

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (Amendment)

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(2), 194A.050(1), 205.520(3), 205.560(1),  
11 216B.042, 42 U.S.C. 1396a

12 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family  
13 Services, Department for Medicaid Services has responsibility to administer the Medi-  
14 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to  
15 comply with any requirement that may be imposed, or opportunity presented, by federal  
16 law to qualify for federal Medicaid funds. This administrative regulation establishes the  
17 Department for Medicaid Services' reimbursement policies for primary care center, fed-  
18 erally-qualified health center, federally-qualified health center look-alike, and rural health  
19 clinic services.

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

1 (2) "Alternative payment methodology" or "APM" means a reimbursement that is an  
2 alternative to the standard reimbursement established in Section 3 of this administrative  
3 regulation in accordance with 42 U.S.C. 1396a(bb)(6)~~["Allowable costs" means costs~~  
4 ~~that are incurred by a federally-qualified health center, federally-qualified health center~~  
5 ~~look-alike, rural health clinic, or primary care center that are reasonable in amount and~~  
6 ~~proper and necessary for the efficient delivery of services].~~

7 (3) "Audit" means an examination ~~that~~~~[, which]~~ may be full or limited in scope~~[,]~~ of a  
8 federally-qualified health center's, federally-qualified health center look-alike's, rural  
9 health clinic's, or primary care center's:

- 10 (a) Financial transactions, accounts, and reports; and
- 11 (b) Compliance with applicable Medicare and Medicaid regulations, manual instruc-  
12 tions, and directives.

13 (4) "Base year" means the first full fiscal year following the effective date of an  
14 FQHC's, FQHC look-alike's, or RHC's enrollment in the Medicaid program in which the  
15 FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per  
16 week, and weeks per year of intended operation.

17 (5) "Certified psychologist with autonomous functioning" means an individual who is a  
18 certified psychologist with autonomous functioning pursuant to KRS 319.056.

19 (6) "Certified social worker" means an individual who meets the requirements estab-  
20 lished in KRS 335.080.

21 (7) "Change in scope of service" means a change in the type, intensity, duration, or  
22 amount of service.

23 ~~(8)~~~~(5) "Clinical psychologist" is defined by 42 C.F.R. 410.71(d).~~

1        ~~(6)~~] "Department" means the Department for Medicaid Services or its designated  
2 agent.

3        ~~(9)~~~~(7)~~] "Enrollee" means a recipient who is enrolled with a managed care organiza-  
4 tion for the purpose of receiving Medicaid or KCHIP covered services.

5        ~~(10)~~~~(8)~~] "Federal financial participation" is defined in 42 C.F.R. 400.203.

6        ~~(11)~~~~(9)~~] "Federally-qualified health center" or "FQHC" is defined in 42 C.F.R.  
7 405.2401.

8        ~~(12)~~~~(10)~~] "Federally-qualified health center look-alike" or "FQHC look-alike" means  
9 an entity that is currently approved by the United States Department of Health and Hu-  
10 man Services, Health Resources and Services Administration, and the Centers for Med-  
11 icare and Medicaid Services to be a federally-qualified health center look-alike.

12        (13) "Final PPS rate" means an all-inclusive reimbursement amount per visit for an  
13 FQHC, FQHC look-alike, or RHC that:

14        (a) Is unique to the FQHC, FQHC look-alike, or RHC;

15        (b) Encompasses reimbursement for all services rendered during the visit;

16        (c) Is based on:

17        1. Twelve (12) full months of Medicaid cost report data in which the FQHC, FQHC  
18 look-alike, or RHC has reached its maximum hours per day, days per week, and weeks  
19 per year of intended operation;

20        a. Submitted to the department by the FQHC, FQHC look-alike, or RHC; and

21        b. That has been reviewed and approved by the department; and

22        2. A paid claims listing corresponding to the twelve (12) full months of Medicaid cost  
23 report data in which the FQHC, FQHC look-alike, or RHC has reached its maximum

1 hours per day, days per week, and weeks per year of intended operation; and

2 (d) Is established by the department.

3 (14)[(11)] "Health care provider" means, for:

4 (a) A primary care center, an FQHC, an FQHC look-alike, or an RHC:

5 1. A licensed physician;

6 2. A licensed osteopathic physician;

7 3. A licensed podiatrist;

8 4. A licensed optometrist;

9 5. ~~An~~[A licensed or certified] advanced practice registered nurse;

10 6. A licensed dentist or oral surgeon;

11 7. A physician assistant;

12 8. A licensed clinical social worker; ~~[or]~~

13 9. A licensed~~[clinical]~~ psychologist;

14 10. A licensed marriage and family therapist;

15 11. A licensed professional clinical counselor;

16 12. A licensed psychological practitioner;

17 13. A certified psychologist with autonomous functioning; or

18 14. A practitioner authorized pursuant to 907 KAR 1:054 to provide services in a

19 PCC, an FQHC, an FQHC look-alike, or an RHC who is not listed in subparagraphs 1

20 through 13 of this paragraph; or

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

22 1. A provider or practitioner listed in paragraph (a) of this subsection; or

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

1 ~~and Medicaid Services, a:~~

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

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

4 ~~(c)] An FQHC or FQHC look-alike, in addition to the professionals established in par-~~  
5 ~~agraph (a) of this subsection:~~

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

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

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

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

13 c. The teaching physician:

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

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

16 d. The teaching physician:

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

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

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

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

23 (v) Documents the extent of the teaching physician's participation in the review and

1 direction of the services furnished to each recipient.

2 ~~(15)~~~~(12)~~ "Interim PPS rate" means an all-inclusive per visit~~[a]~~ reimbursement  
3 amount established by the department to pay an FQHC, FQHC look-alike, or an RHC~~[r]~~  
4 ~~or a PGC]~~ for covered services prior to the establishment of a final PPS rate.

5 ~~(16)~~~~(13)~~ "Licensed clinical social worker" means an individual who is currently li-  
6 censed in accordance with KRS 335.100.

7 ~~(17)~~~~(14)~~ "Licensed marriage and family therapist" is defined by KRS 335.300(2).

8 ~~(18)~~~~(15)~~ "Licensed professional clinical counselor" is defined by KRS 335.500(3).

9 ~~(19)~~ "Licensed psychological practitioner" means an individual who meets the re-  
10 quirements established in KRS 319.053.

11 ~~(20)~~~~(16)~~ "Managed care organization" means an entity for which the Department for  
12 Medicaid Services has contracted to serve as a managed care organization as defined  
13 in 42 C.F.R. 438.2.

14 ~~(21)~~ "Medical Group Management Association Medical Directorship and On-Call  
15 Compensation Survey" means a report developed and owned by the Medical Group  
16 Management Association that:

17 (a) Highlights the critical relationship between medical director compensation and  
18 time spent in the medical director function;

19 (b) Aligns medical director compensation with time spent as medical director; and

20 (c) Contains tables illustrating the relationship of medical director salary to time spent  
21 in the medical director function.

22 ~~(22)~~~~(17)~~ "Medical Group Management Association Physician Compensation and  
23 Production Survey Report" means a report developed and owned by the Medical Group

1 Management Association that~~[which]~~:

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

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

4 (c) Contains:

5 1. Performance ratios illustrating the relationship between compensation and produc-  
6 tion; and

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

8 ~~(23)~~~~(18)~~ "Medically necessary" or "medical necessity" means that a covered benefit  
9 is determined to be needed in accordance with 907 KAR 3:130.

10 ~~(24)~~~~(19)~~ "Medicare Economic Index" or "MEI" means the economic index referred to  
11 in 42 U.S.C. 1395u(b)(3)(L).

12 (25) "Paid claims listing" means a report of claims paid by the department for a given  
13 FQHC, FQHC look-alike, or RHC.

14 ~~(26)~~~~(20)~~ "Parent facility" means a federally-qualified health center, federally-qualified  
15 health center look-alike, or primary care center that is:

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

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

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

20 ~~(27)~~~~(21)~~ "PCC" or "primary care center" means an entity that is currently licensed as  
21 a PCC in accordance with 902 KAR 20:058.

22 ~~(28)~~~~(22)~~ "Percentage increase in the MEI" is defined in 42 U.S.C. 1395u(i)(3).

23 ~~(29)~~~~(23)~~ "Physician assistant" is defined by KRS 311.840(3).

- 1        ~~(30)~~~~(24)~~ "PPS" means prospective payment system.
- 2        ~~(31)~~~~(25)~~ "Rate year" means, for the purposes of the MEI, the twelve (12) month pe-  
3        riod beginning July 1 of each year for which a rate is established for an FQHC, FQHC  
4        look-alike, or RHC~~[, or a PGC]~~ under the prospective payment system.
- 5        ~~(32)~~~~(26)~~ "Reasonable cost" means:
- 6        (a) A cost as determined by the:
- 7        1.~~(a)~~ Applicable Medicare cost reimbursement principles established in 42 C.F.R.  
8        Part 413, 45 C.F.R. 74.27, and 48 C.F.R. Part 31; and
- 9        2.~~(b)~~ Medical Group Management Association Physician Compensation and Pro-  
10        duction Survey Report for the applicable year and region; and
- 11        (b) Costs determined to be reasonable in accordance with a comprehensive desk re-  
12        view or audit.
- 13        ~~(33)~~~~(27)~~ "Recipient" is defined by KRS 205.8451(9).
- 14        ~~(34)~~~~(28)~~ "RHC" or "rural health clinic" is defined in 42 C.F.R. 405.2401(b).
- 15        ~~(35)~~~~(29)~~ "Satellite facility" means a federally-qualified health center, federally-  
16        qualified health center look-alike, or primary care center that:
- 17        (a) Is at a different location than the parent facility; and
- 18        (b) Operates under the same management as the parent facility.
- 19        ~~(36)~~~~(30)~~ "Telehealth" means two (2)-way, real time interactive communication be-  
20        tween a patient and a physician or practitioner located at a distant site for the purpose  
21        of improving a patient's health through the use of interactive telecommunication equip-  
22        ment that includes, at a minimum, audio and video equipment.
- 23        ~~(37)~~~~(34)~~ "Visit" means an~~[a face-to-face]~~ encounter;

1 ~~(a) [or encounter which occurs via Telehealth]~~ Between a recipient or enrollee and a  
2 health care provider during which an FQHC, FQHC look-alike, or RHC service is deliv-  
3 ered; and

4 (b) Which occurs:

5 1. In person; or

6 2. Via telehealth if authorized by 907 KAR 3:170.

7 Section 2. Provider Participation Requirements. (1)(a) A participating FQHC, FQHC  
8 look-alike, RHC, or PCC shall be currently:

9 1. Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

10 and

11 2. Except as established in paragraph (c) of this subsection, participating in the Ken-  
12 tucky Medicaid program in accordance with 907 KAR 1:671.

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

14 1. Be currently listed on the parent facility's license in accordance with 902 KAR  
15 20:058;

16 2. Comply with the requirements regarding extensions established in 902 KAR  
17 20:058; and

18 3. Comply with 907 KAR 1:671.

19 (c) In accordance with 907 KAR 17:015, Section 3(3), an FQHC, FQHC look-alike,  
20 RHC, or PCC that provides a service to an enrollee shall not be required to be currently  
21 participating in the fee-for-service Medicaid Program.

22 (2)(a) To be initially enrolled with the department, an:

23 1. FQHC or [ ] FQHC look-alike [ ] or RHC shall:

- 1     ~~a.[1-]~~ Enroll in accordance with 907 KAR 1:672; and
- 2     ~~b.[2-]~~ Submit to the department proof of its FQHC or FQHC look-alike designation is-
- 3     sued by the Centers for Medicare and Medicaid Services; or
- 4     2. RHC shall:
- 5     a. Enroll in accordance with 907 KAR 1:672; and
- 6     b. Submit to the department proof of its RHC license issued by the Cabinet for Health
- 7     and Family Services Office of Inspector General~~[certification by the United States De-~~
- 8     ~~partment of Health and Human Services, Health Resources and Services Administration~~
- 9     ~~as an FQHC, FQHC look-alike, or RHC].~~
- 10    (b) To remain enrolled and participating in the Kentucky Medicaid program, an:
- 11    1. FQHC or~~[,]~~ FQHC look-alike~~[, or RHC]~~ shall:
- 12    ~~a.[1-]~~ Comply with the enrollment requirements established in 907 KAR 1:672;
- 13    ~~b.[2-]~~ Comply with the participation requirements established in 907 KAR 1:671; and
- 14    ~~c.[3-]~~ Annually submit to the department proof of its FQHC or FQHC look-alike desig-
- 15    nation issued by the Centers for Medicare and Medicaid Services; or
- 16    2. RHC shall:
- 17    a. Comply with the enrollment requirements established in 907 KAR 1:672;
- 18    b. Comply with the participation requirements established in 907 KAR 1:671; and
- 19    c. Annually submit to the department proof of its RHC license issued by the Cabinet
- 20    for Health and Family Services Office of Inspector General~~[certification by the United~~
- 21    ~~States Department of Health and Human Services, Health Resources and Services~~
- 22    ~~Administration as an FQHC, FQHC look-alike, or RHC to the department].~~
- 23    (c) The requirements established in paragraphs (a) and (b) of this subsection shall

1 apply to a satellite facility of an FQHC or FQHC look-alike.

2 (3)(a) An FQHC ~~or~~ FQHC look-alike~~, or PCC~~ that operates multiple satellite facili-  
3 ties shall:

4 ~~1.(a)~~ List each satellite facility on the parent facility's license in accordance with 902  
5 KAR 20:058; and

6 ~~2.(b)~~ Consolidate claims and cost report data of its satellite facilities with the parent  
7 facility.

8 (b) A PCC that operates multiple satellite facilities shall list each satellite facility on  
9 the parent facility's license in accordance with 902 KAR 20:058.

10 (4) An FQHC, FQHC look-alike, RHC, or PCC that has been terminated from federal  
11 participation shall be terminated from Kentucky Medicaid program participation.

12 (5) A participating:

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

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

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

22 (d) PCC and its staff shall comply with all applicable federal laws and regulations,  
23 state laws and administrative regulations, and local laws and regulations regarding the

1 administration and operation of a PCC~~[PPG]~~.

2 (6) An FQHC, FQHC look-alike, RHC, or PCC performing laboratory services shall  
3 meet the requirements established in 907 KAR 1:028 and 907 KAR 1:575.

4 Section 3. Standard Reimbursement for an FQHC, FQHC look-alike, or RHC for a  
5 Visit by a Recipient Who is not an Enrollee and that is Covered by the Department. (1)  
6 Except as established in Section 5 or Section 9 of this administrative regulation, for a  
7 visit by a recipient who is not an enrollee and that is covered by the department, the de-  
8 partment shall reimburse:

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

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

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

18 (3) The department shall calculate a final PPS rate for a new FQHC, FQHC look-  
19 alike, or RHC in accordance with Section 4 of this administrative regulation.

20 (4) The department shall adjust a final PPS rate ~~[per visit]~~:

21 (a) By the percentage increase in the MEI applicable to FQHC, FQHC look-alike, or  
22 RHC services on July 1 of each year; ~~[and]~~

23 (b) In accordance with Section 10~~[8]~~ of this administrative regulation:

1 1. Upon request and documentation by an FQHC, FQHC look-alike, or RHC that  
2 there has been a change in scope of services; or

3 2. Upon review and determination by the department that there has been a change in  
4 scope of services; and

5 (c) If necessary as a result of a desk review or audit.

6 (5) A final PPS rate established in accordance with this administrative regulation shall  
7 not be subject to an end of the year cost settlement.

8 Section 4. Establishment of a Final PPS Rate for a New FQHC, FQHC look-alike, or  
9 RHC.

10 (1)(a) The department shall establish a final PPS rate to reimburse a new FQHC,  
11 FQHC look-alike, or RHC 100 percent of its reasonable cost of providing Medicaid cov-  
12 ered services utilizing information from~~during~~ the FQHC's, FQHC look-alike's, or  
13 RHC's base year upon completion of a comprehensive desk review or audit of an  
14 FQHC's, FQHC look-alike's, or RHC's Universal Cost Report.

15 (b) Except for a time frame in which the department reimburses an FQHC, FQHC  
16 look-alike, or RHC an interim PPS rate, the ~~[initial and subsequent]~~ final PPS rate estab-  
17 lished for an FQHC, FQHC look-alike, or RHC shall:

18 1. Be prospective; and

19 2. Not settled to cost.

20 (2)~~(a)~~ The department shall determine the reasonable costs of an FQHC, FQHC  
21 look-alike, or RHC based on the:

22 (a) Universal Cost Report:

23 1. Submitted by the FQHC, FQHC look-alike, or RHC to the department and pre-

1 pared by the FQHC, FQHC look-alike, or RHC in accordance with the Universal Cost  
2 Report Instructions; and

3 2. That [which] contains twelve (12) full months of operating data for the first full fiscal  
4 year of operations that the FQHC, FQHC look-alike, or RHC has reached its maximum  
5 hours per day, days per week, and weeks per year of intended operation;

6 (b) Department's review of the Universal Cost Report referenced in paragraph (a) of  
7 this subsection; and

8 (c) Costs and visits as adjusted by the department for full-time operation for a facility  
9 that is not in operation at least forty (40) hours per week [most recently submitted to the  
10 department by the FQHC, FQHC look-alike, or RHC].

11 ~~[(b) The base rate referenced in subsection (1)(a) of this section shall be based on~~  
12 ~~the reasonable cost determination made by the department pursuant to paragraph (a) of~~  
13 ~~this subsection.]~~

14 ~~(3)(a) [Until an FQHC, FQHC look-alike, or RHC submits a Medicaid cost report con-~~  
15 ~~taining twelve (12) full months of operating data for the facility's base year, the depart-~~  
16 ~~ment shall reimburse the FQHC, FQHC look-alike, or RHC an interim rate equal to the~~  
17 ~~all-inclusive per visit rate established for the FQHC, FQHC look-alike, or RHC by Medi-~~  
18 ~~care.~~

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

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

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

3 ~~(4)(a)] An FQHC, FQHC look-alike, or RHC shall submit a Universal Cost Report to~~  
4 ~~the department by the end of the fifth month following the end of the FQHC's, FQHC~~  
5 ~~look-alike's, or RHC's first full fiscal year that the FQHC, FQHC look-alike, or RHC has~~  
6 ~~reached its maximum hours per day, days per week, and weeks per year of intended~~  
7 ~~operation.~~

8 (b) The department shall:

9 1. Review the Universal Cost Report referenced in paragraph (a) of this subsection  
10 submitted by an FQHC, FQHC look-alike, or RHC within ninety (90) business days of  
11 receiving the Universal Cost Report; and

12 2. Notify the FQHC, FQHC look-alike, or RHC of the[;

13 a.] necessity of the FQHC, FQHC look-alike, or RHC to submit additional documenta-  
14 tion if necessary[;

15 ~~b. Final rate established;~~

16 ~~c. Appeal rights regarding the final rate; and~~

17 ~~d. Estimated time for determining a final rate if a final rate is not established within~~  
18 ~~ninety (90) days].~~

19 (c)1. If additional documentation is necessary to establish a final PPS rate, the  
20 FQHC, FQHC look-alike, or RHC shall:

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

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

1 tion.

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

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

4 (d)1. If the department requests additional documentation from an FQHC, FQHC  
5 look-alike, or RHC but does not receive additional documentation or an extension re-  
6 quest within thirty (30) days, the department shall reimburse the FQHC, FQHC look-  
7 alike, or RHC based on the Medicaid physician fee schedule applied to physician ser-  
8 vices pursuant to 907 KAR 3:010 until:

9 a.~~[1.]~~ The additional documentation has been received by the department; and

10 b.~~[2.]~~ The department has established a final PPS rate.

11 2. If an FQHC, FQHC look-alike, or RHC does not submit a Universal Cost Report to  
12 the department, the department shall reimburse the FQHC, FQHC look-alike, or RHC  
13 based on the Medicaid physician fee schedule applied to physician services pursuant to  
14 907 KAR 3:010 until the FQHC, FQHC look-alike, or RHC submits a Universal Cost Re-  
15 port to the department.

16 (e) The department shall review an FQHC's, FQHC look-alike's, or RHC's paid claims  
17 listing for the period of time corresponding to the FQHC's, FQHC look-alike's, or RHC's  
18 cost report period of time referenced in paragraph (a) of this subsection.

19 (f)1. If an FQHC, FQHC look-alike, or RHC has submitted all necessary information  
20 to the department, within forty-five (45) days of reviewing the FQHC's, FQHC look-  
21 alike's, or RHC's paid claims listing, the department shall:

22 a. Establish a final PPS rate for the FQHC, FQHC look-alike, or RHC; and

23 b. Notify the FQHC, FQHC look-alike, or RHC in writing of the FQHC's, FQHC look-

1 alike's, or RHC's:

2 (i) Final PPS rate; and

3 (ii) Appeal rights regarding the PPS final rate.

4 2. To allow adequate time for claim adjudication, a paid claims listing shall not be re-  
5 quested until at least fourteen (14) months after an FQHC's, FQHC look-alike's, or  
6 RHC's fiscal year end.

7 3. If an FQHC, FQHC look-alike, or RHC has not submitted all necessary information  
8 to the department to establish a final PPS rate, the department shall continue to pay the  
9 FQHC, FQHC look-alike, or RHC based on the Medicaid physician fee schedule applied  
10 to physician services pursuant to 907 KAR 3:010.

11 (4) Along with a Universal Cost Report, an FQHC, FQHC look-alike, or RHC shall  
12 submit to the department a written statement of the FQHC's, FQHC look-alike's, or  
13 RHC's maximum hours per day, days per week, and weeks per year of operation.

14 Section 5. Interim Reimbursement for a New FQHC, FQHC Look-alike, or RHC.

15 (1)(a) Until a final PPS rate is established for an FQHC, FQHC look-alike, or RHC,  
16 the department shall reimburse the FQHC, FQHC look-alike, or RHC an interim PPS  
17 rate based on the average final PPS rates of entities with similar caseloads.

18 (b) To identify an entity with a similar caseload, the department shall consider:

19 1. Entity type (FQHC, FQHC look-alike, or RHC);

20 2. Managed care organization region;

21 3. Operating hours per day, days per week, and weeks per year; and

22 4. Specialty services, obstetrical services, or hospital-based entities, if applicable.

23 (2) If no entity with a similar caseload exists, the department shall establish an interim

1 PPS rate using cost reporting methods.

2 (3) After the department establishes a final PPS rate for an FQHC, FQHC look-alike,  
3 or RHC, the department shall retroactively adjust reimbursement to the FQHC, FQHC  
4 look-alike, or RHC that was made on an interim basis to comport with the final PPS rate.

5 (4) An FQHC, FQHC look-alike, or RHC, upon enrolling with the Medicaid Program,  
6 shall submit in writing to the department a statement stating the FQHC's, FQHC look-  
7 alike's, or RHC's maximum hours per day, days per week, and weeks per year of opera-  
8 tion.

9 Section 6. Reimbursement for Services or Drugs Provided to an Enrollee by a PCC  
10 That is Not an FQHC, FQHC Look-Alike, or RHC and that are Covered by an MCO. (1)  
11 For a service or drug provided to an enrollee by a PCC that is not an FQHC, FQHC  
12 look-alike, or RHC and that is covered by an MCO, the PCC's reimbursement shall be  
13 the reimbursement established pursuant to an agreement between the PCC and the  
14 managed care organization with whom the enrollee is enrolled.

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

17 Section 7.[6.] Reimbursement for Services or Drugs Provided to a Recipient by a  
18 PCC That is Not an FQHC, FQHC Look-Alike, or RHC and that are Covered by the De-  
19 partment. (1)(a) For a service or drug provided to a recipient that is not an enrollee by a  
20 PCC that is not an FQHC, FQHC look-alike, or RHC, the department shall reimburse  
21 the rate or reimbursement established for the service or drug on the current Kentucky-  
22 specific Medicare Physician Fee Schedule~~[-established for Kentucky].~~

23 (b)1. If no rate or reimbursement exists on the Kentucky-specific Medicare Physi-

1 cian's Fee schedule for a service or drug referenced in paragraph (a) of this subsection,  
2 the department shall reimburse for the service or drug the same amount that the de-  
3 partment reimburses for the service or drug pursuant to the applicable administrative  
4 regulation established in Title 907 of the Kentucky Administrative Regulations.

5 2. For example, if no reimbursement exists on the current Kentucky-specific Medicare  
6 Physician Fee Schedule for a dental service, the department shall reimburse for the  
7 dental service pursuant to 907 KAR 1:626.

8 (2) The reimbursement referenced in subsection (1) of this section shall not exceed  
9 the federal upper payment limit determined in accordance with 42 C.F.R. 447.321.

10 (3)(a) The coverage provisions and requirements established in 907 KAR  
11 3:005[1:054] shall apply to a service or drug provided by a PCC.

12 (b) If a Medicare coverage provision or requirement exists regarding a given service  
13 or drug that contradicts a provision or requirement established in 907 KAR 3:005[1:054],  
14 the provision or requirement established in 907 KAR 3:005[1:054] shall supersede the  
15 Medicare provision or requirement.

16 Section 8.[7-] Supplemental Reimbursement for FQHC Visits, FQHC Look-Alike Vis-  
17 its, and RHC Visits. If a managed care organization's reimbursement to an FQHC,  
18 FQHC look-alike, or RHC for a visit by an enrollee to the FQHC, FQHC look-alike, or  
19 RHC is less than what the FQHC, FQHC look-alike, or RHC would receive pursuant to  
20 Sections 3, ~~and~~ 4, 5, or 9 of this administrative regulation, the department shall sup-  
21 plement the reimbursement made by the managed care organization in a manner that:

22 (1) Equals the difference between what the managed care organization reimbursed  
23 and what the reimbursement would have been if it had been made in accordance with

1 Sections 3, ~~and~~ 4, 5, or 9 of this administrative regulation;

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

3 (3) Ensures that total reimbursement does not exceed the federal upper payment lim-  
4 it in accordance with[;

5 ~~(a)] 42 C.F.R. 447.304[; and~~

6 ~~(b) 42 C.F.R. 447.321].~~

7 Section 9. Alternative Payment Methodology for an FQHC, FQHC Look-alike, or  
8 RHC.

9 (1)(a) The department shall pay to an FQHC, FQHC look-alike, or RHC, for which a  
10 final PPS rate exists, an alternative payment methodology if the FQHC, FQHC look-  
11 alike, or RHC notifies the department in writing that it requests to receive the alternate  
12 reimbursement.

13 (b)1. The APM shall equal 125% of the Medicare upper payment limit for rural health  
14 clinics in effect on September 30, 2014.

15 2. The APM referenced in subparagraph 1 of this paragraph shall not be adjusted for  
16 inflation.

17 (2)(a) An APM established in this section shall be effective for dates of service begin-  
18 ning with the date requested in writing by an FQHC, FQHC look-alike, or RHC except as  
19 established in paragraph (b) of this subsection.

20 (b) An APM effective date shall not precede the date in which the department re-  
21 ceived the written request for the APM.

22 Section 10.[8.] Change in Scope and Final PPS Rate Adjustment: (1)(a) If an FQHC,  
23 FQHC look-alike, or RHC changes its scope of services after the base year, the de-

1    partment shall adjust the FQHC's, FQHC look-alike's, or RHC's final PPS rate if the  
2    change in scope qualifies for an adjustment in accordance with this section upon de-  
3    partmental review and approval of the change in scope.

4       (b) An adjustment to a final PPS rate resulting from a change in scope that occurred  
5    after an FQHC's, FQHC look-alike's, or RHC's base year shall be [~~retroactively~~] effec-  
6    tive to the date that the [~~FQHC, FQHC look-alike, or RHC applied for the~~] change in  
7    scope occurred.

8       (c)1. A revised PPS rate shall be calculated in accordance with the MAP 100501.

9       2. There shall be no rebasing regarding a revised PPS rate.

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

11      (a) Adding or deleting a covered service;

12      (b) Increasing or decreasing the intensity of a covered service pursuant to subsection  
13    (5) of this section; or

14      (c) A statutory or regulatory change that materially impacts the costs or visits of an  
15    FQHC, FQHC look-alike, or RHC.

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

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

18      (b) A reduction or an expansion of [office] hours per day, days per week, or weeks  
19    per year;

20      (c) An addition of a new site that provides the same Medicaid covered services;

21      (d) A wage increase;

22      (e) A renovation or other capital expenditure;

23      (f) A change in ownership; or

1 (g) An addition or deletion of a service provided by a non-licensed professional or  
2 specialist.

3 (4)(a) An addition of a covered service shall be restricted to the addition of a licensed  
4 professional staff member who can perform a Medicaid covered service that is not cur-  
5 rently being performed within the FQHC, FQHC look-alike, or RHC by a licensed pro-  
6 fessional employed or contracted by the facility.

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

11 (5) A change in intensity shall:

12 (a) Include a material change;

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

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

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

18 (a) A government entity imposes a mandatory minimum wage increase and the in-  
19 crease was:

20 1. Not included in the calculation of the final PPS rate; or

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

22 (b)1. A new licensure requirement or modification of an existing requirement by the  
23 state results in a change that affects all facilities within the class.

1 2. A provider shall document that an increase or decrease in the cost of a visit oc-  
2 curred as a result of a licensure requirement or policy modification.

3 (7) A requested change in scope shall:

4 (a) Increase or decrease the existing final PPS rate by at least five (5) percent; ~~[and]~~

5 (b) Last at least twelve (12) months; and

6 (c) Be submitted to the department in writing.

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

12 ~~(9)~~ the following documents ~~[shall be submitted]~~ to the department within six (6)  
13 months of the requested effective date of a change in scope:

14 1. ~~(a)~~ A narrative describing the change in scope;

15 2. ~~(b)~~ A projected Universal Cost Report containing twelve (12) months of projected  
16 cost report data for the interim PPS rate change; ~~[and]~~

17 3. ~~(c)~~ A completed MAP 100501, Prospective Payment System Rate Adjustment,  
18 completed according to the Instructions for Completing the MAP 100501 Form; and

19 4. A signed letter requesting the change in scope.

20 (b) If the department does not receive the documentation required regarding a  
21 change in scope within six (6) months after the requested effective date of a change in  
22 scope, the change in scope shall be denied.

23 (c)1. ~~(10)~~ The department shall:

1 ~~a. (a)~~ Review the documentation listed ~~this (in)~~ subsection ~~(9) of this section~~; and

2 ~~b. (b)~~ Notify the FQHC, FQHC look-alike, or RHC in writing of the:

3 (i) Approval or denial of the request for change in scope within ninety (90) business

4 days from the date the department received the request; or

5 (ii) Need for additional documentation from the FQHC, FQHC look-alike, or RHC to

6 establish a PPS interim PPS rate associated with the change in scope.

7 ~~2. (11)(a)~~ If the department requests additional documentation to calculate the inter-

8 im PPS rate for a change in scope, the FQHC, FQHC look-alike, or RHC shall:

9 ~~a. (1-)~~ Provide the additional documentation to the department within thirty (30) days

10 of the notification of need for additional documentation; or

11 ~~b. (2-)~~ Request an extension beyond thirty (30) days to provide the additional docu-

12 mentation.

13 ~~3. a. (b) (1-)~~ The department shall grant no more than one (1) extension.

14 ~~b. (2-)~~ An extension shall not exceed thirty (30) days.

15 4. If the department approves the request for a change in scope and receives all of

16 the necessary documentation from an FQHC, FQHC look-alike, or RHC within the time-

17 lines established in this section, the department shall establish an interim PPS rate for

18 the FQHC, FQHC look-alike, or RHC based on the projected costs contained in the Uni-

19 versal Cost Report referenced in paragraph (a)2 of this subsection.

20 (9)(a) To establish a PPS final rate resulting from a change in scope, the department

21 shall use a Universal Cost Report submitted by the FQHC, FQHC look-alike, or RHC to

22 the department that contains twelve (12) months of cost data beginning with the effec-

23 tive date of the change in scope.

1 (b) Within six (6) months of the end of the twelve (12) month cost data period refer-  
2 enced in paragraph (a) of this subsection, the FQHC, FQHC look-alike, or RHC shall  
3 submit to the department the Universal Cost Report containing cost data corresponding  
4 to the twelve (12) month cost data period associated with the change in scope.

5 (c) The department shall:

6 1. Review the Universal Cost Report referenced in paragraph (a) of this subsection  
7 submitted by an FQHC, FQHC look-alike, or RHC within ninety (90) business days of  
8 receiving the Universal Cost Report; and

9 2. Notify the FQHC, FQHC look-alike, or RHC of the necessity of the FQHC, FQHC  
10 look-alike, or RHC to submit additional documentation if necessary.

11 (d)1. If additional documentation is necessary to establish a PPS final rate, the  
12 FQHC, FQHC look-alike, or RHC shall:

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

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

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

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

19 (e)1. If the department requests additional documentation from an FQHC, FQHC  
20 look-alike, or RHC but does not receive additional documentation or an extension re-  
21 quest within thirty (30) days, the department shall reimburse the FQHC, FQHC look-  
22 alike, or RHC the FQHC's, FQHC look-alike's, or RHC's PPS final rate that was in effect  
23 prior to the FQHC's, FQHC look-alike's, or RHC's request for a change in scope until:

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

2 b. The department establishes a new final PPS rate associated with the change in  
3 scope.

4 2. If an FQHC, FQHC look-alike, or RHC does not submit a Universal Cost Report to  
5 the department in accordance with paragraph (b) of this subsection, the department  
6 shall:

7 a. Not issue a new PPS final rate associated with the change in scope; and

8 b. Revert to paying the FQHC, FQHC look-alike, or RHC the FQHC's, FQHC look-  
9 alike's, or RHC's PPS final rate that was in effect prior to the FQHC, FQHC look-alike,  
10 or RHC requesting a change in scope.

11 (f)1. If any service included in a change in scope is a service that can be identified on  
12 a paid claims listing, the department shall review the FQHC's, FQHC look-alike's, or  
13 RHC's paid claims listing for the period of time corresponding to the FQHC's, FQHC  
14 look-alike's, or RHC's cost report period of time referenced in paragraphs (a) and (b) of  
15 this subsection.

16 2. If an FQHC, FQHC look-alike, or RHC has submitted all necessary information to  
17 the department, within forty-five (45) days of reviewing the FQHC's, FQHC look-alike's,  
18 or RHC's paid claims listing, the department shall:

19 a. Establish a final PPS rate, resulting from the change in scope, for the FQHC,  
20 FQHC look-alike, or RHC; and

21 b. Notify the FQHC, FQHC look-alike, or RHC in writing of the FQHC's, FQHC look-  
22 alike's, or RHC's:

23 (i) Final PPS rate; and

1 (ii) Appeal rights regarding the PPS final rate.

2 3. To allow adequate time for claim adjudication, a paid claims listing shall not be re-  
3 quested until at least fourteen (14) months after the end of the FQHC's, FQHC look-  
4 alike's, or RHC's cost report period associated with the change in scope.

5 (g)1. If no service included in a change in scope can be identified on a paid claims  
6 listing, and the department has received a Universal Cost Report referenced in para-  
7 graphs (a) and (b) of this subsection, and no additional documentation is needed from  
8 the FQHC, FQHC look-alike, or RHC, the department shall:

9 a. Not review a paid claims listing in establishing a new PPS final rate for an FQHC,  
10 FQHC look-alike, or RHC resulting from the change in scope; and

11 b. Establish a new PPS final rate for an FQHC, FQHC look-alike, or RHC resulting  
12 from the change in scope within ninety (90) days of receiving the Universal Cost Report.

13 Section 11.[9.] Limitations and Exclusions. (1)(a) Except for a case in which a recipi-  
14 ent or enrollee, subsequent to the first encounter at an FQHC, FQHC look-alike, or  
15 RHC, suffers an illness or injury requiring additional diagnosis or treatment, an encoun-  
16 ter with more than one (1) health care provider or multiple encounters with the same  
17 health care provider which take place on the same day and at a single location shall  
18 constitute a single visit.

19 (b) The limit established in paragraph (a) of this subsection shall:

20 1. Apply to an FQHC, FQHC look-alike, or RHC; and

21 2. Not apply to a PCC that is not an FQHC, FQHC look-alike, or RHC.

22 (2)(a) Except as established in paragraph (b) of this subsection, a vaccine available  
23 without charge to an FQHC, FQHC look-alike, RHC, or PCC through the department's

1 Vaccines for Children Program and the administration of the vaccine shall not be re-  
2 ported as a cost to the Medicaid Program.

3 (b) Adult flu vaccine costs shall be allowed as Medicaid costs reported on a Universal  
4 Cost Report.

5 (3) The department shall not reimburse for services provided by an FQHC, FQHC  
6 look-alike, or RHC to a recipient in a hospital.

7 Section 12.[10.] Out-of-State Providers. (1) Except as established in subsection (2) of  
8 this section, reimbursement to an out-of-state FQHC, FQHC look-alike, or RHC shall be  
9 based on the rate on file with the FQHC's, FQHC look-alike's, or RHC's state Medicaid  
10 agency.

11 (2) If an out-of-state FQHC's, FQHC look-alike's, or RHC's reimbursement is an  
12 APM, the department's reimbursement to the out-of-state FQHC, FQHC look-alike, or  
13 RHC shall:

14 (a) Not be the APM the FQHC, FQHC look-alike, or RHC receives in its state; and

15 (b) Be the final PPS rate that the FQHC, FQHC look-alike, or RHC would receive in  
16 its state if it were not receiving an APM.

17 Section 13.[11.] Federal Approval and Federal Financial Participation. The depart-  
18 ment's reimbursement for services pursuant to this administrative regulation shall be  
19 contingent upon:

20 (1) Receipt of federal financial participation for the reimbursement; and

21 (2)[A policy established in this administrative regulation shall be null and void if the]  
22 Centers for Medicare and Medicaid Services' approval for the reimbursement[Services:

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

1 ~~(2) Disapproves the policy].~~

2 Section 14. Not Applicable to Managed Care Organizations. A managed care organi-  
3 zation shall not be required to reimburse in accordance with this administrative regula-  
4 tion for a service covered pursuant to:

5 (1)(a) 907 KAR 1:054; or

6 (b) 907 KAR 1:082; and

7 (2) This administrative regulation.

8 Section 15.[12.] Appeal Rights. [(1) An appeal of a negative action taken by the de-  
9 partment regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

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

12 ~~(3)] An FQHC, FQHC look-alike, PCC, or RHC may appeal a department decision as~~  
13 ~~to the application of this administrative regulation as it impacts the facility's reimburse-~~  
14 ~~ment rate in accordance with 907 KAR 1:671.~~

15 Section 16.[13.] Incorporation by Reference. (1) The following material is incorpo-  
16 rated by reference:

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

19 (b) "Instructions for Completing the MAP 100501 Form", February 2013 edition;

20 (c) "Universal Cost Report", May 2015; and

21 (d) "Universal Cost Report Instructions", May 2015.

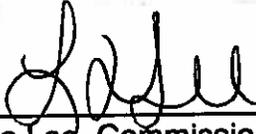
22 (2) This material may be inspected, copied, or obtained, subject to applicable copy-  
23 right law, at the Department for Medicaid Services, 275 East Main Street, Frankfort,

1 Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:055

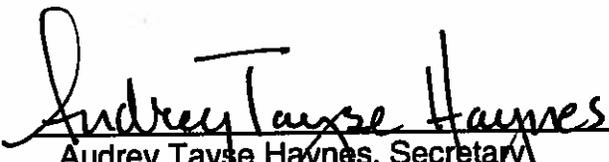
REVIEWED:

4-15-15  
Date

  
\_\_\_\_\_  
Lisa Lee, Commissioner  
Department for Medicaid Services

APPROVED:

5/13/15  
Date

  
\_\_\_\_\_  
Audrey Tayse Haynes, Secretary  
Cabinet for Health and Family Services

907 KAR 1:055

**PUBLIC HEARING AND PUBLIC COMMENT PERIOD**

A public hearing on this administrative regulation shall, if requested, be held on June 22, 2015 at 9:00 a.m. in Suite B of 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 June 15, 2015, 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 June 30, 2015. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

**CONTACT PERSON:** Tricia Orme, [tricia.orme@ky.gov](mailto:tricia.orme@ky.gov), 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 1:055  
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 establishes an alternative reimbursement option (an alternative payment methodology or APM) for FQHCs, FQHC look-alikes, or rural health clinics which choose to receive such reimbursement; amends the reimbursement methodology for a new FQHC, FQHC-look-alike, or RHC and elaborates on the process for establishing reimbursement for such a facility; incorporates by reference specific documents – Universal Cost Report and Universal Cost Report Instructions – used in establishing reimbursement for a new FQHC, FQHC look-alike, or RHC; elaborates on the process and requirements related to requesting

and establishing a new reimbursement due to a change in scope (of services); establishes that DMS will not pay an APM for an out-of-state FQHC, FQHC look-alike, or RHC; clarifies that managed care organizations are not required to reimburse in the same way for FQHC, FQHC look-alike, or RHC services as DMS reimburses; inserts definitions for clarity; and clarifies miscellaneous provisions.

- (b) The necessity of the amendment to this administrative regulation: The alternative reimbursement option (an APM) is necessary to maintain the viability of a handful of FQHCs/RHCs whose current reimbursement is well below the average of others in Kentucky. Reimbursement for these entities is federally mandated. The federally-mandated model (which is customized for each entity) was introduced in 2001, but over time the reimbursement for a few such facilities participating in Kentucky's Medicaid program has proved to be significantly lower than the other entities and is at a level that threatens the viability of the entities. Consequently, DMS proposed to the Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides federal funding to Medicaid programs – an APM to help sustain the entities and which would be available to all entities. The APM is a rate equal to 125% of the Medicare PPS rate for rural health clinics in effect as of September 30, 2014. Any FQHC, FQHC look-alike, or RHC can choose this option; however, DMS only anticipates that the few RHCs whose current prospective payment system (PPS) encounter rate is lower than the alternative will actually choose the alternative. CMS has approved the alternative reimbursement. The amendments regarding interim reimbursement for new FQHCs, FQHC look-alikes, and RHCs are necessary to comply with a mandate by CMS. The elaboration on the process of establishing reimbursement for a new FQHC, FQHC look-alike, or RHC as well as elaboration on changing reimbursement due to a change in scope are necessary for clarity. Not offering the APM option to out-of-state FQHCs, FQHC look-alikes, or RHCs is necessary to ensure that only in-state facilities are eligible for the enhanced reimbursement. Incorporating by reference the Universal Cost Report and Universal Cost Report Instructions is necessary to ensure that entities use the correct documents to report costs. Other amendments are necessary for clarity.
- (c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by helping sustain FQHCs/FQHC look-alikes/RHCs whose current reimbursement is inadequate to survive and in order to ensure Medicaid recipient access to services.
- (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 helping sustain FQHCs/FQHC look-alikes/RHCs whose current reimbursement is inadequate to survive and in order to ensure Medicaid recipient access to services.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There were thirty-five (35) FQHCs/FQHC look-alikes, 152 RHCs, and sixty-four (64) PCCs enrolled in Kentucky's Medicaid Program as of March 2015.

- (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 FQHC, FQHC look-alike, or RHC that wishes to receive the alternative reimbursement must submit a written request to DMS expressing the request to receive the alternative reimbursement.
    - (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.
    - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Any FQHC, FQHC look-alike, or RHC that chooses to receive the alternative reimbursement will receive increased Medicaid reimbursement if the entity's current reimbursement is lesser than the alternative reimbursement.
  - (5) Provide an estimate of how much it will cost to implement this administrative regulation:
    - (a) Initially: The costs of the amendment is indeterminable as it depends on how many, if any, FQHCs/FQHC look-alikes/RHCs elect to receive the APM, and how soon, and upon the difference in current reimbursement for such an entity compared to the APM.
    - (b) On a continuing basis: The response stated in (a) also applies here.
  - (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 not applied as the requirements apply to all regulated entities.
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## 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(a)(10)(B) and 42 U.S.C. 1396a(a)(30)(A).
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(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid.) Expanding the base of authorized behavioral health practitioners will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. Similarly, 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."
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 statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(30)(A).
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 costs of the amendment is indeterminable as it depends on how many, if any, FQHCs/FQHC look-alikes/RHCs elect to receive the alternative reimbursement, and how soon, and upon the difference in current reimbursement for such an entity compared to the alternative reimbursement.
  - (d) How much will it cost to administer this program for subsequent years? The response stated in (c) also applies here.

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 Department for Medicaid Services (DMS) is adding the following material to the material incorporated by reference:

(1) The "Universal Cost Report", May 2015 is a twenty-three (23) page document to be completed by new federally-qualified health centers (FQHCs), FQHC look-alikes, and rural health clinics (RHCs) and submitted to DMS for the purpose of establishing a prospective payment system (PPS) rate for the new entity.

(2) The "Universal Cost Report Instructions", May 2015 is a twenty-two (22) page document which contains instructions on how to properly complete a Universal Cost Report.

A total of forty-five (45) pages of new material are incorporated by reference into this administrative regulation.