twelve-Month Periods: (FY 1 Cost-Based Rate + FY 2 Cost-Based Rate) /2.
  - (ii) One or Both Base Years Less Than Twelve-Month Periods:  
[(FY 1 Cost-Based Rate x No. of Mo.)+(FY 2 Cost-Based Rate x No. of Mo.)] / Total No. of Months
  - (iii) Only One Base Year Cost Report Available: Cost-based rate derived from the available cost report.
  - (iv) No Base Year Cost Report Available: The lower of current rate (eff. On 12/31/2000) or average of baseline rates of other RHCs in the same Metropolitan Statistical Area (MSA) as defined by Department of Commerce.
2. **Frequency** - Once if the "final" rate is available at the time of initial rate setting, otherwise twice:
  - (i) Initial Baseline Rate: After the approval of the SPA (for current providers) or at the time of enrollment (for new providers). This rate can be "preliminary" or "final" depending on the availability of cost reports.
  - (ii) Final Baseline Rate: When Medicare cost reports for both base years become available.

##### B. Payment Procedure for January 1, 2001 to September 30, 2001

1. Prior to approval of this state plan, Medicaid has continued to pay interim rates effective 12/31/2000.
2. Upon SPA approval, initial PPS baseline rates will be computed using Medicare cost reports for facility fiscal years 1999 and 2000 received in our office before July 1, 2001.

TN # MS 02-07 Approval Date JUN 29 2001 Effective Date 01/01/02 Supersedes TN # 01-04

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#### **Rural Health Clinics**

3. Interim payments will be reconciled to the initial baseline rates retroactive to January 1, 2001.
4. In cases where the initial baseline rate is “preliminary”, interim payments will again be retroactively reconciled to the “final” baseline rate when it becomes available.

#### **C. Payment Procedure for October 1, 2001 to September 30, 2002**

1. PPS baseline rates effective on September 30, 2001 times the MEI index will be set as payment rates.
2. In cases where the baseline rate is preliminary”, when the “final” baseline rate becomes available it will be adjust by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payment will be retroactively reconciled to the finalized rate.

- #### **D.**
1. The PPS rates effective on the previous day (9/30 of the same year) shall be adjusted by the MEI index.
  2. In cases where the baseline rate used for this rate setting is “preliminary”, when the “final” baseline rate becomes available it will be adjusted by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.

#### **E. Baseline Rate for New Providers**

1. **If Historic Cost Reports Are Available:** If the facility is an established RHC, cost-based rates from Medicare cost reports from the two most recent fiscal years will be used to determine the initial PPS baseline rate. If it is available only from one fiscal year, that will be used for rate setting, provided it is at least a twelve-month period. Data covering the first year of business as a RHC will be excluded.
2. **If No Historic Cost Reports Are Available:** The payment rate shall be the average of the rates paid to other RHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce.

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**F. Adjustment for Laboratory**

Effective July 1, 2002, clinical diagnostic lab services furnished by a clinic are no longer within the scope of RHC services under the Kansas Medicaid Program. An RHC that provides this service will be reimbursed on fee-for-service basis. Medicare implemented this change effective January 1, 2001. KDHE will retroactively adjust PPS rates effective 7/1/02 to exclude all expenses associated with laboratory services after receiving relevant date that facilitates identification of these expenditures.

**G. Long Acting Reversible Contraceptives (LARC)**

Effective February 27, 2018, LARCs insertion and removal visits will be paid at the RHC PPS encounter rate. The devices will be reimbursed as outlined on Attachment 4.19-B #12.a., Prescribed Drugs, Methods and Standards for Establishing Payment Rates, Physician Administered Drugs (PADS).

**H. Hospice Care – Attending Physician Services**

Effective January 1, 2022, an RHC can bill and receive payment under the RHC Prospective Payment System (PPS) when a designated attending physician employed by or working under contract with the RHC furnishes hospice attending physician services (as described in section 1812(d)(2)(A)(ii) of the Act) during a patient’s hospice election.

**I. Change in Scope of Services**

To receive a PPS rate adjusted for a proposed increase or decrease in the scope of covered RHC services in a future fiscal year as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. At a minimum, this shall include a description of the change, budgeted expenditures, and change in total number of visits. Any rate change would be implemented on the first of the month following the KDHE decision.

**IV. ALTERNATIVE PAYMENT METHODOLOGY – “REBASED PROSPECTIVE PAYMENT SYSTEM” (RPPS)**

Under this methodology, RHCs shall be paid RPPS rates based on an average of the reasonable costs of providing covered RHC services during the base years, with no retroactive settlement.

**A. Determination of RPPS Rate**

1. Methodology – Determined by two most recent available cost reports of 2008, 2009, or 2010, as follows:
  - (i) Two Re-Base Years full Twelve-Month Periods:  $(\text{RFY1 Cost-Based Rate} + \text{RFY2 Cost-Based Rate})/2$  and applied a trended MEI factor.

**B. Payment Procedure for January 1, 2013 to September 30, 2013.**

1. Prior to approval of this state plan, Medicaid has paid the RPPS rates calculated in IV.A.1.

**C. Payment Rate Effective Each October 1 After September 30, 2013**

1. The RPPS rates effective on the previous day (9/30 of the same year) shall be adjusted for the MEI index.

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**D. Baseline Rate for New Providers**

1. **If Historic Cost Reports Are Available:** If the facility is an established RHC, cost-based rates from Medicare cost reports from the two most recent fiscal years will be used to determine the initial PPS baseline rate. If it is available only from one fiscal year, that will be used for rate setting, provided it is at least a twelve month period. Data covering the first year of business as a RHC will be excluded.
2. **If No Historic Cost Reports Are Available:** The payment rate shall be the average of the rates paid to other RHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce.

**E. Change in Scope of Services**

To receive a APPS rate adjusted for a proposed increase or decrease in the scope of covered RHC services in a future fiscal year as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. At a minimum, this shall include a description of the change, budgeted expenditure, and change in total number of visits. In addition to change of scope, clinics will have the opportunity to submit a request to increase the APPS rate if costs exceed the APPS rate by 15% or more. Again, documentation must be provided to determine the case for reconsideration of the APPS rate. Any rate change would be implemented on the first of the month following the KDHE decision.

Revised Submission

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**V. SERVICES FURNISHED UNDER CONTRACT WITH MANAGED CARE ORGANIZATIONS (MCOs)**

MCOs must reimburse providers using the higher rate between the PPS rate and the APPS rate. APPS rates will be re-evaluated at least every 5 years.

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(Reserved for future use)

TN #KS 13-07 Approval Date JUN 24 2013 Effective Date 03/15/13 Supersedes TN #02-07

**Methods & Standards for Establishing Payment Rates****Federally Qualified Health Centers**

Effective January 1, 2001, federally qualified health centers enrolled in the Kansas Medicaid Program shall be reimbursed for covered services furnished to eligible beneficiaries under a prospective payment system (PPS) in accordance with the requirements of section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. An alternative payment system that assures the amount determined under the Medicaid PPS mandated by BIPA as minimum reimbursement, will also be available to providers at their option. An FQHC shall be reimbursed at the greater rate between the PPS rate and the alternative methodology rate. Under both options, reimbursement for services covered by Medicare plus dental services shall be made through an all-inclusive encounter rate determined by the agency for each qualified visit.

When a federally qualified health center furnishes “other ambulatory services” excluding dental services, the Kansas Medicaid Program shall reimburse the provider using the methodologies utilized in paying for same services in other settings, provided all requirements under the state plan are met. “Other ambulatory services” are those which do not meet the Medicare definition of federally qualified health center services but are covered under the Medicaid state plan.

**I. ENCOUNTER BILLING**

The federally qualified health center program under the Kansas Medicaid Program complies with scope, definitions, criteria, and basis of payment for FQHC services under Medicare set forth in 42 CFR Part 405.2411 and 405.2446 through 405.2452, and Publication 27. In addition, Medicaid covers certain preventative services.

**A. Billable Visit or Encounter**

A federally qualified health center “visit” means a face-to-face encounter between a center patient and a center health care professional including a physician, optometrist, physician assistant (PA), advanced practice registered nurse (APRN), nurse-midwife, dentist, dental hygienist with an “Extended Care Permit” per the Kansas Dental Practice Act, clinical psychologist, clinical social worker, Marriage and Family Therapists (MFTs), Mental Health Counselors (MHCs), and for Kan-Be-Healthy nursing assessments only, registered nurse. This may also include a visiting nurse provided all the conditions listed in I(D)(4) are fulfilled. Encounters with more than one certified health professional or multiple encounters with the same practitioner on the same day shall constitute a single visit.

**B. More Than One Encounter on the Same Day**

1. If the patient suffers illness or injury subsequent to the first visit on the same day, requiring additional diagnosis and treatment which are different from the first visit, the second encounter will qualify as an additional FQHC visit.
2. If the patient has a different type of visit on the same day such as a dental visit or a medical visit.

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## Methods & Standards for Establishing Payment Rates

### Federally Qualified Health Centers

#### C. Health Care Professional Requirements

For services to be covered, the practitioner should be employed by, under arrangement to receive compensation from, or an owner of the FQHC. The RN that performs KBH nursing assessments must be an employee of the FQHC.

#### D. Place of Service Criteria

1. **Services at the Center:** Covered services provided at the center facility by practitioners defined in I(A) & I(B), excluding visiting nurse, may be billed as FQHC visits. Services performed in the center are payable only to the center. Practitioners may not bill for these services under any other Medicaid provider number.
2. **Services Away from the Center:** Covered services provided at the patient's place of residence, in a residential facility, nursing facility, intermediate care facility, or elsewhere (e.g., at the scene of an accident) by an FQHC practitioner excluding visiting nurse may be billed as a visit only if the practitioner is employed or in a location other than the center facility. These services are payable only to the center. The practitioner may not bill Medicaid for these services under any other provider number. If, on the other hand, the practitioner is NOT compensated by the FQHC for provision of services in a location away from the center facility, services provided away from the center shall not constitute FQHC services and the practitioner may bill Medicaid under a professional provider number. However, if these services are furnished during a time period for which he/she is compensated by the FQHC, the center is required to carve out all expenditure associated with these services on the cost report.
3. **Services in a Hospital:** Services provided by a center practitioner in outpatient, inpatient, or emergency room of a hospital do not constitute FQHC services under the Kansas Medicaid Program. These services may be billed under the practitioner's professional Medicaid provider number. However, if these services are provided by a center practitioner during a time period for which he/she is compensated by the FQHC, the center must carve out all expenditure associated with these services on the cost report. Services furnished to Skilled Nursing Facility residents and swing-bed Skilled Nursing Facility patients may be billed as an FQHC service.
4. **Visiting Nurse Services:** Part time or intermittent nursing care provided in a patient's place of residence may be billed as an encounter only if each of the following requirements is fulfilled:

- (i) The FQHC is located in an area designated by the Secretary of Health and Human Services as an area with a shortage of home health agencies;

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### **Federally Qualified Health Centers**

- (ii) the services are rendered to a patient who is confined, either temporarily or permanently, to his or her place of residence as a result of a medical or health condition;
- (iii) the "place of residence" may be a private home, a home for the aged, or other type of institution as long as it is NOT a hospital or a long term facility;
- (iv) the services are furnished by a registered nurse (RN) or licensed practical nurse (LPN) who is employed by or receives compensation for providing these services from the FQHC;
- (v) the services are furnished under a written plan of treatment established by a supervising physician, ARNP, or PA of the center which is
  - reviewed at least every 60 days by a supervising physician, and
  - signed by a supervising physician, ARNP, or PA of the center;
- (vi) the services consist of:
  - nursing care that must be performed by an RN or LPN to assure the safety of the patient and to achieve the medically desired results; and
  - personal care services to the extent covered under home health services.

This does not include household and housekeeping services.

### **E. Content-of-Service**

Content-of-service is a service or supply which does not constitute a billable encounter by itself, but its cost is included in the encounter rate. These should neither be billed as an FQHC encounter nor as a service under any other Medicaid provider number. Examples of services that are content-of-service:

1. Services furnished by the auxiliary health care staff employed by the center that are "incident to" the services provided by the certified health care professionals.
2. Administration of vaccine, immunization, or other injection.
3. Professional component of Radiology or EKG if performed by a center health care professional.
4. Drugs and biologicals which cannot be self-administered.

### **F. Exclusions**

Services & supplies, both direct and indirect, not related to patient care and not reasonable & necessary for the efficient delivery of health care services for diagnosis &

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treatment of center patients are not covered. These should neither be billed as FQHC visits nor reported on the cost report as allowable FQHC expenditure. In addition, the following are not covered as FQHC benefit:

1. All services furnished by the auxiliary health care staff who are not employed by the center.
2. Services provided by the FQHC's auxiliary health care employees without direct supervision of a center practitioner.
3. Technical components of Radiology and EKG.
4. Clinical diagnostic laboratory services.
5. Health care services **performed by** outside entities, including those entities which are owned by the center's owner(s) or staff. These include but are not limited to Lab, Radiology, EKG, Pharmacy, PT, and psychotherapy. The State Plan requires that providers of these services bill Medicaid directly.

**G. Preventative Services**

1. Preventive primary services must be furnished by or under the direct supervision of a physician, a nurse practitioner, a physician assistant, certified nurse midwife, clinical psychologist, or a clinical social worker.
2. Preventive primary services must be furnished by a member of the center's health care staff who is an employee of the center or by a physician under arrangements with the center.
3. Preventive primary services include only drugs and biologicals that are not usually self-administered, unless §1861(s) of the Act provides for coverage of the drug irrespective of whether it is self-administered.
4. The following preventive primary services may be covered and billed to the intermediary when provided by FQHCs to Medicaid beneficiaries:
  - i. Medical social services;
  - ii. Nutritional assessment and referral;
  - iii. Preventive health education;
  - iv. Children's eye and ear examinations;
  - v. Prenatal and post-partum care;
  - vi. Prenatal services;
  - vii. Well child care, including periodic screening;
  - viii. Immunizations, including tetanus-diphtheria booster and influenza vaccine;
  - ix. Voluntary family planning services;
  - x. Taking patient history;
  - xi. Blood pressure measurement;
  - xii. Weight measurement;

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- xiii. Physical examination targeted to risk;
- xiv. Visual acuity screening;
- xv. Hearing screening;
- xvi. Cholesterol screening;
- xvii. Stool testing for occult blood;
- xviii. Dipstick urinalysis;
- xix. Risk assessment and initial counseling regarding risks; and
- xx. For women only:
  - a) Clinical breast exam;
  - b) Referral for mammography; and
  - c) Thyroid function test
- xxi. Preventive Services do NOT include group or mass information programs, health education classes, or group education activities, including media productions and publications; eyeglasses, and hearing aids.

**II. REIMBURSEMENT METHODS**

Effective January 1, 2001, the Kansas Medicaid Program implemented the prospective payment system (PPS) for federally qualified health centers to conform with BIPA 2000. There are no retroactive cost settlements under this system. Effective January 1, 2013, as an alternative to the PPS, providers are offered the opportunity for reimbursement under a Alternative Prospective Payment System (APPS) that will be calculated based on 2009 and 2010 facility final cost settlements. The FQHCs will be reimbursed at the higher rate of the PPS rate or APPS rate.

**A. Definitions**

- 1. **Rate** – Payment for each qualified encounter or visit.
- 2. **Base Years or FY 1 & FY 2 – Current Providers** – Facility fiscal years 1999 and 2000.
- 3. **Base Years or FY 1 & FY 2 – New Providers** – Two facility fiscal years subsequent to the first year of business as a federally qualified health center
- 4. **Cost-Based Rate or Payment** – Based on reasonable cost of covered services.

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5. **Baseline Rate** - Average of cost-based rates from the base years.
6. **MEI** - Percentage increase in the Medicare Economic Index for primary care services.
7. **PPS Rate or Payment** - Meets PPS requirements outlined in the BIPA 2000.
8. **Non-PPS Rate or Payment** - Does not meet BIPA requirements.
9. **Preliminary** - Derived from unaudited cost report(s) or from only one base year.
10. **Final or Finalized** - Derived from Medicare cost reports for both base years.
11. **Re-Base Years or RFY1 and RFY2** – Current Providers – Facility fiscal years 2009 and 2010.
12. **Re-Base Years or RFY1 and RFY2** – New Providers – Two facility fiscal years subsequent to the first year of business as a federally qualified health center.

#### **B. Cost Reports**

Each provider shall be required to submit a federally qualified health center cost report on facility fiscal year basis using the most recent version of Form HCFA-222-92 (Rev. July 1994) within five (5) months after the fiscal year end. Non-reimbursable costs shall be reported in the appropriate sections of the cost report and shall not be co-mingled with allowable costs. All space, equipment, personnel and other expenses associated with laboratory services shall be separated from allowable FQHC expenses, and reported as a separate cost center in the non-FQHC or non-reimbursable section.

The cost report should be supplemented by a detailed trial balance which includes cost report line numbers for cross-checking, independent auditor's report & management letter, and any additional information necessary to facilitate reconciliation of reported expenditures with the trial balance and financial statements. Support for all information must be available for review.

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##### C. Determination of Cost-Based Rate

1. **Total Reasonable Cost:** Total allowable cost of FQHC core services and dental services, after overhead allocation and revenue offsets, as described in section V.
2. **Cost-based Encounter Rate:** Total reasonable cost divided by adjusted total visits.

### III. PROSPECTIVE PAYMENT SYSTEM (PPS)

Under this methodology, FQHCs shall be paid prospective rates based on an average of the reasonable costs of providing covered FQHC services during the base years, with no retroactive settlement.

#### A. Determination of PPS Baseline Rate

1. **Methodology** – It will depend on the time frames covered by an availability of cost reports as follows:
  - (i) Both Base Years Full Twelve-Month Periods:  
(FY 1 Cost-Based Rate + FY 2 Cost-Based Rate) / 2.
  - (ii) One or Both Base Years Less Than Twelve-Month Periods:  
[FY 1 Cost-Based Rate x No. of Mo.]+(FY 2 Cost-Based Rate x No. of Mo.) / Total No. of Months
  - (iii) Only One Base Year Cost Report Available: Cost-based rate derived from the available cost report.
  - (iv) No Base Year Cost Report Available: The lower of current rate (eff. On 12/31/2000) or average of baseline rates of other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by Department of Commerce. The rates will be adjusted for dental services (not provided by all FQHCs).
2. **Frequency** – Once if *audited* cost reports from *both* base years are available at the time of initial rate setting, otherwise twice:
  - (i) Initial Baseline Rate: After the approval of the state plan amendment (for current providers) or at the time of enrollment (for new providers). Initial rate can be preliminary or finalized.
  - (ii) Final Baseline Rate: When audited cost reports for both base years become available.

TN # KS 13-06 Approval Date JUN 24 2013 Effective Date 03/15/13 Supersedes TN # 08-04

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- B. Payment Procedure for January 1, 2001 to September 30, 2001**
1. Prior to approval of this state plan, Medicaid has continued to pay interim rates effective 12/31/2000.
  2. Upon SPA approval, initial PPS baseline rates will be computed using Medicare cost reports for facility fiscal years 1999 and 2000 received in our office before July 1, 2001.
  3. Interim payments will be reconciled to the initial baseline rates retroactive to January 1, 2001.
  4. In cases where the initial baseline rate is “preliminary”, interim payments will again be retroactively reconciled to the “final” baseline rate when it becomes available.
- C. Payment Procedure for October 1, 2001 to September 30, 2002**
1. PPS baseline rates effective on September 30, 2001 times the MEI index will be set as payment rates.
  2. In cases where the baseline rate is “preliminary”, when the “final” baseline rate becomes available it will be adjusted by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.
- D. Payment Rate Effective Each October 1 After September 30, 2002**
1. The PPS rates effective on the previous day (9/30 of the same year) shall be adjusted by the MEI index.
  2. In cases where the baseline rate used for this rate setting is “preliminary”, when the “final” baseline rate becomes available it will be adjusted by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.
- E. Baseline Rate for New Providers**
1. **If Historic Cost Reports Are Available:** If the facility is an established FQHC, cost-based rates from Medicare cost reports from the two most recent fiscal years will be used to determine the initial PPS baseline rate. If it is available only from one fiscal year, that will be used for rate setting, provided it is at least a twelve-month period. Data covering the first year of business as a FQHC will be excluded.
  2. **If No Historic Cost Reports Are Available:** The payment rate shall be the average of the rates paid to other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce.

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3. **If Neither Historic Nor Budgeted Data Available:** If neither is available, the payment rate shall be the average of the rates paid to other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce, with an adjustment for dental services since they are not provided by all FQHCs.

**F. Adjustment for Laboratory**

Effective July 1, 2002, clinical diagnostic lab services furnished by a center are no longer within the scope of FQHC services under the Kansas Medicaid Program. An FQHC that provides this service will be reimbursed on fee-for-service basis. Medicare implemented this change effective January 1, 2001. KDHE will retroactively adjust PPS rates effective 7/1/02 to exclude all expenses associated with laboratory services after receiving relevant data that facilitates identification of these expenditures.

**G. Long Acting Reversible Contraceptives (LARC)**

Effective February 27, 2018, LARCs insertion and removal visits will be paid at the FQHC PPS encounter rate. The devices will be reimbursed as outlined on Attachment 4.19-B #12.a., Prescribed Drugs, Methods and Standards for Establishing Payment Rates, Physician Administered Drugs (PADS)

**H. Hospice Care – Attending Physician Services**

Effective January 1, 2022, an FQHC can bill and receive payment under the FQHC Prospective Payment System (PPS) when a designated attending physician employed by or working under contract with the FQHC furnishes hospice attending physician services (as described in section 1812(d)(2)(A)(ii) of the Act) during a patient’s hospice election.

**I. Change in Scope of Services**

To receive PPS rate adjusted for a proposed increase or decrease in the scope of covered FQHC & dental services in a future fiscal year as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. At a minimum, this shall include a description of the change, budgeted expenditure, and change in total number of visits. Any rate change would be implemented on the first of the month following the KDHE decision.

**IV. ALTERNATIVE METHODOLOGY – REBASED PROSPECTIVE PAYMENT SYSTEM (RPPS)**

Under this methodology, FQHCs shall be paid RPPS rates based on an average of the reasonable costs of providing covered FQHC services during the base years, with no retroactive settlement.

**A. Determination of RPPS Rate**

1. Methodology – Determined by cost reports as follows:
  - (i) Both Re-Base Years (2009 and 2010) full Twelve-Month Periods: (RFY1 Cost-Based Rate + RFY2 Cost-Based Rate)/2 and applied a trended MEI factor.

**B. Payment Procedure for January 1, 2013 to September 30, 2013.**

1. Prior to approval of this state plan, Medicaid has paid the RPPS rates calculated in IV.A.1.

**C. Payment Rate Effective Each October 1 After September 30, 2013**

1. The RPPS rates effective on the previous day (9/30 of the same year) shall be adjusted for the MEI index.

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**C. Baseline Rate for New Providers**

1. **If Historic Cost Reports are Available:** If the facility is an established FQHC, cost-based rates from Medicare cost reports from the two most recent fiscal years will be used to determine the initial PPS baseline rate. If it is available only from one fiscal year, that will be used for rate setting, provided it is at least a twelve month period. Data covering the first year of business as a FQHC will be excluded.
2. **If No Historic Cost Reports are Available:** The payment rate shall be the average of the rates paid to other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce, with an adjustment for dental services since they are not provided by all FQHCs.
3. **If Neither Historic nor Budgeted Data Available:** If neither is available, the payment rate shall be the average of the rates paid to other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce, with an adjustment for dental services since they are not provided by all FQHCs.

**D. Change in Scope of Services**

To receive a APPS rate adjusted for a proposed increase or decrease in the scope of covered FQHC and dental services in a future fiscal year as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. At a minimum, this shall include a description of the change, budgeted expenditure, and change in total number of visits. In addition to change of scope, clinics will have the opportunity to submit a request to increase the APPS rate if costs exceed the APPS rate by 15% or more. Again, documentation must be provided to determine the case for reconsideration of the APPS rate. Any rate change would be implemented on the first of the month following the KDHE decision.

**V. DETERMINATION OF REASONABLE COST**

Reasonable cost consists of necessary and proper cost incurred in providing covered federally qualified health center services and dental services to all patients. Cost reimbursement principles, and coverage criteria set forth in K.A.R. 129-5-118, K.A.R. 129-5-118a, K.A.R. 129-5-118b, 42 CFR Part 405.2411 and 405.2446 through 405.2452. Medicaid state plan, Medicaid provider manual, 42 CFR Part 413, and Medicare Publications 10 & 27 shall be applied to the data submitted to Medicaid as tests of reasonableness.

**A. Review & Analysis of Reported Data**

Expenditures & income reported to Medicaid will be reconciled with the trial balance, financial statements prepared by the independent auditor, and the finalized Medicare cost report. Expenses reported as allowable, including overhead cost, will be analyzed to evaluate if they are accurate, reasonable, necessary, patient related, associated with covered services, and reported in appropriate cost centers. Revenue will be analyzed for

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refunds received. Any findings will be deducted from reported expenses to yield total allowable cost. The encounter data will be analyzed for reasonableness, accuracy, inclusion of nursing assessments, and visits not meeting the definition of billable visits.

**B. Revenue Offsets**

Income will also be analyzed to confirm that Medicaid payments do not duplicate revenue received from other sources to cover specific programs or expenses, whether in part or whole. If such duplication is found, it will be offset before rate calculation. **NOTE:** Public Health Service Grants under section 329, 330, and 340 shall not be offset against expenses in determining allowable cost. To prevent such offset, the provider shall clearly identify these grants by name, not just numbers, in the supplemental data submitted with the cost report.

**C. Total Reasonable FQHC & Dental Cost for the Facility**

Allowable overhead (indirect) expense will be allocated to total allowable FQHC & Dental (direct) costs and total non-reimbursable (direct) expenses based on the proportion of each "direct" cost center to their summation. Post-allocation total FQHC & Dental expenses minus any revenue offsets shall be the total reasonable cost of covered FQHC and Dental services furnished to all patients, regardless of payer.

**VI. SERVICES FURNISHED UNDER CONTRACT WITH MANAGED CARE ORGANIZATIONS (MCOs)**

MCOs must reimburse providers using the higher rate between the PPS rate and the APPS rate. APPS rates will be re-evaluated at least every 5 years.

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(Reserved for future use)

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#3

### Methods and Standards for Establishing Payment Rates

#### Other Laboratory and X-ray Services

Laboratory and x-ray services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

Reimbursement for physician-referred laboratory services performed by an independent laboratory shall be made directly to the laboratory.

Effective July 1, 2020, the reimbursement code for cytogenomic microarray (CMA) testing is set at 85% of non-rural Medicare rates as set on January 1 of each year.

Effective January 1, 2023, the reimbursement rates for oncologic Positron Emission Tomography (PET) scans are set at 85% of Medicare.

Effective July 1, 2023:

1. Laboratory reimbursement rates that are below 85% of Medicare rates will be raised to 85% of Medicare rates;
2. Laboratory reimbursement rates between 85% and 100% of Medicare rates will remain the same; and
3. Laboratory reimbursement rates that are over 100% of Medicare rates will be reduced to 100% of Medicare rates.

Effective January 1, 2024, all radiology reimbursement rates are set at 85% of Medicare rates. A selected subset of radiology reimbursement rates over 100% of Medicare rates will be set at 100% of Medicare rates.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of January 1, 2024 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

This link will take the user to a page titled "Reference Copyright Notice." Scroll to the bottom of the page and click on the word "Accept" to access the fee schedule. The next page that appears is titled "KMAP Fee Schedules."

To access a fee schedule:

- a. Select the program from the drop-down list -TXIX;
- b. Choose the type of rates – Medicaid;
- c. After choosing the rate type, the user will see a list of the current and historical versions of the corresponding schedule;
- d. Click the schedule TXIX.

KS 23-0042 Approval Date December 19, 2023 Effective Date 1/1/2024 Supersedes KS 23-0027

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Methods and Standards for Establishing Payment Rates <sup>4a</sup>

#4a Skilled Nursing Facility Services for  
Individuals 21 Years of Age or Older

See Attachment 4.19-D

State Plan MS-83-37

Trans. No. ~~9-28-83~~

Submitted 9-28-83

Approved 11-22-83

## KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#4.b.

### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Methods and Standards for Establishing Payment Rates**

Agency staff will individually review claims for medically necessary services not normally covered under the plan when these services are provided to an EPSDT participant. Staff will consult with agency medical experts and compare the service to comparable services and determine a price based on expert advice and rates for similar services.

Reimbursement for positive behavior support services, Consultative Clinical and Therapeutic Services, and Intensive Individual Supports are based upon a Medicaid fee schedule established by the State of Kansas. Commercial third-party payers and market rates will be considered when establishing the fee schedules. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, if applicable. If a service has no Kansas specific Medicare rate, Kansas will establish pricing based on similar services. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of EPSDT services. The agency's fee schedule rate was set as of April 1, 2025 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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### EPSDT Services

#### Child Behavior Interventionist Service Methods and Standards for Establishing Payment Rates

The requirement for this service is that it must be billed with the family present. This service will be reimbursed per diem.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of October 1, 2023 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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- a. Select the program from the drop-down list -TXIX;
- b. Choose the type of rates – Medicaid;
- c. After choosing the rate type, the user will see a list of the current and historical versions of the corresponding schedule;
- d. Click the schedule TXIX.

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### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Methods and Standards for Establishing Payment Rates (Continued)**

#### **A. Reimbursement Methodology for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services**

School-based Services (SBS) are delivered by Local Education Agencies (herein after referred to as “providers” for this section of the State Plan), and include the following Medicaid services identified in an Individualized Family Service Program or Individualized Education Program under the Individuals with Disabilities Education Act (IDEA):

1. Specialized Transportation
2. Nursing Services
3. Occupational Therapy
4. Physical Therapy
5. Speech, Language and Hearing Services
6. Counseling Services
7. Social Work Services
8. Psychological Services

#### **B. Direct Medical Payment Methodology**

Effective with dates of service on or after July 1, 2009, providers will be reimbursed on a cost basis. Providers will be paid interim rates for school-based direct medical services on a per unit basis. On an annual basis, a provider-specific cost reconciliation and cost settlement for all over and under payments will be processed.

The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes. Direct medical services may be encounter-based or in 15-minute unit increments. Fee-based reimbursement for a specific service for a period is an interim payment, pending the completion of cost reconciliation and cost settlement for that period.

JUL 13 2010

TN # 09-07 Approval Date \_\_\_\_\_ Effective Date 07/01/09 Supersedes 07-14

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### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Methods and Standards for Establishing Payment Rates (Continued)**

#### C. Data Capture for the cost of Providing Health-Related Services

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal payments for these costs, will be capture utilizing the following data:
  - a. School Health Services cost reports received from LEAs;
  - b. Kansas Department of Education (KDE) Unrestricted Indirect Cost Rate (ICR);
  - c. Random Moment Time Study (RMTS) Activity Code 1200 (Direct Medical Services) and Activity Code 3100 (General Administration);
  - d. LEA-specific IEP Ratios.

#### D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. Allowable Costs: Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by LEAs, excluding transportation personnel. These direct costs will be calculated on a provider-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. These direct costs are accumulated on the annual Kansas School-based Services Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

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### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Methods and Standards for Establishing Payment Rates (Continued)**

The source of this financial data will be audited Chart of Account records kept at the LEA level. The Chart of Accounts is uniform throughout the State of Kansas. Costs will be reported on a cash or accrual basis, depending on the district.

a. Direct Medical Services

Non-federal cost pool for allowable providers consists of:

- i. Salaries;
- ii. Benefits;
- iii. Medically-related purchased services; and
- iv. Medically-related supplies and materials.

2. Indirect Costs: Indirect costs are determined by applying the LEA's specific unrestricted indirect cost rate to its adjusted direct costs. Kansas LEAs use predetermined fixed rates for indirect costs. Kansas Department of Education has, in cooperation with the United State Department of Education (ED), developed an indirect cost plan to be used by LEAS in Kansas. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate

Apply the Kansas Department of Education Cognizant Agency Unrestricted Indirect Cost Rate applicable for the dates of service in the rate year.

The Kansas Department of Education UICR is the unrestricted indirect cost rate calculated by the Kansas Department of Education.

3. Time Study Percentages: A CMS-approved time study is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The appropriate time study results will be applied to the direct medical services cost pool. The direct medical services costs and time study results will be maintained by the State of Kansas. The use of CMS-approved time study methodology assures that no more than 100 percent of time and costs are captured and that the time study is statistically valid per OMB Circular A-87 cost allocation requirements.

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### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Methods and Standards for Establishing Payment Rates (Continued)**

4. IEP Ratio Determination: A provider-specific IEP Ratio will be established for each participating LEA. When applied, this IEP Ratio will discount the Direct Medical cost pool by the percentage of IEP Medicaid students.

The names and birthdates of students with a health related IEP will be identified from the December 1 Count Report and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid.

The numerator of the rate will be the students with an IEP that are eligible for Medicaid and the denominator will be the total number of students with an IEP.

5. Total Medicaid Reimbursable Cost: The result of the previous steps will be a total Medicaid reimbursable cost for each LEA for Direct Medical Services.

After CMS-approved time study results have been produced for at least four consecutive quarters, the Kansas Health Policy Authority (KHPA) will submit for CMS review and approval a proposed methodology for documenting (backcasting) prior period claims by applying the valid time study results for purposes of adjusting the prior period claims. Reported expenditures must be reasonable, allowable, and allocable, and must be adjusted, if necessary, to comport with the guidelines specified in the CMS-approved time study.

#### **E. Specialized Transportation Services Payment Methodology**

Effective with dates of service on or after July 1, 2009, providers will be paid on a cost basis. Providers will be reimbursed interim rates for School-based Specialized Transportation services at the statewide enterprise interim rate. Federal matching funds will be available for interim rates paid by the State. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

Specialized Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1. Special transportation is specifically listed in the IEP as a required services;
2. The child required specialized transportation in a vehicle adapted to service the needs of an individual with a disability;

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### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Methods and Standards for Establishing Payment Rates (Continued)**

3. A medical service is provided on the day that specialized transportation is billed; and
4. The service billed only represents a one-way trip.

Specialized transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1. Bus Drivers
2. Mechanics
3. Substitute Drivers
4. Fuel
5. Repairs & Maintenance
6. Rentals
7. Contract Use Cost
8. Depreciation

The source of these costs will be audited Chart of Accounts data kept at the LEA level. The Chart of Accounts is uniform through the State of Kansas. Costs will be reported on a cash or accrual basis, depending on the district.

Specialized transportation costs include those for wheelchair lifts and other special modifications which are necessary to equip a school bus in order to transport children with disabilities.

When LEAS are not able to discretely identify the specialized transportation cost from the general education transportation costs, a specialized transportation cost discounting methodology will be applied. A rate will be established and applied to the total transportation cost of the LEA. This rate will be based on the *Total IEP Special Educations (SPED) Students in District Receiving Specialized Transportation* divided by the *Total Students in District Receiving Transportation*. The result of this rate (%) multiplied by the *Total School LEA Transportation Cost* for each of the categories listed above will be included on the cost report. It is important to note that this cost will be further discounted by the ratio of *Medicaid Eligible SPED IEP One Way Trips* divided by

## KANSAS MEDICAID STATE PLAN

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#4.b

Page 2f

### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Methods and Standards for Establishing Payment Rates (Continued)**

the total number of *SPED IEP One Way Trips*. This data will be provided from bus logs. The process will ensure that only one way trips for Medicaid eligible Special Education children with IEP's are billed and reimbursed for.

#### F. Certification of Funds Process

Each provider certifies on an annual basis an amount equal to each fee reimbursed interim rate times the units of service reimbursed during the previous federal fiscal year. In addition, each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and the non-federal share.

Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

#### G. Annual Cost Report Settlement Process

Each provider will complete an annual cost report for all school-based services delivered during the previous state fiscal year covering July 1 through June 30. The cost report must be filed no later than 6 months after the end of the fiscal period (December 31). The primary purposes of the cost report are to:

1. Document provider's total CMS-approved, Medicaid allowable scope of costs for delivering school-based services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and
2. Reconcile its interim payments to its total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual School-based Services Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual School-based Services Cost Reports are subject to a desk review by the Kansas Health Policy Authority (KHPA) or its designee.

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual School-based Services Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the

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**Early and Periodic Screening, Diagnosis and Treatment (EPSDT)  
Methods and Standards for Establishing Payment Rates (Continued)**

provider's Medicaid interim payments for school-based services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or the CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

If a provider's interim payments exceed the actual, certified costs of the provider for school-based services to Medicaid clients, the provider will return an amount equal to the overpayment.

If the actual, certified costs of a provider for school-based services exceed the interim Medicaid payments, KHPA will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

KHPA shall issue a notice of settlement that denotes the amount due to or from the provider.

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Methods and Standards for Establishing Payment Rates

4c

#4c Family Planning Services

Payment to health departments for family planning services are based on fee maximums determined by the Department.

See Attachment 4.19B#5 for physician's services.

State Plan

Trans. No. MS 83-39

Submitted 9-28-83

Approved 11-22-83

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#5

## Methods and Standards for Establishing Payment Rates

### #5 Physician's Services

Physician's services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges, except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

Payment for physician extender services is limited to a maximum of 75% of the maximum reimbursement to the billing physician.

Reimbursement for physician-referred laboratory services performed by an independent laboratory or outpatient hospital department, shall be made directly to the independent laboratory or outpatient hospital department.

Effective April 1, 2021, Physician therapeutic phlebotomy reimbursement rates will be set at 85% of the non-rural Medicare rates as of January 1 of each year.

Effective January 1, 2022, additional varicose vein treatment modalities reimbursement rates are included in the plan.

Effective July 1, 2023, select procedure codes will be increase by 3% for physicians.

Effective April 1, 2025, additional pelvic examination reimbursement rates for females and visit complexity reimbursement rates are included in the plan.

Effective June 1, 2025, drug eluted stent procedure reimbursement rates are added.

Effective July 1, 2025, Cognitive Assessment and Care Plan Services are added.

Effective July 1, 2025, Pediatrician Office Visits rates and Vagus Nerve Stimulation rates are increased.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of July 1, 2025 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at

<https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

This link will take the user to a page titled "Reference Copyright Notice." Scroll to the bottom of the page and click on the word "Accept" to access the fee schedule. The next page that appears is titled "KMAP Fee Schedules."

To access a fee schedule:

- a. Select the program from the drop-down list -TXIX;
- b. Choose the type of rates – Medicaid;
- c. After choosing the rate type, the user will see a list of the current and historical versions of the corresponding schedule;
- d. Click the schedule TXIX.

KS 25-0018 Approval Date 10/14/2025 Effective Date 7/1/2025 Supersedes KS 25-0015

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#5

Page 1

### Methods and Standards for Establishing Payment Rates

#### Outpatient Services

Outpatient services for hospitals are reimbursed based on reasonable fees as related to customary charges.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of July 1, 2022 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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## Methods and Standards for Establishing Payment Rates

### Outpatient Services

#### Critical Access Hospital (CAH)

Effective for dates of service on or after October 5, 2007, critical access hospital outpatient services are reimbursed 100% of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of cost or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. Payments are adjusted to reflect elimination of fee schedule methods for specific services such as laboratory and radiology services. Final reimbursement for these and other outpatient services is made in accordance with reasonable cost principles.

Allowable Medicaid costs are defined as the costs Medicare defines as allowable on the Medicare finalized cost report. The Medicare cost report will be used to determine the Medicaid allowable costs and the Medicare fiscal intermediary's review of the Medicare cost report will be relied on for determining allowable costs.

The Critical Access Hospital (CAH) cost settlement process will end for outpatient dates of services on or after 1/1/2013. Settlement related to outpatient dates of service prior to 1/1/2013 will continue per previous State Plan Amendment methodology until finalized.

Effective 3/22/2013, a CAH Adjustment Factor (CAF) will be applied to CAH reimbursement for Outpatient dates of services on or after 3/22/2013. The CAF will be applied and reimbursed on a per claim basis. The hospital-specific CAF is a prospective factor calculated using experience in previous cost reporting years. The factor for Year 1 (calendar 2013) is based upon the 2011 cost reporting period. Year 2 will be calculated using year-end 2012 cost reports, and so forth. The funds associated with the CAF are capped prospectively with hospital specific factors. (By contract, managed care organizations adopt the CAF methodology as the basis for their CAH reimbursement.)

For calendar year 2013, the CAF is calculated as the difference between each hospital's Fee For Service incurred costs and Fee For Service payments received as a ratio to total payments received. The period for this calculation is based on each CAH's cost reporting period ending in 2011, and factors are developed separately for both inpatient and outpatient. The CAF is adjusted to make it consistent prospectively with statewide aggregate CAH cost settlements during the 2011 cost reporting period. Effective 1/1/2025 the Kansas State Legislature added eight million dollars to the statewide aggregate CAH cost settlements during the 2011 cost report period. These funds will be split between inpatient CAF settlements and outpatient CAF settlements using the same percentage split as the inpatient and outpatient CAF settlements in 2013.

After 2013, an adjustment to the CAF will be included for prior year overpayment or underpayment that may have occurred in the aggregate relative to the estimated cap. CAHs will always receive at least the fee-for-service rate. Beginning with cost reporting year 2013, all allowable Medicaid charges will be used to calculate the CAF.

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#5

Page 1b

## Methods and Standards for Establishing Payment Rates

### Qualified Licensed Professional Services

Supplemental medical education payments for certain licensed professional services

- (1) Notwithstanding other provisions of this section, effective February 8, 2008, and in recognition of the cost of providing teaching services, supplemental payments shall be paid pursuant to this paragraph for those services designated under clause (2) which are performed by Qualified Licensed Professionals. In order to be a Qualified Licensed Professional, a professional must be:
  - (i) A Kansas licensed professional; and
  - (ii) Enrolled as a Kansas Medicaid provider; and
  - (iii) Employed by, affiliated with, or providing services at a Large Public Kansas Teaching Hospital, as defined in Attachment 4.19-A, or employed by the University of Kansas School of Medicine-Wichita Medical Practice Association.
- (2) A Large Public Kansas Teaching Hospital or the University of Kansas School of Medicine-Wichita Medical Practice Association shall designate those services rendered by Qualified Licensed Professionals that are eligible for a supplemental payment. Such supplemental payments will be equal to the difference between the Medicaid payments otherwise made for the services and payments for the services at the Medicare Equivalent of the Average Commercial Rate. Payment will be made quarterly and will not be made prior to the delivery of services.
- (3) The Medicare Equivalent of the Average Commercial Rate to be paid to Qualified Licensed Professionals will be determined as follows:
  - (i) Compute Average Commercial Fee Schedule: For the base period, compute the average commercial allowed amount per CPT Code, including patient share amounts, for the top five payers for procedure codes with payment rates. The top five commercial third party payers will be determined by total billed charges.
  - (ii) Calculate the Base Period Average Commercial Payment Ceiling: Multiply the Average Commercial Fee Schedule as determined in clause (3)(i) by the number of times each procedure code was rendered in the base period and paid to Qualified Licensed Professionals on behalf of Medicaid beneficiaries as reported from the MMIS. The sum of the product for all procedure codes shall determine the Base Period Average Commercial Payment Ceiling.

SEP 16 2008

# 08-02 Approval Date \_\_\_\_\_ Effective Date 02/08/08 Supersedes #TN New

# KANSAS MEDICAID STATE PLAN

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#5

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## Methods and Standards for Establishing Payment Rates

### Qualified Licensed Professional Services (continued)

- (iii) Determine the Base Period Medicare Payment Ceiling: For each of the procedure codes used to determine the Average Commercial Payment Ceiling in clause (3)(ii), multiply the base period non-facility, Medicare allowed rate from the April release Resource Based Relative Value Scale (RBRVS) by the number of times each procedure code was rendered in the base period and paid to Qualified Licensed Professionals on behalf of Medicaid beneficiaries as reported from the MMIS. The sum of the product for all procedure codes shall represent the Base Period Medicare-Equivalent Payment Ceiling.
  - (iv) Determine the Medicare-Equivalent of the Average Commercial Rate: Divide the Base Period Average Commercial Payment Ceiling computed in clause (3)(ii) by the Base Period Medicare Payment Ceiling determined in clause (3)(iii).
  - (v) Periodic Updates to the Medicare Equivalent of the Average Commercial Rate: The State may periodically update this ratio.
- (4) Determination of Supplemental Payment
- (i) The supplemental payment ceiling will be determined as follows: The Medicare-Equivalent of the Average Commercial Rate is multiplied by Medicare payment at the non-facility rate per CPT Code then multiplied by Medicaid volume by CPT Code for the same period as reported through the MMIS.  
  
$$\text{(Medicare Equivalent of the Average Commercial Rate)} \times \text{(Medicare Payment per CPT Code)} \times \text{(Medicaid Volume per CPT Code)} = \text{Payment Ceiling.}$$

Medicare payment at the non-facility rate and Medicaid volume for those services are derived from the same period.
  - (ii) The Medicaid Supplemental Payment to Qualified Licensed Professionals shall equal the current period supplemental payment ceiling at the Medicare Equivalent of the Average Commercial Rate less all Medicaid payments, including enhanced payments, for procedure codes rendered in the current period and paid to Qualified Licensed Professionals on behalf of Medicaid beneficiaries as reported from the MMIS. Medicaid volume and payments shall include all available payments and adjustments.

**Reimbursement Template -Physician Services**

**Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415**

**Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment**

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

- The rates reflect all Medicare site of service and locality adjustments.
  - The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting. The methodology recognizes that Kansas only has one geographic locality.  
The January 2013 release was used to develop the fee schedule.  
The State will **not** be changing rates with Medicare updates.
  - The rates reflect all Medicare geographic/locality adjustments.

- The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: \_\_\_\_\_

**Method of Payment**

- The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.
- The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made:  monthly  quarterly  semi-annually  annually

**Primary Care Services Affected by this Payment Methodology**

- This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
- The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). 99241 – 99245, 99251 – 99255, 99315 – 99316, 99339 – 99340, 99358 – 99359, 99374 – 99375, 99377 – 99380, 99401, 99403, 99406 – 99409, 99420, 99429, 99441 – 99444, 99450, 99455, 99467, 99485 – 99489, 99495 – 99496, 99499

**(Primary Care Services Affected by this Payment Methodology – continued)**

The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

99224 – 99226 Added January 1, 2011

The specific rate calculation methodology for each eligible procedure code was as follows (using the 2009 conversion factor):

2013 Non-Facility Pricing Amount =  
(2013 Work RVU \* Work GPCI of 0.962) +  
(2013 Non-Facility PE RVU \* PE GPCI of 0.894) +  
(2013 MP RVU \* MP GPCI of .0957) \* 2009 Conversion Factor of \$36.0666

**Physician Services – Vaccine Administration within the VFC Program**

For calendar years (CYs) 2013 and 2014, the state reimburses VFC vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate as implemented by the state in CYs 2013 and 2014.

Identify one of the following options:

- Medicare Physician Fee Schedule rate as implemented by the state and using the 2009 conversion factor
- State regional maximum administration fee set by the Vaccines for Children program

**Documentation of Vaccine Administration Rates in Effect 7/1/09**

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: \$14.17.

A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: \_\_\_\_\_.

Alternative methodology to calculate the vaccine administration rate in effect  
7/1/09: \_\_\_\_\_

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Note: This section contains a description of the state's methodology and specifies the affected billing codes.

**Effective Date of Payment**

**E & M Services**

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at <https://www.kmap-state-ks.us/Public/Provider.asp>.

**Vaccine Administration**

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at <https://www.kmap-state-ks.us/Public/Provider.asp>.

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 20 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#5, Obstetrical  
Practitioner Services  
Page 2

## Physicians' Services Methods and Standards of Established Payment Rates

### Obstetrical Practitioner Services

Obstetrical practitioners are paid fee schedule rates.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of July 1, 2024 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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- b. Choose the type of rates – Medicaid;
- c. After choosing the rate type, the user will see a list of the current and historical versions of the corresponding schedule;
- d. Click the schedule TXIX.

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#5, Pediatric  
Practitioner Services  
Page 3

## Physicians' Services Pediatric Practitioner Services Methods and Standards of Established Payment Rates

### Explanation of Method and Standards of Established Fee for Service Payment Rates

This report is based on information collected by the fiscal agent from SFY1995 paid claims for the period of the fiscal year (July 1, 1994 - June 30, 1995). For this report, fiscal year data is used to provide an average payment rate per procedure code for SFY '95, the second previous year. Regardless of current maximum reimbursement rates, providers are instructed to bill their usual and customary charge.

**Procedure Code:** This reflects the CPT code for a specific medical procedure.

**Procedure Description:** This reflects the CPT nomenclature for the specified procedure code. Due to availability of space, the description may be shortened or abbreviations utilized.

**Current Rate:** This reflects the maximum rate currently reimbursed by the Kansas Medicaid program for the specified procedure code. Rates do not vary by geographic location of provider.

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#5, Pediatric  
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Physicians' Services  
Pediatric Practitioner Services  
Methods and Standards of Established Payment Rates

Explanation of Method and Standards of  
Established HMO Payment Rates

HMO rates were established using the fee for service rates for pediatric services in calendar year 1995, which is then inflated to the present time. The first HMO for Medicaid started on 12/1/95.

Due to the methodology used to establish HMO rates, there should be no direct affect due to the rate setting methodology upon Pediatric access.

MAY 12 1997 APR 1 1997  
TN#MS-97-07 Approval Date \_\_\_\_\_ Effective Date \_\_\_\_\_ Supersedes TN#MS-96-05

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# 5, Pediatric

Provider Access

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## PEDIATRIC PROVIDER ACCESS

#	GEOGRAPHIC AREA	H & E LICENSED	PARTICIPATING IN THE MEDICAID PROGRAM	% PARTICIPATION
1	CHANUTE	34	28	82.4%
2	EMPORIA	40	19	47.5%
3	GARDEN CITY	56	51	91.1%
4	HAYS	53	51	96.2%
5	HIAWATHA	24	24	100.0%
6	HUTCHINSON	73	31	42.5%
7&9	KANSAS CITY METRO	424	260	61.3%
8	MANHATTAN	48	42	87.5%
10	OSAWATOMIE	50	21	42.0%
11	PARSONS	49	18	36.7%
12	PITTSBURG	21	17	81.0%
13	PRATT	54	42	77.8%
14	SALINA	47	31	66.0%
15	TOPEKA	147	72	49.0%
16	WICHITA	322	174	54.0%
17	WINFIELD	57	20	35.1%
	TOTAL	1,499	901	60.1%

TN # MS-97-07 App Date MAY 12 1997 Eff Date APR 1 1997 Supercedes MS-96-05

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# 5, Pediatric Practitioner Services

## Physicians' Services Pediatric Practitioner Services

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PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
<b>EVALUATION AND MANAGEMENT</b>			
99201	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, NEW PATIENT	\$25.56	\$24.32
99202	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, NEW PATIENT	\$31.34	\$35.00
99203	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, NEW PATIENT	\$33.74	\$40.00
99204	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, NEW PATIENT	\$39.44	\$50.00
99205	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, NEW PATIENT	\$59.41	\$76.00
99211	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, ESTABLISHED PATIENT	\$28.66	\$11.24
99212	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, ESTABLISHED PATIENT	\$23.34	\$19.78
99213	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, ESTABLISHED PATIENT	\$25.56	\$27.00
99214	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, ESTABLISHED PATIENT	\$36.69	\$45.00
99215	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, ESTABLISHED PATIENT	\$54.84	\$68.00
99241	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR E & M, NEW OR ESTABLISHED		\$18.00
99242	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR E & M, NEW OR ESTABLISHED		\$24.00
99243	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR E & M, NEW OR ESTABLISHED		\$30.00
99244	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR E & M, NEW OR ESTABLISHED		\$45.00
99245	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR E & M, NEW OR ESTABLISHED		\$45.00
99271	CONFIRMATORY CONSULTATION FOR E & M, NEW OR ESTABLISHED PATIENT		\$30.00
99272	CONFIRMATORY CONSULTATION FOR E & M, NEW OR ESTABLISHED PATIENT		\$30.00
99273	CONFIRMATORY CONSULTATION FOR E & M, NEW OR ESTABLISHED PATIENT		\$30.00
99274	CONFIRMATORY CONSULTATION FOR E & M, NEW OR ESTABLISHED PATIENT		\$30.00
99275	CONFIRMATORY CONSULTATION FOR E & M, NEW OR ESTABLISHED PATIENT		\$30.00

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement. Rates do not vary by geographic area.

TN # MS-97-07 App Date MAY 12 1997 Eff Date APR 1 1996 Supersedes MS-96-05

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# 5, Pediatric Practitioner Services

## Physicians' Services Pediatric Practitioner Services

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PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
99341	HOME SERVICES, NEW PATIENT		\$8.00
99342	HOME SERVICES, NEW PATIENT		\$8.00
99343	HOME SERVICES, NEW PATIENT		\$12.00
99351	HOME SERVICES, ESTABLISHED PATIENT		\$10.00
99352	HOME SERVICES, ESTABLISHED PATIENT		\$10.00
99353	HOME SERVICES, ESTABLISHED PATIENT		\$10.00
99354	PROLONGED PHYSICIAN SERVICE WITH DIRECT (FACE-TO-FACE) PATIENT CONTACT BEYOND THE USUAL SERVICE; FIRST HOUR		\$55.21
99355	PROLONGED PHYSICIAN SERVICE WITH DIRECT (FACE-TO-FACE) PATIENT CONTACT BEYOND THE USUAL SERVICE; EACH ADDITIONAL 30 MINUTES		\$24.88
99358	PROLONGED PHYSICIAN SERVICE WITHOUT DIRECT (FACE-TO-FACE) PATIENT CONTACT, E&M SERVICE; FIRST HOUR		\$5.18
99359	PROLONGED PHYSICIAN SERVICE WITHOUT DIRECT (FACE-TO-FACE) PATIENT CONTACT, E&M SERVICE; EACH ADDITIONAL 30 MINUTES		Non Covered
PREVENTIVE MEDICINE SERVICES			
99381	INITIAL EVALUATION AND MANAGEMENT; INFANT (UNDER 1)	\$41.93	\$40.00
99382	INITIAL EVALUATION AND MANAGEMENT; EARLY CHILDHOOD (1-4 YRS)	\$39.13	\$35.00
99383	INITIAL EVALUATION AND MANAGEMENT; LATE CHILDHOOD (5-11 YRS)	\$38.43	\$35.00
99384	INITIAL EVALUATION AND MANAGEMENT; ADOLESCENT (12-17 YRS)	\$34.87	\$35.00
99391	PERIODIC REEVALUATION AND MANAGEMENT; INFANT (UNDER 1)	\$28.95	\$26.00
99392	PERIODIC REEVALUATION AND MANAGEMENT; EARLY CHILDHOOD (1-4 YRS)	\$31.96	\$25.00
99393	PERIODIC REEVALUATION AND MANAGEMENT; LATE CHILDHOOD (5-11 YRS)	\$30.82	\$25.00
99394	PERIODIC REEVALUATION AND MANAGEMENT; ADOLESCENT (12-17 YRS)	\$29.05	\$25.00
99401	PREVENTIVE MEDICINE INDIVIDUAL COUNSELING, NEW OR ESTABLISHED		Non Covered
99402	PREVENTIVE MEDICINE INDIVIDUAL COUNSELING, NEW OR ESTABLISHED		\$20.00
99403	PREVENTIVE MEDICINE INDIVIDUAL COUNSELING, NEW OR ESTABLISHED		Non Covered

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement. Rates do not vary by geographic area.

TN # MS-97-07 App Date MAY 12 1997 Eff Date APR 1 1997 Supersedes MS-96-05

# KANSAS MEDICAID STATE PLAN

## Physicians' Services Pediatric Practitioner Services

Attachment 4.19 - B  
# 5, Pediatric Practitioner Services

Page 3E

PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
99404	PREVENTIVE MEDICINE INDIVIDUAL COUNSELING, NEW OR ESTABLISHED		\$40.00
99411	PREVENTIVE MEDICINE GROUP COUNSELING, NEW OR ESTABLISHED		\$20.00
99412	PREVENTIVE MEDICINE GROUP COUNSELING, NEW OR ESTABLISHED		\$40.00
99420	OTHER PREVENTIVE MEDICINE SERVICES, ADMN. AND INTERPRETATION		Non-Covered
99429	OTHER PREVENTIVE MEDICINE SERVICES, UNLISTED		Non-Covered
99432	NORMAL NEWBORN CARE, OTHER THAN HOSPITAL		\$45.00
<b>IMMUNIZATIONS</b>			
90700	DTaP		\$8.00
90701	DTP	\$6.37	\$8.00
90702	DT		\$8.00
90703	TETANUS		\$2.03
90704	MUMPS		Non-Covered
90705	MEASLES		Non-Covered
90706	RUBELLA		Non-Covered
90707	MEASLES, MUMPS, AND RUBELLA	\$6.56	\$8.00
90708	MEASLES AND RUBELLA		Non-Covered
90709	RUBELLA AND MUMPS		Non-Covered
99710	MEASLES, MUMPS, RUBELLA, AND VARICELLA		Non-Covered
90711	DTP AND INJECTABLE POLIOMYELITIS		Non-Covered
90712	POLIO, ORAL	\$5.95	\$8.00
90713	POLIO VACCINE		\$8.00
90714	TYPHOID		\$11.75
90716	VARICELLA (CHICKEN POX)		\$8.00

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement. Rates do not vary by geographic area.

TN # MS-97-07 App Date MAY 12 1997 Eff Date APR 1 1997 Supercedes MS-96-05

# KANSAS MEDICAID STATE PLAN

Attachment 4.19 - B  
# 6, Pediatric Practitioner Services

## Physicians' Services Pediatric Practitioner Services

Page 3F

PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
90717	YELLOW FEVER		Non-Covered
90719	DIPHTHERIA		Non-Covered
90720	DTP AND HIB		\$8.00
90721	DTaP and HIB		
90724	INFLUENZA VIRUS		\$4.38
90725	CHOLERA		\$6.48
90726	RABIES		\$130.00
90727	PLAGUE		Non-Covered
90728	BCG		\$30.00
90730	HEPATITIS A		Non-Covered
90732	PNEUMOCOCCAL VACCINE, POLYVALENT		\$27.11
90733	MENINGOCOCCAL POLYSACCHARIDE		Non-Covered
90737	HEMOPHILUS INFLUENZA B	\$4.49	\$8.00
90741	IMMUNIZATION, PASSIVE; IMMUNE SERUM GLOBULIN, HUMAN (ISG)		Non-Covered
90742	SPECIFIC HYPERIMMUNE SERUM GLOBULIN		\$3.00
90744	HEPATITIS B, NEWBORN TO 11 YEARS		
90745	HEPATITIS B, 11 TO 19 YEARS		
90749	UNLISTED IMMUNIZATION PROCEDURE		Non-Covered

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement. Rates do not vary by geographic area.

**KANSAS MEDICAID STATE PLAN**

**PHYSICIAN SERVICES**

**Attachment 4.19-B**

**#5**

**Page 4**

Reimbursement for heart, heart-lung and lung transplant procedures were established based upon 85% of the current Medicare fee schedule rates when billed separately for professional services.

Payment for transplants received out of state will be contractually negotiated with the transplant facility for up to 70% of billed charges. Medicaid will reimburse providers using the current FMAP. All hospitals providing transplant services must be a Medicare approved transplant facility.

**KANSAS MEDICAID STATE PLAN**

**PHYSICIAN SERVICES**

**Attachment 4.19-B  
#5  
Page 5**

**Reimbursement for bariatric procedures were established based upon 85% of the current Medicare fee schedule rates when billed separately for professional services. Kansas Medicaid will reimburse Centers of Excellence providers for bariatric surgery for services rendered to Medicaid beneficiaries when selection criteria are met.**

**TN #KS 13-01 Approval Date FEB 20 2014 Effective Date 01/18/13 Supersedes TN# New**

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-B

#6.a.

Page 1

## Targeted Case Management

“Reimbursement for Targeted Case Management Services (TCM) for individuals meeting criteria for mental health (MH), intellectual and/or developmental disabilities (IDD), brain injury (BI), physical disabilities (PD), frail elderly (FE) and early inter family services coordination (FSC) is based on a fee schedule established by the State of Kansas.

The agency’s TCM reimbursement rates for MH, BI, PD, and FE were set as of July 1, 2007 and are effective for services on or after that date. All rates are published on the agency’s website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of targeted case management services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency’s website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for IDD TCM reimbursement. The agency’s fee schedule rate was set as of July 1, 2023, and is effective for services provided on or after that date. The agency’s established fee schedule rates are published on the agency’s website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for FSC TCM reimbursement. The agency’s fee schedule rate was set as of October 1, 2024, and is effective for services provided on or after that date. The agency’s established fee schedule rates are published on the agency’s website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

The link in the paragraphs above will take the user to a page titled “Reference Copyright Notice.” Scroll to the bottom of the page and click on the word “Accept” to access the fee schedule. The next page that appears is titled “KMAP Fee Schedules.”

To access a fee schedule:

- a. Select the program from the drop-down list -TXIX;
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KANSAS MEDICAID STATE PLAN

Attachment 4.19B

6b

Methods and Standards for Establishing Payment Rates

#6b Optometrist's Services

Optometrist's services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges, except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

State Plan

Trans. No. MS-83-42

Submitted 9-28-83

Approved 11-22-83

**KANSAS MEDICAID STATE PLAN**

Attachment 4.19B

**Methods and Standards for Establishing Payment Rates**

**#6c Chiropractor's Services**

Chiropractor's services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges, except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

State Plan

Trans. No. MS-83-43

Submitted 9-28-83

Approved 11-22-83

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#6.d.

## **Other Practitioner's Services Methods and Standards for Establishing Payment Rates**

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Kansas.

Effective January 1, 2022, additional varicose vein treatment modalities reimbursement rates have been added to the plan.

Effective January 1, 2023, reimbursement rates for LMHP visits in nursing facilities have been added to the state plan.

Effective July 1, 2023, reimbursement rates for Community Health Workers have been added to the state plan.

Effective August 1, 2023, reimbursement rates for Pharmacists as Providers have been added to the state plan.

Effective July 1, 2024, reimbursement rates for Sleep Study Services have been added to the state plan.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of July 1, 2024 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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Revised Submission 10.29.12

**KANSAS MEDICAID STATE PLAN**

Attachment 4.19-B

#6.d.

Page 1

**Other Practitioner's Services  
Methods and Standards for Establishing Payment Rates (continued)**

A vaccine administration fee of \$14.15 may be paid to pharmacy providers certified to administer vaccines. Proof of certification must be on file with Medicaid. Certified pharmacists are required to submit proof of certification required by K.S.A. 65-1626 to the Provider Enrollment department in order to be eligible for vaccine administration reimbursement.

TN # KS 12-03 Approval Date JAN 22 2013 Effective Date 08/03/12 Supersedes TN # New

**Other Practitioner's Services  
Methods and Standards for Establishing Payment Rates**

Mid-Level Obstetrical Practitioners

Mid-level obstetrical practitioners are paid fee schedule rates.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of January 1, 2022 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp>

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**Other Practitioner's Services  
Methods and Standards for Establishing Payment Rates**

Medication Therapy Management (MTM) Intervention Services

Pharmacists are paid fee schedule rates.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of January 1, 2025 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at

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**Other Practitioner’s Services  
Methods and Standards for Establishing Payment Rates**

Psychiatric Collaborative Care Services

Psychiatric collaborative care practitioners are paid fee schedule rates.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency’s fee schedule rate was set as of January 1, 2025 and is effective for services provided on or after that date. The agency’s established fee schedule rates are published on the agency’s website at

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## KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#7

### Home Health Services Methods and Standards for Establishing Payment Rates

Home health services are reimbursed per unit of service provided. Kansas Medicaid establishes individual rates for the following units of service:

- Skilled nursing services
- Physical therapy services
- Occupational therapy services
- Speech therapy services
- Home health aide services
- Restorative Aide services

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the home health services noted above. The agency's fee schedule rate was set as of March 1, 2010 and is effective for services provided on and after that date. All rates are published at

<https://www.kmap-state-ks.us/Provider/PRICING/Disclaimer.asp?goto=/Provider/PRICING/HCPCSSearch.asp>

Revised Submission 9.23.11

**KANSAS MEDICAID STATE PLAN**

Attachment 4.19-B  
#8

Freestanding Birth Centers  
Methods and Standards for Establishing Payment Rates

Freestanding Birth Centers (Maternity Centers)

These centers are reimbursed on the basis of the lesser of the Medicaid fee-for-service rate, or customary charges. This reimbursement is for the facility component. Professionals working in the centers may bill for Medicaid professional fee reimbursement.

TN# 11-01 Approval Date NOV 02 2011 Effective Date 07/01/10 Supercedes TN# New

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#9

## Methods and Standards for Establishing Payment Rates

### Clinical Services

#### Day Treatment Programs

Adult day health services are reimbursed on the basis of a negotiated rate.

#### Ambulatory Surgical Centers

Ambulatory surgical centers are reimbursed on the basis of a rate determined by Medicaid customary charges. Payments may not exceed reasonable fees as related to customary charges, whichever is less.

Effective January 1, 2021 and thereafter, cardiac catheterization services will be reimbursed as described on Att. 4.19-B, #1.

Effective January 1, 2022, additional varicose vein treatment modalities will be reimbursed as described on Att. 4.19-B, #1.

#### Local Health Departments

Local health departments are reimbursed on the basis of reasonable fees as related to customary charges within range maximums.

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#10

## **Dental Services** **Methods and Standards for Establishing Payment Rates**

Dental services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services. The agency's fee schedule rate was set as of July 1, 2025 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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## KANSAS MEDICAID STATE PLAN

**Attachment 4.19-B**  
**#11 a, b, c, d**  
**Page 1**

### Methods and Standards for Establishing Rates

#11 a, b, c, d. Physical Therapy, Occupational Therapy, Speech, Hearing, and Language Disorders, Wheelchair Seating Assessments

Inpatient Hospital – services are reimbursed in accordance with the payment methodology described in Attachment 4.19-A

Outpatient Hospital – services are reimbursed in accordance with the payment methodology described in Attachment 4.19-B #1, with the exception of wheelchair seating assessment services which are reimbursed by fee schedule as described on page 11 a, b, c, d below.

Home Health Agency – services are reimbursed in accordance with the payment methodology described in Attachment 4.19-B #7

Physician – services are reimbursed in accordance with the payment methodology described in Attachment 4.19-B #5

Hearing aid services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a statewide maximum. Provider representatives are consulted in reviewing the maximum rate. The statewide maximum rate is found on the fee schedule referenced in the payment methodology described in Attachment 4.19-B #12c, Paragraph 5.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of October 1, 2021 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp>

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KS 21-0017 Approval Date 11/12/2021 Effective Date 10/1/21 Supersedes KS 20-0015

## KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#11 a, b, c, d  
Page 2

### Methods and Standards for Establishing Rates

#11 a, b, c, d. Physical Therapy, Occupational Therapy, Speech, Hearing, and Language Disorders, Wheelchair Seating Assessments (cont.)

Wheelchair seating assessment reimbursements are capped, except as medically necessary, at \$500 per beneficiary per year. The reimbursement codes are set at 85% of non-rural Medicare rates as set on January 1 of each year. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for wheelchair seating assessments and hearing aid services. The agency's fee schedule rate for wheelchair assessment services and hearing aid services were set as of July 1, 2020 and January 1, 2019, respectively, and are effective for wheelchair seating assessments and hearing aid services provided on or after those dates, with the wheelchair assessment rates updated on an annual basis as noted above and effective beginning January 1 of each year beginning January 1, 2021. The agency's established fee schedule rates are published on the agency's website at <https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp>

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Prescribed Drugs  
Methods and Standards for Establishing Payment Rates

Reimbursement to pharmacy providers is based upon agency-determined allowable product cost for covered drugs plus an agency-determined dispensing fee.

Fee-for-service providers: Pharmacy

1. Payment for covered outpatient legend and non-legend drugs dispensed by a retail community pharmacy will include the drug ingredient cost plus a professional dispensing fee of \$10.50. The drug ingredient cost reimbursement shall be the lowest of:
  - a) The National Average Drug Acquisition Cost (NADAC) of the drug; or
  - b) Generic NADAC; or
  - c) Wholesale Acquisition Cost (WAC) + 0%; or
  - d) The Federal Upper Limit (FUL); or
  - e) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge. No dispensing fee given; or
  - f) Pharmacy submitted ingredient cost; or
  - g) SMAC (State Maximum Allowable Cost).
  
2. Payment for specialty drugs not dispensed by a retail community pharmacy but dispensed primarily through the mail will include the drug ingredient cost plus a professional dispensing fee of \$10.50. The drug ingredient cost reimbursement shall be the lowest of:
  - a) The National Average Drug Acquisition Cost (NADAC) of the drug; or
  - b) Generic NADAC; or
  - c) Wholesale Acquisition Cost (WAC) + 0%; or
  - d) The Federal Upper Limit (FUL); or
  - e) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge. No dispensing fee given; or
  - f) Pharmacy submitted ingredient cost; or
  - g) SMAC (State Maximum Allowable Cost).
  
3. Payment for covered outpatient legend and non-legend drugs dispensed primarily by a mail order pharmacy will include the drug ingredient cost plus a professional dispensing fee of \$10.50. The drug ingredient cost reimbursement shall be the lowest of:
  - a) The National Average Drug Acquisition Cost (NADAC) of the drug; or
  - b) Generic NADAC; or
  - c) Wholesale Acquisition Cost (WAC) + 0%; or
  - d) The Federal Upper Limit (FUL); or

## KANSAS MEDICAID STATE PLAN

Attachment 4.19-B

#12.a.

Page 1.1

### Prescribed Drugs Methods and Standards for Establishing Payment Rates

- e) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge. No dispensing fee given; or
  - f) Pharmacy submitted ingredient cost; or
  - g) SMAC (State Maximum Allowable Cost).
4. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence will include the drug ingredient cost plus a professional dispensing fee of \$10.50. The drug ingredient cost reimbursement shall be the lowest of:
- a) The National Average Drug Acquisition Cost (NADAC) of the drug; or
  - b) Generic NADAC; or
  - c) Wholesale Acquisition Cost (WAC) + 0%; or
  - d) The Federal Upper Limit (FUL); or
  - e) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge. No dispensing fee given; or
  - f) Pharmacy submitted ingredient cost; or
  - g) SMAC (State Maximum Allowable Cost).
5. Payment for pharmacies providing covered outpatient prescription services for Certified Long-Term Care beneficiaries will include the drug ingredient cost plus a professional dispensing fee of \$10.50. The drug ingredient cost reimbursement shall be the lowest of:
- a) The National Average Drug Acquisition Cost (NADAC) of the drug; or
  - b) Generic NADAC; or
  - c) Wholesale Acquisition Cost (WAC) + 0%; or
  - d) The Federal Upper Limit (FUL); or
  - e) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge. No dispensing fee given; or
  - f) Pharmacy submitted ingredient cost; or
  - g) SMAC (State Maximum Allowable Cost).
6. Payment for Dispense as Written 1 (DAW1) – Approved pharmacy claims, in sections 1 through 5 above, will be reimbursed the drug ingredient cost plus a professional dispensing fee of \$10.50. The drug ingredient cost reimbursement shall be the lowest of:
- a) The National Average Drug Acquisition Cost (NADAC) of the drug; or
  - b) Wholesale Acquisition Cost (WAC) + 0%; or
  - c) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge. No dispensing fee given; or
  - d) Pharmacy submitted ingredient cost.

## KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#12.a.  
Page 1.2

### Prescribed Drugs Methods and Standards for Establishing Payment Rates

7. Physician Administered Drugs (PADS) submitted under the medical benefit, including those drugs purchased through the 340B program, will be reimbursed at Medicare Part B fee schedule rates. If a Medicare Part B fee schedule rate is not on file, its reimbursement basis will be WAC + 0%.
8. Covered Legend and non-legend drugs purchased through the Public Health Service's 340B Drug Pricing Program (340B) by pharmacies that carve Medicaid into the 340B Drug Pricing Program shall be reimbursed at the 340B actual invoice price, but no more than the 340B Ceiling Price plus a dispensing fee of \$10.50. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B Contract Pharmacies will not be reimbursed.
9. Facilities purchasing drugs through the Federal Supply Scheduled (FSS) or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program will be reimbursed no more than the acquisition cost price plus a professional dispensing fee of \$10.50.
10. Facilities purchasing drugs at Nominal Price (outside of 340B or FFS) will be reimbursed no more than the Nominal Price plus a professional dispensing fee of \$10.50.
11. Payment to Indian Health Services (IHS) and Tribal/Urban pharmacy providers will be no more than the acquisition cost plus a professional dispensing fee of \$10.50.
12. Payment for prescribed drugs that are not considered covered outpatient drugs will follow the same reimbursement methodologies as covered outpatient drugs.
13. Investigational drugs are not a covered service under the Medicaid pharmacy program.

**KANSAS MEDICAID STATE PLAN**

Attachment 4.19-B  
#12.a., page 1a

**Reimbursement for Unused Drugs from Long Term Care Facility**

If a drug product is issued to a patient of a long-term care facility and subsequently is not used, the long-term care facility shall return the drug product to the vendor pharmacy for repackaging and crediting to the secretary if the drug product meets all of the following conditions:

1. The drug product is a prescription drug product that is not a controlled substance.
2. The drug product is sealed in individually packaged units or in a multiple-dose, sealed container approved by the federal food and drug administration from which no doses have been withdrawn.
3. The drug product is returned to the vendor pharmacy at least 90 days before the expiration date.
4. The drug product is determined to be of acceptable integrity by a licensed pharmacist.

Each long-term care facility shall establish procedures for the return of unused drug products to the vendor pharmacy from which the unused drug products were received.

Each provider of pharmacy services may be reimbursed the reasonable cost of returning and crediting unused drug products, as determined by the secretary, described in the following table:

Level	Credited Prescription Amount	Adjusted Dispensing Fee
1	\$5.00 - \$8.25	\$1.70
2	\$8.26 - \$11.50	\$2.50
3	\$11.51 - \$14.75	\$3.25
4	\$14.76 - \$17.99	\$4.00
5	\$18.00 and over	\$4.50

After prior notification of each provider, reimbursement under the unused drug return program may be denied for any of the following:

1. Certain drugs determined by the secretary to be less than effective;
2. Drugs that do not meet the requirements of section 1927 of the Social Security Act;
3. Drugs restricted by the secretary under the provisions of section 1927 of the social security act, 42 U.S.C. 1396r-8 regarding permissible restrictions.

## KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#12.b.

### Methods and Standards for Establishing Payment Rates

#### Dentures

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of July 1, 2023 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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# KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#12 c  
Page 1

## Methods and Standards for Establishing Payment Rates

### **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**

- (1) To satisfy the statute at 1903(i)(27) of the Social Security Act, if the item of DMEPOS is covered by Medicare, the Medicaid fee will be 80% of the Non-Rural Medicare fee schedule. State Only Funds will be used when access issues arise.
- (2) For items of DMEPOS not paid at the Medicare fee, the fee will be set by the State Medicaid agency and will be determined from pricing information gathered from providers, manufacturers, surveys of the Medicaid fees for other states, survey information from national fee analyzers, or other relevant fee-related information.
- (3) Manual pricing is reasonable when one procedure code covers a broad range of items with a broad range of costs, since a single fee may not be a reasonable fee for all items covered under the procedure code, resulting in access-to-care issues. Examples include 1) procedure codes with a description of “not otherwise specified,” “unclassified,” or “other miscellaneous;” and 2) procedure codes covering customized items.
- (4) The Medicaid fees for oxygen equipment, oxygen, and oxygen-related supplies will be 80% of the Non-Rural Medicare fee schedule, as stated in Section (1), for the same procedure code.
- (5) Effective May 1, 2020, the manual pricing rules for Total Parenteral Nutrition (TPN) solutions are replaced with a fee schedule of reimbursement codes.
- (6) Effective July 1, 2023, self-monitoring blood pressure devices are added to the DMEPOS list.
- (7) Effective January 1, 2024, subcutaneous continuous glucose monitors (CGM) are added to the DMEPOS list.
- (8) Effective July 1, 2024, positive air pressure (PAP) devices and accessories are added to the DMEPOS list.
- (9) Effective July 1, 2024, selected wheelchair cushion replacements are added to the DMEPOS list.
- (10) Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency’s fee schedule rate was set as of July 1, 2024 and is effective for services provided on or after that date. The agency’s established fee schedule rates are published on the agency’s website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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KS 24-0010 Approval Date August 14, 2024 Effective Date 7/1/2024 Supersedes KS 23-0045

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Methods and Standards for Establishing Payment Rates

**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**

(Reserved for Later Use)

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Page 1

Methods and Standards for Establishing Payment Rates

**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**

Normal Daily Enteral Nutrition for Age 0 Through Age 4

Kansas Medicaid is the primary payor for exempt enteral formula for normal daily nutrition for members, age 0 through age 4, with an Inherited Error of Metabolism (IEM), specified gastrointestinal disorders or specified malabsorption disorders. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is the secondary payor.

Reimbursement will be invoiced at provider cost plus 35%. A valid invoice is required when billing for these products.

**KANSAS MEDICAID STATE PLAN**

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#12.c.2

**Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)  
Maintenance and Repair  
Methods and Standards for Establishing Payment Rates**

Effective January 1, 2023, DMEPOS maintenance and repair services are paid fee schedule rates at 65% of the Medicare fee schedule.

Effective April 1, 2025, DMEPOS maintenance and repair services are paid fee schedule rates at 80% of the Medicare fee schedule.

Effective October 1, 2025, annual preventive maintenance, up to one hour per year, will be allowed for DMEPOS equipment and devices that are no longer under manufacturer warranty. No prior authorization is required.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of DMEPOS maintenance and repair services. The agency's fee schedule rate was set as of October 1, 2025 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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**KANSAS MEDICAID STATE PLAN**

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#12.c.3

Methods and Standards for Establishing Payment Rates

**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**

**Low Profile G-Tubes**

Low profile G-tubes and accompanying extension sets are covered at invoice cost plus 35%. A valid invoice is required when billing for these products.

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#12.c.4

## Methods and Standards for Establishing Payment Rates

### **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**

#### **Bath and Toilet Aids**

1. Select reimbursement rates are set at \$75.
2. Other reimbursement rates will be manually priced using the Manufacturer Suggested Retail Price (MSRP), minus 20%. Note: All MSRPs must be official from the manufacturer.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of January 1, 2024 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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KANSAS MEDICAID STATE PLAN

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12d

Methods and Standards for Establishing Payment Rates

#12d Eyeglasses

Eyeglasses are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a Statewide maximum. Provider representatives are consulted in reviewing the maximum rate.

State Plan

MS-83-53

9-28-83

11-22-83

## KANSAS MEDICAID STATE PLAN

Attachment 4.19-B  
#13.b.

### SCREENING SERVICES

#### Maternal Depression Screening Services

Effective January 1, 2021, Maternal Depression Screening services are added to the state plan.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers these screening services. The agency's fee schedule rate for maternal depression screening services was set as of January 1, 2021 and is effective for this service provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp>

When the user is on the landing page of the above link, select the link Download Fee Schedules. This link will take the user to a page titled "Reference Copyright Notice." Scroll to the bottom of the page and click on the word "Accept" to access the fee schedule. The next page that appears is titled "KMAP Fee Schedules."

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## KANSAS MEDICAID STATE PLAN

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#13.c.

### PREVENTIVE SERVICES

#### Tobacco Cessation Counseling Services

Except as otherwise noted in the plan, the state-developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of September 21, 2018 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://www.kmap-state-ks.us>.

## KANSAS MEDICAID STATE PLAN

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#13.c.1  
Page 1

### PREVENTIVE SERVICES LIMITATIONS

#### Immunization Services Vaccines, Administration, and Counseling

##### **Vaccines:**

1. Adult vaccines are listed on the KMAP fee schedule.
2. Childhood vaccines are covered by the VFC Program.

##### **Administration:**

1. The administration fees for vaccines:
  - a. Adults – See Attachment 4.19-B, #6.d., Page 1;
  - b. Children – See Section 4 – General Program Administration, Pediatric Immunization.

##### **Counseling:**

1. EPSDT vaccine counseling is content of service if the counseling and vaccine occur on the same date of service.
2. EPSDT stand-alone vaccine counseling may be billed separately from the vaccine if the counseling for the vaccine and the administration of the vaccine occur on different dates of service.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above immunization services. The agency's fee schedule rate was set as of April 1, 2023 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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## KANSAS MEDICAID STATE PLAN

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#13.c.2.  
Page 1

### PREVENTIVE SERVICES LIMITATIONS

#### Methods and Standards for Establishing Payment Rates Diabetes Self-Management Training (DSMT)

DSMT will be reimbursed at 75% of the Medicare rate.

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# KANSAS MEDICAID STATE PLAN

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#13.c.3.  
Page 1

## PREVENTIVE SERVICES LIMITATIONS

### Methods and Standards for Establishing Payment Rates

#### Management of Self-monitoring Blood Pressure (SMBP) Treatment Plan

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of January 1, 2024 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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# KANSAS MEDICAID STATE PLAN

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#13.c.4.  
Page 1

## PREVENTIVE SERVICES LIMITATIONS

### Methods and Standards for Establishing Payment Rates

#### Subcutaneous Continuous Glucose Monitors (CGM) Support

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# KANSAS MEDICAID STATE PLAN

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#13.c.5.  
Page 1

## PREVENTIVE SERVICES LIMITATIONS

### Methods and Standards for Establishing Payment Rates

#### Doula Services

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of July 1, 2024 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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## KANSAS MEDICAID STATE PLAN

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#13.c.6.  
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### PREVENTIVE SERVICES LIMITATIONS

#### Methods and Standards for Establishing Payment Rates

##### RN Education Visits for Elevated Blood Lead Levels

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of October 1, 2024 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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Page 1

### PREVENTIVE SERVICES LIMITATIONS

#### Methods and Standards for Establishing Payment Rates

##### Lead Hazard Risk Assessments

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of October 1, 2024 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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KS 24-0023  
Supersedes: New

Approval Date: 11/26/2024

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**Rehabilitation Services  
Methods and Standards for Establishing Payment Rates**

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Kansas. Commercial third-party payers and market rates will be considered when establishing the fee schedules. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(30)(A) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, if applicable. If a service has no Kansas specific Medicare rate, Kansas will establish pricing based on similar services. Room and board costs are not included in the Medicaid fee schedule.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of behavioral health services. The agency's fee schedule rate was set as of July 1, 2022 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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Page 2

### Rehabilitation Services Methods and Standards for Establishing Payment Rates

based on, as appropriate, costs, charges, Medicare limits, and other information which is relevant. No fee will be paid in excess of the range maximum. Room, board, and maintenance costs for Therapeutic Foster Care and Residential Group Treatment are not reimbursable.

For these providers, payments are made on a case rate basis. These providers have negotiated and signed contracts with the Department of Social and Rehabilitation Services. The amount to be claimed for federal Medicaid reimbursement is determined as follows:

- 1) Encounter data is collected for each service provided.
- 2) When all eligibility criteria are met, the Medicaid fee-for-service payment rate is multiplied times the number of services provided to determine the Medicaid allowable cost.
- 3) The amounts determined above in steps 1 and 2, for each Medicaid eligible individual, are totaled.
- 4) The amounts paid to the provider, for each Medicaid eligible individual, are totaled.
- 5) The lesser of the amounts determined in steps 3 and 4 is the amount claimable to federal financial participation for each Medicaid eligible individual.
- 6) The amounts determined in step 5 above is accumulated for all Medicaid eligible individuals.

The net effect of this computation is that the federal financial participation is charged no more than the fee-for-service rates already in effect for the same eligible individuals and existing Medicaid eligible services given actual usage of services.

All charges for federal financial participation are based on actual encounter data and the steps described above.

All services listed in sections A and B as well as behavior management targeted case management are included in the contractual arrangements and are subject to this payment methodology .

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**D. Local Education Services (cont.)**

**Rehabilitation Services**

For local education agency services, payment for rehabilitation services will be made on a monthly blended rate basis. This methodology uses a single monthly payment rate to reimburse districts and cooperatives for the full range of medically necessary medical services authorized as part of an Individualized Education Program (IEP). The blended rates were developed for groupings of children identified by their primary disability diagnosis established in the IEP process. The grouping of children by disability diagnosis was used to reflect the similarities in treatment plans and costs for children with the same type of disability.

The blended rate setting methodology is similar to the payment practices used in hospital Diagnosis Related Grouping (DRG) payment systems. This methodology uses actual cost and historical utilization factors to develop a global fee to reimburse providers for the medically necessary services used to treat the child with the diagnosed disability. The blended rate method establishes a fixed individual monthly fee based on the diagnosed disability. In other words, the same monthly diagnosis based payment will be made for each similarly diagnosed individual, based on the historical costs and units of service to be consumed. Appropriate rate setting practices and statistical probability will ensure that, over time, appropriate financial reimbursement will be made for each diagnosis class member. Reimbursement levels will be reviewed annually to determine if inflationary adjustments are necessary.

**E. Long-Term Head Injury Rehabilitation Facility Services**

For long-term head injury rehabilitation services provided in a Head Injury Rehabilitation Facility, reimbursement shall be based upon a negotiated daily rate amount pursuant to a contract with each provider.

**Rehabilitation Services  
Methods and Standards for Establishing Payment Rates**

**Mobile Crisis Intervention**

Mobile Crisis Intervention services, as provided by professional staff employed by a Licensed Mental Health Professional (LMHP) or a Qualified Mental Health Professional (QMHP), are reimbursed in fifteen-minute increments.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of July 1, 2024 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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**Rehabilitation Services  
Methods and Standards for Establishing Payment Rates**

Family Psychotherapy (without patient present) is reimbursed in fifty-minute increments.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of May 1, 2022 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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## Methods and Standards for Establishing Payment Rates Certified Community Behavioral Health Center (CCBHC)

Certified Community Behavioral Health Center (CCBHC) services include a comprehensive and integrated package of mental health and substance use disorder treatment services and supports and physical health services.

The state reimburses CCBHC providers on a per visit basis using a provider specific bundled daily payment rate when any of the services listed below in (1) and (2) are provided. The bundled payment represents the daily cost of providing CCBHC services. A CCBHC provider receives payment for each day CCBHC services are provided to a Medicaid member. Payment is limited to one payment per day, per CCBHC, per member for each CCBHC visit. Visits eligible for reimbursement include days on which at least one CCBHC service is provided to a member. Care coordination alone is not eligible to be reimbursed at the daily CCBHC bundled rate.

The daily bundled rate for CCBHC services will be paid when a CCBHC program delivers at least one CCBH bundled code, which includes one of the services specified in (1) and (2) below, and when a valid individual procedure code is reported for a date of service. While care coordination is a CCBHC service, it is not eligible to be reimbursed at the daily CCBHC bundled rate.

1. **CCBHC Rehabilitative Services** – The daily CCBHC bundled payment is inclusive of all CCBHC rehabilitative services described under the Rehabilitative Services benefit (§13.d.) in Attachment 3.1-A
2. **Other State Plan Covered Services** – The daily CCBHC bundled payment includes services covered elsewhere in the plan (see table below).

CCBHC Activity/Service	Medicaid Authority	State Plan Page
Targeted Case Management	Targeted Case Management	Supplement 1 to Attachment 3.1-A, Page 3
Primary care screening and monitoring	Physician Services	Attachment 3.1-A, #5a, Page 1
Tobacco Cessation	Face-to-Face Tobacco Cessation Counseling Services	Attachment 3.1-A, #13c Attachment 3.1-A, #4d, Page 1

Effective May 1, 2022, payments for CCBHC services will be made using the following methodology. The payment rate for CCBHC services is based on the total annual allowable

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### **Methods and Standards for Establishing Payment Rates Certified Community Behavioral Health Center (CCBHC)**

CCBHC costs divided by the total annual number of CCBHC visits. For the purposes of calculating rates, visits include all visits for CCBHC services including both Medicaid and non-Medicaid visits. Allowable direct and indirect costs are identified using requirements in 45 CFR §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement.

CCBHCs must provide data on costs and visits to the department annually using the CMS CCBHC cost report. Annual CCBHC cost reports based on audited financials are due to the state by September. Upon receipt from the CCBHC, the cost reports are reviewed independently by the Kansas Department of Aging and Disability Services' (KDADS) audit staff or a qualified Certified Public Accountant (reviewer). Upon acceptance of the CCBHC cost reports by KDADS based on the recommendation from the reviewer, the state sets the rates for the following rate year. The initial rate period begins May 1, 2022, for the first year and follows the calendar year thereafter, subsequent to the reporting year of the cost report. Each cost report will include one full year of expense and visit data, with a reporting period of the state fiscal year. For the clinics qualifying to begin May 1, 2022, the initial rate period will be from May 1, 2022, to December 31, 2023. After the initial rate period for each clinic, the rate period will follow the calendar year.

For the initial year of the CCBHC, the state will establish a provider-specific bundled daily payment rate using audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates shall include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period. Expected costs will be based on estimates for salaries and expected visits per Full-Time Employee (FTE) plus projected costs for non-wage expenses, including indirect costs. Salary data available from recent studies of the Kansas market and the Bureau of Labor Statistics will guide the reasonableness of expected wages for new FTEs. The initial rates include expected costs and visits that are subject to review by a Certified Public Accountant or the KDADS' audit staff. The bundled daily rate is calculated by dividing the total annual allowable expected costs of CCBHC services by the total annual number of expected CCBHC Medicaid and non-Medicaid visits and adjusted from the reporting period to the rate period using the Medicare Economic Index (MEI).

Initial payment rates are rebased once the CCBHC submits the first audited cost report including a full year of actual cost and visit data for CCBHC services under the state plan.

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### **Methods and Standards for Establishing Payment Rates Certified Community Behavioral Health Center (CCBHC)**

These initial rates are rebased using actual data on costs and visits and adjusted for the following rate period using the MEI. Once the final rate is calculated using a year of actual costs, the state will reconcile previous payments made with the initial payment rate to cost if actual costs are less than total payments. These final rates will then be the effective rate at the beginning of the next rate year the following January. Rates will be adjusted annually using the MEI, or rebased using actual, annual cost data and visits adjusted for the effective rate period using the MEI as indicated below.

CCBHC payment rates are rebased after an initial rate period, following a rate adjustment for a change in scope, and every three years. Rates are rebased at least once every three years, by dividing the total annual allowable costs for CCBHC services from the CCBHC's most recent 12-month audited cost report by the total annual number of CCBHC visits during that 12-month time period. The resulting rate is trended from the midpoint of the cost year to the midpoint of the rate year using the MEI.

CCBHC providers may request a rate adjustment for changes in scope expected to change individual CCBHC provider payment rates by 2.5 percent or more. The provider must submit information to the state regarding changes in the scope of services, including changes in the type, intensity, or duration of services, the actual or expected cost of providing the new or modified services, and any projected increase or decrease in the number of visits resulting from the change. If twelve months of actual data is not available, the CCBHC provider may use projections of expected costs and visits. Projections are subject to review by KDADS' audit staff or a qualified Certified Public Accountant.

Provider-specific rate adjustments for changes in scope are permitted no more than once per year and take effect with annual rate updates.

Rates adjusted for a change in scope using expected cost and visit data are rebased once the CCBHC submits the first cost report with a full year of cost and visit data including the change in scope.

**Rehabilitation Services  
Methods and Standards for Establishing Payment Rates**

Parent Peer Support is reimbursed in fifteen-minute increments.

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**Rehabilitation Services  
Methods and Standards for Establishing Payment Rates**

**Peer Support Services**

Peer Support Services may be billed by physicians and other licensed providers within their scope of practice.

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**Rehabilitation Services  
Methods and Standards for Establishing Payment Rates**

**Partial Hospitalization Psychiatric Care (PHP)/Intensive Outpatient Treatment (IOP)**

PHP and IOP Services are paid per diem rates.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of January 1, 2025 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at

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**Rehabilitation Services**

**Pulmonary Rehabilitation  
Methods and Standards for Establishing Payment Rates**

Pulmonary rehabilitation services are paid fee schedule rates set at 80 percent of Medicare pulmonary rehabilitation services rates.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of pulmonary rehabilitation services. The agency's fee schedule rate was set as of January 1, 2023 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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Methods and Standards for Establishing Payment Rates

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#14b Services for Individuals Age 65 or Older in Institutions  
for Mental Diseases

- (1) Inpatient Hospital - See Attachment 4.19-A
- (2) Intermediate Care Facility - See Attachment 4.19-D

State Plan

Trans. No. MS-83-55

Standard 9-28-83

Approval 11-22-83

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Methods and Standards for Establishing Payment Rates

#15 Intermediate Care Facility Services

See Attachment 4.19-D

State Plan

Trans. No. MS-83-54

Submitted 9-28-83

Approved 11-22-83

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Methods and Standards for Establishing Payment Rates

#16 Inpatient Psychiatric Services for Individuals Under 22

See Attachment 4.19-A

State Plan

Trans. No. MS-83-57

Effective 9-28-83

Trans. No. 11-22-83

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## **Nurse-Midwife Services Methods and Standards for Establishing Payment Rates**

Nurse-midwives are paid fee schedule rates.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of October 1, 2024 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at <https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/Disclaimer?searchBy=ScheduleList>

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Hospice Services  
Methods and Standards for Establishing Payment Rates

Payments for hospice services payments are effective October 1<sup>st</sup> annually and are equivalent to the annual Medicaid hospice rates published by CMS with the application of the current hospice wage index.

For each day that an individual is under the care of a hospice, the hospice is paid an amount applicable to the type and intensity of the service furnished to the individual for that day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. A description of each level of care follows.

- A. Routine Home Care – The hospice is paid at one of two routine home care rates for each day the patient is under the care of the hospice and no other hospice rate is paid. This rate is paid without regard to the volume or intensity of services provided on any given day.
  1. Providers are paid at two different rates:
    - a. Days 1 through 60;
    - b. Days 61 and longer.
- B. Continuous Home Care – The hospice is paid at the continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours per day must be provided. The hospice is paid for every hour or part of an hour that continuous care is furnished up to a maximum of 24 hours a day.
- C. Inpatient Respite Care – The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Respite care is paid for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. The sixth and any subsequent days are paid at the routine home care rate.
- D. General Inpatient Care – Payment is made at the general inpatient rate when general inpatient care is provided.
- E. Service Intensity Add-on (SIA) – An SIA payment is paid for visits made by a social worker or a registered nurse, when provided during routine home care in the last seven days of life. The SIA payment is in addition to the routine home care rate. The SIA payment will be equal to the continuous home care hourly rate, multiplied by the hours of nursing or social work provided (up to four hours total) that occurred on the day of service. The SIA payment will also be adjusted by the appropriate hospice wage index.

Hospice Nursing Facility Room and Board—Hospice nursing facility room and board per diem rates are reimbursed to the hospice provider at a rate equal to 100% of the skilled nursing facility rate, less any Post Eligibility Treatment of Income amount (amount an individual in an institution is able to contribute to cost of his/her own care) for Medicaid clients who are receiving hospice services. The hospice provider is responsible for passing the room and board payment through to the nursing facility.

Hospice providers that do not comply with hospice quality data submission will be subject to hospice payments with a 4% market basket reduction.

Physician services will be reimbursed in accordance with Medicaid reimbursement policy for physician services based on the lower of the actual charge or the Medicaid maximum allowable amount for the specific service.

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning October 1 of each year and ending September 30, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20% of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied once each year, at the end of the hospices' cap period.

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Emergency Hospital Services  
Methods and Standards for Establishing Payment Rates

Emergency hospital services are reimbursed on the basis of the reimbursement methodology for comparable services rendered by non-hospital providers.

Laboratory and radiology services relating to emergency hospital services are reimbursed according to the customary charges not to exceed range maximums plus two percent.

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(Reserve for future use)

TN # 08-14 Approval Date NOV 17 2008 Effective Date 08/01/08 Supersedes MS87-12

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**Pediatric or Family Nurse Practitioners' Services  
Pursuant to OBRA 1989  
Methods and Standards for Establishing Payment Rates**

Pediatric or family nurse practitioners' services pursuant to OBRA 1989 are reimbursed at the lesser of the billed charges or at 75% of the maximum rate. Kan Be Healthy (EPSDT) and anesthesiology are reimbursed at the lesser of the billed charges or at the maximum rate.

TN#MS-90-35 Approval Date 10/4/90 Effective Date 7/1/90 Supercedes TN# Nothing

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## Methods and Standards for Establishing Payment Rates

### Transportation

#### Ambulance

Ambulance transportation services are paid fee schedule rates.

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# KANSAS MEDICAID STATE PLAN

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## Methods and Standards for Establishing Payment Rates

### Transportation

#### Non-Emergency Medical Transportation (NEMT)

Motor carrier services are paid fee schedule rates.

Subsistence services are paid fee schedule rates.

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When the user is on the landing page of the above link, select the link [Download Fee Schedules](#). This link will take the user to a page titled "Reference Copyright Notice." Scroll to the bottom of the page and click on the word "Accept" to access the fee schedule. The next page that appears is titled "KMAP Fee Schedules."

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### REIMBURSEMENT FOR INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH FACILITIES Methods and Standards for Payment Rates

For services provided by a qualified facility operated by the Indian Health Service or tribal governments, the applicable Office of Management and Budget (OMB) rate will be paid as published and specified in the Federal Register.

For purposes of being designated as an FQHC by Medicaid, Tribal 638 or IHS health program facilities need not meet any requirement other than being operated by a Tribe or Tribal organization under P.L. 93-638.

#### Encounter reimbursement of IHS and Tribal 638 Facilities

Services included in the all-inclusive rate are jointly determined by CMS and IHS. Services that are billable to Kansas Medicaid would include all professional services in the State Plan.

Reimbursement is made for an individual medical, dental, and outpatient behavioral health encounter per member per day. Reimbursement for more than one outpatient visit within a 24-hour period is made when services are provided for a distinctly different diagnosis.

#### Alternative Payment Methodology for Tribal Facilities Recognized as FQHCs

Effective January 30, 2021, tribal facilities that enroll in Kansas Medicaid as a Tribal Federally Qualified Health Center (Tribal FQHC) will be paid using an alternative payment methodology (APM) that is the published all-inclusive rate. Tribal facilities must agree to the APM.

The agency establishes a Prospective Payment System (PPS) methodology for the Tribal FQHCs so that the agency can determine on an annual basis that the published all-inclusive rate is higher than the PPS rate. The PPS rate is established by reference to payment to one or more other clinics in the same or adjacent areas with similar caseloads. Tribal FQHCs are not required to report their costs for the purposes of establishing a PPS rate.

Reimbursement is made for an individual medical, dental, and outpatient behavioral health encounter per member per day. Reimbursement for more than one outpatient visit within a 24-hour period is made when services are provided for a distinctly different diagnosis.

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REIMBURSEMENT FOR ALTERNATIVE BENEFIT PLANS (ABP)  
Methods and Standards for Payment Rates

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