XVII. FQHC, FQHC look-alike and RHC Services

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

1. For a visit by a FFS recipient, the department shall reimburse:
   a. An FQHC, FQHC look-alike, or RHC an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 U.S.C. 1396a(aa); or
   b. A satellite facility of an FQHC or FQHC look-alike an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 U.S.C. 1396a(aa).

2. Costs related to outpatient drugs or pharmacy services shall be excluded from the all-inclusive encounter rate per patient visit.

3. The department shall calculate a PPS rate for a new FQHC, FQHC look-alike, or RHC as outlined in Section B below.

4. The department shall adjust a PPS rate per visit:
   a. By the percentage increase in the MEI applicable to FQHC, FQHC look-alike, or RHC services on July 1 of each year; and
   b. In accordance to Section C below.
      (1) Upon request and documentation by an FQHC, FQHC look-alike, or RHC that there has been a change in scope of services; or
      (2) Upon review and determination by the department that there has been a change in scope of services.
5. A rate established in accordance with this State Plan Amendment shall not be subject to an end of the year cost settlement.

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

1. Newly qualified FQHCs/RHCs, after fiscal year 2000, will have initial payments established either by reference to payments to other FQHCs/RHCs with similar caseloads, or in the absence of such other FQHCs/RHC facilities, through cost reporting methods. Further, the costs that must be considered in calculating the payment rate are those reasonable costs used in calculating the rates for FQHCs/RHCs with similar caseloads. After the initial year, PPS shall be set using the actual cost of the FQHC/RHC and trended annually by the Medicare Economic Index (MEI).

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

C. Alternative Payment Methodology

Kentucky Medicaid has established an Alternate Payment Methodology (APM) effective July 1, 2014, for services provided on and after July 1, 2014, consistent with 1902(bb)(6) of the Social Security Act, Section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000, and SMDL #01-014 dated 1/19/2001. The Alternate Payment Methodology, available to both newly qualified and established centers shall be 125% of the Medicare Upper Payment Limit for RHC's as of September 30, 2014. An FQHC, FQHC look-alike or RHC may choose the higher of the PPS rate developed as per the above guidelines, or the APM.

D. Change in Scope and PPS Rate Adjustment.

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

2. An adjustment to a PPS rate resulting from a change in scope that occurred after an FQHC's, FQHC look-alike's, or RHC's base year shall be effective within six months of notification by the health center provided sufficient documentation has been provided to the state.

3. A change in scope of service shall be restricted to:
   a. Adding or deleting a covered service;
   b. Increasing or decreasing the intensity of a covered service; or
   c. A statutory or regulatory change that materially impacts the services type, intensity, duration and/or amount of services of an FQHC, FQHC look-alike, or RHC.

4. The following *items* individually shall not constitute a change in scope:
   a. A general increase or decrease in the costs of existing services;
   b. An expansion of office hours;
   c. An addition of a new site that provides the same Medicaid covered services;
   d. A renovation or other capital expenditure;
   e. A change in ownership.

5. A change in scope or intensity shall include an increase or decrease, by at least five (5) percent. Additionally, the change must be demonstrated by a provider over a reasonable period of time to be evaluated by the state in consultation with the provider.

6. The following documents shall be submitted by the provider, to the department, within six (6) months of the effective date of a change in scope:
   a. A narrative describing the change in scope;

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

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

c. A completed MAP 100501, Prospective Payment System Rate Adjustment, *completed according to the Instructions for Completing the MAP 100501 Form* - http://chfs.ky.gov/NR/rdonlyres/0876931B-F876-4700-B1D3-4C51CD0A2A71/0/1055.pdf.

7. The department shall:
   a. Review the documentation; and
   b. Notify the FQHC, FQHC look-alike, or RHC in writing of the approval or denial of the request for change in scope within ninety (90) business days *from the date the department received the request.*

8. If the department requests additional documentation to calculate the rate for a change in scope, the FQHC, FQHC look-alike, or RHC shall:
   a. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or
   b. Request an extension beyond thirty (30) days to provide the additional documentation.
   c. If the provider does not submit the requested material within the specified timeframes, this may delay implementation, by the state, of any approved change in scope and service.

E. Exceptions

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

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

1. If a managed care organization's reimbursement to an FQHC, FQHC look-alike, or RHC for a visit by an enrollee to the FQHC, FQHC look-alike, or RHC is less than what the FQHC, FQHC look-alike, or RHC would receive pursuant to above guidelines, the department shall supplement the reimbursement made by the managed care organization in a manner that:
   a. Equals the difference between what the managed care organization reimbursed, in total, and what the reimbursement would have been if it *had* been made in accordance with the above PPS or APM methodology for FFS members;
   b. Is in accordance with 42 U.S.C. 1396a(bb)(5)(A); and
   c. FQHCs/RHCs must report all managed care payments to the state, whether or not a particular beneficiary received a service, in order for the state to determine if wrap-around payments must be made.

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

XVII. REH

A. In-State Rural Emergency Hospital Service Reimbursement.

1. a. The department shall reimburse on an interim basis for in-state rural emergency hospital services at a facility specific outpatient cost-to-charge ratio based on the facility's most recently filed Medicaid cost report.

b. An outpatient cost-to-charge ratio shall be expressed as a percent of the rural emergency hospital's charges.

2. A facility specific outpatient cost-to-charge ratio paid during the course of a rural emergency hospital's fiscal year shall be designed to result in reimbursement, at the rural emergency hospital's fiscal year end, equaling one-hundred and one (101) percent of a facility's total allowable Medicaid outpatient costs incurred during the rural emergency hospital's fiscal year.

3. Except as established in item 4. of the In-State Rural Emergency Hospital Services section:

a. Upon reviewing an in-state rural emergency hospital's as submitted Medicaid cost report for the hospital's fiscal year, the department shall preliminarily settle reimbursement to the facility equal to one-hundred and one (101) percent of the facility's allowable Medicaid outpatient costs incurred in the corresponding fiscal year; and

b. Upon receiving and reviewing an in-state rural emergency hospital's finalized Medicaid cost report for the hospital's fiscal year, the department shall settle final reimbursement to the facility equal to one-hundred and one (101) percent of the facility's total allowable Medicaid outpatient costs incurred in the corresponding fiscal year.

4. These services shall be limited to the facility's aggregate limit established in 42 C.F.R. 447.321.

5. In accordance with 42 USC 1396r-8(a)(7), a rural emergency hospital shall include the corresponding National Drug Code (NDC) when billing a physician administered drug in the rural emergency hospital setting.

6. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 5 will be bundled with the fixed rate payment and not reimbursed separately.

B. Out-of-State Rural Emergency Hospital Service Reimbursement. Excluding services provided in a laboratory, reimbursement for a rural emergency hospital service provided by an out-of-state rural emergency hospital shall be ninety-five (95) percent of the average in-state outpatient hospital cost-to-charge ratio times the Medicaid covered charges billed by the out-of-state rural emergency hospital.

XVII. REH (cont.)

C. Cost Reporting Requirements.

1. An in-state rural emergency hospital participating in the Medicaid program shall submit to the department a copy of the Medicare cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1, the Supplemental Medicaid Schedule KMAP–4 and the Supplemental Medicaid Schedule KMAP-6 as follows:

   a. A cost report shall be submitted:

      (1) For the fiscal year used by the hospital; and

      (2) Within five (5) months after the close of the rural emergency hospital's fiscal year.

   b. Except as follows, the department shall not grant a cost report submittal extension:

      (1) The department shall grant an extension if an extension has been granted by Medicare. If an extension has been granted by Medicare, when the facility submits its cost report to Medicare it shall simultaneously submit a copy of the cost report to the department; or

      (2) If a catastrophic circumstance exists, as determined by the department (for example flood, fire, or other equivalent occurrence), the department shall grant a thirty (30) day extension.

2. If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a completed cost report is received.

3. If a cost report indicates payment is due by a rural emergency hospital to the department, the rural emergency hospital shall submit the amount due or submit a payment plan request with the cost report.

4. If a cost report indicates a payment is due by a rural emergency hospital to the department and the rural emergency hospital fails to remit the amount due or request a payment plan, the department shall suspend future

payment to the rural emergency hospital until the hospital remits the payment or submits a request for a payment plan.

5. A cost report submitted by a rural emergency hospital to the department shall be subject to departmental audit and review.

6. Within seventy (70) days of receipt from the Medicare intermediary, a rural emergency hospital shall submit to the department a printed copy of the final Medicare-audited cost report including adjustments.

7. a. If it is determined that an additional payment is due by a rural emergency hospital after a final determination of cost has been made by the department, the additional payment shall be due to the department within sixty (60) days after notification.

   b. If a rural emergency hospital does not submit the additional payment within sixty (60) days, the department shall withhold future payment to the rural emergency hospital until the department has collected in full the amount owed by the rural emergency hospital to the department.