



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

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February 14, 2014

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

Re: KY SPA 13-012 - FQHC, FQHC Look-alikes, RHC Reimbursement

Dear Ms. Glaze:

In response to your letter dated December 19, 2013, we have provided the following responses to the questions CMS had regarding KY SPA 13-012.

1. Please confirm that providers both retain and receive 100 percent of the Medicaid payment.

DMS Response - Providers do retain and receive 100 percent of the Medicaid payment.

2. Attachment. 4.19-B, Page 20.16, Paragraph A.2

This paragraph currently reads, "Costs related to outpatient drugs or pharmacy services shall be excluded from the all-inclusive encounter rate per patient visit."

CMS requests the state to clarify whether these items historically have been excluded from the Prospective Payment System (PPS) rate.

DMS Response - These items were historically excluded, if drugs integral to (e.g., dental pain blockers), or incident to (e.g., ophthalmological drops) are recognized as "not prescribed".



3. Attachment 4.19-B, Page 20.16(1), Paragraph B.5.

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

CMS requests the state to modify its interim rate methodology to adhere to the guidance provided in Question 31 of the BIPA Questions and Answers (previously provided to the state).

DMS Response - In order to not only comply with the BIPA Questions and Answers, but also to comply with the guidance contained in the HCFA Letter to State Medical Directors (SMDL #01-014, 1/19/2001) the rates will be determined as follows.

"Newly qualified FQHCs/RHCs after fiscal year 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent areas, or in the absence of such other clinics, through cost reporting methods. *After the initial year, payment shall be set using the MEI methods used for other clinics.*" (SMDL) Further, "The costs that must be considered in calculating the payment rate are those reasonable costs used in calculating the rates for neighboring clinics with similar caseloads. The key issue is similarity of caseload." (BIPA Q's & A's.)

Kentucky Medicaid will define "caseload" as a Medicare reprice payment per case. "Initial payments" will be defined as the PPS payments in the first year, eliminating the category of "interim rates". "Adjacent areas" will be defined as within a 50 mile radius." "Reasonable costs" will those costs accepted during fiscal years 1999 & 2000.

For a newly qualified center, where no center is in operation within a 50 mile radius, a pre-forma cost report, subject to tests for allowable costs (using Medicare principles) and reasonable costs (e.g., costs that would accrue to a center operating full time, not a limited hours of operation entity), will be used to establish the PPS rate. Subsequent to the initial year, the PPS rate will be subject only to the MEI enhancement, and there will be no mass adjustment to initial year claims based on an actual cost report.

Kentucky Medicaid will also establish an Alternate Payment Methodology, consistent with the guidance referred to above (BIPA Q's & A's, and SMDL.) The Alternate Payment Methodology, available to both newly qualified and established centers shall

be 125% of the Medicare Upper Payment Limit for RHC's. A center may choose the higher of the PPS rate developed as per the above guidelines, or the APM.

4. Attachment 4.19-B, Page 20.16(1), Paragraph B.6.

This paragraph currently reads, "An FQHC, FQHC look-alike, or RHC shall provide the department with a copy of the Medicare rate letter for the rates in effect during the FQHC's, FQHC look-alike's or RHC's interim period; a) The department shall adjust an interim rate for an FQHC, FQHC look-alike, or RHC based on the establishment of the final rate; and b) All claims submitted to the department and paid by the department based on the interim rate shall be adjusted to comport with the final rate."

Please see CMS comment number three and modify the proposed language describing the interim payment methodology accordingly.

DMS Response - A PPS rate will be established as per the answer provided in #3. We have removed this section on the attached State Plan pages.

5. Att. 4.19-B, Page 20.16(2), Paragraph C.2.

The state is proposing to recognize a change in scope in service tied to the date a health center or clinic applies for a rebased PPS. This is inconsistent with the statute which contemplates an annual ratemaking cycle, with the rate increasing each fiscal year by the MEI. The state should be recognizing a change of scope in services for the prior period at the same time it applies the MEI to the prior period's rate. CMS requires the state to remove this language from the state plan.

DMS Response - Wording in the state plan will be revised to indicate that a revised change in scope will be effective on July 1 following the date on which the change in scope took place.

6. Attachment 4.19-B, Page 20.16(2), Paragraph C.3.c.

This currently reads, "A statutory or regulatory change that materially impacts the costs or visits of an FQHC, FQHC look-alike, or RHC."

CMS requires the state to modify its change of scope language to adhere to the guidance provided in Question 20 of the BIPA Questions and Answers (see attached document). A change in cost is not considered a change in scope in services.

DMS Response -The wording will be revised to read, “A statutory or regulatory change that materially impacts the services type, intensity, duration and/or amount of services of an FQHC, FQHC look-alike, or RHC.”

7. Attachment 4.19-B, Page 20.16(2), Paragraph C.4

This paragraph lists items individually that shall not constitute a change in scope, one of which is a wage increase. This statement conflicts with the language in 8.a. on the same page which has language regarding when department shall consider a change in scope specifically when “A government entity imposes a mandatory minimum wage increase...”

CMS requires the state to remove any reference to an item that represents a change in cost because in and of itself this does not represent a change in scope in services.

DMS Response - Changes have been made in the Plan Pages

8. Attachment 4.19-B, Page 20.16(2), Paragraph C.4.g

This states that “An addition or deletion of a service provided by a non-licensed professional or specialist.”

The statute requires payment of at least PPS. Therefore, states may not impose new criteria that would modify the rate. CMS requests the state to explain whether this provision is currently being applied to evaluate change of scope in service requests. If no, then this language must be deleted.

DMS Response - Changes have been made in the Plan Pages

9. Attachment 4.19-B, Page 20.16(2), Paragraph C.5.

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

The statute requires payment of at least PPS. Therefore, state may not impose new criteria that would modify the rate. CMS requests the state to explain whether this provision is currently being applied to evaluate change of scope in service requests. If not, then this language must be deleted.

DMS Response - Changes have been made in the Plan Pages

10. Attachment 4.19-B, Page 20.16(2), Paragraph C.6.

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

The statute requires payment of at least PPS. Therefore, state may not impose new criteria that would modify the rate. CMS requests the state to explain whether this provision is currently being applied to evaluate change of scope in service requests. If no, then this language must be deleted.

DMS Response - Changes have been made in the Plan Pages

11. Attachment 4.19-B, Page 20.16(2), Paragraph C.7.b.

This currently reads, "A change in intensity shall: b) increase or decrease the existing PPS rate by at least five (5) percent".

CMS requests the state to explain if this is a new threshold and to provide examples to demonstrate how this provision would be made operational.

DMS Response - This is a new threshold intended to avoid a relatively small change in operations from requiring an actual PPS rate change.

12. Attachment 4.19-B, Page 20.16(2), Paragraph 8.b.

Recognition of a change of scope in service may not be triggered by a change in cost, which is suggested by this item. CMS requests the state to remove this provision.

DMS Response - Changes have been made in the Plan Pages

13. Attachment 4.190B, Page 20.16(3), Paragraph C.9.a.

This currently reads, "A requested change in scope shall: a) Increase or decrease the existing PPS rate by at least five (5) percent".

CMS requests the state to explain if this is a new threshold and to provide examples to demonstrate how this provision would be made operational.

DMS Response - This is a new threshold intended to avoid a relatively small change in operations from requiring an actual PPS rate change.

14. Attachment 4.19-B, Page 20.16(3), Paragraph C.10.

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

CMS requests the states to explain how this provision is consistent with the statutory requirement that a change of scope in services must be recognized and is part of the annual ratemaking cycle.

DMS Response - The language above will be removed from the state plan.

15. Attachment 4.19-B, Page 20.16(3), Paragraph C.11.c.

This paragraph currently reads, "The following documents shall be submitted within six (6) months of the effective dates of a change in scope; c) A completed MAP 100501, Prospective Payment System Rate Adjustment, completed according to the Instructions for completing the MAP 100501 Form."

Is the MAP 100501 a cost report? If so, then specify this in the state plan. Please bear in mind, to assure payment of a least PPS, the state must continue to determine PPS in the same manner it has historically followed. If this cost report represents a change in how PPS is determined then the state may not use it.

DMS Response - The MAP 10051 is a form used to add cost and visits for new services to the cost array used in developing the original PPS rate. The resulting rate is calculated using a method similar to the calculation of a PPS rate for a new center.

16. Attachment 4.19-B, Page 20.16(3), Paragraph C.13

While the state may require documentation from health centers and clinics it is bound to adjust PPS for a change of scope in service and should fold the revised rate into the annual ratemaking process. Please confirm this provision would allow for that.

DMS Response - Confirmed that a change in scope review will result in a new (or confirmed) rate at the time of the next annual rate setting.

17. Attachment 4.19-B, Pages 20.16(3) and 20.16(4), Section D, Provider Participation Requirements

Attachment 4.19-B of the state plan is reserved for payment methodologies. Please remove Section D.

DMS Response - Section D will be removed.

18. Attachment 4.19-B, Page 20.16(4), Paragraph E.1 and E.2 - Limitations

To the extent that these limitations represent new policy the state may not implement them because they would be in conflict with the minimum payment of PPS. Please confirm the status of these limitations and make changes as indicated to the SPA Language.

DMS Response - The "Limitations" have been designated as "Exceptions", are not new, and allow multiple PPS rates in the first instance, and recognize, in the second instance, that centers may also provide "services" that are not diagnostic or treatment services of a clinic.

19. Attachment 4.19-B, Page 20.16(5), Paragraphs F, l.c.(1) and (2)

Please remove these references because they do not apply to FQHC or RHC services.

DMS Response - These have been removed.

If you have additional questions, please contact Sharley Hughes.

Sincerely,



Lawrence Kissner
Commissioner

LK/sjh

Enclosure

XVII. FQHC, FQHC look-alike and RHC Services

- A. Standard Reimbursement for an FQHC, FQHC look-alike, or RHC for a visit by a Fee-For-Service (FFS) Medicaid recipient.
1. For a visit by a FFS recipient, the department shall reimburse:
 - a. An FQHC, FQHC look-alike, or RHC an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 U.S.C. 1396a(aa); or
 - b. A satellite facility of an FQHC or FQHC look-alike an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 U.S.C. 1396a(aa).
 2. Costs related to outpatient drugs or pharmacy services shall be excluded from the all-inclusive encounter rate per patient visit.
 3. The department shall calculate a PPS rate for a new FQHC, FQHC look-alike, or RHC as outlined in Section B below.
 4. The department shall adjust a PPS rate per visit:
 - a. By the percentage increase in the MEI applicable to FQHC, FQHC look-alike, or RHC services on July 1 of each year; and
 - b. And in accordance to Section C below.
 - (1) Upon request and documentation by an FQHC, FQHC look-alike, or RHC that there has been a change in scope of services; or
 - (2) Upon review and determination by the department that there has been a change in scope of services.
 5. A rate established in accordance with this State Plan Amendment shall not be subject to an end of the year cost settlement.
- B. Establishment of a PPS Rate for a New FQHC, FQHC look-alike, or RHC.
1. Newly qualified FQHCs/RHCs after fiscal year 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent areas, or in the absence of such other clinics, through cost reporting methods. After the initial year, payment shall be set using the MEI methods used for other clinics. (SMDL) Further, the costs that must be considered in calculating the payment rate are those reasonable costs used in calculating the rates for neighboring clinics with similar caseloads. The key issue is similarity of caseload.

Kentucky Medicaid will define "caseload" as a Medicare reprice payment per case. "Initial payments" will be defined as the PPS payments in the first year, eliminating the category of "interim rates". "Adjacent areas" will be defined as within a 50 mile radius." "Reasonable costs" will those costs accepted during fiscal years 1999 & 2000.

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

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

For a newly qualified center, where no center is in operation within a 50 mile radius, a pre-forma cost report, subject to tests for allowable costs (using Medicare principles) and reasonable costs (e.g., costs that would accrue to a center operating full time, not a limited hours of operation entity), with will be used to establish the PPS rate. Subsequent to the initial year, the PPS rate will be subject only to the MEI enhancement, and there will be no mass adjustment to initial year claims based on an actual cost report.

Kentucky Medicaid will also establish an Alternate Payment Methodology, consistent with the guidance referred to above (BIPA Q's & A's, and SMDL.) The Alternate Payment Methodology, available to both newly qualified and established centers shall be 125% of the Medicare Upper Payment Limit for RHC's. A center may choose the higher of the PPS rate developed as per the above guidelines, or the APM.

2. If the department requests additional documentation from an FQHC, FQHC look-alike, or RHC but does not receive additional documentation or an extension request within thirty (30) days, the department shall reimburse the FQHC, FQHC look-alike, or RHC based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010 until:
 - a. The additional documentation has been received by the department; and
 - b. The department has established a rate.

C. Change in Scope and PPS Rate Adjustment.

1. If an FQHC, FQHC look-alike, or RHC changes its scope of services after the base year, the department shall adjust the FQHC's, FQHC look-alike's, or RHC's PPS rate.
2. An adjustment to a PPS rate resulting from a change in scope that occurred after an FQHC's, FQHC look-alike's, or RHC's base year shall be effective on July 1st following the date on which the change in scope took place.
3. A change in scope of service shall be restricted to:
 - a. Adding or deleting a covered service;
 - b. Increasing or decreasing the intensity of a covered service; or
 - c. A statutory or regulatory change that materially impacts the services type, intensity, duration and/or amount of services of an FQHC, FQHC look-alike, or RHC.
4. The following *items* individually shall not constitute a change in scope:
 - a. A general increase or decrease in the costs of existing services;
 - b. An expansion of office hours;
 - c. An addition of a new site that provides the same Medicaid covered services;
 - d. A renovation or other capital expenditure;
 - e. A change in ownership.

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

C. Change in Scope and PPS Rate Adjustment. (cont)

5. A change in intensity shall:
 - a. Include a material change;
 - b. Increase or decrease the existing PPS rate by at least five (5) percent; and
 - c. Last at least twelve (12) months.
6. The department shall consider a change in scope request due to a statutory or regulatory change that materially impacts the costs of visits at an FQHC, FQHC look-alike, or RHC if:
 - a. A government entity imposes a mandatory minimum wage increase and the increase was:
 - (1) Not included in the calculation of the final PPS rate; or
 - (2) Subsequently included in the MEI applied yearly; or
7. A requested change in scope shall:
 - a. Increase or decrease the existing PPS rate by at least five (5) percent; and
 - b. Last at least twelve (12) months.
8. The following documents shall be submitted to the department within six (6) months of the effective date of a change in scope:
 - a. A narrative describing the change in scope;
 - b. A projected cost report containing twelve (12) months of data for the interim rate change; and
 - c. A completed MAP 100501, Prospective Payment System Rate Adjustment, *completed according to the Instructions for Completing the MAP 100501 Form.*
9. The department shall:
 - a. Review the documentation; and
 - b. Notify the FQHC, FQHC look-alike, or RHC in writing of the approval or denial of the request for change in scope within ninety (90) business days *from the date the department received the request.*
10. If the department requests additional documentation to calculate the rate for a change in scope, the FQHC, FQHC look-alike, or RHC shall:
 - a. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or
 - b. Request an extension beyond thirty (30) days to provide the additional documentation.
 - c. The department shall grant no more than one (1) extension.
 - d. An extension shall not exceed thirty (30) days.

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

C. Change in Scope and PPS Rate Adjustment. (cont)

11. To be initially enrolled with the department, an FQHC, FQHC look-alike, or RHC shall:
 - a. Enroll in accordance with 907 KAR 1:672; and
 - b. Submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC, FQHC look-alike, or RHC.
12. To remain enrolled and participating in the Kentucky Medicaid program, an FQHC, FQHC look-alike, or RHC shall:
 - a. Comply with the enrollment requirements established in 907 KAR 1:672;
 - b. Comply with the participation requirements established in 907 KAR 1:671; and
 - c. Annually submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC, FQHC look-alike, or RHC to the department.
 - d. The requirements established above shall apply to a satellite facility of an FQHC or FQHC look-alike.
13. An FQHC, FQHC look-alike, or RHC that operates multiple satellite facilities shall:
 - a. List each satellite facility on the parent facility's license in accordance with 902 KAR 20:058; and
 - b. Consolidate claims and cost report data of its satellite facilities *with the parent facility*.
14. An FQHC, FQHC look-alike or RHC, that has been terminated from federal participation shall be terminated from Kentucky Medicaid program participation.
15. A participating FQHC, FQHC look-alike, RHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC;
16. An FQHC, FQHC look-alike or RHC performing laboratory services shall meet the requirements established in 907 KAR 1:028 and 907 KAR 1:575.

D. Limitations.

1. Except for a case in which a recipient or enrollee, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment, an encounter with more than one (1) health care provider *or* multiple encounters with the same health care provider which take place on the same day and at a single location shall constitute a single visit.
2. A vaccine available without charge to an[a] FQHC, FQHC look-alike, RHC through the department's Vaccines for Children Program and the administration of the vaccine shall not be reported as a cost to the Medicaid Program.

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

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

1. If a managed care organization's reimbursement to an FQHC, FQHC look-alike, or RHC for a visit by an enrollee to the FQHC, FQHC look-alike, or RHC is less than what the FQHC, FQHC look-alike, or RHC would receive pursuant to above guidelines, the department shall supplement the reimbursement made by the managed care organization in a manner that:
 - a. Equals the difference between what the managed care organization reimbursed and what the reimbursement would have been if it *had* been made in accordance with the above payment methodology for FFS members;
 - b. Is in accordance with 42 U.S.C. 1396a(bb)(5)(A); and

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

XVII. FQHC, FQHC look-alike and RHC Services

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

- 1 For a visit by a FFS recipient, the department shall reimburse:
 - a An FQHC, FQHC look-alike, or RHC an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 U.S.C. 1396a(aa); or
 - b A satellite facility of an FQHC or FQHC look-alike an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 U.S.C. 1396a(aa).
- 2 Costs related to outpatient drugs or pharmacy services shall be excluded from the all-inclusive encounter rate per patient visit.
- 3 The department shall calculate a PPS rate for a new FQHC, FQHC look-alike, or RHC as outlined in Section B below.
- 4 The department shall adjust a PPS rate per visit:
 - a By the percentage increase in the MEI applicable to FQHC, FQHC look-alike, or RHC services on July 1 of each year; and
 - b And in accordance to Section C below.
 - (1) Upon request and documentation by an FQHC, FQHC look-alike, or RHC that there has been a change in scope of services; or
 - (2) Upon review and determination by the department that there has been a change in scope of services.
- 5 A rate established in accordance with this State Plan Amendment shall not be subject to an end of the year cost settlement.

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

- 1 ~~The department shall establish a PPS rate to reimburse a new FQHC, FQHC look-alike, or RHC 100 percent of its reasonable cost of providing Medicaid covered services during the FQHC's, FQHC look-alike's, or RHC's base year.~~
2. ~~Except for a time frame in which the department reimburses an FQHC, FQHC look-alike, or RHC an interim rate, the initial and subsequent final PPS rate established for an FQHC, FQHC look-alike, or RHC shall:~~
 - a. ~~Be prospective; and~~
 - b. ~~Not settled to cost.~~
- 3 ~~The department shall determine the reasonable costs of an FQHC, FQHC look-alike, or RHC based on the cost report which contains twelve (12) full months of operating data most recently submitted to the department by the FQHC, FQHC look-alike, or RHC.~~
- 4 ~~The base rate referenced in #1 above shall be based on the reasonable cost determination made by the department.~~

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

~~5-1~~ Newly qualified FQHCs/RHCs after fiscal year 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent areas, or in the absence of such other clinics, through cost reporting methods. After the initial year, payment shall be set using the MEI methods used for other clinics. (SMDL) Further, the costs that must be considered in calculating the payment rate are those reasonable costs used in calculating the rates for neighboring clinics with similar caseloads. The key issue is similarity of caseload.

Kentucky Medicaid will define "caseload" as a Medicare reprice payment per case. "Initial payments" will be defined as the PPS payments in the first year, eliminating the category of "interim rates". "Adjacent areas" will be defined as within a 50 mile radius." "Reasonable costs" will those costs accepted during fiscal years 1999 & 2000.

For a newly qualified center, where no center is in operation within a 50 mile radius, a pre-forma cost report, subject to tests for allowable costs (using Medicare principles) and reasonable costs (e.g., costs that would accrue to a center operating full time, not a limited hours of operation entity), with will be used to establish the PPS rate. Subsequent to the initial year, the PPS rate will be subject only to the MEI enhancement, and there will be no mass adjustment to initial year claims based on an actual cost report.

Kentucky Medicaid will also establish an Alternate Payment Methodology, consistent with the guidance referred to above (BIPA Q's & A's, and SMDL.) The Alternate Payment Methodology, available to both newly qualified and established centers shall be 125% of the Medicare Upper Payment Limit for RHC's. A center may choose the higher of the PPS rate developed as per the above guidelines, or the APM.

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

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

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

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

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

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

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

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

~~(2) Final rate established;~~

~~(3) Appeal rights regarding the final rate; and~~

- (4) ~~Estimated time for determining a final rate if a final rate is not established within ninety (90) days.~~
- e ~~If additional documentation is necessary to establish a final rate, the FQHC, FQHC look-alike, or RHC shall:~~
 - (1) ~~Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or~~
 - (2) ~~Request an extension beyond thirty (30) days to provide the additional documentation.~~
 - (3) ~~The department shall grant no more than one (1) extension.~~
 - (4) ~~An extension shall not exceed thirty (30) days.~~
- d If the department requests additional documentation from an FQHC, FQHC look-alike, or RHC but does not receive additional documentation or an extension request within thirty (30) days, the department shall reimburse the FQHC, FQHC look-alike, or RHC based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010 until:
 - (1) The additional documentation has been received by the department; and
 - (2) The department has established a final rate.

C Change in Scope and PPS Rate Adjustment.

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

TN No. 13-012 '
Supersedes
TN No. New

Approval Date: _____

Effective Date 09/06/2013

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

- 2 An adjustment to a PPS rate resulting from a change in scope that occurred after an FQHC's, FQHC look-alike's, or RHC's base year shall be ~~retroactively~~ effective on July 1st following the date on which the change in scope took place. ~~to the date that the FQHC, FQHC look-alike, or RHC applied for the change in scope.~~
- 3 A change in scope of service shall be restricted to:
- a Adding or deleting a covered service;
 - b Increasing or decreasing the intensity of a covered service; or
 - c A statutory or regulatory change that materially impacts the services type, intensity, duration and/or amount of services of an FQHC, FQHC look-alike, or RHC. ~~A statutory or regulatory change that materially impacts the costs or visits of an FQHC, FQHC look-alike, or RHC.~~
- 4 The following *items* individually shall not constitute a change in scope:
- a A general increase or decrease in the costs of existing services;
 - b An expansion of office hours;
 - c An addition of a new site that provides the same Medicaid covered services;
 - ~~d~~ A wage increase;
 - ~~e-d~~ A renovation or other capital expenditure;
 - ~~f-e~~ A change in ownership; ~~or;~~
 - ~~g~~ An addition or deletion of a service provided by a non-licensed professional or specialist.
- ~~5~~ An addition of a covered service shall be restricted to the addition of a licensed professional staff member who can perform a Medicaid covered service that is not currently being performed within the FQHC, FQHC look-alike, or RHC by a licensed professional employed or contracted by the facility.
- ~~6~~ The deletion of a covered service shall be restricted to the deletion of a licensed professional staff member who can perform a Medicaid covered service that was being performed within the FQHC, FQHC look-alike, or RHC by the licensed professional staff member.
- ~~7-5~~ A change in intensity shall:
- a Include a material change;
 - b Increase or decrease the existing PPS rate by at least five (5) percent; and
 - c Last at least twelve (12) months.
- ~~8-6~~ The department shall consider a change in scope request due to a statutory or regulatory change that materially impacts the costs of visits at an FQHC, FQHC look-alike, or RHC if:
- a A government entity imposes a mandatory minimum wage increase and the increase was:
 - (1) Not included in the calculation of the final PPS rate; or
 - (2) Subsequently included in the MEI applied yearly; or
 - ~~b~~ A new licensure requirement or modification of an existing requirement by the state results in a change that affects all facilities within the class. A provider shall document that an increase or decrease in the cost of a visit occurred as a result of a licensure requirement or policy modification.

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

- 9 A requested change in scope shall:
- a Increase or decrease the existing PPS rate by at least five (5) percent; and
 - b Last at least twelve (12) months.
- ~~10 For a change in scope that is effective during a base year for determining an FQHC's, FQHC look-alike's, or RHC's final PPS rate, the base year costs associated with the change in scope shall not be duplicated when determining the revised PPS rate due to the change in scope.~~
- ~~11~~ 10 The following documents shall be submitted to the department within six (6) months of the effective date of a change in scope:
- a A narrative describing the change in scope;
 - b A projected cost report containing twelve (12) months of data for the interim rate change; and
 - c A completed MAP 100501, Prospective Payment System Rate Adjustment, *completed according to the Instructions for Completing the MAP 100501 Form.*
- ~~12~~ 11 The department shall:
- a Review the documentation; and
 - b Notify the FQHC, FQHC look-alike, or RHC in writing of the approval or denial of the request for change in scope within ninety (90) business days *from the date the department received the request.*
- ~~13~~ 12 If the department requests additional documentation to calculate the rate for a change in scope, the FQHC, FQHC look-alike, or RHC shall:
- a Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or
 - b Request an extension beyond thirty (30) days to provide the additional documentation.
 - c The department shall grant no more than one (1) extension.
 - d An extension shall not exceed thirty (30) days.

~~D~~ Provider Participation Requirements:

- ~~1 A participating FQHC, FQHC look alike, RHC, shall be currently:~~
- ~~a Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and~~
 - ~~b Participating in the Kentucky Medicaid program in accordance with 907 KAR 1:671.~~
- ~~2 A satellite facility of an FQHC, an FQHC look alike, or a RHC shall:~~
- ~~a Be currently listed on the parent facility's license in accordance with 902 KAR 20:058;~~
 - ~~b Comply with the requirements regarding extensions established in 902 KAR 20:058; and~~
 - ~~c Comply with 907 KAR 1:671.~~

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

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

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

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

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

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

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

E Limitations.

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

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

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

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

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

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

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

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

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

~~(2) 42 C.F.R. 447.321~~

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