TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

FQHC and RHC Cost Reporting Guidelines for Kentucky Medicaid

Presented by the Department for Medicaid Services

May 2026

Preface

This manual has been created to provide a structural tool for providers, preparers, and users of the Universal Cost Report (UCR) to use to establish prospective payment system (PPS) rates in the Commonwealth of Kentucky. This manual is designed to assist providers in understanding the rate setting process, the nature of reasonable cost, and how PPS rates are established. This manual should enhance efficiency and provide a clearer, more concise understanding of some of the more complex regulations and processes that may have been historically challenging to interpret. The goal is to expedite the Medicaid cost reporting and rate setting process to better serve the provider community.

Contents

I. Telephone/Fax Contact Listing

Resource	Contact Information
Rate Setting Branch	P: (502) 564-8196 Policy P: (502) 564-6890
Mailbox for WRAP	DMSWRAPQuestions@ky.gov
Claims and Mass Adjustment Payments (Gainwell Technologies)	P: (800) 807-1232
Cost Report Instructions, Rate Setting Contractor (Myers and Stauffer)	P: (502) 695-6870
Desk Reviews and Changes In Scope of Services	P: (888) 749-5799 F: (502) 695-3068

II. Introduction – Federally Qualified Health Centers and Rural Health Clinics

Benefits Improvement and Protection Act of 2000

In accordance with the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA), the Commonwealth implemented the PPS for reimbursing federally qualified health centers (FQHCs) and rural health clinics (RHCs) for covered services.

BIPA mandated that Medicaid agencies reimburse FQHCs and RHCs the average reasonable cost per visit, based on 1999 and 2000 cost data. The resulting rate is considered the PPS rate and is adjusted annually thereafter based on an inflationary factor, the Medicare Economic Index (MEI). For new providers entering the program after BIPA was implemented, the reasonable cost per visit is determined using the provider's "Base Year."

Department for Medicaid Services – 907 Kentucky Administrative Regulations 1:055

In response to BIPA, the Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS or the Department) promulgated 907 Kentucky Administrative Regulations (KAR) 1:055. 907 KAR 1:055 establishes, among other things, reimbursement policies for FQHCs, FQHC look-alikes, and RHCs and governs the methodology used to establish a final PPS rate.

Until a final PPS rate is established, the Department reimburses the FQHC, FQHC look-alike, or RHC an interim PPS rate based on the average final PPS rates of entities with similar caseloads. When a provider's first full 12-month fiscal year has ended, a provider must submit a final cost report with actual costs. Once actual cost data is submitted and desk reviewed or audited, the final rate is determined, and all previously submitted claims paid at the interim rate are adjusted retroactively from the date of entry

into the Medicaid program to present. This process may result in a provider owing the Department for any overpayment. This may also result in the Department owing the provider for any underpayment.

III. Cost Reports and Desk Reviews

Interim Reimbursement for New Providers

Providers will receive an interim PPS rate for covered services until the final PPS rate is established. Interim PPS rates are based on the average final PPS rates of entities with similar caseloads. According to 907 KAR 1:055, Section 5, the Department considers four criteria to identify an entity with a similar caseload entity type (FQHC, FQHC look-alike, or RHC); managed care organization (MCO) region; operating hours per day, days per week, and weeks per year; and specialty services, obstetrical services, or hospital-based entities, if applicable.

Cost Report Period

Pursuant to 907 KAR 1:055, Section 4, a provider must submit its final cost report (also referred to as Base Year cost report) by the end of the fifth month following the end of the provider's designated base year. Base Year means the first full fiscal year following the effective date of enrollment in Kentucky Medicaid in which the provider has reached its maximum hours per day, days per week, and weeks per year of intended operation, not to exceed 24 months from the Medicaid effective date. Near the end of the first full fiscal year following the effective date, the rate setting contractor will contact the provider to request information about visits so the Department can determine whether the provider has operated at its full intended level of operation during that time. The Department will use this information to determine the provider's designated base year.

The Universal Cost Report and Instructions

Final PPS rates are determined using data reported in the UCR. To access the UCR and its corresponding instructions, start by visiting the Provider Information page on the CHFS website. From there, navigate to the section for the clinic's provider type — either RHC or FQHC.[1]

Accrual Method of Accounting

The cost report must be submitted on an accrual basis of accounting. If a cash basis of accounting was used to prepare the financial statements and trial balance, a list of adjustments necessary to convert financial information to an accrual basis of accounting must be submitted.

Timeline of Cost Report

Upon receipt of the cost report, a preliminary review will be performed to determine if all required documentation has been submitted. If the cost report is incomplete, or if all required documentation has not been submitted, the Department's rate setting contractor will contact the provider to request

[1] Kentucky CHFS. Universal Cost Report Form.

corrections or missing documentation. A delinquent letter will be issued regarding cost reports not received by the rate setting contractor within the specified timeframe.

Upon receipt of a complete cost report and all required documentation, the Department reviews the cost report within 90 business days. The Department will notify the provider if additional documentation is necessary. If additional documentation is necessary, the provider will have 30 days to provide the documentation or request an extension. The Department will grant one extension not to exceed 30 days.

For claims to be completely processed and finalized, a paid claims listing will not be requested until at least 14 months after the fiscal year end of the cost report. If all necessary information has been received, the Department will begin the process to establish a final PPS rate within 45 days of reviewing the paid claims listing. Please see Finalizing Cost Report Data section for more details.

Non-Responsive Providers

Federal guidelines and the Department require providers to maintain records related to costs and claims submitted. If, after multiple requests, a provider has not submitted the requested information necessary to establish the interim or final PPS rate, the Department reserves the right to end date the provider's Medicaid number and/or move the provider to the physician fee schedule for reimbursement purposes.

Final Rate Setting

Upon receipt of the provider's completed cost report, the rate setting contractor will perform a clerical review to determine reasonableness and identify obvious material errors. If material errors exist, the cost report may be returned to the provider for correction and resubmission. The cost report must also be submitted with a minimum amount of data to be considered complete and ready for review. During the desk review, the rate setting contractor may also request additional information to better understand the center/clinic or a transaction and/or to determine if a cost is allowable for rate setting purposes. In general, the following information should be submitted along with the cost report filing:

- Name, phone number, and email of the person to contact for questions and/or additional information related to the cost report review.
- Cost report that is formatted in Microsoft Excel and completed using the accrual method of accounting.
- Certification by the Officer or Administrator's schedule of the cost report with original signature.
- A complete copy of the Medicare cost report for the base/cost report year, if applicable.
- Completed Cost Checklist with original signature.
- Working trial balance and lead schedules, including revenue, expenses, etc.
- Vaccine tables.
- Supporting documentation for medical director (compensation, hours worked, and credentials).

- Financial statements — audited, if available.
- Depreciation schedules that include costs, useful life, and depreciation method.
- Monthly encounter supporting documentation.
- Scope of Services Survey (baseline documentation) available at: Medicaid Assistance Program Forms.
- Work papers for cost report adjustments and reclassifications.
- Floor plan, including square footage allocated to cost centers.
- List of affiliates or related parties, if any.
- Independent contractor physician agreements.
- Supporting documentation for any travel expense included on the cost report, specifically identifying out-of-state travel.
- Copies of any contracts over $10,000.
- Breakdown of hours and wages by location for all employees working at more than one clinic.
- Supporting documentation for all staff, including the following:
    - Position.
    - Full-time equivalents/annual hours.
    - Visits/encounters (when applicable).
    - Compensation.
    - Specialty (when applicable).
    - Indicate single or multispecialty clinic.

Finalizing Cost Report Data

The Department reserves the right to conduct an on-site audit when deemed necessary. In accordance with the provider enrollment agreement, the provider is expected to cooperate fully with on-site auditors.

Prior to issuing the final rate, the rate setting contractor will share the draft desk review adjustments with the provider. The provider has 30 days to review and comment on any adjustments. After this period, the rate will be finalized. Once finalized, the provider will receive a final adjusted cost report and calculated rate.

Appeals

A provider may request a dispute resolution meeting (DRM) to discuss issues related to establishing their PPS rate. At the conclusion of the DRM, the Department has 30 days to issue a decision letter. If a

provider is dissatisfied with the decision letter, the provider can request an Administrative Hearing. The DRM and administrative hearing processes are outlined in 907 KAR 1:671.

IV. Desk Review Information

A variety of desk review procedures will be conducted to determine the reasonable cost per visit. The following items are provided for clarification purposes and are not intended to be all-inclusive.

Reasonable Cost Reimbursement

Per 42 Code of Federal Regulations (CFR) Part 413.9, reimbursement will be based on the reasonable costs of services related to patient care. For a cost to be related to patient care, it must be necessary and proper in delivering services. These costs may be direct or indirect and include normal standby costs.

Costs from the provision of luxury items or services are not allowable. Items or services substantially more expensive than what is generally considered necessary will be considered luxury items or services. Other costs that would be considered not related to patient care include expenses that are unusual or not generally accepted within the provider's field of practice.

Operating Hours

The Department will review clinics operating fewer than 40 hours per week during a standard work week to determine if adjustments to costs or visit volumes are needed to calculate a fair PPS rate. Clinics with limited operating hours will not be permitted to spread excessive costs over a small number of visits.

Satellite Locations and Mobile Units

Satellite locations for FQHCs are reimbursable through the PPS rate if the location has been properly licensed during the period. For locations that obtained a license to operate a satellite in the middle of the base year, an allocation of costs and visits for the time licensed will be performed. RHCs are not eligible for satellite locations.

RHCs may be permanent or mobile units, per 42 CFR 491.5. The mobile unit should have a fixed schedule of location(s) and contain all objects, equipment, and supplies necessary to furnish the services directly provided by the clinic. The normal considerations for certification of rural area location and a service shortage area still apply.

The Department will cover services provided to a Medicaid-eligible RHC patient in a location other than the RHC by a physician compensated under an agreement with the RHC, per 907 KAR 1:082.

Related-Party Transactions

According to Generally Accepted Accounting Principles (GAAP), a related party is an entity or person with which a reporting entity has a relationship that could give them the ability to control or influence the other party's management or operations:

- **Management.** The entity's management and their immediate family members.
- **Owners.** The entity's principal owners and their immediate family members.
- **Affiliates.** Affiliates of the entity.
- **Trusts.** Trusts for the benefit of employees, such as pension and profit-sharing trusts.
- **Other parties.** Other parties that could significantly influence the entity's management or operations.

A related-party transaction is a business arrangement between two related parties. These transactions are not illegal, but they can create conflicts of interest and may favor close associates of the business. Additionally, related-party transactions must be considered "arms-length" transactions. An "arms-length" transaction means that the buyer and seller of a product or service are independent, and the transaction is made freely without influence from any special relationship, such as a relative, other business association, personal association, or one party having control over the other. It is important to determine if a transaction is "arms-length" to demonstrate that the price, requirements, arrangements, and conditions are fair, appropriate, and reflect the actual costs received for similar services in the open market. This ensures the costs are considered reasonable and allowable for the PPS rate determination.

In accordance with GAAP, related-party transactions are recorded at the lower cost to the providing organization or market cost. 42 CFR 413.17 is consistent with GAAP guidance for related-party transactions. Costs applicable to services, facilities, and supplies furnished to the clinic by organizations related to the clinic by common ownership or control are includable at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

If the clinic obtains services, facilities, or supplies from an organization that is owned or controlled by its owner(s), even though it is a separate legal entity, in effect, the items are obtained from itself. An example would be a corporation building a clinic and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider may not exceed the market price.

In practice, the allowable cost to be included on the cost report is equal to the cost incurred by the supplying organization to maintain the property. Examples of these allowable costs are building depreciation, property maintenance costs, property insurance, and real property taxes. Any expenses

paid by the clinic itself to operate from the property should be reported separately on the cost report as operating expenses.

Any related-party transactions would be adjusted in a similar situation, although rent is the most commonly found related-party transaction.

Overhead Allocations

A reasonableness review will be performed on any overhead allocation or step down of cost. Step down of cost and overhead should be allocated based on reasonable statistics, which are commonly acceptable to the Centers for Medicare & Medicaid Services (CMS) and found on the Medicare cost report. Overhead must be reasonable and related to patient care before being allowed as part of the PPS rate.

Visits

In accordance with 907 KAR 1:055, Section 1(37), a visit is defined as an in-person or telehealth (as authorized by 907 KAR 3:170) encounter between a patient and a health care provider during which an FQHC, FQHC look-alike, or RHC service is delivered. Visits are limited to one visit per patient per day (907 KAR 1:055, Section 11[1]). An encounter with more than one health care provider or multiple encounters with the same provider at the same location on the same day constitutes a single visit.

Managed Care Visits

The PPS rate determines the overall reimbursement rate for both patients covered by Medicaid and those covered by MCOs (through supplemental payments). Therefore, MCO visits should be included in Title XIX visits to appropriately divide the clinic's expenses over the entire population covered by the PPS rate.

Hospital Visits

In accordance with 907 KAR 1:055, Section 11(3), a provider may bill for services provided to a patient in a hospital if the FQHC, FQHC look-alike, Primary Care Center (PCC), or RHC has previously provided care to the patient at the clinic's location prior to the hospital admission.

If a clinic employs physicians solely to conduct patient rounds at the hospital and these physicians do not see patients in the clinic, their entire compensation, along with any related costs for performing hospital visits, must be excluded from the cost report used to calculate the PPS rate.

During the desk review, Medicaid visits and procedures are adjusted to match Medicaid records in the Department's Medicaid Management Information System (MMIS). Visits will be adjusted to the amount of non-crossover visits paid at an amount greater than zero, while procedures will be adjusted to the amount of non-crossover claims. To capture all claims, Medicaid claim information will be available at a minimum of 14 months following the cost report fiscal year end.

Long-Term Care Visits

FQHCs and RHCs may bill through the PPS rate for visits provided to a clinic patient being seen at a long-term care (LTC) facility by an established clinic provider. As a result, costs and visits associated with LTC visits should be included on the cost report.

Visits to Other Locations

This is not an exhaustive list of valid places of service. Complete lists of valid place-of-service codes for FQHCs and RHCs can be found under Provider Billing Instructions[2] on the Provider Relations page of the Kentucky MMIS website. Please note that visits performed at other locations must be in accordance with 907 KAR 1:055. They must meet the definition of a visit and the recipient must have been seen at the FQHC or RHC location prior to services at the other location. Any related costs must meet the definition of reasonable cost.

Laboratory Procedures

Contracted Laboratory Procedures

Laboratory costs and procedures should be classified in the following manner:

- If laboratory analysis is performed in house, costs associated with the laboratory (e.g., salary or supplies) should be reported on line 19 of the UCR. In-house laboratory procedures should be included in the 'Laboratory' line on Schedule C of the UCR.
- If a contracted laboratory is used for laboratory procedure analysis, the following guidelines apply:
    - If the contracted laboratory bills Medicaid for the procedure, any contractual fees paid to the agency will be reviewed for reasonableness. These fees should be included in either line 18a or line 19 of the cost report, depending on the classification of Clinical Laboratory Improvement Amendments (CLIA) laboratory procedures as discussed in the next section. Minimal costs associated with blood draws (e.g., salary or supplies) should be included on line 18a of the UCR since a nursing service has been provided. Laboratory procedures should not be included in the 'Laboratory' line on Schedule C of the UCR.
    - If the clinic bills Medicaid for the procedure, any contractual fees paid to the agency should be reported on line 19 of the UCR. Minimal costs associated with blood draws (e.g., salary or supplies) should be included on line 18a of the UCR, since a nursing service has been provided. Laboratory procedures should be included in the 'Laboratory' line on Schedule C of the UCR.

CLIA-Waived Laboratory Procedures

CLIA-waived laboratory costs and procedures should be classified in the following manner:

[2] Kentucky CHFS, Kentucky Medicaid Management Information System. Provider Billing Instructions. May 15, 2019.

- If the provider has an in-house laboratory that performs both CLIA-waived tests and complex analysis, the cost of lab salaries and supplies should be included on line 19 of the UCR.
- If the provider has an in-house laboratory that performs only CLIA-waived tests, the costs for CLIA-waived procedures, if they cannot be segregated from Medical and Nursing costs, should be reported on line 18a of the UCR. In this scenario, CLIA-waived procedures should be excluded from Schedule C of the cost report.

Compensation

Compensation will be reviewed in multiple ways. Per CMS guidance, compensation must be paid to all employees, regardless of ownership status. Owners and related parties may be employed by the center, but all compensation must be considered an "arms-length" transaction.

Compensation paid during the cost report period will be allowed for services performed that are related to patient care, provided that paid compensation is reasonable for the services performed and does not include a profit element. Owners' personal expenses should not be commingled with center/clinic expenses in the trial balance or on the cost report.

Compensation will also be reviewed for imputed salaries. Imputed salaries are taxable noncash items or services given or provided to an employee. These items or services are not allowable as compensation paid during the cost report period.

Health Care Providers

Compensation paid to health care providers (as defined in 907 KAR 1:055, Section 1[14]) will be inspected using the Medical Group Management Association (MGMA) Physician Compensation and Production Survey Report. The MGMA is a nationally recognized publication that surveys compensation in various regions throughout the United States. The Department will use metrics from the Southern Region (which includes Kentucky) when determining if compensation is reasonable based on the number of visits the physician or service provider is performing.

Medical Directors

Medical Director compensation, like physician compensation, will be reviewed using the MGMA Medical Directorship and On-Call Compensation Survey based on annual hours worked in the Medical Director capacity that is documented with adequate time records. Compensation paid to the Medical Director will be allowed if determined reasonable, using data from the MGMA report.

Other Staff Members

All other staff members' compensation paid will be reviewed for reasonableness. If employee compensation appears unusually high for the position held within the clinic/center, the rate setting contractor may inquire further about the position to determine if a related-party transaction exists. If a provider is paying an employee significantly more than what is considered reasonable in the open market, a rate setting adjustment will be made to cap compensation for calculating the PPS rate. This

determination will rely on commonly available salary surveys to assess reasonable pay within the provider's region of the Commonwealth.

Profit Sharing and Excess Fund Balance

In accordance with CMS guidance, profit is not an allowable expense for reimbursement purposes. Therefore, a clinic that operates under a for-profit status will be reviewed to ensure that owners' profit is not built into the PPS rate. Likewise, not-for-profit entities will be reviewed to ensure that any excess fund balance is not claimed for reimbursement through the PPS rate. Any items deemed as profit or excess of receipts over expenditures will be removed from the reasonable, allowable cost determination.

Compensation programs established to pay employees and/or owners a bonus based on year-end profit, or anything related to profit, are not allowable costs in determining the PPS reasonable rate.

Leases

Leases, in general, are a reasonable and allowable expense. However, the rate setting contractor will review documentation related to property leases or other contracts/leases for reasonableness and may analyze the transaction for areas, such as related-party leases, leases of property shared with other businesses or provider types, etc. In general, for shared property, an allocation must be performed that is reasonable in determining costs for purposes of the PPS rate determination.

Automobile leases are generally not allowed unless the automobile is for business purposes, and then a reasonableness determination will be made for purposes of establishing the rate.

Depreciation

The cost report instructions clearly describe that the cost report is to be completed using the accrual method of accounting and that GAAP should be used. GAAP requires that any asset with a useful life be depreciated. For purposes of determining the PPS rate, any asset with a useful life of two years or greater and with a value of $5,000 or greater should be depreciated. Therefore, the rate setting contractor performing the desk review will review trial balance accounts to identify any depreciable assets over $5,000 that were expensed.

Vaccinations

Vaccinations for children under 18 are provided free of charge through the Vaccines for Children (VFC) program and, per 907 KAR 1:055, Section 11(2), should not be reported as a cost on the cost report. Furthermore, since vaccines from the VFC program are exclusively available for Medicaid-eligible children, the costs of vaccines administered to non-Medicaid eligible patients must also be excluded from the rate setting calculation. These costs should not be factored into the determination of the Medicaid PPS rate.

All adult vaccines are allowable. For purposes of determining the PPS rate, a listing of adult vaccinations can be submitted with your cost report. The listing should include the Current Procedural Terminology (CPT) code, vaccine, expense amount, and trial balance account or cost report line. These vaccinations will be considered an allowable cost for establishing the PPS rate using the current Medicaid Pay Code schedule.

In-State and Out-of-State Travel and Education

Out-of-state travel expense is not allowed except for educational training for licensed professionals. Company meetings held out of state are not allowed. Because RHCs are stand-alone clinics without satellites, the cost incurred by clinic employees for travel between RHCs and costs to transport patients are not allowed for inclusion on the cost report. Patient transportation may be reimbursable through other Medicaid programs.

Allowable travel and education costs will be reviewed for reasonableness.

Recruitment

Recruitment expenses are generally allowable. These expenses will be tested for reasonableness during the desk review.

Advertising

In accordance with 42 CFR 413.9, advertising intended to increase patient volume is not allowable on the cost report for purposes of determining the PPS rate. Exceptions include telephone directory listings and newspaper advertising solely to hire employees for the clinic/center.

Advertising costs will be reviewed during the desk review. The provider should submit documentation to support the cost of the advertisements, place of advertisements, purpose of advertisements, and content of advertisements.

Meals and Entertainment

Generally, meals and entertainment are not allowable on the cost report for purposes of determining the PPS rate per 42 CFR 413.9. The costs of meals served to executives in separate executive dining facilities, by separate executive food staff, or from an executive menu, are not allowable.

Reasonable unrecovered cost of a provider's personnel meals is allowable when deemed a fringe benefit related to patient care. An example of this would be employee meals for meetings or conferences or employee meals when providers work through lunch to provide patient care during mealtime. Additionally, costs incurred for purposes of employee morale, such as an annual employee picnic, holiday party, or award ceremony, are allowable to the extent they are reasonable. However, retirement party expenses are not considered an allowable cost associated with patient care for purposes of determining the PPS rate.

Gifts

Generally, gifts are not allowable on the cost report for purposes of determining the PPS rate, as outlined in 42 CFR 413.9. Fringe benefits designed to increase employee work efficiency and productivity, reduce personnel turnover, or increase employee morale may be allowable. Costs incurred by providers for purposes of employee morale, such as an annual employee picnic, an annual Christmas or holiday party, an annual employee award ceremony, or sponsorship of employee athletic programs (e.g., bowling, softball, basketball teams) are allowable to the extent that they are reasonable. However, gifts, such as flowers or other items given during times of bereavement are not allowable and must be excluded from the cost report.

Bad Debt Expense

Bad debt expense is not allowable on the cost report for purposes of determining the PPS rate per 42 CFR 413.9.

Political Contributions

Political contributions are not allowable on the cost report for purposes of determining the PPS rate per 42 CFR 413.9.

Donations/Other Contributions

Costs incurred by providers for gifts, donations, or community sponsorships to charitable, civic, educational, or medical entities are not allowable on the cost report for purposes of determining the PPS rate per 42 CFR 413.9.

Pharmacy

Drug costs for prescriptions filled at a clinic pharmacy are not allowable on the cost report for purposes of determining the PPS rate. Pharmacy expenses are reimbursed through a separate benefit paid under the Medicaid program.

Revenue Offsets/Refunds

Any revenue from nonpatient-related services (e.g., interest revenue, rental revenue, miscellaneous revenue) should be offset up to the reported amount for the corresponding expense. Refunds are considered a reduction of revenue and are not allowable on the cost report for purposes of determining the PPS rate.

V. Rate Adjustments

Medicare Economic Index

In accordance with 907 KAR 1:055 Section 3(4)(a), providers will receive a percentage increase in their PPS rate based on the MEI on July 1 of each year.

Alternative Payment Methodology

907 KAR 1:055 Section 9 establishes an alternative payment methodology (APM) for an FQHC, FQHC look-alike, or RHC. The provider must send a written notification to the Department requesting the APM. After receiving written notification, the Department will reimburse under the APM rate instead of the existing final PPS rate. The APM becomes effective on the date the provider requested it in writing. The APM will equal 125% of the Medicare upper payment limit for RHCs in effect on September 30, 2014, and will not be adjusted for inflation. As of the date of this manual, the APM is $99.75. This APM rate is subject to change.

The final PPS rate established for the provider will be adjusted by the MEI annually and compared to the APM. Providers will receive the final PPS rate once it surpasses the APM. This process happens automatically and there is no action required of the provider.

Change in Scope of Services

A change in scope of services (CIS), as defined in 907 KAR 1:055, occurs when a provider experiences a significant change in business practice. As a result of the change, a provider may request a rate increase or decrease. The Department reserves the right to notify providers when a reduction in scope of services is noted for which the provider is still being reimbursed through the PPS rate.

To request a CIS, the provider should submit a narrative that explains the details of the change and specifies the date the new or revised services were first provided. This date is referred to as the effective date of the CIS. However, if the effective date is more than six months prior to the date the provider submits the CIS request to the Department, the effective date for rate setting purposes will be limited to no more than six months before the request submission date. Additionally, providers should submit a signed letter requesting the CIS and a completed Medicaid Assistance Program (MAP) 100501 form. To access the MAP 100501 and its corresponding instructions, start by visiting the Provider Information page on the CHFS website. From there, navigate to the section for the clinic's provider type — either RHC or FQHC.[3]

The process for a CIS rate adjustment is similar to the process for establishing a base rate. An interim CIS rate will be set using projected costs (direct and indirect) specifically related to the change, which will be reported on the MAP 100501 and supported by the provider.

A preliminary desk review of the provider's projected CIS costs will be performed to determine an interim CIS rate. This desk review focuses on areas that often require adjustment during the final review. During this process, the rate setting contractor may ask additional questions related to the CIS to gain a better understanding of the business model or expenses/visits. The intent is to set the interim CIS rate as close as possible to the final CIS rate.

[3] Kentucky CHFS. Prospective Payment System Rate Adjustment – MAP 100501.

To establish the final CIS rate, the provider will submit a final MAP 100501 form based on the first full 12 months of fiscal year data following the date the new or revised services were first provided. The final MAP 100501 will go through a desk review, during which the rate setting contractor may ask additional questions. As discussed above, the only costs that will be considered for the CIS are those specifically related to the change (direct and indirect).

Appeal rights outlined in 907 KAR 1:671 will be issued with the interim and final CIS rates. After the final CIS rate is issued and any appeal rights have been exhausted, all previously submitted claims will be retroactively adjusted to the new rate from the CIS effective date going forward.

The CIS process is outlined in 907 KAR 1:055.