

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 1:055

Department for Medicaid Services
Amended After Comments

(1) A public hearing regarding 907 KAR 1:055 was not requested and; therefore, not held.

(2) The following individuals submitted written comments regarding 907 KAR 1:055:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Aaron Frye, LPCC Abigail Thompson, Graduate Student	University of Louisville; Louisville, KY
Ada Braun, MAC, LPCC, NCC Addition Services IOP Coordinator	Comprehend, Inc.; Maysville, KY
Amanda Brantley, M. Ed. Ann Hayes Ronald, M. Ed, Licensed Professional Counselor Associate	
Ashley Stout, Patient Assistance Coordinator	Hematology and Oncology Center; Somerset, KY
Barbara Ballard, LPCC Barbara Tipmore, Director of Counseling Services	Louisville, KY Owensboro Community and Technical College; Owensboro, KY
Benjamin Arnold, LPCC, NCC, Child and Family Therapist	Bluegrass.org – Mercer County Office; Harrodsburg, KY
Beverly Martin, LPCC, School Guidance Counselor	Martin, KY
Brandt Briggs Brian E. Daly, Ed.D., Senior Director of Kentucky Campuses	Webster University; Louisville, KY
Brittany Rigney, LPCA, Early Childhood Coordinator	Communicare; Brandenburg, KY
Caitlin RC Mudd, LPCC, NCC, MBACP Caleb Bonner, WKU Graduate and Future LPCC	Oxford, United Kingdom

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Carol Lewis, M.A.Ed., LPCC, NCC Carol A. Sommer, Ph.D, NCC, LPCC, ACS, Associate Professor of Counseling	Eastern Kentucky University, Department of Counseling and Educational Psychology; Richmond, KY
Caroline Curry Celeste Sizmore, MA Ed., LPCA, Guidance Counselor	Phelps Day Treatment, Phelps Elementary and Majestic Elementary; Phelps, KY
Charlene Scites-Thompson, M.Ed., LPCC, UR Clinician	Beacon Health Strategies; Louisville, KY
Charles. R. Nelton, LPCC Chris Isgrigg, Ph.D. Student	Counselor Education and Supervisor Program, University of Louisville; Louisville, KY
Chris Moons, M.Ed., LPCC, Treatment Director Cynthia M. Coscia, M.Ed., LPCC, NCC Cynthia Stewart, MA, LPCA Daniel Bondurant, LPCC Danielle Fuller, GCDF, PTEC Job Coach/ Retention Advisor	Necco; Somerset, KY
Dave Gerkin, LPCA Director	Cincinnati State Technical and Community College; Cincinnati, OH
David Kingsbury, MSC, LPCA Dawn Rowe, M.Ed., LPCC, NCC Debbie Ellis Deborah I. McCoy, MA, LPCC, NBCC Deidra Boyken, RN, LPCA Devonne Stirman, M.Ed., NCC, LPCA Donna S. Butler, Guidance Counselor	Strategic Partnerships, Inc.; Owensboro, KY
Donna Mahan, LPCC, CADC Dr. Bill Braden, Associate Executive Director	Clinton County High School; Albany, KY
Dr. Martin C. Wesley, M.Ed., Ph.D., Regional Director	Kentucky Counseling Association; Frankfort, KY
	Department of School of Professional Counseling, Lindsey Wilson College; Columbia, KY

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Dr. Larry Sexton, Department Chair and Professor	Department of Counseling and Educational Psychology, Eastern Kentucky University; Richmond, KY
John R. Rigney, Ed.D, NCC, LPCC Project Development Consultant	Counselor Education Learning Systems; Fontana, WI
Accreditation Project Director	Lipscomb University; Nashville, TN
Dr. Kim A. Naugle, Ph.D., HSPP, NCC, LPCC Associate Dean and r Professor	Office of the Dean, College of Education, Eastern Kentucky University; Richmond, KY Department of Counseling and Educational Psychology, Eastern Kentucky University; Richmond, KY
Tim Robertson, MA, LPCC, Professor Adjunct Faculty	School of Professional Counseling, Lindsey Wilson College; Columbia, KY
Instructor	Eastern Kentucky University; Richmond, KY
Dr. Jill Duba Sauerheber, Ph.D., LPCC, NCC, RTC, EMDR Certified, Associate Professor, CMHC and MCFC Program Coordinator	Western Kentucky University; Bowling Green, KY
Natalie Stipanovic, Ph.D	
Dr. Roger Noe, LPCC, Ed.D, Professor of Psychology	Southeast Kentucky Community and Technical College, Harlan Campus; Harlan, KY
Eileen Moore, LPCC, Director of Community Based Services	Holly Hill Children Services
Elizabeth G. Madriaga, LPCC, NCC, Sexual Assault Services Coordinator, Staff Counselor	Counseling and Testing Center, Western Kentucky University; Bowling Green, KY
Erica Johnston, M.Ed., LPCA	
Erika Mayers	
Garnetta Nickell, MA, LPCC	
Gary L. Patton, Ph.D., LPCC, NCC Associate Professor	School of Professional Counseling, Lindsey Wilson College; Columbia, KY
Gary Santana	

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Ginger Blakeley, Guidance Counselor Building Assessment Coordinator	West Broadway Elementary School, Madisonville, KY
Heather Wells, Probation Officer Current Student in Master's Program	Hazard Office; Hazard, KY Lindsey Wilson College; Columbia, KY
Helen Hinton, LCC, Unit Manager	Seven Counties School Based Services, Seven Counties; Louisville, KY
Hillary Lewis, BCMS Guidance Counselor	Bath County Schools; Bath County, KY
Holly Abel, Ph.D, LPCC, NCC, NCSC, Associate Professor – Regional Academic Director	School of Professional Counseling, Lindsey Wilson College; Hazard, KY
Holly R. Taylor, LPCC, Therapist	Appalachian Children's Home; Barbourville, KY
Jacob Hamlin, Counseling Student	Western Kentucky University; Bowling Green, KY
Jacob Wright, BA (Future LPCC)	
Janice Clark	Somerset, KY
Janice R. Greutz, NCC, LPCC, CSAT	Healing Journey of Recovery; London, KY
Jason Rickard, LPCC	
Jennifer Milburn, Future Counselor in Kentucky	
Jennifer Vandiver-Vertrees, LPCC	
Jeri Harrell, LPCC	
Jessica Jones, BA, Graduate Student	Benton, KY School of Professional Counseling, Lindsey Wilson College
Jessica Robinson, Graduate Assistant	School of Professional Counseling, Lindsey Wilson College – Madis- onville Campus; Madisonville, KY
Joanne Branson, LPCA	The Lighthouse Counseling Services, Inc., Henderson County Drug Court; Henderson, KY
John A. Dewell, Ph.D, Assistant Professor	University of Louisville, College of Education and Human Development; Louisville, KY
Joseph E. Smith, Executive Director	Kentucky Primary Care Association of Kentucky; Frankfort, KY
Joseph Hall, LMFT, LPCC, CADC, USMC Retired,	
Joseph Yazvac, Ed.D., LPCC, Professional Counselor/Professor	Owensboro Community and Tech- nical College; Owensboro, KY

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Joshua Elliott, MA, LPCA	
Judith Curry	
Julia Ray	
Karen Cook, Executive Director	Kentucky Counseling Association
Kate C. Scheurich, LPCA	
Kathleen Nagle Barnett, M.Ed., Doctoral Candidate	Counselor Education and Program, University of Louisville; Louisville, KY
Behavior Specialist	Booth and Company
Kathy G. Whitson, LPCC, CADC, MA	
Katie C. Stratton, MS, LPCA Therapist	Lowe Cottage, Sunrise Children's Services, Woodlawn PRTF
Kelli Truelove, Hopkinsville Enrollment Coordinator	Lindsey Wilson College; Hopkinsville, KY
Keri Brockman, LPCC	Communicare
Kimberly A. Cook, LPCC, NCC, Forensic Interviewer/Senior Therapist	Family and Children's Place, Child Advocacy Center; Louisville, KY
Kimberly Stickler	
Kim Watkins, Ed.S., LPCA	
Kimberly Calhoun	
Kimberly Dunn	
Laticia Slone, M.Ed., LPCC, NCC	
Laurie Page	
Jason Sharp	
Laura K. Black, M.Ed., NCC, LPCA, Coordinator of Extended Programs	School of Professional Counseling, Lindsey Wilson College – Hopkinsville Campus; Hopkinsville, KY
Linda Lear, MD	Hometown Pediatrics & Primary Care Center; Nicholasville, KY
Linda Jasper, NCC, LPCC	
Linda L. Reynolds, Guidance Counselor	Whitley County High School; Williamsburg, KY
Lindsey Brown, Graduate Assistant	Women and Gender Studies, Eastern Kentucky University; Richmond, KY
Lindsey Lanham, LPCC, Impact Plus Program Director	Sunrise Children's Service; Owensboro, KY

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Lindsey Horner Williams, LPCC	Washington Counties)
Lora Meadows-Keltner, LPCC, NCC Supervisor Offsite	Communicare (Marion and
Loretta Deaton, LPCA	
Lynita Greer	
Maria Bokeno, LPCC	
Mark Hamm, M.Ed., NCC, LPCC, CEO	Phoenix Preferred Care; Lake Cumberland Area Development District Russell Springs, KY
Mary Lynn Bailey, M.Ed., NCC, LPCC	
Maureen Kennedy Bensman, MED, LPCC President and CEO	Solutions in Living, LLC
Maurice McCormick, Ed.D., Licensed Professional Clinical Counselor, Licensed Mental Health Counselor, College Professor	Louisville, KY
Maxi Kolb, Guidance Counselor	Heath Elementary School; Heath, KY
Megan McMillen	
Melinda Mays	
Melissa Austin	
Melissa Deaton	
Melissa Ludka, MA, NCC, LPCA, Impact Plus Clinician	KVC Behavioral HealthCare Kentucky, Inc., Lexington, KY
Michael H. Fulkerson, MAE, LPCC, Licensed Professional Clinical Counselor	RiverValley Behavioral Health, Owensboro, KY
Mike Burton, LPCC, CTRP Team Leader	Communicare
Mohamad H. Alnahhas, MD	Bright Future Primary Care, Inc; Middlesboro, KY
Mona Gallo, Ed.D., LPCC, Assistant Professor, Residential Faculty Supervisor	School of Professional Counseling, Lindsey Wilson College – Lexington Campus
Nancy J. Cunningham, Ph.D, Professor, Educational and Counseling Psychology, Counseling, and College Student Personnel Coordinator, Clinical Mental Health Counseling M.Ed. Program Coordinator, Counselor Education and Supervision Ph.D. Program Counseling Psychologist	University of Louisville; Louisville, KY

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Nancy C. Rich, student on the verge of Graduating from Western Kentucky University and applying for an LPCC license	Northern Kentucky University; Highland Heights, KY Catholic Charities
Naomi Colliver, School Counseling Student	
School Counseling Intern	
Pam Thurman, Counseling Graduate eligible to work as an LPCA	
Phyllis Stinson, LPCC	
Rachel Knuehl	
Racquel Strickland	
Rebecca Miller, LPCA	
Rebecca Pittman, LPCA	
Rebecca Rose	
Robert Kyle Macy	Kentucky River Foothills Rural Health Clinic; Richmond, KY Bluegrass Children's Intensive Treatment Team (Fayette and Jessamine Counties); Lexington, KY
Robert Slone, MA, LPCC, Mobile Clinic QMHC	
Robin R. Showalter, MS, LPCC	
Robin Bohanon Vaughn, LPCC	
Rodney Hadley, LPCC, MHE	
Ronda N. Lambert	
Ronetra Wills-Ratcliff, Counselor Intern	
Sammy Schwienher	
Sarah Hurt, LPCC	
Sarah E. Tucker, Graduate Assistant	
Shannon M. Derrick, LPCC	Office of Educator Development and Clinical Practice, University of Louisville; Louisville, KY
Sharon Boyd Hayes, LPCC, Intensive Treatment Team Therapist	
Sharon A. McQuinn, LPCC	
Shawn Benningfield, LPCA, Off-Site Therapist	
Shawn Luchtefeld, M.Ed., LPCC, Social Services Coordinator	
Shelia R. Wallen, M.Ed., LPCA, Regional Enrollment Director	
Stacy Springston, M.Ed., LPCC	
Stephanie Hartman, Mental Health Counseling Intern	
Sumner Lagow	
	Communicare
	Hope Center
	Lindsey Wilson College, SPC; Betsy Layne, KY Lindsey Wilson College Coordinator Extended Programs; Lexington, KY
	Northern Kentucky University; Highland Heights, KY

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Talmadge V. Hays, MD, PSC	Pineville, KY
Tara Brooks, MAE, LPCC, QMHP, Director of Crisis Programs	
Tasha Miller	
Terri J. Dugan, LPCA	
Thomas M. Yerkey, MA, LPA, Clinic Manager of a Community Mental Health Xenter	Meade County, KY
Tiffany Dominey, LPCA, M.Ed.	
Tina M. Hamm, NCC, LPCC, RPT-S	Phoenix Preferred Care
Tommy Lemaster, Salyersville Grade School Counselor	
Tonia Marcum, M.Ed., Logan Campus Coordinator	School of Professional Counseling, Lindsey Wilson College; Mt. Gay, West Virginia
Tracy Lee Mattingly-Miller, NCC, Therapist/Forensic Interviewer	Cumberland Valley Children's Advocacy Center; London, KY
Trudy J. Bramblett, LPCC	
Valerie Crume, M.Ed., LPCC	Sunrise Children's Services, Jefferson Salt River Trail Regions, Elizabeth/Mt. Washington, KY
Vicki Fowler, BCES Guidance Counselor	
Wanda Sexton, LPCA	
William Z. Nance, M.Ed., PC, NCC	
Yvonne Wilkinson, Guidance Counselor	South Green Elementary; Glasgow, KY

(3) The following individual from the promulgating agency responded to comments received regarding 907 KAR 17:010:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Lee Guice, Director	Department for Medicaid Services, Division of Policy and Operations
Charles Douglass, Manager	Department for Medicaid Services, Division of Policy and Operations, Benefit Policy Branch
Teresa Cooper, Nurse Consultant/Inspector	Department for Medicaid Services, Division of Policy and Operations, Benefit Policy Branch
Stuart Owen, Regulation Coordinator	Department for Medicaid Services

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Practitioners Authorized to Provide Behavioral Health Services

(a) Comment: Abigail Thompson, Graduate Student, University of Louisville; Ada Braun, MAC, LPCC, NCC, Addition Services IOP Coordinator, Comprehend, Inc.; Amanda Brantley, M. Ed.; Ann Hayes Ronald, M. Ed, Licensed Professional Counselor Associate; Ashley Stout, Patient Assistance Coordinator, Hematology and Oncology Center; Barbara Ballard, LPCC; Barbara Tipmore, Director of Counseling Services, Owensboro Community and Technical College; Benjamin Arnold, LPCC, NCC, Child and Family Therapist Bluegrass.org – Mercer County Office; Beverly Martin, LPCC, School Guidance Counselor Martin, KY; Brandt Briggs; Brittany Rigney, LPCA, Early Childhood Coordinator, Communicare; Caleb Bonner, WKU Graduate and Future LPCC; Carol Lewis, M.A.Ed., LPCC, NCC; Carol A. Sommer, Ph.D, NCC, LPCC, ACS, Associate Professor of Counseling, Eastern Kentucky University, Department of Counseling and Educational Psychology; Caroline Curry; Celeste Sizmore, MA Ed., LPCA, Guidance Counselor, Phelps Day Treatment; Phelps Elementary and Majestic Elementary; Charlene Scites-Thompson, M.Ed., LPCC, UR Clinician, Beacon Health Strategies; Charles. R. Nelton, LPCC; Chris Isgrigg, Ph.D. Student Counselor Education and Supervisor Program, University of Louisville; Chris Moons, M.Ed., LPCC, Treatment Director, Necco; Cynthia M. Coscia, M.Ed., LPCC, NCC; Cynthia Stewart, MA, LPCA; Daniel Bondurant, LPCC; Danielle Fuller, GCDF, PTEC Job Coach/Retention Advisor, Cincinnati State Technical and Community College; Dave Gerkin, LPCA, Director Strategic Partnerships, Inc.; David Kingsbury, MSC, LPCA; Dawn Rowe, M.Ed., LPCC, NCC; Debbie Ellis; Deborah I. McCoy, MA, LPCC, NBCC; Deidra Boyken, RN, LPCA; Devonne Stirsman, M.Ed., NCC, LPCA; Donna S. Butler, Guidance Counselor Clinton County High School; Donna Mahan, LPCC, CADC; Dr. Bill Braden, Associate Executive Director Kentucky Counseling Association; Dr. Martin C. Wesley, M.Ed., Ph.D., Regional Director Department of School of Professional Counseling, Lindsey Wilson College; Dr. Larry Sexton, Department Chair and Professor, Department of Counseling and Educational Psychology, Eastern Kentucky University; John R. Rigney, Ed.D, NCC, LPCC, Project Development Consultant, Counselor Education Learning Systems; Accreditation Project Director Lipscomb University; Dr. Kim A. Naugle, Ph.D., HSPP, NCC, LPCC, Associate Dean, Office of the Dean, College of Education, Eastern Kentucky University, Professor, Department of Counseling and Educational Psychology, Eastern Kentucky University; Tim Robertson, MA, LPCC, Professor Adjunct Faculty School of Professional Counseling, Lindsey Wilson College, Instructor, Eastern Kentucky University; Dr. Jill Duba Sauerheber, Ph.D., LPCC, NCC, RTC, EMDR Certified, Associate Professor, CMHC and MCFC Program Coordinator, Western Kentucky University; Natalie Stipanovic, Ph.D; Dr. Roger Noe, LPCC, Ed.D, Professor of Psychology, Southeast Kentucky Community and Technical College, Harlan Campus; Eileen Moore, LPCC, Director of Community Based Services, Holly Hill Children Services; Elizabeth G. Madriaga, LPCC, NCC, Sexual Assault Services Coordinator, Staff Counselor, Counseling and Testing Center, Western Kentucky University; Erica Johnston, M.Ed., LPCA; Erika Mayers; Garnetta Nickell, MA, LPCC; Gary Santana; Ginger Blakeley, Guidance Counselor, Building Assessment Coordinator, West Broadway Elementary School; Heather Wells, Probation Officer, Hazard Office, Current Student in Master's Program Lindsey Wilson College; Helen Hinton, LCC, Unit Manager Seven Counties School Based Services, Seven Counties; Hillary Lewis, BCMS

Guidance Counselor, Bath County Schools; Holly Abel, Ph.D, LPCC, NCC, NCSC, Associate Professor – Regional Academic Director, School of Professional Counseling, Lindsey Wilson College; Holly R. Taylor, LPCC, Therapist, Appalachian Children’s Home; Jacob Hamlin, Counseling Student, Western Kentucky University; Jacob Wright, BA (Future LPCC); Janice Clark; Janice R. Grentz, NCC, LPCC, CSAT, Healing Journey of Recovery; Jason Rickard, LPCC; Jennifer Milburn, future counselor in Kentucky; Jennifer Vandiver-Vertrees, LPCC; Jeri Harrell, LPCC; Jessica Jones, BA, Graduate Student School of Professional Counseling, Lindsey Wilson College; Jessica Robinson, Graduate Assistant, School of Professional Counseling, Lindsey Wilson College – Madisonville Campus; Joshua Elliott, MA, LPCA; Judith Curry; Julia Ray; Kate C. Scheurich, LPCA; Kathleen Nagle Barnett, M.Ed., Doctoral Candidate, Counselor Education and Program, University of Louisville and Behavior Specialist Booth and Company; Kathy G. Whitson, LPCC, CADC, MA; Katie C. Stratton, MS, LPCA, Therapist, Lowe Cottage, Sunrise Children’s Services, Woodlawn PRTF; Kelli Truelove, Hopkinsville Enrollment Coordinator, Lindsey Wilson College; Keri Brockman, LPCC, Communicare; Karen Cook, Executive Director Kentucky Counseling Association; Kimberly A. Cook, LPCC, NCC, Forensic Interviewer/Senior Therapist, Family and Children’s Place, Child Advocacy Center; Kimberly Stickler; Kim Watkins, Ed.S., LPCA; Kimberly Calhoun; Kimberly Dunn; Laticia Slone, M.Ed., LPCC, NCC; Laurie Page; Jason Sharp; Laura K. Black, M.Ed., NCC, LPCA, Coordinator of Extended Programs, School of Professional Counseling, Lindsey Wilson College – Hopkinsville Campus; Linda Jasper, NCC, LPCC; Linda L. Reynolds, Guidance Counselor, Whitley County High School; Lindsey Brown, Graduate Assistant, Women and Gender Studies, Eastern Kentucky University; Lindsey Lanham, LPCC, Impact Plus Program Director, Sunrise Children’s Service; Lindsey Horner Williams, LPCC; Lora Meadows-Keltner, LPCC, NCC, Supervisor Offsite, Communicare; Loretta Deaton, LPCA; Lynita Greer; Maria Bokeno, LPCC; Mark Hamm, M.Ed., NCC, LPCC, CEO, Phoenix Preferred Care; Mary Lynn Bailey, M.Ed., NCC, LPCC; Maureen Kennedy Bensman, MED, LPCC, President and CEO, Solutions in Living, LLC; Maxi Kolb, Guidance Counselor, Heath Elementary School; Megan McMillen; Melinda Mays; Melissa Austin; Melissa Deaton; Melissa Ludka, MA, NCC, LPCA, Impact Plus Clinician, KVC Behavioral HealthCare Kentucky, Inc.; Michael H. Fulkerson, MAE, LPCC, Licensed Professional Clinical Counselor, RiverValley Behavioral Health; Mike Burton, LPCC, CTRP Team Leader, Communicare; Mona Gallo, Ed.D., LPCC, Assistant Professor, Residential Faculty Supervisor, School of Professional Counseling, Lindsey Wilson College – Lexington Campus; Nancy C. Rich, student on the verge of graduating from Western Kentucky University and applying for an LPCC license; Naomi Colliver, School Counseling Student, Northern Kentucky University, School Counseling Intern, Catholic Charities; Pam Thurman, Counseling Graduate eligible to work as an LPCA; Phyllis Stinson, LPCC; Rachel Knuehl; Racquel Strickland; Rebecca Miller, LPCA; Rebecca Pittman, LPCA; Robert Kyle Macy; Robert Slone, MA, LPCC, Mobile Clinic QMHC, Kentucky River Foothills Rural Health Clinic; Robin R. Showalter, MS, LPCC, Bluegrass Children’s Intensive Treatment Team (Fayette and Jessamine Counties); Robin Bohanon Vaughn, LPCC; Rodney Hadley, LPCC, MHE; Ronda N. Lambert; Ronetra Wills-Ratcliff, Counselor Intern; Sammy Schwienher; Sarah Hurt, LPCC; Sarah E. Tucker, Graduate Assistant, Office of Educator Development and Clinical Practice, University of Louisville; Shannon

M. Derrick, LPCC; Sharon Boyd Hayes, LPCC, Intensive Treatment Team Therapist, Bluegrass.org; Sharon A. McQuinn, LPCC; Shawn Benningfield, LPCA, Off-Site Therapist, Communicare; Shelia R. Wallen, M.Ed., LPCA, Regional Enrollment Director, Lindsey Wilson College, SPC; Stacy Springston, M.Ed., LPCC, Lindsey Wilson College Coordinator Extended Programs; Stephanie Hartman, Mental Health Counseling Intern, Northern Kentucky University; Sumner Lagow; Tara Brooks, MAE, LPCC, QMHP, Director of Crisis Programs; Tasha Miller; Terri J. Dugan, LPCA; Tiffany Dominey, LPCA, M.Ed.; Tina M. Hamm, NCC, LPCC, RPT-S, Phoenix Preferred Care; Tommy Lemaster, Salyersville Grade School Counselor; Tonia Marcum, M.Ed., Logan Campus Coordinator, School of Professional Counseling, Lindsey Wilson College; Tracy Lee Mattingly-Miller, NCC, Therapist/Forensic Interviewer, Cumberland Valley Children's Advocacy Center; Trudy J. Bramblett, LPCC; Valerie Crume, M.Ed., LPCC, Sunrise Children's Services, Jefferson Salt River Trail Regions; Vicki Fowler, BCES Guidance Counselor; Wanda Sexton, LPCA; William Z. Nance, M.Ed., PC, NCC; and Yvonne Wilkinson, Guidance Counselor, South Green Elementary stated the following:

"I am requesting that 907 KAR 1:055, a regulation under the purview of Kentucky Medicaid which outlines the payment structure for primary care centers (PCC), federally qualified health centers (FQHC) / look-alikes and rural health clinic (RHC) facilities include payment to Licensed Professional Counselors (LPCCs) as providers of mental health services.

I am concerned that PCCs, FQHCs / look-alikes and RHC should be given the authority to choose for employment from a broader array of mental health practitioners – those that include licensed professional clinical counselors (LPCCs). Adding these licensed mental health practitioners to the regulation would impose no additional costs to the operations of a PCCs, FQHCs / look-alikes and RHC but would, instead, only enhance the quality of care provided by PCCs, FQHCs / look-alikes and RHC. The facilities should be given more latitude in choosing the most qualified and trained licensed mental health clinicians who meet the unique educational requirements for employment in the PCCs, FQHCs / look-alikes and RHCs.

These facilities must be afforded the opportunity to employ licensed and trained clinicians who are confident in their practice of whole person models, biopsychosocial intervention strategies and the benefits of collaborative care, and that they should not be restricted to hiring only clinical psychologists and clinical social workers. Training in these specific areas of practice would result in better outcomes to Medicaid members. As collaborative care models are within the scope of practice of LPCCs, I am asking that they be included in the regulation to allow for the employment of LPCCs in PCCs, FQHCs / look-alikes and RHCs.

Thank you for listening to my comments and trust they will become a part of the public record and duly considered as you move to finalize an amendment to this regulation."

In addition to the comments expressed above, Karen Cook, Executive Director of the Kentucky Counseling Association, also stated: "I am the Executive Director for the

Kentucky Counseling Association, which is the state branch of the American Counseling Association. We are a group of approximately 1200 professional counselors who serve in a variety of settings and include school counselors, mental health counselors, counselor educators, career, and rehabilitation counselors. All of our professional counselors have at least a Master Degree in Counseling and have completed rigorous curriculum requirements to earn specific certifications. Professional counselors that meet the Licensed Professional Clinical Counselor (LPCC) credentials in Kentucky are among the best prepared practitioners in the nation.”

Jennifer Milburn, future counselor in Kentucky, also expressed the comments represented above stated by many and added the following:

“I am a 36 year old wife and mother of four children who, after working in the nonprofit sector for Kentucky for 10 years, decided to work toward a Master’s degree in clinical mental health counseling. Ultimately, I will be a licensed professional clinical counselor (LPCC). When I weighed my options, the clinical mental health degree from U of L seemed to fit both my professional goals and my personal aspiration to continue living in a rural area. However, now that I am in my second semester, I am very concerned to hear about regulation that would prevent me from qualifying for jobs that I know my education prepares me well for.

As a lifelong Kentuckian who plans to stay here until my final days and who wants employment opportunities that should fairly be mine, I ask that you listen to my comments. I trust they will become a part of the public record and duly considered as you move to finalize an amendment to this regulation.”

Caitlin RC Mudd, LPCC, NCC, MBACP, of Oxford, United Kingdom, also stated the comments represented by so many above and also stated that she is “gravely concerned about this regulation.”

In addition to the comments expressed by many above, John A. Dewell, Ph.D., Assistant Professor, College of Education and Human Development, University of Louisville, also stated the following:

“I don’t pretend to know why Clinical Mental Health Counselors were originally left off of this bill but it seems to be a travesty for all parties involved. Clinical Mental Health Counselors have strict standards in their training and the training is typically more clearly focused on providing direct care services than it is in either Social Work or Counseling Psychology. Perhaps it is simply a matter of name recognition but leaving Clinical Mental Health Counselors off of this bill is not only painful for our profession but for the clients we serve. As a state we struggle to provide effective mental health treatment and this bill would only continue to limit our efficacy and overall response to the mental health needs of the people of this state.

Thanks for your time and again I strongly encourage you to add Clinical Mental Health Counselors to the regulations that outline the payment structure for primary care centers

(PCC), federally qualified health centers (FQHC) / look-alikes and rural health clinic (RHC) facilities. If it would be helpful I'd also be more than willing to discuss training standards and the differences between these disciplines (here at U of L there is almost no difference between Clinical Mental Health Counseling training and Counseling Psychology training)."

Gary L. Patton, Ph.D., LPCC, NCC, Associate Professor, School of Professional Counseling, Lindsey Wilson College, echoed the comments expressed by many above and also added the following:

"In fairness to patients as well as to providers and facilities, I do not believe that facilities should be restricted to hiring only clinical psychologists and clinical social workers."

Shawn Luchtefeld, M.Ed., LPCC, Social Services Coordinator, Hope Center, stated the comments expressed by many above and also stated the following:

"In my career as a mental health counselor I have supervised several psychology and social work students who were required to have professional supervision. I find it unreasonable and incongruent that I can help train these professionals in counseling practice but seem to be given a lower professional status than those I train. There is a shortage of mental health professionals in many areas of the US, especially Kentucky. Bypassing LPCCs will make this issue more pronounced while including them will help alleviate the problem while maintaining or lowering the overall cost of care."

Joseph Yazvac, Ed.D., LPCC, Professional Counselor and Professor at Owensboro Community and Technical College, echoed much of the aforementioned expressed comments and also stated, "There are not enough mental health practitioners available in rural Kentucky. Furthermore, all qualified mental health practitioners should be treated equitably." Dr. Yazvac, also cited "professional territorial discrimination against LPCCs" as a reason to grant PCCs, FQHCs, FQHC look-alikes, and RHCs the authority to employ LPCCs.

Joseph Hall, LMFT, LPCC, CADC, USMC Retired stated: "I request that 907 KAR 1:055, a regulation under KY Medicaid, regarding pay structure for primary care centers (PCC), federally qualified health centers (FQHC)/ look-alikes and rural health clinics (RHC), include Licensed Professional Counselors (LPCCs) and Licensed Marriage & Family Therapists (LMFTs), as mental health service providers.

I opine the above facilities should be allowed to include employees from a broader array of Qualified Mental Health Professionals (QMHPs) – including LPCCs and LMFTs, instead of only LCSWs and Psychologists.

Besides no additional cost, a comparison of all the above QMHPs' feeder-school curriculums reveals no superiority for any, in regards to core competency training. After school, all the above must gain thousands of hours' supervised experience, and then pass a rigorous exam, before full licensure. After licensure, all the above must actively

work for three years before recognition as Kentucky QMHPs.

I believe what is different among the above is specialty focus and problem conceptualization, i.e. LCSWs' societal problems & fixes, LMFTs' circular causality in marriage & family problems, LPCCs' focus on individuals' problems, and psychologists' "formal" testing & diagnosis of problems (versus informal for others). These differences result in turf pride akin to Army versus Marine. Just as our nation benefits from all armed services, adding LPCCs and LMFTs would enhance quality of care by bringing more diversified training & experience to the care team.

Please consider my comments as you move to amend this regulation."

Aaron Frye, LPCC, stated the following:

"I am requesting that 907 KAR 1:055, a regulation under the purview of Kentucky Medicaid which outlines the payment structure for primary care centers (PCC), federally qualified health centers (FQHC) / look-alikes and rural health clinic (RHC) facilities include payment to Licensed Professional Counselors (LPCCs) as providers of mental health services.

While I believe LCSWs and Licensed Psychologists will offer a unique approach to mental health care that can only serve to benefit clients, I also believe that LPCCs have just as much to offer in a complete biopsychosocial approach. To exclude one profession over another is not only limiting to workers, it is also limiting for clients. Just as pediatricians, urologists, etc are all doctors and yet specialize in their own branches of practice, so too are LPCCs in the realm of licensed mental health workers. I imagine a pediatrician would have some complaint if he/she was told that they were not eligible to practice at a RHC or a PCC based on their specialty. Quite honestly, I realize that would never happen, though, because pediatricians are viewed as equal if not greater than other specialties. On the other hand, I am a licensed professional clinical counselor. I am licensed by the state of KY to practice autonomously as a counselor.

Why then would my license be seen as somehow inferior to the above mentioned independent licenses of psychologists and social workers? Are they not also licensed by the state in which they practice? We all had to meet at least a minimum requirement of education, supervision, and counseling experience to achieve our licenses. It would seem to me that this is not a legal or jurisdictional matter since all our licenses allow all of us to practice independently in the state of KY. So, I am curious, as I always am about this matter, what is the rationale behind this exclusion?

I would ask that you amend this regulation to include LPCCs, as to ignore this profession would mean to ignore experience and quality in mental health care that has been proven to deliver results. In fact, I would argue that no other specialty has as much experience in the actual practice of face to face counseling, evidence-based intervention strategies, and treatment planning.

Thank you for your time and consideration. I look forward to seeing these changes

implemented in the pursuit of quality care and diversity.”

Brian E. Daly, Ed.D., Senior Director of Kentucky Campuses, Webster University, stated the following:

“The current version of 907 KAR 1:055, a regulation under the purview of Kentucky Medicaid which outlines the payment structure for primary care centers (PCC), federally qualified health centers (FQHC) / look-alikes and rural health clinic (RHC) facilities **excludes an essential category of mental health providers: Licensed Professional Counselors (LPCCs)**. This is definitely an unfortunate oversight in the proposed regulation. Its effect would be to prevent high quality mental healthcare in Kentucky. The above treatment centers need professional counselors as employees. The proposed regulation prevents this option. Adding LPCCs to the regulation would enhance the quality of care provided by PCCs, FQHCs / look-alikes and RHC. These facilities need the most qualified and trained licensed mental health clinicians who meet the unique educational requirements for employment. The proposed regulation constructs an unnecessary barrier.

As collaborative care models are within the scope of practice of LPCCs, I am asking that they be included in the regulation to allow for the employment of LPCCs in PCCs, FQHCs / look-alikes and RHCs. **These facilities must be afforded the opportunity to employ licensed and trained clinicians** who are confident in their practice of whole person models, biopsychosocial intervention strategies and the benefits of collaborative care. Clinics should not be restricted to hiring only clinical psychologists and clinical social workers.

I appreciate the opportunity to express my concerns about the proposed narrow interpretation of mental health professionals in the Commonwealth. I ask that you move to finalize an amendment to this regulation that permits all qualified mental health professionals to benefit.”

Maurice McCormick, Ed.D., Licensed Professional Clinical Counselor, Licensed Mental Health Counselor, College Professor, stated the following:

“All you have to do is look at the course preparation for a social worker, professional counselor or psychologist and you will see that professional counselors have the best preparation for counseling. Look at U of K, U of L, and you will be convinced. Licensed Professional Clinical Counselors (LPCC) should be included in 907 KAR 1:055.”

Nancy J. Cunningham, Ph.D, Professor, Educational and Counseling Psychology, Counseling, and College Student Personnel Coordinator, Clinical Mental Health Counseling M.Ed. Program Coordinator, Counselor Education and Supervision Ph.D. Program Counseling Psychologist, University of Louisville stated the following:

“I am requesting that 907 KAR 1:055, a regulation under the purview of Kentucky Medicaid which outlines the payment structure for primary care centers (PCC), federally

qualified health centers (FQHC) / look-alikes and rural health clinic (RHC) facilities include payment to Licensed Professional Counselors (LPCCs) as providers of mental health services.

We train highly-qualified clinical mental health counselors who become licensed in Kentucky as LPCCs. They should have equal access to these positions by virtue of their training and licensure.”

Joanne Branson, LPCA, The Lighthouse Counseling Services, Inc., Henderson County Drug Court stated the following:

“In order to provide the best care possible 907 KAR 1:055, a regulation under the purview of Kentucky Medicaid, needs to be amended to include the services of a Licensed Professional Clinical Counselor (LPCC). These professionals have been trained in both educational and clinical settings to provide face to face mental health counseling that is vital to the well being of many of our citizens. This degree already requires 60 graduate hours which is quickly becoming the standard across the nation. In many cases an LPCC has more training and education than the other two providers now included in this program.”

Rebecca Rose stated the following:

“I am requesting that 907 KAR 1:055, a regulation under the purview of Kentucky Medicaid include payment to Licensed Professional Counselors (LPCCs) as providers of mental health services. These professionals are qualified to provide the services that are currently labeled for licensed psychologists and clinical social workers only. My experience as a guidance counselor in a public school has shown me that LPCCs are capable of providing the same level of care as psychologists and social workers.”

Thomas M. Yerkey, MA, LPA, Clinic Manager of a Community Mental Health Center, stated the following:

“I was just reviewing 907 KAR 1:055, and I have some serious concerns. Should this law pass in its current form, it will dramatically decrease the quantity and quality of mental health care services that are provided in KY. It will also put a lot of mental health professionals out of work. At this point, 907 KAR 1:055 would not allow any license holders other than Licensed Clinical Psychologists and Licensed Clinical Social workers to work in federally funded rural health clinics. We do not have enough qualified professionals who hold these licenses to meet current need. So it is very important that the law include other well trained license holders such as LPCC’s, LPA’s, LMFT’s, and MSW’s. I am the manager of a Community Mental Health Center in Meade county Kentucky. I realize this law does not directly impact our operations now, but if the language in a law pertaining to CMHC’s included the same limitations, I would be unable to employ all but 2 of my current therapists and social workers. That would leave 2 licensed providers to left to provide services that are currently provided by 12 quality mental healthcare providers. That does not include the 10 social workers providing case

management services to adults and children. Please revise this law to include a broader array of providers. This change will allow clinics to provide a broader array of services to a growing population of KY citizens who deal with mental illness.”

(b) Response: The current practitioners authorized in the regulation [which addresses reimbursement] to provide behavioral health services in federally qualified health centers (FQHCs), FQHC look-alikes, rural health clinics (RHCs) and primary care centers (PCCs) - clinical psychologists, licensed clinical social workers and advanced practice registered nurses – are the authorized practitioners because those are the specific practitioners referenced in federal regulations (42 CFR 405.2446 and 42 CFR 405.2450) as being authorized to provide behavioral health services in FQHCs and RHCs.

The federal agency which oversees Medicaid programs (the Centers for Medicare and Medicaid Services or CMS) must approve DMS’s policies and provide federal funding in order for DMS to implement a given policy. CMS provides the Kentucky Medicaid program approximately 70% of the funding for Medicaid services.

DMS is amending the definition of health care provider in an “amended after comments” regulation to include licensed professional clinical counselors (LPCCs) and licensed marriage and family therapists (LMFTs) for FQHCs, FQHC look-alikes, and RHCs contingent upon CMS approval of a state plan amendment to authorize the change.

To authorize licensed professional clinical counselors (LPCCs) and licensed marriage and family therapists (LMFTs) to provide services in FQHCs, FQHC look-alikes, RHCs and PCCs, DMS will need to amend two even more relevant regulations - 907 KAR 1:054 (Primary care center and federally-qualified health center services) and 907 KAR 1:082 (Rural health clinic services) – as these regulations explicitly establish covered service requirements including practitioners authorized to provide given services.

Currently, 907 KAR 1:082 states the following regarding coverage of behavioral health services:

“Behavioral health services provided by a clinical psychologist, licensed clinical social worker, or advanced registered nurse practitioner if the services are:

- (a) Provided by an individual who is employed by or furnishes services under contract to the RHC; and
- (b) Within the provider’s legally-authorized scope of practice;”.

907 KAR 1:054 currently states the following regarding coverage of behavioral health services:

“Behavioral health services provided by a clinical psychologist, licensed clinical social worker, or advanced registered nurse practitioner within the provider’s legally authorized scope of service;

(f) Services or supplies furnished as an incident to services provided by a physician, physician assistant, advanced registered nurse practitioner, or nurse midwife if the service or supply meets the criteria established in 42 C.F.R. 405.2413 or 42 C.F.R. 405.2415; or

(g) Services or supplies incidental to a clinical psychologist's or licensed clinical social worker's behavioral health services if the service or supply meets the criteria established in 42 C.F.R.”

Another issue is regarding Medicare program coverage. Currently, Medicare covers behavioral health services provided by physicians, physician assistants, nurse practitioners, certified nurse-midwives, clinical psychologists, independently practicing psychologists, clinical nurse specialists, and clinical social workers. Consequently, if DMS authorizes LPCCs and LMFTs to provide services in an FQHC, FQHC look-alike, RHC, or PCC, any such facility which employed an LPCC or LMFT would have to ensure that it also employed a practitioner authorized by the Medicare program to provide behavioral health services to ensure that individuals who have coverage under Medicare including “dual eligible” (individuals who have Medicare and Medicaid coverage) would be able to receive behavioral services.

(c) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 1. (10), page 3, line 6, - It is suggested that the terms ‘licensed professional clinical counselor’ and ‘licensed marriage and family therapist’ definitions be added to the list of disciplines listed under the definition of ‘health care provider.’”

(d) Response: Please see the response (a) listed under this same subject.

(2) Subject: Medical Group Management Association Physician Compensation and Production Survey Report

(a) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 1 (14), p. 5, line 1, defines ‘medical group management association physician compensation and production survey report’. This survey is also referenced at (23) of Section 1, p. 6, line 9, as a factor in the definition of ‘reasonable cost.’ There are two concerns and objections concerning use of MGMA figures to determine reasonable cost:

MGMA benchmarks are very general in nature. These benchmarks are not applicable to rural areas of Kentucky where recruiting providers is drastically different than in other areas. Use of MGMA data will lead to unreasonable disallowance of provider costs. The regulation should be flexible so that if a FQHC, FQHC Look-Alike, RHC and PCC can demonstrate that it was a prudent buyer and looked for lower cost alternatives, actual cost should be allowed that is not subject to the MGMA limit.

The proposed regulation incorporates the MGMA survey by reference in that it purports to give this survey and schedule produced by a private entity the force of law. KRS 13A.2251 applies to materials incorporated by reference and requires an agency to provide and make available such information for public inspection. It is submitted that the process for incorporation by reference as set forth in KRS Chapter 13A must be complied with and that the MGMA documents must be made available for public inspection.

(b) Response: DMS disagrees with the portrait of the MGMA survey report as stated in the comments. In contrast to the comments, the MGMA survey does a very good job of capturing and representing data for rural areas. DMS uses the South region survey and it applies to Kentucky extremely well. Additionally, MGMA is a very well established and nationally recognized industry tool.

The requirement to make information available for public inspection does not apply to material that is proprietary as established in KRS 13A.2251(1)(c) [relevant language underlined below]:

“(1) An administrative body shall incorporate material by reference in the last section of an administrative regulation. This section shall include:

- (a) The title of the material incorporated by reference placed in quotation marks, followed by the edition date of the material;
- (b) Information on how the material may be obtained; and
- (c) A statement that the material is available for public inspection and copying, **subject to copyright law**, at the main, regional, or branch offices of the administrative body, and the address and office hours of each. Following the required statement, the administrative body may include optional information that states the administrative body's Web site address or telephone number or that provides contact information for other sources that may have the material available to the public.”

MGMA is the proprietary owner of the MGMA Physician Compensation and Production Survey and the Department for Medicaid Services is not going to violate copyright law by releasing the report publicly.

Below is the MGMA Web Site containing details about the report including how one can purchase the report:

<http://www.mgma.com/store/Surveys-and-Benchmarking/Physician-Compensation-and-Production-Survey-2012-Report-Based-on-2011-Data-Print-Edition/>

(3) Subject: Satellite Office Enrollment as Medicaid Providers

(a) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 2 (1)(a), p. 7, line 5, This subsection appears to impose a new requirement that all satellites individually enroll with DMS. We understand that this is the intent. The cross-reference to 907 KAR 1:672 is confusing, however. That regulation refers to contracting and enrollment by the “entity” and so it is not clear why satellites would be separately enrolled if they are operated by the same entity.”

(b) Response: DMS is removing the requirement as it does not independently enroll satellite facilities. DMS understands that the Cabinet for Health and Family Services, Office of Inspector General, which regulates and licenses primary care centers, does not license satellite facilities (to which it refers as extensions) but licenses the parent facility. OIG requires that extensions (satellite facilities) be listed on a PCC’s license and DMS is inserting this requirement via an “amended after comments” regulation.

(4) Subject: Clarification Regarding RHCs and PCCs

(a) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 2(5) refers to 42 CFR 405.2436 and deals with termination from participation in the Kentucky Medicaid Program. Clarification is sought since RHC and PCC are not mentioned in the cited Federal regulation. Is this provision meant to apply to RHC and PCC, as well as FQHC and FQHC Look Alikes?”

(b) Response: The Department for Medicaid Services is deleting the reference to 42 CFR 405.2436 in an “amended after comments” regulation.

(5) Subject: Clarification Regarding Fee for Service Medicaid Recipients

(a) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“At Section 3, p. 9, line 10, -- Clarification is requested as to reimbursement for Medicaid services for persons (recipients) not assigned to an MCO. It is requested that DMS confirm that payment for an FQHC, FQHC Look Alike, RHC and PCC is, pursuant to federal law, the PPS rate for traditional fee for service Medicaid.”

(b) Response: DMS is amending the title of the section as well as language in subsection (1) in an “amended after comments” regulation to establish that the policies apply to visits (encounter between a provider and a Medicaid recipient who is not enrolled with a managed care organization) which occurs in an FQHC, FQHC Look-alike, or RHC.

DMS is amending, in an “amended after comments” regulation, reimbursement for PCC services (to a Medicaid recipient who is not enrolled with a managed care organization) from a prospective payment system (PPS) rate to reimbursement or rate on the

Medicare fee schedule established for Kentucky for the given service or drug. Such PCC reimbursement is stated in Section 6 of the amended after comments regulation.

(6) Subject: Drugs Administered In-house

(a) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

Section 3(2), p. 9, line 8, is confusing and clarification is sought. While it is understood that outpatient drugs and pharmacy services are not part of the PPS rate, the regulation as drafted fails to take into account drugs dispensed and administered in-house by a clinician? If drugs and pharmacy are not in the all-inclusive encounter rate, how is reimbursement to be made for the cost of drugs dispensed and administered in-house? Further, the sentence seems to contain an internal contradiction. Should the first clause be deleted? Or should it read, "Except for provider dispensed and administered drugs ..."?

(b) Response: DMS is revising the language in an "amended after comments" regulation as follows (the revisions are bold-faced):

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

(7) Subject: Interim Reimbursement for New Facilities

(a) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

"Section 4(3)(a), p. 13, line 5, –This provision sets up inadequate compensation for new clinics. It appears to eliminate the submission of a projected cost report to determine an interim rate and instead uses the Medicare upper payment limit. The Medicare service package is not as inclusive as the Medicaid service package. For example, Medicare does not cover laboratory or dental services, as does Medicaid. It is, therefore, submitted that this subsection is not consistent with federal law in that it fails to cover the reasonable cost for services. Any caps on reimbursement established in this subsection, or elsewhere, must be sufficient to ensure that all FQHCs, FQHC Look-Alikes, and RHCs will be paid 100% of costs which are "reasonable and related to the cost of furnishing services." Further, depending on the timing, a provider could be paid under the interim rate for up to two years. Since new providers generally experience cash flow issues during their base year, the Medicare rate (\$79.17 for an RHC) would be inadequate, especially for those affiliated with a hospital or health system. It is suggested that providers should have a choice to accept the Medicare rate **or** submit a projected cost report. In summary, if the Medicare payment system is to be used, it is understood that CMS has required states to be certain, through studies, analysis or the like, that such caps are set high enough to ensure that payments will be at one hundred

(100%) of costs which are reasonable and related to the cost of furnishing such services. (See 42 U.S.C. 1396 a(bb)(2)).

Also, it is submitted that the use of the term “per diem rate” in Section 4 (3)(a), page 13, line 8, is inappropriate because reimbursement is not made on a daily rate basis. There are instances where there will be multiple encounters in one day and it is suggested that the word “encounter” be inserted in lieu of “per diem.”

(b) Response: DMS disagrees that the Medicare reimbursement, on an interim basis, is inadequate. DMS notes that under current practice new facilities routinely overestimate projected costs, in some cases greatly so, resulting in the facility owing the department a very large cost settlement and, in some cases, balking at reconciliation. In this scenario, the owners of a given facility could file bankruptcy and leave Kentucky after pocketing a financial windfall. The end result harms state and federal taxpayers (whose revenues fund the Medicaid program.)

DMS is deleting the “per diem” language and revising the language to read as follows in an “amended after comments” regulation (the revision is bold-faced):

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

Additionally, as DMS is amending, in an “amended after comments” regulation, reimbursement for PCCs that are not FQHCs, FQHC look-alikes, or RHCs, from a PPS reimbursement to the Medicare fee schedule established for Kentucky (which eliminates the need for an interim reimbursement), DMS is deleting the following language from Section 4 (the deleted language is bold-faced):

1. Until a PCC submits a Medicaid cost report containing twelve (12) full months of operating data for the facility’s base year, the department shall reimburse the PCC an interim rate equal to the average PPS rate paid to PCCs in the same region in which the PCC is located.

2. The department shall adjust an interim rate for a PCC based on the establishment of the final rate.

3. 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.”

(c) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 4(3)(c), p. 13, line 13, – Clarification is requested on whether the adjustment to an interim rate would prospective or retrospective only? We understand that the intent of this subsection is that the adjustment is retroactive to the date when services start.”

(d) Response: That is correct, the adjustment would be retrospective. The interim rate only applies to the interim period.

(8) Subject: Cost Report

(a) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 4(4)(b), p. 14, line 6, -- Clarification is sought on whether the cost report referred to is only applicable to new clinics? Would it only be applicable until the PPS rate is set? It is understood that DMS will continue to ask for 1 fiscal year of data. Is this correct?”

(b) Response: DMS is revising the language in an “amended after comments” regulation to clarify that the cost report is indeed only applicable to new facilities and for the purpose of establishing a PPS rate. The revision reads as follows (the revisions are bold-faced):

“(4)(a) An FQHC, FQHC look-alike, RHC, or PCC shall submit **a[an annual]** cost report to the department by the end of the fifth month following the end of the FQHC’s, FQHC look-alike’s, RHC’s, or PCC’s first full fiscal year.

(b) The department shall:

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

(9) Subject: Establish DMS Deadline for Rate Setting

(a) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 4(4)(c), p. 14, line 5, – There is no time frame or deadline for DMS to set a final rate. A time frame should be established for determination of final rates by DMS.”

(b) Response: DMS does not think it necessary to establish a deadline as DMS prefers that a PPS rate be established as soon as possible rather than continue to pay based on an interim rate that is too often based on excessively high projected costs. DMS acts very expeditiously to facilitate the establishment of a PPS rate, but typically a provider fails to provide all required information initially or other issues with the provider surface along the path of establishing a PPS rate.

(10) Subject: Federal Upper Payment Limit

(a) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 6 (3), page 16, line 1, dealing with supplemental payments, refers to the “Federal upper payment limits” cites two Federal regulations in order to set such limits. It is submitted that this provision is both too vague and conflicts with Federal law. DMS must define the “federal upper payment limits” with specificity. The two regulations cited are inappropriate for this purpose. Rather than the cited regulations, it is submitted that the upper limit of payment is governed by 42 U.S.C. Section 1396(a)(bb)(6)(B) as a payment which:

Results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.”

(b) Response: The cited federal regulations (42 CFR 447.304 and 42 CFR 447.321) comport, rather than conflict, with federal law. Both are located within Subpart F of 42 Chapter 447. Subpart F is located within Title 42 (Public Health), Chapter IV (Centers for Medicare and Medicaid Services, Department of Health and Human Services), Subchapter C – Medical Assistance Programs and is comprised of 42 CFR 447.300 through 371. Subpart F establishes the Medicaid payment methods for institutional or non-institutional services.

42 CFR 447.300 establishes the basis and purpose for Subpart F and states:

“In this subpart, § 447.302 through § 447.325 and § 447.361 implement section 1902(a)(30) of the Act, which requires that payments be consistent with efficiency, economy and quality of care. Section 447.371 implements section 1902(a)(15) of the Act, which requires that the State plan provide for payment for rural health clinic services in accordance with regulations prescribed by the Secretary.”

42 CFR 447.302, another federal regulation within Subpart F, states:

“A State plan must provide that the requirements of this subpart are met.”

42 CFR 447.304 (one of the two federal regulations cited in Section 6(3) of 907 KAR 1:055 states:

“42 CFR 447.304, Adherence to Upper Limits; FFP.

“(a) The Medicaid agency must not pay more than the upper limits described in this subpart.

(b) In the case of payments made under the plan for deductibles and coinsurance payable on an assigned Medicare claim for noninstitutional services, those payments may be made only up to the reasonable charge under Medicare.

(c) FFP is not available for a State's expenditures for services that are in excess of the amounts allowable under this subpart.”

42 CFR 447.321 states:

“42 CFR 447.321. Outpatient hospital and clinic services: Application of upper payment limits.

(a) *Scope*. This section applies to rates set by the agency to pay for outpatient services furnished by hospitals and clinics within one of the following categories:

(1) State government-owned or operated facilities (that is, all facilities that are owned or operated by the State.)

(2) Non-State government owned or operated facilities (that is, all government operated facilities that are neither owned nor operated by the State).

(3) Privately-owned and operated facilities.

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

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

(c) *Exceptions*. Indian Health Services and tribal facilities. The limitation in paragraph (b) of this section does not apply to Indian Health Services facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638).

(d) *Compliance dates*. Except as permitted under paragraph (e) of this section, a State must comply with the upper payment limit described in paragraph (b)(1) of this section by one of the following dates:

(1) For non-State government-owned or operated hospitals—March 19, 2002.

(2) For all other facilities—March 13, 2001.”

The upper payment limit is established in aggregate for the entire category of providers rather than on a facility-by-facility basis.

In correspondence submitted to DMS by the Centers for Medicare and Medicaid Services (CMS) regarding primary care center reimbursement, CMS stated “Regulations at 42 CFR 447.321 require clinics to be paid no more for services than what Medicare would pay.”

(11) Subject: Change in Scope

(a) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 7(1), p. 16, line 13, – This subsection refers to adjustment of the PPS rate based on change in scope. We understand the intent of this provision is that adjustment be retroactive to the date of application.”

(b) Response: DMS will adjust a PPS rate associated with a change in scope retroactively effective to the date that the application for a change occurred, provided that DMS confirms that the change occurred. DMS is inserting language in an “amended after comments” language to clarify the effective date. The amendment reads as follows (the revisions are bold-faced):

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

(b) An adjustment to a PPS rate resulting from a change in scope that occurs after an FQHC’s, FQHC look-alike’s, RHC’s, or PCC’s base year shall be retroactively effective to the date that the FQHC, FQHC look-alike, RHC, or PCC applied for a change in scope.”

(c) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 7, (2) (b), p. 16, line 22, – This section, dealing with change in scope uses the terms, “intensity” and “material” that are not defined. “Intensity” is somewhat described in subsection 5 of section 7. Is this intended as or may it be read as a definition? As for “material” would you consider tying the term “material” to at least five percent increase?”

(d) Response: Regarding intensity, indeed, subsection (5) establishes the criteria for a change in intensity. DMS is inserting language, as follows, in an “amended after comments” regulation to clarify this (the revision is bold-faced):

“(2) 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 **pursuant to subsection (5) of this section;** or”

The change in intensity criteria of a material change is separate from the criteria of a five (5) percent increase.

(e) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

Section 7(3)(e), p. 17, line 7, – Clarification of the intent of the regulation as to renovation or other capital expenditure is requested. Many new providers under budget constraints operate in mobile or manufactured facilities. It appears that the regulation as currently written would prevent such new providers from building a bricks and mortar site because capital costs could not be covered in their rate. The regulation should be amended to allow capital increase of over 20 percent to be considered in determining whether there has been a change in scope.”

(f) Response: Capital cost is not included in the calculation of a PPS rate for an FQHC, FQHC look-alike, RHC, or PCC. It is a cost assumed by the provider in conducting business.

(g) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 7(5)(b), page 17, 17, – It is submitted that the term “PPS rate” as used in this subsection is inappropriate and that “cost” should be used in its place. The PPS rate is set according to law and administrative action and will not change. Cost, however, will change as a result of an addition or deletion of a covered service and it is this increase in cost that leads to the change in scope and increase in the PPS rate.”

(h) Response: It is true that costs will likely change, but a criteria for a change in intensity to qualify as a change in intensity recognized by DMS is that the change ultimately results in a PPS rate adjustment, up or down, of at least five (5) percent.

(i) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“Section 7(4), p. 17, line 11, – Clarification of this subsection is requested. There is no definition of “professional staff.” As currently written, with a limit on change of scope to addition or deletion of “professional staff” the provision may be overly restrictive? We submit that ancillary staff and infrastructure such as information technology personnel must also be considered since the expense of this staff will affect the cost of providing services.”

(j) Response: DMS views ancillary staff and infrastructure as part of an FQHC’s, FQHC look-alike’s, RHC’s, or PCC’s assumed cost of conducting business.

(12) Subject: Certification

(a) Comment: Joseph E. Smith, Executive Director of the Kentucky Primary Care Association of Kentucky, stated the following:

“At Section 2 (2)(b)(3), page 7, line 19, there is a reference to “recertification” for FQHCs, FQHC look-alikes, or RHCs and submission of proof concerning continued certification. Clarification is requested of this reference to recertification of FQHCs and RHC’s since there does not appear any requirement under the Federal statutes or regulations that FQHCs or RHC’s be recertified.”

(b) Response: DMS is correcting the language in an “amended after comments” regulation to eliminate the reference to a recertification and, rather, to require an annual submittal of proof of certification.

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

1. Comply with the enrollment requirements established in 907 KAR 1:672;
2. Comply with the participation requirement established in 907 KAR 1:671; and
3. **Annually submit proof of its certification by [Upon recertification with] the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC, FQHC look-alike, or RHC[, submit proof of its**

~~continued certification] to the department[upon obtaining recertification].”~~

(13) Subject: Regulation Impairs Community Health Care Resources

(a) Comment: Talmadge V. Hays, MD, PSC; Linda Lear, MD; and Mohamad H. Alnahhas, MD, stated the following:

“The E-Reg purports to exclude Kentucky’s Primary Care Centers from a prospective payment system (‘PPS’) reimbursement methodology that pays for health care services on a per-patient cost basis. The E-Reg purports to force Primary Care Centers to instead render services in exchange for fee-for-service (‘FFS’) payments allowed by the Cabinet’s Medicaid managed care organization contractors (‘MCO Contractors’).

We believe that the purported changes imposed by the E-Reg on PCC reimbursement will be unsustainable for PCCs. Primary Care Centers are required by state law to provide a broad range of patient care services, including primary care services, emergency services, preventive health services, health care education and chronic illness management. PCCs are required to cooperate with other providers to provide laboratory and x-ray services, and at least two of pharmacy, dental, family planning, optometry, nutrition, midwife, home health or social services. In addition, PCCs are required by the Cabinet to establish, update, maintain and train their staff on safety, quality and other patient care policies and procedures. Finally, PCCs are required to maintain a full complement of health care professionals including at least one physician and one ancillary provider, as well as an office administrator and support staff.

The E-Reg lacks a clear reimbursement methodology to fairly reimburse the broad spectrum of services the Cabinet requires of PCCs. We oppose the E-Reg changes that apparently terminate cost-based PPS reimbursement for PCC services and impose a FFS methodology that reimburses a PCC’s physician services only. Under the E-Reg’s purported changes, the PCC may receive only the FFS payment for primary care services from the Medicaid MCO Contractor, between \$45 and \$55 per-patient visit in most cases, and does not qualify for additional reimbursement. Historically, the Cabinet would pay PCCs a “supplemental wrap-around” payment to cover the difference between MCO Contractor payments and the cost to provide PCC services.

PCCs are often located in Kentucky’s rural and underserved areas that are overlooked by the Federal rural and underserved designations for FQHCs and RHCs. Frequently, a Primary Care Center is the only comprehensive provider of health care services in the local community. We encourage the Cabinet to revise the E-Reg to clearly provide a viable cost-based reimbursement methodology that will cover required PCC services. Without a PPS cost-based reimbursement methodology, PCCs, will not be able to provide required services and will be required to reduce services or close. Such an outcome would significantly impair community-based health care resources available to Medicaid beneficiaries.

We oppose the E-Reg in its current form because it does not offer a viable alternative to

the PPS reimbursement methodology available to PCCs in the past.

Under the E-Reg, PCCs are reimbursed for physician services only, while being required to provide many additional services; an untenable position for these community providers. We encourage the Cabinet to pursue a cost-based approach to reimburse the full complement of PCC services fairly.”

(b) Response: The Centers for Medicare and Medicaid Services (CMS), in February of this year, began refusing to provide federal matching funds to Kentucky’s Department for Medicaid Services (DMS) for payments to primary care centers [that are not federally qualified health centers (FQHCs) or rural health clinics (RHCs)] that exceed payments made to PCCs by managed care organizations. CMS cited federal law, 42 USC 1396a(bb)(5)(A), which only authorizes Medicaid programs to supplement an FQHC’s or RHC’s reimbursement (in addition to the reimbursement the FQHC/RHC received from a managed care organization) if necessary to elevate FQHC and RHC reimbursement to the mandated prospective payment system (PPS) level required in federal law for FQHCs and RHCs. The aforementioned PPS reimbursement is initially based, pursuant to 42 USC 1396a(bb)(3) and (4), on reasonable cost experienced by the FQHC or RHC.

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

CMS also cited federal regulation 42 CFR 438.60, which is in the chapter of federal regulations which establish managed care requirements, which prohibits Medicaid program payment (in addition to managed care organization payment) to providers except for the following exceptions:

- Disproportionate share hospital payments
- Prospective payments to FQHCs/RHCs
- Graduate medical education

Consequently, DMS ceased the supplemental payments to PCCs that are not FQHCs, FQHC look-alikes, or RHCs.

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

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

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

Consequently, DMS is amending its reimbursement for services or drugs provided by PCCs to Medicaid recipients who are not enrolled with managed care organizations. DMS is amending the reimbursement in an “amended after comments” regulation from being the current prospective payment system (PPS) rate to the Medicare fee schedule rate established for Kentucky. The amended language reads as follows:

“Reimbursement for Services or Drugs Provided to a Recipient by a PCC That is Not an FQHC, FQHC look-alike, or RHC and that are Covered by the Department.

(1) For a service or drug provided to a recipient that is not an enrollee by a PCC that is not an FQHC, FQHC look-alike, or RHC, the department shall reimburse for the service or drug the rate or reimbursement established for the service or drug on the Medicare Fee Schedule established for Kentucky.

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

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

(14) Subject: Inconsistency with Longstanding Reimbursement Policy Permitted by Federal Law

(a) Comment: Talmadge V. Hays, MD, PSC; Linda Lear, MD; and Mohamad H. Alnahhas, MD, stated the following:

“We support the Cabinet’s efforts to comply with federal Medicaid regulations and encourage the Cabinet to seek additional federal health care program funding wherever available. As reflected in prior versions of Kentucky’s Medicaid regulations, 42 C.F.R. 447.325 has been the federal authorization for the Kentucky Medicaid program’s cost-based PCC reimbursement since the 1970s. Section 447.325 provides that a state Medicaid program may pay the customary charges of a provider as long as those charges do not exceed the prevailing changes in the locality for comparable services under comparable circumstances.

We disagree with the Cabinet’s assertions in E-Reg notes that supplemental wrap-around payments to ‘true-up’ PCC costs are prohibited by federal law. We encourage the Cabinet to consider section 447.325’s broad latitude to set reimbursement based on

cost and ask that the Cabinet revise the E-Reg to clearly provide for a cost-based PPS reimbursement methodology for PCCs. A PPS rate methodology ensures that PCC customary charges do not exceed the 'prevailing charges in the locality for comparable services' in compliance with section 447.325 while at the same time providing meaningful reimbursement of the costs incurred by PCCs to provide the broad scope of services required under state law.

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

CMS cited federal law, 42 USC 1396a(bb)(5)(A), which only authorizes Medicaid programs to supplement an FQHC's or RHC's reimbursement (in addition to the reimbursement the FQHC/RHC received from a managed care organization) if necessary to elevate FQHC and RHC reimbursement to the mandated prospective payment system (PPS) level required in federal law for FQHCs and RHCs. The aforementioned PPS reimbursement is initially based, pursuant to 42 USC 1396a(bb)(3) and (4), on reasonable cost experienced by the FQHC or RHC.

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

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

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

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

In addition to no longer providing federal matching funds for supplements to managed care organization payments, CMS is no longer providing federal matching funds for payments to PCCs (that are not FQHCs, FQHC look-alikes, or RHCs) for Medicaid "fee-for-service" claims (non-managed care) that exceed the Medicare fee schedule rate.

CMS cited 42 CFR 447.321 in correspondence to DMS regarding DMS's reimbursement to the aforementioned PCCs.

Consequently, DMS is amending its reimbursement for services or drugs provided by PCCs to Medicaid recipients who are not enrolled with managed care organizations. DMS is amending the reimbursement in an "amended after comments" regulation from being the current prospective payment system (PPS) rate to the Medicare fee schedule rate established for Kentucky. The amended language reads as follows:

"Reimbursement for Services or Drugs Provided to a Recipient by a PCC That is Not an FQHC, FQHC look-alike, or RHC and that are Covered by the Department.

(1) For a service or drug provided to a recipient that is not an enrollee by a PCC that is not an FQHC, FQHC look-alike, or RHC, the department shall reimburse for the service or drug the rate or reimbursement established for the service or drug on the Medicare Fee Schedule established for Kentucky.

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

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

Additional detail regarding this issue is stated in response (b) corresponding to subject (13) of this statement of consideration.

(15) Subject: Regulation May Violate Access Requirements

(a) Comment: Talmadge V. Hays, MD, PSC; Linda Lear, MD; and Mohamad H. Alnahhas, MD, stated the following:

"The E-Reg's purported change of PCC reimbursement methodology will cause many PCCs to reduce health care resources available to the Cabinet's Medicaid Program beneficiaries. Without access to the important community health care services provided by PCCs, the Cabinet's Medicaid Program may fall short of federal Medicaid access requirements. Federal law requires that state Medicaid programs pay providers at least enough 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.

Due to the unique scope of services, staffing and patient care resources that PCCs must provide to meet the Cabinet's licensure requirements, PCCs are not economically viable under the FFS payment methodology offered by the Cabinet's MCO Contractors, which covers only the physician services component of the PCC's care. Because MCO reimbursement of physician services does not reimburse the PCC for all of the other

services it provides to Medicaid beneficiaries, the PCC is required to shift costs to non-Medicaid beneficiaries in violation of the most basic principles of Medicaid program reimbursement, or drastically reduce access to care for Medicaid beneficiaries.

Kentucky's PCCs provide a broad and unique scope of services, including in some of the most undeserved areas for Medicaid beneficiaries. We oppose the E-Reg because it does not appear to provide for a viable reimbursement methodology sufficient to cover the entire cost of the care PCCs provide to Medicaid beneficiaries. As a result, Medicaid beneficiary access to care will be significantly reduced across the Commonwealth, potentially in violation of federal Medicaid access requirements."

(b) Response: DMS agrees that a federal requirement, as stated in federal law 42 USC 1396a(a)(30), is as follows:

"A state plan for medical assistance must . . . 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."

DMS regularly monitors recipient access to care and will continue to do so. DMS will also ensure that its reimbursement complies with other federal provisions including those addressed in response (b) under subjects (13) and (14).

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

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

(16) Subject: Regulation is Premature

(a) Comment: Talmadge V. Hays, MD, PSC; Linda Lear, MD; and Mohamad H. Alnahhas, MD, stated the following:

According to the Cabinet, the federal Centers for Medicare & Medicaid Services ('CMS') has deferred amounts used by the Cabinet to pay supplemental wrap-around payments to Primary Care Centers pending additional information from the Cabinet in support of such payments. We oppose the E-Reg's apparent change to PCC reimbursement methodology based on an unfinalized CMS deferral of Medicaid funding. The E-Reg is

premature because CMS offers a mechanism to challenge a Medicaid deferral decision that must be pursued by the Cabinet before seeking regulatory changes. According to CMS, the Cabinet has sixty (60) calendar days to submit information disputing the CMS deferral decision. The Cabinet may request additional time to respond up to one hundred twenty (120) calendar days from the deferral notice.

We ask that the Cabinet follow its statutory duty to take advantage of all federal funds that may be available for medical assistance. Seeking modification of CMS' deferral decision before issuing the E-Reg's revised reimbursement methodology is not optional for the Cabinet.

We believe that the Cabinet's challenge would be successful because, under federal law, Kentucky's Medicaid program is authorized to reimburse a PCC's customary charges to the extent those charges are consistent with the charges of providers offering similar services in a similar locality without regard to whether the PCC participates with a Medicaid MCO Contractor."

(b) Response: The Centers for Medicare and Medicaid Services (CMS) view PCCs that are not FQHCs, FQHC look-alikes, or RHCs as similar to physicians' group practices rather than similar to FQHCs, FQHC look-alikes, or RHCs. DMS and counsel who reviewed the matter, including external counsel as well as cabinet counsel, share a consensus view of the matter and the related decisions.

(17) Subject: Regulation is Internally Irreconcilable

(a) Comment: Talmadge V. Hays, MD, PSC; Linda Lear, MD; and Mohamad H. Alnahhas, MD, stated the following:

"We oppose the current version of the E-Reg because it is confusing and internally irreconcilable. We support the Cabinet's efforts in the E-Reg to maintain the PPS reimbursement for PCCs in Section 3 of the E-Reg, but strongly oppose the conflicting and unnecessary prohibition on the same reimbursement methodology found in the new Section 5 of the E-Reg that prohibits the same payment. Before the E-Reg, the pertinent part of 907 KAR 1:055, Section 3 read as follows:

'Section 3. Reimbursement. (1) For services provided on and after July 1, 2001, the department shall reimburse a PCC, FQHC, or RHC an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 USC 1396a(aa).'

In the E-Reg, the pertinent part of 907 JAR 1:055E, Section 3 reads as follows:

'Section 3. Standard Reimbursement for an FQHC, FQHC look-alike, RHC, or PCC. (1) The department shall reimburse: (a) A PCC, 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 USC 1396a(aa)...

The E-Reg is confusing and does not clearly provide for viable PCC reimbursement. The E-Reg does not change the Cabinet's obligation to pay Primary Care Centers according to a PPS rate reimbursement methodology, including supplemental wrap-around payments, according to the requirements of 42 U.S.C. 1396a(aa). Instead, the E-Reg introduces a new Section 5 in direct and irreconcilable conflict with Section 3. Section 3 requires a PPS rate with supplemental payments for all services provided by Primary Care Centers, including Medicaid MCO Contractor enrollees, and Section 5 prohibits a PPS rate with supplemental payments for all services provided by Primary Care Centers to Medicaid MCO Contractor enrollees.

The new Section 5 reads as follows:

'Section 5. Reimbursement for Services Provided to an Enrollee by a PCC That is Not an FQHC, FQHC look-alike, or RHC. (1) For a visit by an enrollee to a PCC that is not an FQHC, FQHC look-alike, or RHC, the PCC's reimbursement shall be the reimbursement established pursuant to an agreement between the PCC and the managed care organization with whom the enrollee is enrolled. (2) The department shall not supplement the reimbursement referenced in subsection (1) of this section.'

(b) Response: Section 3 applies to services provided to Medicaid recipients who are not enrolled with a managed care organization while Section 5 applies to services provided to Medicaid recipients who are enrolled with a managed care organization.

DMS is revising the Section 3 language in an "amended after comments" regulation to clarify that it applies to reimbursement to a FQHC, FQHC look-alike, or RHC for care provided to a Medicaid recipient who is not enrolled with a managed care organization. The revised language reads as follows (the revisions are bold-faced):

"Section 3. Standard Reimbursement for an FQHC, FQHC look-alike, or RHC for a Visit by a Recipient Who is not an Enrollee and that is Covered by the Department~~[, or PCC]~~. (1) For a visit by a recipient who is not an enrollee and that is covered by the department~~[For services provided on and after July 1, 2004,]~~ the department shall reimburse:"

Additionally, DMS is amending the reimbursement methodology for services or drugs provided by PCCs to Medicaid recipients who are not enrolled with managed care organizations. DMS is amending the reimbursement in an "amended after comments" regulation from being the current prospective payment system (PPS) rate to the Medicare fee schedule rate established for Kentucky. This language is stated in Section 6 of the "amended after comments" regulation and reads as follows:

"Reimbursement for Services or Drugs Provided to a Recipient by a PCC That is Not an FQHC, FQHC look-alike, or RHC and that are Covered by the Department.

(1) For a service or drug provided to a recipient that is not an enrollee by a PCC

that is not an FQHC, FQHC look-alike, or RHC, the department shall reimburse for the service or drug the rate or reimbursement established for the service or drug on the Medicare Fee Schedule established for Kentucky.

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

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

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

(18) Subject: New Section 5 is Wrong

(a) Comment: Talmadge V. Hays, MD, PSC; Linda Lear, MD; and Mohamad H. Alnahhas, MD, stated the following:

“We oppose the E-Regs’s new Section 5 as confusing and in irreconcilable conflict with Section 3. Further, the E-Reg’s new Section 5 is factually wrong. The new Section 5 limits reimbursement for all services provided by a Primary Care Center to a Medicaid MCO Contractor enrollee to payments from the MCO, even if the service is covered by traditional Medicaid and not the Medicaid MCO.

For example, if a PCC provides home health services (covered under traditional Medicaid and not by Medicaid MCOs) to a Medicaid MCO enrollee, the E-Reg appears to provide that the Cabinet will continue to pay the PCC a PPS rate reimbursement regardless of whether the patient is an MCO enrollee because the home health service is covered by traditional Medicaid, not the MCO. Section 5 of the E-Reg expressly provides the opposite, that all services provided by a PCC to an enrollee must be paid for by the MCO.”

(b) Response: Section 5 applies to services provided to a Medicaid recipient who is enrolled with a managed care organization. DMS is revising the language in an “amended after comments” regulation to read as follows (the revisions are bold-faced):

“Section 5. Reimbursement for Services or Drugs Provided to an Enrollee by a PCC That is Not an FQHC, FQHC look-alike, or RHC and that are Covered by an MCO. (1) For a service or drug provided to[visit by] an enrollee by[te] a PCC that is not an FQHC, FQHC look-alike, or RHC and that is covered by an MCO, the PCC’s

reimbursement shall be the reimbursement established pursuant to an agreement between the PCC and the managed care organization with whom the enrollee is enrolled.

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

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 1:055 and is amending the administrative regulation as follows:

Page 3
Section 1(8)
Line 1

After “(8)”, insert the following:

“Federal financial participation” is defined in 42 C.F.R. 400.203.
(9)

Page 3
Section 1(9) and (10)
Lines 2 and 6

Renumber these subsections by inserting “(10)” and “(11)”, respectively, and by deleting “(9)” and “(10)”, respectively.

Line 6
After “provider”, insert the following:
for:
(a) A primary care center

Page 3
Section 1(10)(a), (b), (c), (d), (e), (f), (g), (h), and (i)
Lines 7, 8, 9, 10, 11, 12, 13, 14, and 16

Renumber these paragraphs by inserting “1.”, “2.”, “3.”, “4.”, “5.”, “6.”, “7.”, “8.”, and “9.”, respectively, and by deleting “(a)”, “(b)”, “(c)”, “(d)”, “(e)”, “(f)”, “(g)”, “(h)”, and “(i)”, respectively.

Page 3
Section 1(10)(i) and (j)
Lines 17 and 18

After “; or”, insert the following:
(b) An FQHC, FQHC look-alike, or RHC means:
1. A provider or practitioner listed in paragraph (a); or

2. Contingent upon approval of a state plan amendment by the Centers for Medicare and Medicaid Services, a:

a. Licensed professional clinical counselor; or

b. Licensed marriage and family therapist; or

(c)

Delete "(j) For".

Page 4

Section 1(11) and (12)

Lines 15 and 19

Renumber these subsections by inserting "(12)" and "(13)", respectively, and by deleting "(11)" and "(12)", respectively.

Page 4

Section 1(12) and (13)

Lines 20 and 21

After "KRS 335.100", insert a return and the following:

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

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

(16)

Delete "(13)".

Page 5

Section 1(14), (15), (16), (17), (18), and (19)

Lines 1, 10, 12, 14, 20 and 23

Renumber these subsections by inserting "(17)", "(18)", "(19)", "(20)", "(21)", and "(22)", respectively, and by deleting "(14)", "(15)", "(16)", "(17)", "(18)", and "(19)", respectively.

Page 6

Section 1(20), (21), (22), (23), (24), (25), (26), (27), and (28)

Lines 1, 2, 3, 6, 11, 12, 14, 18 and 22

Renumber these subsections by inserting "(23)", "(24)", "(25)", "(26)", "(27)", "(28)", "(29)", "(30)", and "(31)", respectively, and by deleting "(20)", "(21)", "(22)", "(23)", "(24)", "(25)", "(26)", "(27)", and "(28)", respectively.

Page 7

Section 1(28)

Line 1

After "FQHC look-alike," insert "or".

After "RHC", delete ", or PCC".

Page 7

Section 2(1)

Line 2

After “(1)”, insert “(a)”.

Line 3

After “RHC”, insert “or”

After “PCC”, delete the following:

, satellite facility of an FQHC, satellite facility of an FQHC look-alike, or satellite facility of a PCC

Page 7

Section 2(1)(a) and (b)

Lines 5 and 7

Renumber these paragraphs by inserting “1.” and “2.”, respectively, and by deleting “(a)” and “(b)”, respectively.

Page 7

Section 2(1)(b)

Line 8

After “907 KAR 1:671.”, insert a return and the following:

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

1. Be currently listed on the parent facility’s license in accordance with 902 KAR 20:058;
2. Comply with the requirements regarding extensions established in 902 KAR 20:058; and
3. Comply with 907 KAR 1:671.

Page 7

Section 2(2)(b)3.

Line 19

After “3.”, insert the following:

Annually submit proof of its certification by

Delete “Upon recertification with”.

Line 21

After “RHC”, delete the following:

, submit proof of its continued certification

After “department”, delete “upon obtaining recertification”

Page 8

Section 2(3)(a)

Line 2

After “(3)”, delete “(a)”.

Page 8
Section 2(3)(a)
Lines 3 - 4

After “shall”, insert a colon and the following:

(a) List each satellite facility on the parent facility’s license in accordance with 902 KAR 20:058; and

Delete the following:

separately enroll each satellite facility with the department in accordance with 907 KAR 1:672.

Page 8
Section 2(3)(b)
Line 5

After “(b)”, delete the following:

An FQHC, FQHC look-alike, or PCC that operates multiple satellite facilities shall

Page 8
Section 2(4) and (5)
Lines 7 - 11

After “(4)”, delete the following:

An FQHC, FQHC look-alike, or PCC shall not submit a claim for a service provided at a satellite facility if the satellite facility is not currently:

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

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

(5)

Page 8
Section 2(5)
Line 12

After “participation”, delete “pursuant to 42 C.F.R. 405.2436”.

Page 8
Section 2(6)
Line 14

Renumber this subsection by inserting “(5)” and by deleting “(6)”.

Page 9
Section 2(7)
Line 6

Renumber this subsection by inserting “(6)” and by deleting “(7)”.

Page 9
Section 3, Title
Line 11

After "FQHC look-alike", insert "or".

After "RHC", insert the following:
for a Visit by a Recipient Who is not an Enrollee and that is Covered by the Department

Delete ", or PCC".

Page 9

Section 3(1)

Line 12

After "(1)", insert the following:

For a visit by a recipient who is not an enrollee and that is covered by the department.

Page 9

Section 3(1)(a)

Line 13

After "(a)", insert "An".

Delete "A PCC,".

Page 9

Section 3(1)(b)

Line 13

After "FQHC", insert "or".

Delete the comma.

After "FQHC look-alike", delete ", or PCC".

Page 9

Section 3(2)

Line 19

After "(2)", delete the following:

Except for drugs or pharmacy services.

After "to", insert "outpatient".

Page 10

Section 3(3)

Line 3

After "FQHC look-alike", insert "or RHC".

Delete "RCH, or PCC".

Page 10

Section 3(4)(a)

Line 8

After "FQHC look-alike," insert "or".

Line 9

After "RHC", delete ", or PCC".

Page 10

Section 3(4)(b)

Line 11

After "Section", insert "g".

Delete "7".

Page 10

Section 3(4)(b)1.

Line 12

After "FQHC look-alike," insert "or".

After "RHC", delete ", or PCC".

Page 12

Section 4, Title

Line 9

After "FQHC look-alike," insert "or".

After "RHC", delete ", or PCC".

Page 12

Section 4(1)(a)

Line 11

After "new", delete "PCC,".

Page 12

Section 4(1)(b)

Line 16

After "look-alike," insert "or".

After "RHC", delete ", or PCC".

Page 12

Section 4(1)(b)

Line 17

After "FQHC look-alike," insert "or".

After "RHC", delete ", or PCC".

Page 12

Section 4(2)(a)

Line 21

After "alike," insert "or".

After "RHC", delete ", or PCC".

Page 13

Section 4(3)(a) and (b)

Line 8

After "to the", insert "all-inclusive".

After "per", insert "visit".

Delete "diem".

Page 13

Section 4(3)(d)1., 2., and 3.

Lines 17 to

Page 14, Line 1

Delete paragraph (d) in its entirety.

Page 14

Section 4(4)(a)

Line 2

After "FQHC look-alike," insert "or".

After "RHC", delete ", or PCC".

After "submit", insert "a".

Delete "an annual".

Line 4

After "look-alike's," insert "or".

After "RHC's", delete ", or PCC's".

Page 14

Section 4(4)(b)1.

Line 6

After "Review", insert "the".

Delete "an annual".

After "cost report", insert "referenced in paragraph (a)".

After "FQHC look-alike," insert "or".

After "RHC", delete ", or PCC".

Page 14
Section 4(4)(b)2.
Line 8

After "FQHC look-alike," insert "or".

After "RHC", delete ", or PCC".

Page 14
Section 4(4)(b)2.a.
Line 9

After "FQHC look-alike," insert "or".

After "RHC", delete ", or PCC".

Page 14
Section 4(4)(c)1.
Line 16

After "FQHC look-alike," insert "or".

After "RHC", delete ", or PCC".

Page 15
Section 4(4)(d)
Line 1

After "alike," insert "or".

After "RHC", delete ", or a PCC".

Line 3
After "alike," insert "or".

After "RHC", delete ", or PCC".

Page 15
Section 5, Title
Line 7

After "Services", insert "or Drugs".

Line 8
After "RHC", insert the following:
and that are Covered by an MCO

Page 15
Section 5(1)
Line 8

After "For a", insert the following:

service or drug provided to
Delete "visit by".

After "enrollee", insert "by".
Delete "to".

Line 9

After "RHC", insert the following:
and that is covered by an MCO,

Page 15

Section 6, Title

Line 14

After "Section 6.", insert the following:

Reimbursement for Services or Drugs Provided to a Recipient by a PCC That is Not an FQHC, FQHC look-alike, or RHC and that are Covered by the Department.

(1) For a service or drug provided to a recipient that is not an enrollee by a PCC that is not an FQHC, FQHC look-alike, or RHC, the department shall reimburse the rate or reimbursement established for the service or drug on the Medicare Fee Schedule established for Kentucky.

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

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

(b) If a Medicare coverage provision or requirement exists regarding a given service or drug that contradicts a provision or requirement established in 907 KAR 1:054, the provision or requirement established in 907 KAR 1:054 shall supersede the Medicare provision or requirement.

Section 7.

After "for FQHC", insert "Visits".
Delete "services".

After "look-alike", insert "Visits".
Delete "services".

Line 15

After "RHC", insert "Visits".
Delete "services".

Page 16

Section 7, Title

Line 13

After "Section", insert "8.".
Delete "7.".

Page 16
Section 7(1)
Line 15

After “(1)”, insert “(a)”.

After “look-alike”, insert “or”.

After “RHC”, delete “, or PCC”.

Line 17

After “rate.”, insert a return and the following:

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

Page 16
Section 7(2)(b)
Line 22

After “service”, insert the following:
pursuant to subsection (5) of this section

Page 17
Section 7(2)(c)
Line 1

After “FQHC look-alike,”, insert “or”.

After “RHC”, delete “, or PCC”.

Page 19
Section 8
Line 9 through
Page 20, Line 10

After “Section”, insert “9.”.

Delete the remainder of Section 8 in its entirety

Page 21
Section 9
Line 16

Delete “Section 9.”.

Page 22
Section 11
Line 4

After “11.”, insert the following:

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

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

(2) Disapproves the policy.

Section 12.

Page 22

Section 12

Line 11

After "Section", insert "13.".

Delete "12.".

Page 22

Section 12(1)(a)

Line 13

After "Adjustment",", insert "February 2013".

Delete "November 2008".