

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Provider Operations

4 (New Administrative Regulation)

5 907 KAR 3:015. Supplemental Payments for Certain Primary Care and Vaccines.

6 RELATES TO: KRS 205.520, 205.560;

7 STATUTORY AUTHORITY: KRS 194A.030(2); 194A.050(1); 205.520(3); 205.560(1);

8 Title V, Subtitle F, Section 5501 of the Affordable Care Act; 42 C.F.R. 447.400; 42

9 C.F.R. 447.405; 42 C.F.R. 447.410; and 42 C.F.R. 447.415

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
11 Services, Department for Medicaid Services, has responsibility to administer the Medi-
12 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to
13 comply with any requirement that may be imposed or opportunity presented by federal
14 law to qualify for federal Medicaid funds. This administrative regulation establishes the
15 policies and requirements regarding Medicaid program supplemental payments for cer-
16 tain primary care services and vaccines in accordance with Title V, Subtitle F, Section
17 5501 of the Affordable Care Act; 42 C.F.R. 447.405; 42 C.F.R. 447.410; and 42 C.F.R.
18 447.415.

19 Section 1. Definitions. (1) "Advanced practice registered nurse" is defined by KRS
20 314.011(7).

1 (2) "CPT code" means a code used for reporting procedures and services performed
2 by physicians and published annually by the American Medical Association in Current
3 Procedural Terminology.

4 (2) "Department" means the Department for Medicaid Services or its designee.

5 (3) "Eligible evaluation and management service" means a service:

6 (a) Which qualifies for supplemental reimbursement in accordance with Section
7 3(1)(a), (b), and (c)1 of this administrative regulation; and

8 (b) For which there is a corresponding paid claim.

9 (4) "Eligible provider" means a provider who qualifies for supplemental reimburse-
10 ment in accordance with Section 2 of this administrative regulation.

11 (5) "Eligible vaccine" means a vaccine:

12 (a) Which qualifies for supplemental reimbursement in accordance with Section
13 3(1)(a), (b) and (c)2 of this administrative regulation; and

14 (b) For which there is a corresponding paid claim.

15 (6) "Federal financial participation" is defined by 42 C.F.R. 400.203.

16 (7) "Managed care organization" or "MCO" means an entity for which the Department
17 for Medicaid Services has contracted to serve as a managed care organization as de-
18 fined in 42 C.F.R. 438.2.

19 (8) "Medically necessary" or "medical necessity" means that a covered benefit is de-
20 termined to be needed in accordance with 907 KAR 3:130.

21 (9) "Medicaid program" means Kentucky's program of services and benefits covered
22 by the Department for Medicaid Services or managed care organizations.

23 (10) "Personal supervision" means being professionally responsible for the services

1 rendered by an advanced practice registered nurse or a physician assistant.

2 (11) "Physician" is defined by KRS 311.550(12).

3 (12) "Physician assistant" is defined by KRS 311.840(3).

4 (13) "Provider" is defined by KRS 205.8451(7).

5 (14) "Recipient" is defined in KRS 205.8451(9).

6 Section 2. Conditions to Qualify for Supplemental Reimbursement for Primary Care
7 Services and Vaccines. (1) To qualify for a supplemental payment a provider shall:

8 (a) Be currently enrolled with the Medicaid program in accordance with 907 KAR
9 1:672;

10 (b)1. Be currently participating in the Medicaid program in accordance with 907 KAR
11 1:671; and

12 2. Comply with 907 KAR 1:671;

13 (c) Be a primary care physician practicing in one of the following areas:

14 1. Family medicine;

15 2. General internal medicine; or

16 3. Pediatric medicine; and

17 (d) Attest to being a primary care physician and to one (1) of the following:

18 1. Currently having board certification as a primary care physician by the:

19 a. American Board of Medical Specialties;

20 b. American Board of Physician Specialties; or

21 c. American Osteopathic Association;

22 2. Unless a newly eligible physician or physician without a prior billing history, having
23 provided the following evaluation and management services or vaccines in an amount

1 that equals at least sixty (60) percent of Medicaid codes billed to the Medicaid program
2 during the most recently completed calendar year:

3 a. Evaluation and management CPT codes:

4 (i) Within the range of 99201 through 99499; and

5 (ii) That are covered by the department in accordance with 907 KAR 3:010 or;

6 b. Vaccine codes which are covered by the department in accordance with 907 KAR
7 1:680 (regardless of the age of the recipient) or 907 KAR 3:010;

8 3. If a newly eligible physician, having provided the services or vaccines referenced
9 in subparagraph 2a or 2b of this paragraph in an amount that equals at least sixty (60)
10 percent of Medicaid codes billed to the Medicaid program during the prior month; or

11 4. Being an eligible primary care physician:

12 a. Without a billing history; and

13 b. For whom sixty (60) percent of total Medicaid billings shall be of codes referenced
14 in subparagraph 2a or 2b of this paragraph.

15 (2) Services or vaccines which meet the qualifying criteria in Section 3 of this admin-
16 istrative regulation and which are provided by a physician assistant or advanced prac-
17 tice registered nurse working under the personal supervision of a qualifying primary
18 care physician shall qualify for the supplemental reimbursement.

19 Section 3. Supplemental Reimbursement for Primary Care Services and Vaccines.

20 (1) Supplemental reimbursement shall be made, as established in subsections (2)
21 and (3) of this section, for providing a service or vaccine:

22 (a) Provided on a day on or after January 1, 2013 until midnight December 31, 2014:

23 1. To a recipient; and

- 1 2. By a:
- 2 a. Provider who qualifies for the supplemental reimbursement pursuant to Section 2
- 3 of this administrative regulation; or
- 4 b. An APRN or a physician assistant working under the personal supervision of a
- 5 primary care physician who qualifies for the supplemental reimbursement pursuant to
- 6 Section 2 of this administrative regulation;
- 7 (b) That is medically necessary for the given recipient; and
- 8 (c) That is:
- 9 1. An evaluation and management service which:
- 10 a. Corresponds to a CPT code within the range of 99201 through 99499; and
- 11 b. Is currently covered by the department in accordance with 907 KAR 3:010; or
- 12 2. Billed using a vaccine code which is covered by the department in accordance
- 13 with 907 KAR 1:680 (regardless of the age of the recipient) or 907 KAR 3:010.
- 14 (2)(a) For a given quarter of paid claims associated with eligible evaluation and man-
- 15 agement services provided by an eligible provider to recipients who were not enrolled in
- 16 a managed care organization and for which:
- 17 1. DMS had an established rate as of July 1, 2009, the department shall make a
- 18 lump sum payment that represents the difference between:
- 19 (i) The DMS established rates as of July 1, 2009 for the claims in aggregate for the
- 20 quarter; and
- 21 (ii) What the provider would have received for the same paid claims in aggregate for
- 22 the same quarter if the provider's reimbursement for the claims had been the amount
- 23 established in 42 C.F.R. 447.405(a); or

1 2. DMS did not have an established rate as of July 1, 2009 but established a rate
2 prior to January 1, 2013, the department shall make a lump sum payment that repre-
3 sents the difference between:

4 (i) The DMS established rates as of December 31, 2012 for the claims in aggregate
5 for the quarter; and

6 (ii) What the provider would have received for the same paid claims in aggregate for
7 the same quarter if the provider's reimbursement for the claims had been the amount
8 established in 42 C.F.R. 447.405(a);

9 (b) For a given quarter of paid claims associated with eligible vaccines provided by
10 an eligible provider to recipients who were not enrolled in a managed care organization
11 and for which:

12 1. DMS had an established rate as of July 1, 2009, the department shall make a
13 lump sum payment that represents the difference between:

14 (i). The DMS established rates as of July 1, 2009 for the claims in aggregate for the
15 quarter; and

16 (ii) What the provider would have received for the same paid claims in aggregate for
17 the same quarter if the provider's reimbursement for the claims had been the amount
18 established in 42 C.F.R. 447.405(b); or

19 2. DMS did not have an established rate as of July 1, 2009 but established a rate
20 prior to January 1, 2013, the department shall make a lump sum payment that repre-
21 sents the difference between:

22 (i). The DMS established rates as of December 31, 2012 for the claims in aggregate
23 for the quarter; and

1 (ii) What the provider would have received for the same paid claims in aggregate for
2 the same quarter if the provider's reimbursement for the claims had been the amount
3 established in 42 C.F.R. 447.405(b);

4 (3)(a) For a given quarter of paid claims associated with eligible evaluation and man-
5 agement services provided by all eligible providers to recipients who were enrolled in a
6 given managed care organization, the:

7 1. Department shall send funds to the managed care organization representing the
8 aggregate supplemental reimbursement amount for the paid claims; and

9 2. The managed care organization shall:

10 a. Within fifteen (15) business days of receiving the funds referenced in subpara-
11 graph 1 of this subsection, supplement reimbursement to each eligible provider
12 in an amount determined using the methodology described in subsection (2)(a) of this
13 section; and

14 b. Submit documentation to the department demonstrating that the supplemental re-
15 imbursement referenced in subparagraph 1 of this paragraph was made to all eligible
16 providers for the corresponding quarter.

17 (b) For a given quarter of paid claims associated with eligible vaccines provided by all
18 eligible providers to recipients who were enrolled in a given managed care organization,
19 the:

20 1. Department shall send funds to the managed care organization representing the
21 aggregate supplemental reimbursement amount for the paid claims; and

22 2. The managed care organization shall:

23 a. Within fifteen (15) business days of receiving the funds referenced in subpara-

1 graph 1 of this subsection, supplement reimbursement to each eligible provider
2 in an amount determined using the methodology described in subsection (2)(b) of this
3 section; and

4 b. Submit documentation to the department demonstrating that the supplemental re-
5 imbursement referenced in subparagraph 1 of this paragraph was made to all eligible
6 providers for the corresponding quarter.

7 Section 4. Applicability. (1) The policies and requirements established in this admin-
8 istrative regulation shall govern supplemental payments for certain primary care ser-
9 vices and vaccines in accordance with Title V, Subtitle F, Section 5501 of the Afforda-
10 ble Care Act; 42 C.F.R. 447.400; 42 C.F.R. 447.405; 42 C.F.R. 447.410; and 42 C.F.R.
11 447.415.

12 (2) Any policy or requirement regarding payments for physician or primary care ser-
13 vices or vaccines established in any other administrative regulation within Title 907 of
14 the Kentucky Administrative Regulations shall not apply to the supplemental payments
15 referenced in subsection (1) of this section.

16 Section 5. Auditing. (1) A provider shall be subject to departmental review or audit.

17 (2) The department shall be authorized to take action regarding fraud or abuse in ac-
18 cordance with:

19 (a) 907 KAR 1:671; or

20 (b) KRS 205.8453.

21 Section 6. Federal Financial Participation. A policy established in this administrative
22 regulation shall be null and void if the Centers for Medicare and Medicaid Services:

23 (1) Denies or does not provide federal financial participation for the policy; or

1 (2) Disapproves the policy.

907 KAR 3:015

REVIEWED:

Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

907 KAR 3:015

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on May 21, 2013, at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing May 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business May 31, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 3:015
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes policies and requirements regarding supplemental Medicaid program payments for certain primary care evaluation and management services and vaccines. To qualify for the supplemental payments, providers must attest to being board certified as primary care physicians, having provided a certain volume [at least sixty (60) percent of Medicaid codes billed to the department] of evaluation and management services or vaccines to Medicaid recipients during the most recently completed calendar year, or for newly eligible physicians attest to the sixty (60) percent threshold for services provided in the prior month, or (for those with no prior Medicaid billing history) attest to providing (in the future) a volume of evaluation and management services or vaccines that will equal at least sixty (60) percent of their Medicaid billing.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with a federal mandate.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by complying with a Medicaid program federal mandate.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by complying with a Medicaid program federal mandate.

- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
 - (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
 - (c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
 - (d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The administrative regulation will affect Medicaid primary care physicians who qualify for the supplemental payments. DMS has identified 3,363 primary care physicians who

meet the criteria to qualify for the supplemental reimbursement.

- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
 - (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Providers will have to attest to meeting the qualifications for the supplemental payments. The Department for Medicaid Services (DMS) has created an option for providers to submit the attestation online.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Providers would experience administrative costs associated with the attestation.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Providers who qualify will benefit by receiving supplemental reimbursement for providing the designated primary care services and vaccines during the enhancement period (January 1, 2013 through December 31, 2014).
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: The Department for Medicaid Services (DMS) estimates that supplemental payments may cost \$64.7 million (100% federal funds) for calendar year 2013.
 - (b) On a continuing basis: DMS estimates that supplemental payments may cost \$64.7 million (100% federal funds) for calendar year 2014.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are entirely federal funds authorized under the Social Security Act, Title XIX.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The current fiscal year budget will not need to be adjusted to provide funds for implementing this administrative regulation.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 3:015
Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. Title V, Subtitle F, Section 5501 of the Affordable Care Act; 42 C.F.R. 447.400, 42 C.F.R. 447.405; 42 C.F.R. 447.410; and 42 C.F.R. 447.415.
2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."
3. Minimum or uniform standards contained in the federal mandate. The federal mandate regarding primary care services is for Medicaid programs to reimburse qualifying primary care physicians for qualifying primary care services based on the lesser of the Medicare Part B fee schedule rate or the primary care physician's actual billed charge for the services.

The federal mandate regarding vaccine administration is for Medicaid programs to reimburse qualifying primary care physicians for the qualifying vaccine administration services at the lesser of the Medicare fee schedule rate or the regional maximum administration fee.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment does not impose stricter, additional or different requirements than those required by the federal mandate.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 3:015
Agency Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.
2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by 42 C.F.R. 447.405, 42 C.F.R. 447.410, 42 C.F.R. 447.415 and this administrative regulation.
4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
 - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This amendment will not generate any additional revenue for state or local governments during the first year of implementation.
 - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment will not generate any additional revenue for state or local governments during subsequent years of implementation.
 - (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that supplemental payments may cost \$64.7 million (100% federal funds) for calendar year 2013.
 - (d) How much will it cost to administer this program for subsequent years? DMS estimates that supplemental payments may cost \$64.7 million (100% federal funds) for calendar year 2014.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): _____

Expenditures (+/-): _____

Other Explanation: No additional expenditures are necessary to implement this amendment.