

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Provider Operations

4 (Amended After Comments)

5 907 KAR 1:055. Payments for primary care center, federally-qualified health center,
6 federally-qualified health center look-alike, and rural health clinic services.

7 RELATES TO: KRS 205.560, 216B.010, 216B.105, 216B.130, 216B.990, 42 C.F.R.
8 413, 438.60, 491, Subpart A, 440.130, 440.230, 447.3251, 45 C.F.R. 74.27, 48 C.F.R.
9 Part 31, 42 U.S.C. 1396a, b, d

10 STATUTORY AUTHORITY: KRS 194A.030(3), 194A.050(1), 205.520(3), 205.560(1),
11 216B.042, 42 U.S.C. 1396a[, ~~EO 2004-726~~]

12 NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004,~~
13 ~~reorganized the Cabinet for Health Services and placed the Department for Medicaid~~
14 ~~Services and the Medicaid Program under the Cabinet for Health and Family Services.]
15 The Cabinet for Health and Family Services, Department for Medicaid Services has re-
16 sponsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet,
17 by administrative regulation, to comply with any requirement that may be imposed, or op-
18 portunity presented, by federal law to qualify for federal Medicaid funds[~~for the provision~~
19 ~~of medical assistance to Kentucky's indigent citizenry. 42 U.S.C. 1396a(aa) establishes~~
20 ~~requirements for federally-qualified health centers and rural health clinics]. This adminis-
21 trative regulation establishes the Department for Medicaid Services' reimbursement poli~~~~

1 ~~cies [provisions for reimbursement]~~ for primary care center, federally-qualified health cen-
2 ter, federally-qualified health center look-alike, and rural health clinic services.

3 Section 1. Definitions. (1) “Advanced practice registered nurse” or “APRN” is defined
4 by KRS 314.011(7).

5 (2) “Allowable costs” means costs that are incurred by a federally-qualified health
6 center, federally-qualified health center look-alike, rural health clinic, or primary care
7 center[or clinic] that are reasonable in amount and proper and necessary for the effi-
8 cient delivery of services.

9 (3)~~(2)~~ “Audit” means an examination, which may be full or limited in scope, of a fed-
10 erally-qualified health center’s, federally-qualified health center look-alike’s, rural health
11 clinic’s, or primary care center’s:

12 (a) ~~[clinic’s or center’s]~~ Financial transactions, accounts, and reports; and

13 (b) ~~[as well as its]~~ Compliance with applicable Medicare and Medicaid regulations,
14 manual instructions, and directives.

15 ~~[(3) “Center” means a federally-qualified health center or a primary care center.]~~

16 (4) “Change in scope of service” means a change in the type, intensity, duration, or
17 amount of service.

18 (5) “Clinical psychologist” is defined by 42 C.F.R. 410.71(d)~~["Clinic" means a rural~~
19 ~~health clinic].~~

20 (6) “Department” means the Department for Medicaid Services or its designated
21 agent.

22 (7) “Enrollee” means a recipient who is enrolled with a managed care organization for
23 the purpose of receiving Medicaid or KCHIP covered services.

1 **(8) "Federal financial participation" is defined in 42 C.F.R. 400.203.**

2 **(9)[(7)] "Federally-qualified health center" or "FQHC" is defined in 42 U.S.C.**
3 **405.2401.**

4 **(10)[(9)] "Federally-qualified health center look-alike" or "FQHC look-alike" means an**
5 **entity that is currently approved by the United States Department of Health and Human**
6 **Services, Health Resources and Services Administration to be a federally-qualified**
7 **health center look-alike.**

8 **(11)[(10)][(8)] "Health care provider" for:**

9 **(a) A primary care center means:**

10 **1.[(a)] A licensed physician;**

11 **2.[(b)] A licensed osteopathic physician;**

12 **3.[(c)] A licensed podiatrist;**

13 **4.[(d)] A licensed optometrist;**

14 **5.[(e)] A licensed and certified advanced practice registered nurse[~~practitioner~~];**

15 **6.[(f)] A licensed dentist or oral surgeon;**

16 **7.[(g)] A [~~certified~~]physician assistant; [~~or~~]**

17 **8.[(h)] [~~For an FQHC:~~**

18 **4.] A licensed clinical social worker;**

19 **9.[(i)] A[~~or~~**

20 **2. A licensed] clinical psychologist; or**

21 **(b) An FQHC, FQHC look-alike, or RHC means:**

22 **1. A provider or practitioner listed in paragraph (a); or**

23 **2. Contingent upon approval of a state plan amendment by the Centers for**

1 **Medicare and Medicaid Services, a:**

2 **a. Licensed professional clinical counselor; or**

3 **b. Licensed marriage and family therapist; or**

4 **(c)[(j) For] An FQHC or FQHC look-alike:**

5 1. A resident in the presence of a teaching physician; or

6 2. A resident without the presence of a teaching physician if:

7 a. The services are furnished in an FQHC or FQHC look-alike in which the time spent
8 by the resident in performing patient care is included in determining any intermediary
9 payment to a hospital in accordance with 42 C.F.R. 413.75 through 413.83;

10 b. The resident furnishing the service without the presence of a teaching physician
11 has completed more than six (6) months of an approved residency program;

12 c. The teaching physician:

13 (i) Does not direct the care of more than four (4) residents at any given time; and

14 (ii) Directs care from a proximity that constitutes immediate availability; and

15 d. The teaching physician:

16 (i) Has no other responsibilities at the time;

17 (ii) Has management responsibility for any recipient seen by the resident;

18 (iii) Ensures that the services furnished are appropriate;

19 (iv) Reviews with the resident during or immediately after each visit by a recipient, the
20 recipient's medical history, physical examination, diagnosis, and record of tests or ther-
21 apies; and

22 (v) Documents the extent of the teaching physician's participation in the review and
23 direction of the services furnished to each recipient.

1 **(12)[(11)](9)** "Interim rate" means a reimbursement amount[fee] established by the
2 department to pay an[a] FQHC, FQHC look-alike, RHC, or a PCC[primary care center]
3 for covered services prior to the establishment of a PPS rate.

4 **(13)[(12)]** "Licensed clinical social worker" means an individual who is currently li-
5 censed in accordance with KRS 335.100.

6 **(14)** "Licensed professional clinical counselor" is defined by KRS 335.500(3).

7 **(15)** "Licensed marriage and family therapist" is defined by KRS 335.300(2).

8 **(16)[(13)]** "Managed care organization" means an entity for which the Department for
9 Medicaid Services has contracted to serve as a managed care organization as defined
10 in 42 C.F.R. 438.2.

11 **(17)[(14)]** "Medical Group Management Association Physician Compensation and
12 Production Survey Report" means a report developed and owned by the Medical Group
13 Management Association which:

14 (a) Highlights the critical relationship between physician salaries and productivity;

15 (b) Is used to align physician salaries and benefits with provider production; and

16 (c) Contains:

17 1. Performance ratios illustrating the relationship between compensation and produc-
18 tion; and

19 2. Comprehensive and summary data tables that cover many specialties.

20 **(18)[(15)](40)** "Medically necessary" or "medical necessity" means that a covered
21 benefit is determined to be needed in accordance with 907 KAR 3:130.

22 **(19)[(16)](41)** "Medicare Economic Index" or "MEI" means the economic index re-
23 ferred to in 42 U.S.C. 1395u(b)(3)(L).

1 (20)[(17)] "Parent facility" means a federally-qualified health center, federally-
2 qualified health center look-alike, or primary care center that is:

3 (a) Licensed and operating with a unique Kentucky Medicaid program provider num-
4 ber;

5 (b) Operating under the same management as a satellite facility; and

6 (c) The original facility which existed prior to the existence of a satellite facility.

7 (21)[(18)][(12)] "PCC" or "primary care center" means an entity that is currently li-

8 censed as a PCC in accordance with~~[that has met the licensure requirements estab-~~
9 ~~lished in]~~ 902 KAR 20:058.

10 (22)[(19)][(13)] "Percentage increase in the MEI" is defined in 42 USC 1395u(i)(3).

11 (23)[(20)] "Physician assistant" is defined by KRS 311.840(3).

12 (24)[(21)][(14)] "PPS" means prospective payment system.

13 (25)[(22)][(15)] "Rate year" means, for the purposes of the MEI, the twelve (12)

14 month period beginning July 1 of each year for which a rate is established for an FQHC,

15 FQHC look-alike, RHC, or a PCC~~[a center or clinic]~~ under the prospective payment sys-

16 tem.

17 (26)[(23)][(16)] "Reasonable cost" means a cost as determined by the:

18 (a) Applicable Medicare cost reimbursement principles established~~[set forth]~~ in 42

19 C.F.R. Part 413, 45 C.F.R. 74.27, and 48 C.F.R. Part 31; and

20 (b) Medical Group Management Association Physician Compensation and Production

21 Survey Report for the applicable year and region.

22 (27)[(24)] "Recipient" is defined by KRS 205.8451(9).

23 (28)[(25)][(17)] "RHC" or "rural health clinic" is defined in 42 C.F.R. 405.2401(b).

1 ~~(29)~~~~(26)~~ "Satellite facility" means a federally-qualified health center, federally-
2 qualified health center look-alike, or primary care center that:

3 (a) Is at a different location than the parent facility; and

4 (b) Operates under the same management as the parent facility.

5 ~~(30)~~~~(27)~~ "Telehealth" means two (2)-way, real time interactive video between a pa-
6 tient and a physician or practitioner located at a distant site for the purpose of improving
7 a patient's health through the use of interactive telecommunication equipment that in-
8 cludes, at a minimum, audio and video equipment.

9 ~~(31)~~~~(28)~~~~(18)~~ "Visit" means a face-to-face encounter or encounter which occurs via
10 telehealth between a recipient or enrollee~~[patient]~~ and a health care provider during
11 which an~~[a]~~ FQHC, FQHC look-alike, or RHC~~[, or PCC]~~ service is delivered.

12 Section 2. Provider Participation Requirements. (1)(a) A participating FQHC, FQHC
13 look-alike, RHC, or PCC~~[, satellite facility of an FQHC, satellite facility of an FQHC~~
14 look-alike, or satellite facility of a PCC]~~[center or clinic]~~ shall be currently:

15 1.~~(a)~~ Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR
16 1:672; and

17 2.~~(b)~~ Participating in the Kentucky Medicaid program in accordance with 907 KAR
18 1:671.

19 **(b) A satellite facility of an FQHC, an FQHC look-alike, or a PCC shall:**

20 **1. Be currently listed on the parent facility's license in accordance with 902**
21 **KAR 20:058;**

22 **2. Comply with the requirements regarding extensions established in 902 KAR**
23 **20:058; and**

1 **3. Comply with 907 KAR 1:671.**

2 (2)(a) To be initially enrolled with the department, an FQHC, FQHC look-alike, or
3 RHC shall:

- 4 1. Enroll in accordance with 907 KAR 1:672; and
5 2. Submit proof of its certification by the United States Department of Health and
6 Human Services, Health Resources and Services Administration as an FQHC, FQHC
7 look-alike, or RHC.

8 (b) To remain enrolled and participating in the Kentucky Medicaid program, an
9 FQHC, FQHC look-alike, or RHC shall:

- 10 1. Comply with the enrollment requirements established in 907 KAR 1:672;
11 2. Comply with the participation requirement established in 907 KAR 1:671; and
12 **3. Annually submit proof of its certification by ~~[Upon recertification with]~~ the**
13 **United States Department of Health and Human Services, Health Resources and Ser-**
14 **vices Administration as an FQHC, FQHC look-alike, or RHC~~], submit proof of its con-~~**
15 **tinued certification] to the department~~[upon obtaining recertification].~~**

16 (c) The requirements established in paragraph (a) and (b) of this subsection shall ap-
17 ply to a satellite facility of an FQHC or FQHC look-alike.

18 (3)~~[(a)]~~ An FQHC, FQHC look-alike, or PCC that operates multiple satellite facilities
19 shall:

20 **(a) List each satellite facility on the parent facility's license in accordance with**
21 **902 KAR 20:058; and ~~[separately enroll each satellite facility with the department~~**
22 **in accordance with 907 KAR 1:672.]**

23 **(b) ~~[An FQHC, FQHC look-alike, or PCC that operates multiple satellite facilities~~**

1 ~~shall~~ Be authorized to consolidate claims and cost report data of its satellite facilities.

2 ~~(4) [An FQHC, FQHC look-alike, or PCC shall not submit a claim for a service~~
3 ~~provided at a satellite facility if the satellite facility is not currently:~~

4 ~~(a) Enrolled with the department in accordance with 907 KAR 1:672; and~~

5 ~~(b) Participating with the department in accordance with 907 KAR 1:671.~~

6 ~~(5) An FQHC, FQHC look-alike, RHC, or PCC that has been terminated from federal~~
7 ~~participation [pursuant to 42 C.F.R. 405.2436] shall be terminated from Kentucky Med-~~
8 ~~icaid program participation.~~

9 ~~(5)[(6)](2) An FQHC shall be enrolled as a primary care center.~~

10 ~~(3) A participating:~~

11 ~~(a) FQHC and its staff shall comply with all applicable federal laws and regulations,~~
12 ~~state laws and administrative regulations, and local laws and regulations regarding the~~
13 ~~administration and operation of an FQHC;~~

14 ~~(b) FQHC look-alike and its staff shall comply with all applicable federal laws and~~
15 ~~regulations, state laws and administrative regulations, and local laws and regulations~~
16 ~~regarding the administration and operation of an FQHC look-alike;~~

17 ~~(c) RHC and its staff shall comply with all applicable federal laws and regulations,~~
18 ~~state laws and administrative regulations, and local laws and regulations regarding the~~
19 ~~administration and operation of an RHC; or~~

20 ~~(d) PCC and its staff shall comply with all applicable federal laws and regulations,~~
21 ~~state laws and administrative regulations, and local laws and regulations regarding the~~
22 ~~administration and operation of a PPC.~~

23 ~~(6)[(7)] An FQHC, FQHC look-alike, RHC, or PCC[center or clinic and staff shall~~

1 ~~comply with all applicable federal, state, and local regulations concerning the admin-~~
2 ~~istration and operation of a PCC, FQHC, or an RHC.~~

3 ~~(4) A center or clinic]~~ performing laboratory services shall meet the requirements es-
4 tablished in 907 KAR 1:028 and 907 KAR 1:575.

5 Section 3. Standard Reimbursement for an FQHC, FQHC look-alike, or RHC for a
6 Visit by a Recipient Who is not an Enrollee and that is Covered by the Depart-
7 ment[, or PCC]. (1) For a visit by a recipient who is not an enrollee and that is
8 covered by the department,~~[For services provided on and after July 1, 2001,]~~ the de-
9 partment shall reimburse:

10 (a) An [A-PCC,] FQHC, FQHC look-alike, or RHC an all-inclusive encounter rate per
11 patient visit in accordance with a prospective payment system (PPS) as required by 42
12 U.S.C. 1396a(aa); or

13 (b) A satellite facility of an FQHC or[,] FQHC look-alike~~[, or PCC]~~ an all-inclusive en-
14 counter rate per patient visit in accordance with a prospective payment system (PPS) as
15 required by 42 U.S.C. 1396a(aa).

16 (2) [Except for drugs or pharmacy services,] Costs related to **outpatient** drugs or
17 pharmacy services shall be excluded from the all-inclusive encounter rate per patient
18 visit referenced in subsection (1) of this section.

19 (3)~~(2)~~ The department shall calculate a PPS ~~[base-]~~rate for[:

20 (a) ~~An existing center or clinic in accordance with Section 4 of this administrative reg-~~
21 ~~ulation; or~~

22 (b)] a new FQHC, FQHC look-alike, or RHC [RCH, or PCC]~~[center or clinic]~~ in ac-
23 cordance with Section 4~~[5]~~ of this administrative regulation.

1 ~~(4)~~~~(3)~~ The department shall adjust a PPS rate per visit:

2 (a) ~~[By fifty (50) percent of the percentage increase in the MEI applicable to primary~~
3 ~~care services on January 1, 2002;~~

4 ~~(b)~~ By the percentage increase in the MEI applicable to FQHC, FQHC look-alike, or
5 RHC~~, or PCC~~~~[primary care]~~ services on July 1 of each year~~[, beginning July 1, 2002];~~

6 and

7 ~~(b)~~~~(c)~~ In accordance with Section ~~8~~~~(7)~~~~(6)~~ of this administrative regulation:

8 1. Upon request and documentation by an FQHC, FQHC look-alike, or RHC~~, or~~
9 PCC ~~[a center or clinic]~~ that there has been a change in scope of services; or

10 2. Upon review and determination by the department that there has been a change in
11 scope of services.

12 (4) A rate established in accordance with this administrative regulation shall not be
13 subject to an end of the year cost settlement.

14 Section 4. ~~[Establishment of a PPS Base Rate for an Existing Provider.~~

15 ~~(1) The department shall establish a PPS base rate to reimburse an existing PCC,~~
16 ~~FQHC, and RHC 100 percent of its average allowable cost of providing Medicaid-~~
17 ~~covered services during a center's or clinic's fiscal years 1999 and 2000. A center's or~~
18 ~~clinic's fiscal year that ends on January 31 shall be considered ending the prior year.~~

19 ~~(2) A center or clinic shall complete MAP 100601 annually and submit it to the de-~~
20 ~~partment by the last calendar day of the third month following the center's or clinic's fis-~~
21 ~~cal year end.~~

22 ~~(3) The department shall:~~

23 ~~(a) Use a center's or clinic's desk reviewed or audited cost reports for fiscal years~~

1 ending February 1999 through January 2000 and February 2000 through January 2001;

2 (b) Trend the cost from the second base year forward to July 1, 2001 by the percent-
3 age of increase as measured by the HCFA hospital market basket index; and

4 (c) Calculate the average cost by dividing the total cost associated with FQHC, PCC,
5 and RHC services by the total visits associated with the FQHC, PCC, and RHC ser-
6 vices.

7 (4) If a center or clinic has only one (1) full year of cost report data, the department
8 shall calculate a PPS base rate using a single audited cost report.

9 (5) The department shall adjust a PPS base rate determined in accordance with this
10 section to account for an increase or decrease in the scope of services provided during
11 fiscal year 2001 in accordance with Section 6 of this administrative regulation.

12 (6) Until the establishment of a PPS base rate by the department, a center or clinic
13 shall be paid for services at an interim rate.

14 (7) Except for a center that has been receiving an incentive payment, the interim rate
15 shall be the rate on file on June 30, 2001.

16 (8) A center that has been receiving an incentive payment shall have an interim rate
17 based upon the average costs of providing services for fiscal years 1999 and 2000. The
18 average shall be calculated in accordance with this section using unaudited cost report
19 data.

20 (9) A center shall not be eligible for an incentive payment for services provided on
21 and after July 1, 2001.

22 (10)(a) A center or clinic shall have thirty (30) days from the date of notice by the de-
23 partment of its PPS rate to request an adjustment based on a change in scope of ser-

1 vices; and

2 (b) ~~The department shall have thirty (30) days to review the request prior to establish-~~
3 ~~ing a final PPS rate that shall be subject to appeal in accordance with Section 9 of this~~
4 ~~administrative regulation.~~

5 ~~Section 5.] Establishment of a PPS Rate for a New FQHC, FQHC look-alike, or~~
6 ~~RHC[, or PCC][Base Rate for a New Provider].~~

7 (1)(a) The department shall establish a PPS [base] rate to reimburse a new [PCC,]
8 FQHC, FQHC look-alike, or[, and] RHC 100 percent of its reasonable cost of providing
9 Medicaid covered services during the FQHC, FQHC look-alike, or RHC's[a center's or
10 clinic's] base year.

11 (b) Except for a time frame in which the department reimburses an FQHC, FQHC
12 look-alike, or RHC[, or PCC] an interim rate, the initial and subsequent final PPS rate
13 established for an FQHC, FQHC look-alike, or RHC[, or PCC] shall:

14 1. Be prospective; and

15 2. Not settled to cost.

16 (2)(a) The department shall determine the reasonable costs of an FQHC, FQHC look-
17 alike, or RHC[, or PCC] based on the cost reported which contains twelve (12) full
18 months of operating data most recently submitted to the department by the FQHC,
19 FQHC look-alike, or RHC[, or PCC].

20 (b) The base rate referenced in subsection (1)(a) of this section shall be based on the
21 reasonable cost determination made by the department pursuant to paragraph (a) of
22 this subsection.~~[(2) Reasonable costs shall be determined by the department based on~~
23 ~~a center's or clinic's cost report used by the department to establish the PPS rate].~~

1 (3)(a) Until an FQHC, FQHC look-alike, or RHC [a center or clinic] submits a Medi-
2 caid cost report containing twelve (12) full months of operating data for the facility's
3 base[a fiscal] year, the department shall reimburse the FQHC, FQHC look-alike, or
4 RHC[make payments to the center or clinic based on] an interim rate equal to the all-
5 inclusive per visit[diem] rate established for the FQHC, FQHC look-alike, or RHC by
6 Medicare.

7 **(b) An FQHC, FQHC look-alike, or RHC shall provide the department with a copy of**
8 **the Medicare rate letter for the rates in effect during the FQHC's, FQHC look-alike's, or**
9 **RHC's interim period.**

10 **(c)1. The department shall adjust an interim rate for an FQHC, FQHC look-alike, or**
11 **RHC based on the establishment of the final rate.**

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

14 **[d)1. Until a PCC submits a Medicaid cost report containing twelve (12) full**
15 **months of operating data for the facility's base year, the department shall reim-**
16 **burse the PCC an interim rate equal to the average PPS rate paid to PCCs in the**
17 **same region in which the PCC is located.**

18 **2. The department shall adjust an interim rate for a PCC based on the estab-**
19 **lishment of the final rate.**

20 **3. All claims submitted to the department and paid by the department based on**
21 **the interim rate shall be adjusted to comport with the final rate.]**

22 **(4)(a) An FQHC, FQHC look-alike, or RHC[, or PCC] shall submit a[an annual] cost**
23 **report to the department by the end of the fifth month following the end of the FQHC's,**

1 FQHC look-alike's, or RHC's, ~~or PCC's~~ first full fiscal year.

2 (b) The department shall:

3 1. Review ~~the~~~~[an annual]~~ cost report **referenced in paragraph (a)** submitted by an
4 FQHC, FQHC look-alike, or RHC, ~~or PCC~~ within ninety (90) business days of receiv-
5 ing the cost report; and

6 2. Notify the FQHC, FQHC look-alike, or RHC, ~~or PCC~~ of the:

7 a. Necessity of the FQHC, FQHC look-alike, or RHC, ~~or PCC~~ to submit additional
8 documentation if necessary;

9 b. Final rate established;

10 c. Appeal rights regarding the final rate; and

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

13 (c)1. If additional documentation is necessary to establish a final rate, the FQHC,
14 FQHC look-alike, or RHC, ~~or PCC~~ shall:

15 a. Provide the additional documentation to the department within thirty (30) days of
16 the notification of need for additional documentation; or

17 b. Request an extension beyond thirty (30) days to provide the additional documenta-
18 tion.

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

20 3. An extension shall not exceed thirty (30) days.

21 (d) If the department requests additional documentation from an FQHC, FQHC look-
22 alike, or RHC, ~~or a PCC~~ but does not receive additional documentation or an exten-
23 sion request within thirty (30) days, the department shall reimburse the FQHC, FQHC

1 look-alike, or RHC[, or PCC] based on the Medicaid physician fee schedule applied to
2 physician services pursuant to 907 KAR 3:010 until:

3 1. The additional documentation has been received by the department; and

4 2. The department has established a final rate.

5 Section 5. Reimbursement for Services or Drugs Provided to an Enrollee by a PCC
6 That is Not an FQHC, FQHC look-alike, or RHC and that are Covered by an MCO. (1)
7 For a service or drug provided to[visit by] an enrollee by[te] a PCC that is not an
8 FQHC, FQHC look-alike, or RHC and that is covered by an MCO, the PCC's reim-
9 bursement shall be the reimbursement established pursuant to an agreement between
10 the PCC and the managed care organization with whom the enrollee is enrolled.

11 (2) The department shall not supplement the reimbursement referenced in subsection
12 (1) of this section.

13 Section 6. Reimbursement for Services or Drugs Provided to a Recipient by a
14 PCC That is Not an FQHC, FQHC look-alike, or RHC and that are Covered by the
15 Department. (1) For a service or drug provided to a recipient that is not an enrol-
16 lee by a PCC that is not an FQHC, FQHC look-alike, or RHC, the department shall
17 reimburse the rate or reimbursement established for the service or drug on the
18 Medicare Fee Schedule established for Kentucky.

19 (2) The reimbursement referenced in subsection (1) of this section shall not ex-
20 ceed the clinic upper payment limit determined in accordance with 42 C.F.R.
21 447.321.

22 (3)(a) The coverage provisions and requirements established in 907 KAR 1:054
23 shall apply to a service or drug provided by a PCC.

1 **(b) If a Medicare coverage provision or requirement exists regarding a given**
2 **service or drug that contradicts a provision or requirement established in 907**
3 **KAR 1:054, the provision or requirement established in 907 KAR 1:054 shall su-**
4 **perse the Medicare provision or requirement.**

5 **Section 7. Supplemental Reimbursement for FQHC Visits[~~services~~], FQHC look-**
6 **alike Visits[~~services~~], and RHC Visits[~~services~~]. If a managed care organization's re-**
7 **imbursement to an FQHC, FQHC look-alike, or RHC for a visit by an enrollee to the**
8 **FQHC, FQHC look-alike, or RHC is less than what the FQHC, FQHC look-alike, or RHC**
9 **would receive pursuant to Sections 3 and 4 of this administrative regulation, the de-**
10 **partment shall supplement the reimbursement made by the managed care organization**
11 **in a manner that:**

12 **(1) Equals the difference between what the managed care organization reimbursed**
13 **and what the reimbursement would have been if it been made in accordance with Sec-**
14 **tions 3 and 4 of this administrative regulation;**

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

16 **(3) Ensures that total reimbursement does not exceed the federal upper payment lim-**
17 **it in accordance with:**

18 **(a) 42 C.F.R. 447.304; and**

19 **(b) 42 C.F.R. 447.321.[~~-~~**

20 **(4) A new center or clinic shall submit a budget that sets forth:**

21 **(a) Estimates of Medicaid allowable costs to be incurred by the center or clinic during**
22 **the initial reporting period of at least twelve (12) months; and**

23 **(b) The number of Medicaid visits a center or clinic expects to provide during the re-**

1 ~~porting period.~~

2 ~~(5) An interim payment shall be based on an annual budgeted or projected average~~
3 ~~cost per visit that shall be subject to reconciliation after a Medicaid cost report with~~
4 ~~twelve (12) months of actual operating data has been received.]~~

5 Section ~~8.~~7. ~~Change in Scope and PPS Rate Adjustment.~~ ~~[6. Adjustments to a PPS~~
6 ~~Rate.]~~

7 (1)(a) ~~If an FQHC, FQHC look-alike, or RHC[, or PCC][a center or clinic]~~ changes its
8 scope of services after the base year, the department shall adjust the FQHC's, FQHC
9 look-alike's, or RHC's~~[a center's or clinic's]~~ PPS rate.

10 **(b) An adjustment to a PPS rate resulting from a change in scope that occurred**
11 **after an FQHC's, FQHC look-alike's, or RHC's base year shall be retroactively ef-**
12 **fective to the date that the FQHC, FQHC look-alike, or RHC applied for the change**
13 **in scope.**~~[by dividing a center's or clinic's total Medicaid costs by total Medicaid visits.~~
14 ~~A provider shall submit MAP 100501 to request a rate adjustment after a change in ser-~~
15 ~~vice.]~~

16 (2) A change in scope of service shall be restricted to:

17 (a) Adding or deleting a covered service;

18 (b) Increasing or decreasing the intensity of a covered service **pursuant to subsec-**
19 **tion (5) of this section;** or

20 (c) A statutory or regulatory change that materially impacts the costs or visits of an
21 FQHC, FQHC look-alike, or RHC[, or PCC].

22 (3) The following individually shall not constitute a change in scope:

23 (a) A general increase or decrease in the costs of existing services;

- 1 (b) An expansion of office hours;
- 2 (c) An addition of a new site that provides the same Medicaid covered services;
- 3 (d) A wage increase;
- 4 (e) A renovation or other capital expenditure;
- 5 (f) A change in ownership; or
- 6 (g) An addition or deletion of a service provided by a non-licensed professional or
- 7 specialist.

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

12 (5) A change in intensity shall:

13 (a) Include a material change;

14 (b) Increase or decrease the existing PPS rate by at least five (5) percent; and

15 (c) Last at least twelve (12) months.

16 (6) The department shall consider a change in scope request due to a statutory or
17 regulatory change that materially impacts the costs of visits at an FQHC, FQHC look-
18 alike, or RHC if:

19 (a) A government entity imposes a mandatory minimum wage increase and the in-
20 crease was not included in the:

21 1. Calculation of the final PPS rate; or

22 2. Subsequently included in the MEI applied yearly; or

23 (b) A new licensure requirement or modification of an existing requirement by the

1 state results in a change that affects all facilities within the class. A provider shall docu-
2 ment that an increase or decrease in the cost of a visit occurred as a result of a licen-
3 sure requirement or policy modification.

4 (7) A requested change in scope shall:

5 (a) Increase or decrease the existing PPS rate by at least five (5) percent; and

6 (b) Last at least twelve (12) months.

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

11 (9) The following documents shall be submitted to the department within six (6)
12 months of the effective date of a change in scope:

13 (a) A narrative describing the change in scope;

14 (b) A projected cost report containing twelve (12) months of data for the interim rate
15 change; and

16 (c) A completed MAP 100501, Prospective Payment System Rate Adjustment.

17 (10) The department shall:

18 (a) Review the documentation listed in subsection (9) of this section; and

19 (b) Notify the FQHC, FQHC look-alike, or RHC in writing of the approval or denial of
20 the request for change in scope within ninety (90) business days.

21 (11)(a) If the department requests additional documentation to calculate the rate for a
22 change in scope, the FQHC, FQHC look-alike, or RHC shall:

23 1. Provide the additional documentation to the department within thirty (30) days of

1 the notification of need for additional documentation; or

2 2. Request an extension beyond thirty (30) days to provide the additional documenta-
3 tion.

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

5 2. An extension shall not exceed thirty (30) days.

6 Section 9.[8. Regions. The following shall be the regions used to determine a
7 PCC's regional location for the purpose of determining a new PCC's interim rate:

8 (1) Region one (1) shall be the region containing Ballard, Caldwell, Calloway,
9 Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, Marshall, and
10 McCracken Counties;

11 (2) Region two (2) shall be the region containing Christian, Daviess, Hancock,
12 Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, and Web-
13 ster Counties;

14 (3) Region three (3) shall be the region containing Breckenridge, Bullitt, Carroll,
15 Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shel-
16 by, Spencer, Trimble, and Washington Counties;

17 (4) Region four (4) shall be the region containing Adair, Allen, Barren, Butler,
18 Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe,
19 Monroe, Pulaski, Russell, Simpson, Taylor, Warren, and Wayne Counties;

20 (5) Region five (5) shall be the region containing Anderson, Bourbon, Boyle,
21 Clark, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madi-
22 son, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, and Wood-
23 ford Counties;

1 ~~(6) Region six (6) shall be the region containing Boone, Campbell, Gallatin,~~
2 ~~Grant, Kenton, and Pendleton Counties;~~

3 ~~(7) Region seven (7) shall be the region containing Bath, Boyd, Bracken, Carter,~~
4 ~~Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Rowan, and~~
5 ~~Robertson Counties; and~~

6 ~~(8) Region eight (8) shall be the region containing Bell, Breathitt, Clay, Floyd,~~
7 ~~Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Ows-~~
8 ~~ley, Perry, Pike, Wolfe, and Whitley Counties.]]~~ Total Medicaid costs shall be deter-

9 mined in accordance with the following:

10 (a) ~~The Medicaid costs of existing services shall be determined by multiplying a cen-~~
11 ~~ter's or clinic's current Medicaid PPS rate by the number of Medicaid visits used to cal-~~
12 ~~culate the base Medicaid PPS rate; and~~

13 (b) ~~The Medicaid costs of a new service shall be determined by:~~

14 1. ~~Adding:~~

15 a. ~~The projected annual direct cost of a new service as determined from a center's or~~
16 ~~clinic's budgeted report; and~~

17 b. ~~The administrative cost of a new service which shall be equal to the ratio of admin-~~
18 ~~istrative costs to direct costs determined from the base year cost reports multiplied by a~~
19 ~~center's or clinic's projected direct cost of a new service; and~~

20 2. ~~Multiplying the sum derived in subparagraph 1 of this paragraph by a center's or~~
21 ~~clinic's projected Medicaid utilization percentage for the change in service.~~

22 (3) ~~The amount determined in subsection (2)(a) of this section shall be added to the~~
23 ~~amount determined in subsection (2)(b) of this section.~~

1 ~~(4) The amount determined in subsection (3) of this section shall be divided by total~~
2 ~~visits to derive a center's or clinic's new PPS rate.~~

3 ~~(5) Total Medicaid visits shall include:~~

4 ~~(a) The annual number of Medicaid visits used in the calculation of the PPS base~~
5 ~~rate; and~~

6 ~~(b) The projected annual number of Medicaid visits for a new service.~~

7 ~~(6) The department shall adjust the PPS rate determined under this section to a final~~
8 ~~rate upon completion of:~~

9 ~~(a) A Medicaid comprehensive desk review of a center's or clinic's cost report;~~

10 ~~(b) A Medicaid audit of a center's or clinic's cost report in accordance with 45 C.F.R.~~
11 ~~74.27 and 48 C.F.R. Part 31; or~~

12 ~~(c) A Medicare audit that has been reviewed and accepted by Medicaid of a center's~~
13 ~~or clinic's cost report.]~~

14 **[Section 9.]**~~[7.]~~ Limitations. (1) Except for a case in which a recipient or enrol-
15 lee~~[patient]~~, subsequent to the first encounter, suffers an illness or injury requiring addi-
16 tional diagnosis or treatment, an encounter with more than one (1) health care provider
17 and multiple encounters with the same health care provider which take place on the
18 same day and at a single location shall constitute a single visit.

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

22 Section 10.~~[8.]~~ Out-of-State Providers. Reimbursement to an out-of-state FQHC,
23 FQHC look-alike, or RHC shall be the rate on file with the FQHC's, FQHC look-alike's,

1 or RHC's[their] state Medicaid agency.

2 Section **11. Federal Financial Participation. A policy established in this adminis-**
3 **trative regulation shall be null and void if the Centers for Medicare and Medicaid**
4 **Services:**

5 **(1) Denies federal financial participation for the policy; or**

6 **(2) Disapproves the policy.**

7 **Section 12.[9-]** Appeal Rights. (1) An appeal of a negative action taken by the de-
8 partment regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

9 (2) An appeal of a negative action taken by the department regarding Medicaid eligi-
10 bility of an individual shall be in accordance with 907 KAR 1:560.

11 (3) An[A] FQHC, FQHC look-alike, PCC, or RHC may appeal a department deci-
12 sion[decisions] as to the application of this administrative regulation as it impacts the
13 facility's reimbursement rate in accordance with 907 KAR 1:671.

14 Section **13.[12-]**[14-] Incorporation by Reference. (1) The following material is incor-
15 porated by reference:

16 (a) "MAP 100501, Prospective Payment System Rate Adjustment", **February**
17 **2013[November 2008]** edition; and

18 (b) "Instructions for Completing the MAP 100501", February 2013 edition["MAP
19 ~~100601, Scope of Services Survey Baseline Documentation, November, 2001 edition~~"].

20 (2) This material may be inspected, copied, or obtained, subject to applicable copy-
21 right law, at the Department for Medicaid Services, 275 East Main Street, Frankfort,
22 Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (Recodified from 904 KAR
23 1:055, 5-2-86; Am. 13 Ky.R. 389; eff. 9-4-86; 15 Ky.R. 1326; eff. 12-13-88; 1981; eff. 3-

- 1 15-89; 16 Ky.R. 281; eff. 9-20-89; 2601; eff. 6-27-90; 18 Ky.R. 543; eff. 10-6-91; 29 Ky.R.
- 2 824; 1279; eff. 10-16-02.)

907 KAR 1:055

REVIEWED:

Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 1:055
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact: Stuart Owen (502) 564-4321

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services (DMS) reimbursement policies for Medicaid covered services provided by a federally-qualified health center (FQHC), rural health clinic (RHC), or primary care center (PCC) that is not an FQHC, FQHC look-alike, or RHC. An FQHC or FQHC look-alike is a federally-recognized entity that serves a population that is medically underserved. An RHC is a federally-recognized entity that is designated or certified by the secretary of the Department of Health and Human Services as being located in an area that is a health professional shortage area or medically underserved area. A PCC is an entity whose licensure requirements are established by the Cabinet for Health and Family Services Office of Inspector General pursuant to 902 KAR 20:058 and are not federally-recognized as being equivalent to an FQHC.
 - (b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the Department for Medicaid Services (DMS) reimbursement policies for Medicaid covered services provided by an FQHC, RHC, or PCC (that is not an FQHC, FQHC look-alike, or RHC.)
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: The administrative regulation conforms to the content of the authorizing statutes by reimbursing for Medicaid covered services provided by an FQHC, RHC, or PCC in a manner which ensures the receipt of federal funding for the reimbursement.
 - (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 reimbursing for Medicaid covered services provided by an FQHC, RHC, or PCC in a manner which ensures the receipt of federal funding for the reimbursement.
- (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: The amendment filed March 1, 2013, eliminated supplemental payments (in addition to payments that PCCs receive from managed care organizations) to PCCs for services provided to Medicaid recipients enrolled with a managed care organization. Additional amendments included elaborating on the provider enrollment/participation process and related requirements; establishing that DMS will reimburse a new FQHC, FQHC look-alike, or RHC on an interim basis - until a full year of cost report data has been submitted, reviewed and finalized to estab-

lish a prospective payment system (PPS) rate - the per diem rate paid by Medicare to the new facility; establishing that DMS would reimburse a new PCC an interim rate equal to the average rate to PCCs in the region in which the PCC is located (currently DMS pays an interim rate based on projected costs submitted to DMS by the PCC); elaborating on reimbursement requirements such as cost report requirements; clarifying policy; inserting criteria for what constitutes a change in scope; and eliminating obsolete statements.

The amendment after comments alters reimbursement for services provided by a PCC that is not an FQHC, FQHC look-alike, or RHC to a Medicaid recipient that is not enrolled with a managed care organization from the prospective payment system (PPS) rate – which is currently in place - to the Medicare fee schedule rate/reimbursement for the service or drug established for Kentucky; clarifies that the interim reimbursement for an FQHCs, FQHC look-alikes, or RHCs will be the all-inclusive per visit rate paid by Medicare to the facility; altogether eliminates interim reimbursement for PCCs that are not FQHCs, FQHC look-alikes, or RHCs; eliminates the requirement that FQHC/FQHC look-alike/RHC/PCC satellite facilities have to enroll with the Medicaid program independently of the parent facility; replaces the requirement that an FQHC, FQHC look-alike, or RHC submit proof of federal recertification upon recertification with the requirement that the facility annually submit proof of its certification; better clarifies that the reimbursement policies in Section 3 apply to services provided by an FQHC, FQHC look-alike, RHC, or PCC to a Medicaid recipient who is not enrolled in a managed care organization; clarifies that costs related to outpatient drugs or pharmacy service are excluded from an FQHC's, FQHC look-alike's, or RHC's prospective payment system (PPS) rate; clarifies that Section 7(5) establishes what constitutes a change in intensity for the purpose of determining a change in scope of service; eliminates the section establishing eight (8) regions for interim reimbursement purposes; inserts a section stating that policies are contingent upon the receipt of federal funding (federal financial participation) for the policy; adds licensed professional clinical counselors and licensed marriage and family therapists as authorized health care providers for FQHCs, FQHC look-alikes, and RHCs contingent upon approval of a corresponding state plan amendment by the Centers for Medicare and Medicaid Services. Additionally, the amendment after comments corrects the edition date of the “MAP 100501, Prospective Payment System Rate Adjustment” and adds the “Instructions for Completing the MAP 100501.

- (b) The necessity of the amendment to this administrative regulation: The primary amendments are necessary to prevent a loss of federal funding for services provided by primary care centers (PCCs) that are not federally qualified health centers (FQHCs), FQHC look-alikes, or rural health clinics (RHCs). The Centers for Medicare and Medicaid Services (CMS) issued letters to the Department for Medicaid Services “deferring” (declining to provide federal matching funds) for payments made by DMS to PCCs (that are not FQHCs, FQHC look-alikes, or RHCs) that supplement the PCC's reimbursement from managed care organizations (MCOs.) CMS cited federal law and regulation - 42 USC 1396a(bb)(5)(A) and 42 C.F.R. 438.60 – as authorizing such payments to the federally-recognized

entities (FQHCs, FQHC look-alikes, and RHCs) entitled to such reimbursement but not to PCCs as they are not recognized by CMS as qualifying for the reimbursement. PCCs were created by Kentucky law with licensure requirements established in Kentucky regulation.

CMS also issued letters deferring (not providing) federal funds to DMS for payments DMS made to the aforementioned PCCs for services provided to “fee-for-service” or (not via managed care) Medicaid recipients that exceed the federal upper payment limit for those services. For years DMS has reimbursed such PCCs in the same manner as FQHCs, FQHC look-alikes, and RHCs. That methodology is a prospective payment system (PPS) rate based on reasonable cost at a point in time. CMS does not view such PCCs as comparable to FQHCs, FQHC look-alikes, or RHCs, but, rather, views them as comparable to physicians’ practices and, thus, has stated that the upper payment limit for such PCCs is the Medicare fee schedule rather than the PPS rate based no reasonable cost.

To date, CMS has issued deferral letters (no longer providing federal funds) to DMS in the amount of \$16,681,223 for payments to PCCs which supplement MCO reimbursements and \$861,011 for payments to PCCs for “fee-for-service” claims that exceed the federal upper payment limit.

As CMS will not provide federal matching funds for the supplemental payments or for the PPS rate reimbursement (fee-for-service claims) which exceeds the federal upper payment limit, DMS is amending the regulation to protect Kentucky taxpayer funds from being used to offset the loss of federal funds and to ensure that DMS operates within the fiscal parameters established by the Kentucky General Assembly and Governor via the biennium budget (in accordance with the Kentucky Constitution.)

In the March 1, 2013 version of the administrative regulation, DMS introduced new interim reimbursement methodologies for FQHCs, FQHC look-alikes, RHCs, and PCCs for the first year of a facility’s operation until DMS has finalized a full year of cost report information on the facility and has established a PPS rate for the facility. The amendment after comments regarding FQHC, FQHC look-alike, and RHC interim reimbursement is necessary to clarify the policy.

The amendment after comments which deletes the interim reimbursement for PCCs that are not FQHCs, FQHC look-alikes, or RHCs, is necessary as these facilities are not entitled to a cost-based reimbursement (per federal regulation and the Centers for Medicare and Medicaid Services) and DMS’s new reimbursement for services provided by these facilities will be the reimbursement or rate on the Medicare fee schedule specific to Kentucky; thus, there is no longer an interim period.

The amendment after comments that removes the requirement that a satellite facility enroll independently with DMS is necessary because DMS does not enroll

these facilities independently; the amendment after comment removing the requirement that an FQHC, FQHC look-alike, or RHC submit proof of recertification upon recertification is necessary because these facilities do not undergo a recertification; the clarification amendments after comments are necessary to better clarify policies; reverting interim reimbursement policies for new facilities to the old methodology is necessary because DMS has not submitted the policy change to the Centers for Medicare and Medicaid Services; the amendment after comments regarding requirements being null and void without federal approval is necessary to clarify that DMS won't implement a policy without federal funding.

- (c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by preventing a loss of federal funds for reimbursement to PCCs, by protecting Kentucky taxpayer funds from being used to offset the loss of federal fund, and by ensuring that DMS operates within the fiscal parameters established by the Kentucky General Assembly and Governor via the biennium budget (in accordance with the Kentucky Constitution.) The amendments after comments conform to the content of the authorizing statutes by clarifying policies and ensuring that policies are contingent upon approval and funding by/from the Centers for Medicare and Medicaid Services' requirements.
 - (d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by preventing a loss of federal funds for reimbursement to PCCs, by protecting Kentucky taxpayer funds from being used to offset the loss of federal fund, and by ensuring that DMS operates within the fiscal parameters established by the Kentucky General Assembly and Governor via the biennium budget (in accordance with the Kentucky Constitution.) The amendments after comments will assist in the effective administration of the authorizing statutes by clarifying policies and ensuring that policies are contingent upon approval and funding by/from the Centers for Medicare and Medicaid Services' requirements.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: DMS has identified ninety-five (95) primary care centers that do not qualify as FQHCs, FQHC look-alikes, or RHCs and; therefore, will no longer receive payments which supplement their reimbursement from managed care organizations nor receive a reimbursement methodology for "fee-for-service" claims that is based on reasonable cost.
- (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. Any primary care center (PCC) that is not a federally-qualified health center (FQHC) or FQHC look-alike and wishes to be reimbursed in the same manner as an FQHC or FQHC look-alike will have to apply to the United States Department of

Health and Human Services (USDHHS), Health Resources and Services Administration (HRSA) and be designed by HRSA as an FQHC or FQHC look-alike. Similarly, any PCC that wishes to be reimbursed in the same manner as an RHC must complete the steps necessary to be federally certified as an RHC.

- (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed by the amendment, but any PCC who does not become an FQHC, FQHC look-alike, or RHC will no longer receive payments supplemental reimbursement they receive from managed care organizations nor will they receive “prospective payment system” or “PPS” reimbursement for services provided to Medicaid recipients in the “fee-for-service” (or non-managed care) realm. PCC reimbursement for fee-for-service claims will be the reimbursement on the Medicare fee schedule specific to Kentucky for the service or drug associated with the claim.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A PCC which applies and is approved by HRSA as an FQHC or FQHC look-alike or is certified as an RHC will benefit by receiving a higher reimbursement for services provided. A PCC that does not take the steps to become an FQHC, FQHC look-alike, or RHC will receive a lower reimbursement than to which they’ve been accustomed. The taxpayers of Kentucky will benefit by ensuring that DMS receives federal funds for Medicaid program reimbursement to PCCs that are not FQHCs, FQHC look-alikes, or RHCs.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: The amendments are necessary to prevent DMS from continuing to not be granted federal funds for reimbursement to PCCs (that are not FQHCs, FQHC look-alikes, or RHCs) that exceed the respective limits allowed by the Centers for Medicare and Medicaid Services (CMS.) In February 2013 CMS did not provide federal funds for the July 2012 through September 2012 quarter for reimbursement to the aforementioned PCCs (in excess of the federally-allowed amounts) totaling \$8,977,945 (\$8,698,208 for payments supplementing MCO reimbursement and \$279,737 for fee-for-service payments exceeding the federal upper limit.) In April 2013 CMS did not provide federal funds for the October 2012 through December 2012 quarter for reimbursement to the aforementioned PCCs (in excess of the federally-allowed amounts) totaling \$8,564,289 (\$7,983,015 for payments supplementing MCO reimbursement and \$581,274 for fee-for-service payments exceeding the federal upper limit.) The loss of federal funds thus far totals \$17,542,234 (\$16,681,223 regarding supplements to MCO payments and \$861,011 regarding fee-for-service payments.)
 - (b) On a continuing basis: As DMS ended the payments to PCCs (that are not FQHCs, FQHC look-alikes, or RHCs) that supplement their reimbursement from managed care organizations (MCOs) earlier this year, DMS anticipates no additional loss of federal funds related to those payments. As this amendment after comments will not become effective until it has completed the ordinary administrative regulation promulgation process (perhaps in September 2013), DMS anticipates a loss of federal funds from CMS in July 2013 for payments to the

aforementioned PCCs for “fee-for-service” Medicaid claims (that exceed the federally-recognized upper payment limit) corresponding to the quarters of January 2013 through March 2013, April 2013 through June 2013, and July 2013 through part of September 2013.

- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under the Social Security Act, Title XIX and state matching funds from general fund and restricted fund appropriations are utilized to fund the this administrative regulation.
- (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. Neither an increase in fees nor funding is necessary to implement the amendment.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment neither establishes nor increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used.) Tiering is applied in the sense that a primary care center that is not a federally-qualified health center (FQHC), FQHC look-alike, or rural health clinic (RHC) will not be reimbursed in the same manner as those entities as the Centers for Medicare and Medicaid Services (CMS), citing federal law and regulation, has indicated that such PCCs are not entitled to the same reimbursement as those facilities .

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:055

Agency Contact: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(bb)(5)(A), and 42 C.F.R. 438.60, and 42 C.F.R. 447.321 mandate the amendments.
2. State compliance standards. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.
3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(bb)(5)(A) authorizes federally-qualified health centers (FQHCs), FQHC look-alikes, or rural health clinics (RHCs) - but not primary care centers (PCCs) - to receive Medicaid reimbursement in addition to reimbursement they receive pursuant to a contract between the FQHC, FQHC look-alike, or RHC and a managed care organization. 42 C.F.R. 438.60 establishes that no Medicaid reimbursement may be made to a provider who is a provider with a managed care organization in addition to what the provider receives from the managed care organization except for delineated exceptions (PCCs are not included in the exceptions but FQHCs, FQHC look-alikes, and RHCs are included.) Payments to PCCs who are not FQHCs, FQHC look-alikes, or RHCs do not qualify as any of the exceptions. 42 C.F.R. 447.321 establishes that the upper payment limit (maximum Medicaid program reimbursement) authorized for clinics is what the Medicare program would pay the clinic for services. Following is the text from 42 C.F.R. 447.321(b):

“(1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.

(2) Except as provided in paragraph (c) of this section, aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed the upper payment limit described in paragraph (b)(1) of this section.”

Additionally, the Centers for Medicare and Medicaid Services (CMS) – the federal agency which provides federal matching funds to Kentucky’s Medicaid program and establishes Medicaid program requirements via rules and regulations – in February of this year began refusing to provide federal matching funds to DMS related to reimbursement of PCCs that do not qualify as federally qualified health centers (FQHCs), FQHC look-alikes, or RHCs.

CMS cited federal law, 42 USC 1396a(bb)(5)(A), which only authorizes Medicaid programs to supplement an FQHC’s or RHC’s reimbursement (in addition to the

reimbursement the FQHC/RHC received from a managed care organization) if necessary to elevate FQHC and RHC reimbursement to the mandated prospective payment system (PPS) level required in federal law for FQHCs and RHCs. The aforementioned PPS reimbursement is initially based, pursuant to 42 USC 1396a(bb)(3) and (4), on reasonable cost experienced by the FQHC or RHC.

The federal law only recognizes FQHCs and RHCs as being eligible for the supplementation and CMS noted that Kentucky's PCCs that had been receiving the supplemental payments "do not appear to have been approved as FQHC or FQHC look-alikes by Health Resources and Services Administration (HRSA), nor do they appear to have an approved RHC certification."

CMS views services provided by a PCC that is not an FQHC, FQHC look-alike, or RHC as comparable to services provided via a physician's practice. DMS understands that the Medicare program reimburses PCCs (that are not an FQHC, FQHC look-alike, or RHC) based on the Medicare program physician fee schedule.

DMS notes that a key federal criterion to becoming an FQHC, FQHC look-alike, or RHC (and the key reason for the federally-recognized enhanced reimbursement) is that the facility provides services in a medically underserved area or to a medically underserved population.

To be eligible for the supplemental payment a PCC must take the steps necessary to be federally recognized as an FQHC, FQHC look-alike, or RHC and DMS will supplement the PCC's reimbursement accordingly. That option is available to PCCs.

In addition to no longer providing federal matching funds for supplements to managed care organization payments, CMS is no longer providing federal matching funds for payments to PCCs (that are not FQHCs, FQHC look-alikes, or RHCs) for Medicaid "fee-for-service" claims (non-managed care) that exceed the Medicare fee schedule rate. CMS cited 42 CFR 447.321 in correspondence to DMS regarding DMS's reimbursement to the aforementioned PCCs.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This administrative regulation does not set stricter requirements.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Neither stricter nor additional standards nor responsibilities are imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 1:055

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. 42 C.F.R. 438.60, 42 C.F.R. 447.321, and this administrative regulation authorize the action taken by this administrative regulation.
3. 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? DMS projects no revenue will initially be generated by the amendment to this administrative regulation.
 - (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? DMS projects no revenue will be generated in subsequent years by the amendment to this administrative regulation.
 - (c) How much will it cost to administer this program for the first year? The amendments are necessary to prevent DMS from continuing to not be granted federal funds for reimbursement to PCCs (that are not FQHCs, FQHC look-alikes, or RHCs) that exceed the respective limits allowed by the Centers for Medicare and Medicaid Services (CMS.) In February 2013 CMS did not provide federal funds for the July 2012 through September 2012 quarter for reimbursement to the aforementioned PCCs (in excess of the federally-allowed amounts) totaling \$8,977,945 (\$8,698,208 for payments supplementing MCO reimbursement and \$279,737 for fee-for-service payments exceeding the federal upper limit.) In April 2013 CMS did not provide federal funds for the October 2012 through December 2012 quarter for reimbursement to the aforementioned PCCs (in excess of the federally-allowed amounts) totaling \$8,564,289 (\$7,983,015 for payments supplementing MCO reimbursement and \$581,274 for fee-for-service payments exceeding the federal upper limit.) The loss of federal funds thus far totals \$17,542,234.
 - (d) How much will it cost to administer this program for subsequent years? As DMS ended the payments to PCCs (that are not FQHCs, FQHC look-alikes, or RHCs) that supplement their reimbursement from managed care organizations (MCOs) earlier this year, DMS anticipates no additional loss of federal funds related to those payments. As this amendment after comments will not become effective

until it has completed the ordinary administrative regulation promulgation process (perhaps in September 2013), DMS anticipates a loss of federal funds from CMS in July 2013 for payments to the aforementioned PCCs for “fee-for-service” Medicaid claims (that exceed the federally-recognized upper payment limit) corresponding to the quarters of January 2013 through March 2013, April 2013 through June 2013, and July 2013 through part of September 2013.

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

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:055

Summary of Material Incorporated by Reference

The "MAP 100501, Prospective Payment System Rate Adjustment", filed on March 1, 2013 was labeled as being the November 2008 edition; however, it was actually the February 2013 edition. The February 2013 edition is the correct edition. This edition replaced the November 2001 edition of the form.

The form contains one (1) page and must be completed by a facility whenever the facility requests a change in scope. The form helps determine whether the facility needs an adjustment to its prospective payment system rate. The form has been reformatted, contains a new section for totals, contains a new area near the top of the form for providers to state their name, Medicaid provider number, reason for change in scope, and effective date of change in scope. The form also contains some terminology changes.

The "Instructions for Completing the MAP 100501 Form", February 2013 edition is a new form that is incorporated by reference. This is a one (1)-page form which explains how to complete a MAP 100501.

When DMS filed the March 1, 2013 edition of this administrative regulation it deleted the "MAP 100601, Scope of Services Survey Baseline Documentation", November, 2001 edition from the incorporated material as it is no longer used.

The material incorporated by reference encompasses a total of two (2) pages.