CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
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Audrey Tayse Haynes
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Lawrence Kissner
Commissioner

September 6, 2013

Jackie Glaze
Associate Regional Director
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

RE: State Plan Amendment 13-012 - FQHC, FQHC look-alikes and RHC reimbursement

Dear Ms. Glaze:

Enclosed for your review and approval is Kentucky Title XIX State Plan Amendment No. 13-0012. The purpose of this State Plan Amendment is to establish revised reimbursement for FQHC's, FCHC look-alikes and RHC's.

The Public Notice is included in this submission. Furthermore, the Federal Fiscal Impact on the CMS 179 form is indeterminable. However, we do not believe this will not have a major impact on either the Federal or State budget.

Also, we have included the funding, tribal and maintenance of effort (MOE) questions below:

Funding Questions:

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19- D of your State plan.

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are

required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

DMS Response - the provider retains all funds

1. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

   DMS Response - Not Applicable

2. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

   DMS Response - Not Applicable

3. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

   DMS Response - Not Applicable

4. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

   DMS Response - Not Applicable

<u>Tribal questions:</u>

The following are questions related to Section 5006(e) of the Recovery Act (Public Law (P.L.) 111-5) requirement for Tribal Consultation, please provide responses to these questions.

a. Is the submittal of this State Plan likely to have a direct impact on Indians or Indian health programs (Indian Health Service, Tribal 638 Health Programs, Urban Indian Organizations).

b. If the submittal of this State Plan is not likely to have a direct impact on Indians or Indian health programs, please explain why not.

c. If the submittal of this State Plan is likely to have a direct impact on Indians or Indian health programs please respond to the following questions.
   1. How did the State consult with the Federally-recognized tribes and Indian health programs prior to submission of this SPA?

   2. If the tribes and Indian health programs were notified in writing, please provide a copy of the notification, the date it was sent and a list of the entities notified. In addition, please provide information about any concerns expressed by the tribes and/or Indian health providers and the outcome.
   3. If the consultation with the tribes and Indians health providers occurred in a meeting please provide a list of invitees, a list of attendees, the date the meeting took place and information about any concerns expressed by the tribes and/or Indian health providers and the outcome.

DMS Response - Not Applicable

Maintenance of Effort (MOE)

A. Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.

MOE Period

- Begins on: March 10, 2010, and
- Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.

Is KY in compliance with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

DMS Response - Yes

B. Section 1905(y) and (z) of the Act provides for increased federal medical assistance percentages (FMAP) for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

This SPA would [ ] / would not [X] violate these provisions, if they remained in effect on or after January 1, 2014.

C.Section 1905(aa) of the Act provides for a "disaster-recovery FMAP" increase effective no earlier than January 1, 2011. Under section 1905(cc) of the Act, the increased FMAP under section 1905(aa) of the Act is not available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

This SPA would [ ] / would not [X] qualify for such increased federal financial participation (FFP) and is not in violation of this requirement.

D. Does KY 13-004 comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims?

DMS Response - Yes

Any questions or correspondence relating to this SPA should be sent to Sharley Hughes.

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

Sincerely,

Lawrence Kissner
Commissioner

LK/sjh

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13-012

2. STATE: Kentucky

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
Effective September 6 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 2301 of the Affordable Care Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $0.00
b. FFY 2014 ~~$Indeterminable (see cover letter)~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-B, Page 20.16
Att. 4.19-B, Page 20.16(1)
Att. 4.19-B, Page 20.16(2)
Att. 4.19-B, Page 20.16(3
Att. 4.19-B, Page 20.16(4)
Att. 4.19-B, Page 20.16(5)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4.19-B, Page 20.16 Same
All other pages new

10. SUBJECT OF AMENDMENT:
The purpose of this State Plan Amendment is to establish new reimbursement for FQHC's, FQHC look-alikes and RHC

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Lawrence Kissner

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 9/6/13

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

XVII. FQHC, FQHC look-alike and RHC Services

A Standard Reimbursement for an FQHC, FQHC look-alike, or RHC for a visit by a Fee-For-Service (FFS) Medicaid recipient.

1 For a visit by a FFS recipient, the department shall reimburse:
- a An FQHC, FQHC look-alike, or RHC an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 U.S.C. 1396a(aa); or
- b A satellite facility of an FQHC or FQHC look-alike an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 U.S.C. 1396a(aa).

2 Costs related to outpatient drugs or pharmacy services shall be excluded from the all-inclusive encounter rate per patient visit.

3 The department shall calculate a PPS rate for a new FQHC, FQHC look-alike, or RHC as outlined in Section B below.

4 The department shall adjust a PPS rate per visit:
- a By the percentage increase in the MEI applicable to FQHC, FQHC look-alike, or RHC services on July 1 of each year; and
- b And in accordance to Section C below.
  - (1) Upon request and documentation by an FQHC, FQHC look-alike, or RHC that there has been a change in scope of services; or
  - (2) Upon review and determination by the department that there has been a change in scope of services.

5 A rate established in accordance with this State Plan Amendment shall not be subject to an end of the year cost settlement.

B Establishment of a PPS Rate for a New FQHC, FQHC look-alike, or RHC.

1 The department shall establish a PPS rate to reimburse a new FQHC, FQHC look-alike, or RHC 100 percent of its reasonable cost of providing Medicaid covered services during the *FQHC's*, FQHC *look-alike's*, or RHC's base year.

2. Except for a time frame in which the department reimburses an FQHC, FQHC look-alike, or RHC an interim rate, the initial and subsequent final PPS rate established for an FQHC, FQHC look-alike, or RHC shall:
- a. Be prospective; and
- b. Not settled to cost.

3 The department shall determine the reasonable costs of an FQHC, FQHC look-alike, or RHC based on the cost *report* which contains twelve (12) full months of operating data most recently submitted to the department by the FQHC, FQHC look-alike, or RHC.

4 The base rate referenced in #1 above shall be based on the reasonable cost determination made by the department.

XVII. FQHC, FQHC look-alike and RHC Services (cont.)

5 Until an FQHC, FQHC look-alike, or RHC submits a Medicaid cost report containing twelve (12) full months of operating data for the facility's base year, the department shall reimburse the FQHC, FQHC look-alike, or RHC an interim rate equal to the all-inclusive per visit rate established for the FQHC, FQHC look-alike, or RHC by Medicare.

6 An FQHC, FQHC look-alike, or RHC shall provide the department with a copy of the Medicare rate letter for the rates in effect during the FQHC's, FQHC look-alike's, or RHC's interim period.

a The department shall adjust an interim rate for an FQHC, FQHC look-alike, or RHC based on the establishment of the final rate.

b All claims submitted to the department and paid by the department based on the interim rate shall be adjusted to comport with the final rate.

7 An FQHC, FQHC look-alike, or RHC shall submit a cost report to the department by the end of the fifth month following the end of the FQHC's, FQHC look-alike's, or RHC's first full fiscal year. The department shall:

a Review the cost report submitted by an FQHC, FQHC look-alike, or RHC within ninety (90) business days of receiving the cost report; and

b Notify the FQHC, FQHC look-alike, or RHC of the:

(1) Necessity of the FQHC, FQHC look-alike, or RHC to submit additional documentation if necessary;

(2) Final rate established;

(3) Appeal rights regarding the final rate; and

(4) Estimated time for determining a final rate if a final rate is not established within ninety (90) days.

c If additional documentation is necessary to establish a final rate, the FQHC, FQHC look-alike, or RHC shall:

(1) Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or

(2) Request an extension beyond thirty (30) days to provide the additional documentation.

(3) The department shall grant no more than one (1) extension.

(4) An extension shall not exceed thirty (30) days.

d If the department requests additional documentation from an FQHC, FQHC look-alike, or RHC but does not receive additional documentation or an extension request within thirty (30) days, the department shall reimburse the FQHC, FQHC look-alike, or RHC based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010 until:

(1) The additional documentation has been received by the department; and

(2) The department has established a final rate.

C Change in Scope and PPS Rate Adjustment.

1 If an FQHC, FQHC look-alike, or RHC changes its scope of services after the base year, the department shall adjust the FQHC's, FQHC look-alike's, or RHC's PPS rate.

XVII. FQHC, FQHC look-alike and RHC Services (cont.)

2 An adjustment to a PPS rate resulting from a change in scope that occurred after an FQHC's, FQHC look-alike's, or RHC's base year shall be retroactively effective to the date that the FQHC, FQHC look-alike, or RHC applied for the change in scope.

3 A change in scope of service shall be restricted to:
- a Adding or deleting a covered service;
- b Increasing or decreasing the intensity of a covered service; or
- c A statutory or regulatory change that materially impacts the costs or visits of an FQHC, FQHC look-alike, or RHC.

4 The following *items* individually shall not constitute a change in scope:
- a A general increase or decrease in the costs of existing services;
- b An expansion of office hours;
- c An addition of a new site that provides the same Medicaid covered services;
- d A wage increase;
- e A renovation or other capital expenditure;
- f A change in ownership; or
- g An addition or deletion of a service provided by a non-licensed professional or specialist.

5 An addition of a covered service shall be restricted to the addition of a licensed professional staff member who can perform a Medicaid covered service that is not currently being performed within the FQHC, FQHC look-alike, or RHC by a licensed professional employed or contracted by the facility.

6 The deletion of a covered service shall be restricted to the deletion of a licensed professional staff member who can perform a Medicaid covered service that was being performed within the FQHC, FQHC look-alike, or RHC by the licensed professional staff member.

7 A change in intensity shall:
- a Include a material change;
- b Increase or decrease the existing PPS rate by at least five (5) percent; and
- c Last at least twelve (12) months.

8 The department shall consider a change in scope request due to a statutory or regulatory change that materially impacts the costs of visits at an FQHC, FQHC look-alike, or RHC if:
- a A government entity imposes a mandatory minimum wage increase and the increase was:
  - (1) Not included in the calculation of the final PPS rate; or
  - (2) Subsequently included in the MEI applied yearly; or
- b A new licensure requirement or modification of an existing requirement by the state results in a change that affects all facilities within the class. A provider shall document that an increase or decrease in the cost of a visit occurred as a result of a licensure requirement or policy modification.

XVII. FQHC, FQHC look-alike and RHC Services (cont.)

9 A requested change in scope shall:
- a Increase or decrease the existing PPS rate by at least five (5) percent; and
- b Last at least twelve (12) months.

10 For a change in scope that is effective during a base year for determining an FQHC's, FQHC look-alike's, or RHC's final PPS rate, the base year costs associated with the change in scope shall not be duplicated when determining the revised PPS rate due to the change in scope.

11 The following documents shall be submitted to the department within six (6) months of the effective date of a change in scope:
- a A narrative describing the change in scope;
- b A projected cost report containing twelve (12) months of data for the interim rate change; and
- c A completed MAP 100501, Prospective Payment System Rate Adjustment, *completed according to the Instructions for Completing the MAP 100501 Form.*

12 The department shall:
- a Review the documentation; and
- b Notify the FQHC, FQHC look-alike, or RHC in writing of the approval or denial of the request for change in scope within ninety (90) business days *from the date the department received the request.*

13 If the department requests additional documentation to calculate the rate for a change in scope, the FQHC, FQHC look-alike, or RHC shall:
- a Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or
- b Request an extension beyond thirty (30) days to provide the additional documentation.
- c The department shall grant no more than one (1) extension.
- d An extension shall not exceed thirty (30) days.

D Provider Participation Requirements.

1 A participating FQHC, FQHC look-alike, RHC, shall be currently:
- a Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and
- b Participating in the Kentucky Medicaid program in accordance with 907 KAR 1:671.

2 A satellite facility of an FQHC, an FQHC look-alike, or a RHC shall:
- a Be currently listed on the parent facility's license in accordance with 902 KAR 20:058;
- b Comply with the requirements regarding extensions established in 902 KAR 20:058; and
- c Comply with 907 KAR 1:671.

XVII. FQHC, FQHC look-alike and RHC Services (cont.)

3 To be initially enrolled with the department, an FQHC, FQHC look-alike, or RHC shall:
- a Enroll in accordance with 907 KAR 1:672; and
- b. Submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC, FQHC look-alike, or RHC.

4. To remain enrolled and participating in the Kentucky Medicaid program, an FQHC, FQHC look-alike, or RHC shall:
- a Comply with the enrollment requirements established in 907 KAR 1:672;
- b Comply with the participation requirements established in 907 KAR 1:671; and
- c Annually submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC, FQHC look-alike, or RHC to the department.
- d The requirements established above shall apply to a satellite facility of an FQHC or FQHC look-alike.

5. An FQHC, FQHC look-alike, or RHC that operates multiple satellite facilities shall:
- a List each satellite facility on the parent facility's license in accordance with 902 KAR 20:058; and
- b Consolidate claims and cost report data of its satellite facilities *with the parent facility*.

6 An FQHC, FQHC look-alike or RHC, that has been terminated from federal participation shall be terminated from Kentucky Medicaid program participation.

7 A participating FQHC, FQHC look-alike, RHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC;

8 An FQHC, FQHC look-alike or RHC performing laboratory services shall meet the requirements established in 907 KAR 1:028 and 907 KAR 1:575.

E Limitations.

1 Except for a case in which a recipient or enrollee, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment, an encounter with more than one (1) health care provider *or* multiple encounters with the same health care provider which take place on the same day and at a single location shall constitute a single visit.

2 A vaccine available without charge to an[a] FQHC, FQHC look-alike, RHC through the department's Vaccines for Children Program and the administration of the vaccine shall not be reported as a cost to the Medicaid Program.

XVII. FQHC, FQHC look-alike and RHC Services (cont.)

F Supplemental Reimbursement for FQHC Visits, FQHC Look-alike Visits, and RHC Visits.

1 If a managed care organization's reimbursement to an FQHC, FQHC look-alike, or RHC for a visit by an enrollee to the FQHC, FQHC look-alike, or RHC is less than what the FQHC, FQHC look-alike, or RHC would receive pursuant to above guidelines, the department shall supplement the reimbursement made by the managed care organization in a manner that:

a Equals the difference between what the managed care organization reimbursed and what the reimbursement would have been if it *had* been made in accordance with the above payment methodology for FFS members;

b Is in accordance with 42 U.S.C. 1396a(bb)(5)(A); and

c Ensures that total reimbursement does not exceed the federal upper payment limit in accordance with:

(1) 42 C.F.R. 447.304; and

(2) 42 C.F.R. 447.321

G. Out-of-State Providers. Reimbursement to an out-of-state FQHC, FQHC look-alike, or RHC shall be the rate on file with the FQHC's, FQHC look-alike's, or RHC's state Medicaid agency.