Revised Submission 6.10.13

KANSAS MEDICAID STATE PLAN

Attachment 3.1A
#2.c.

Limitations of Federally Qualified Health Centers

Federally Qualified Health Centers (FQHC) are defined in section 1905(a)(2)(C) of the Social Security Act. FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nurses and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished as incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife and, for visiting nurse care, related medical supplies other than drugs and biological. Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the state plan.

Revised Submission 5.24.13

Methods & Standards for Establishing Payment Rates

Federally Qualified Health Centers

Effective January 1, 2001, federally qualified health centers enrolled in the Kansas Medicaid Program shall be reimbursed for covered services furnished to eligible beneficiaries under a prospective payment system (PPS) in accordance with the requirements of section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. An alternative payment system that assures the amount determined under the Medicaid PPS mandated by BIPA as minimum reimbursement, will also be available to providers at their option. An FQHC shall be reimbursed at the greater rate between the PPS rate and the alternative methodology rate. Under both options, reimbursement for services covered by Medicare plus dental services shall be made through an all-inclusive encounter rate determined by the agency for each qualified visit.

When a federally qualified health center furnishes "other ambulatory services" excluding dental services, the Kansas Medicaid Program shall reimburse the provider using the methodologies utilized in paying for same services in other settings, provided all requirements under the state plan are met. "Other ambulatory services" are those which do not meet the Medicare definition of federally qualified health center services, but are covered under the Medicaid state plan.

I. ENCOUNTER BILLING

The federally qualified health center program under the Kansas Medicaid Program complies with scope, definitions, criteria, and basis of payment for FQHC services under Medicare set forth in 42 CFR Part 405.2411 and 405.2446 through 405.2452, and Publication 27. In addition, Medicaid covers certain preventative services.

A. Billable Visit or Encounter

A federally qualified health center "visit" means a face-to-face encounter between a center patient and a center health care professional including a physician, physician assistant (PA), advanced practice registered nurse (APRN), nurse-midwife, dentist, dental hygienist with an "Extended Care Permit" per the Kansas Dental Practice Act, clinical psychologist, clinical social worker, and for Kan-Be-Healthy nursing assessments only, registered nurse. This may also include a visiting nurse provided all the conditions listed in I(D)(4) are fulfilled. Encounters with more than one certified health professional or multiple encounters with the same practitioner on the same day shall constitute a single visit.

B. More Than One Encounter on the Same Day

1. If the patient suffers illness or injury subsequent to the first visit on the same day, requiring additional diagnosis and treatment which are different from the first visit, the second encounter will qualify as an additional FQHC visit.
2. If the patient has a different type of visit on the same day such as a dental visit or a medical visit.

Revised Submission 5.24.13

Methods & Standards for Establishing Payment Rates

Federally Qualified Health Centers

xiii. Physical examination targeted to risk;
xiv. Visual acuity screening;
xv. Hearing screening;
xvi. Cholesterol screening;
xvii. Stool testing for occult blood;
xviii. Dipstick urinalysis;
xix. Risk assessment and initial counseling regarding risks; and
xx. For women only:
  a) Clinical breast exam;
  b) Referral for mammography; and
  c) Thyroid function test
xxi. Preventive Services do NOT include group or mass information programs, health education classes, or group education activities, including media productions and publications; eyeglasses, and hearing aids.

II. REIMBURSEMENT METHODS

Effective January 1, 2001, the Kansas Medicaid Program implemented the prospective payment system (PPS) for federally qualified health centers to conform with BIPA 2000. There are no retroactive cost settlements under this system. Effective January 1, 2013, as an alternative to the PPS, providers are offered the opportunity for reimbursement under a Alternative Prospective Payment System (APPS) that will be calculated based on 2009 and 2010 facility final cost settlements. The FQHCs will be reimbursed at the higher rate of the PPS rate or APPS rate.

A. Definitions

1. **Rate** – Payment for each qualified encounter or visit.
2. **Base Years or FY 1 & FY 2 – Current Providers** – Facility fiscal years 1999 and 2000.
3. **Base Years or FY 1 & FY 2 – New Providers** – Two facility fiscal years subsequent to the first year of business as a federally qualified health center
4. **Cost-Based Rate or Payment** – Based on reasonable cost of covered services.

Methods & Standards for Establishing Payment Rates

Federally Qualified Health Centers

5. **Baseline Rate** - Average of cost-based rates from the base years.
6. **MEI** - Percentage increase in the Medicare Economic Index for primary care services.
7. **PPS Rate or Payment** - Meets PPS requirements outlined in the BIPA 2000.
8. **Non-PPS Rate or Payment** - Does not meet BIPA requirements.
9. **Preliminary** - Derived from unaudited cost report(s) or from only one base year.
10. **Final or Finalized** - Derived from Medicare cost reports for both base years.
11. **Re-Base Years or RFY1 and RFY2** – Current Providers – Facility fiscal years 2009 and 2010.
12. **Re-Base Years or RFY1 and RFY2** – New Providers – Two facility fiscal years subsequent to the first year of business as a federally qualified health center.

B. Cost Reports

Each provider shall be required to submit a federally qualified health center cost report on facility fiscal year basis using the most recent version of Form HCFA-222-92 (Rev. July 1994) within five (5) months after the fiscal year end. Non-reimbursable costs shall be reported in the appropriate sections of the cost report and shall not be co-mingled with allowable costs. All space, equipment, personnel and other expenses associated with laboratory services shall be separated from allowable FQHC expenses, and reported as a separate cost center in the non-FQHC or non-reimbursable section.

The cost report should be supplemented by a detailed trial balance which includes cost report line numbers for cross-checking, independent auditor's report & management letter, and any additional information necessary to facilitate reconciliation of reported expenditures with the trial balance and financial statements. Support for all information must be available for review.

Methods & Standards for Establishing Payment Rates

Federally Qualified Health Centers

C. **Determination of Cost-Based Rate**

1. **Total Reasonable Cost:** Total allowable cost of FQHC core services and dental services, after overhead allocation and revenue offsets, as described in section V.
2. **Cost-based Encounter Rate:** Total reasonable cost divided by adjusted total visits.

III. PROSPECTIVE PAYMENT SYSTEM (PPS)

Under this methodology, FQHCs shall be paid prospective rates based on an average of the reasonable costs of providing covered FQHC services during the base years, with no retroactive settlement.

A. **Determination of PPS Baseline Rate**

1. **Methodology** – It will depend on the time frames covered by an availability of cost reports as follows:
   - (i) Both Base Years Full Twelve-Month Periods:
     (FY 1 Cost-Based Rate + FY 2 Cost-Based Rate) /2.
   - (ii) One or Both Base Years Less Than Twelve-Month Periods:
     [FY 1 Cost-Based Rate x No. of Mo.)+(FY 2 Cost-Based Rate x No. of Mo.)] / Total No. of Months
   - (iii) Only One Base Year Cost Report Available: Cost-based rate derived from the available cost report.
   - (iv) No Base Year Cost Report Available: The lower of current rate (eff. On 12/31/2000) or average of baseline rates of other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by Department of Commerce. The rates will be adjusted for dental services (not provided by all FQHCs).
2. **Frequency** – Once if *audited* cost reports from *both* base years are available at the time of initial rate setting, otherwise twice:
   - (i) Initial Baseline Rate: After the approval of the state plan amendment (for current providers) or at the time of enrollment (for new providers). Initial rate can be preliminary or finalized.
   - (ii) Final Baseline Rate: When audited cost reports for both base years become available.

Methods & Standards for Establishing Payment Rates

Federally Qualified Health Centers

3. **If Neither Historic Nor Budgeted Data Available:** If neither is available, the payment rate shall be the average of the rates paid to other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce, with an adjustment for dental services since they are not provided by all FQHCs.

F. **Adjustment for Laboratory**

Effective July 1, 2002, clinical diagnostic lab services furnished by a center are no longer within the scope of FQHC services under the Kansas Medicaid Program. A FQHC that provides this service will be reimbursed on fee-for-service basis. Medicare implemented this change effective January 1, 2001. KDHE will retroactively adjust PPS rates effective 7/1/02 to exclude all expenses associated with laboratory services after receiving relevant data that facilitates identification of these expenditures.

G. **Change in Scope of Services**

To receive PPS rate adjusted for a proposed increase or decrease in the scope of covered FQHC & dental services in a future fiscal year as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. At a minimum, this shall include a description of the change, budgeted expenditure, and change in total number of visits. Any rate change would be implemented on the first of the month following the KDHE decision.

IV. ALTERNATIVE METHODOLOGY – ALTERNATIVE PROSPECTIVE PAYMENT SYSTEM (APPS)

Under this methodology, FQHCs shall be paid APPS rates based on an average of the reasonable costs of providing covered FQHC services during the base years, with no retroactive settlement.

A. **Determination of APPS Rate**

1. Methodology – Determined by cost reports as follows:
   (i) Both Re-Base Years (2009 and 2010) full Twelve-Month Periods: (RFY1 Cost-Based Rate + RFY2 Cost-Based Rate)/2 and applied a trended MEI factor.

B. **Payment Procedure for January 1, 2013 to September 30, 2013.**

1. Prior to approval of this state plan, Medicaid has paid the APPS rates calculated in IV.A.1.

C. **Payment Rate Effective Each October 1 After September 30, 2013**

1. The APPS rates effective on the previous day (9/30 of the same year) shall be adjusted for the MEI index.

Methods & Standards for Establishing Payment Rates

Federally Qualified Health Centers

C. **Baseline Rate for New Providers**

1. **If Historic Cost Reports are Available:** If the facility is an established FQHC, cost-based rates from Medicare cost reports from the two most recent fiscal years will be used to determine the initial PPS baseline rate. If it is available only from one fiscal year, that will be used for rate setting, provided it is at least a twelve month period. Data covering the first year of business as a FQHC will be excluded.
2. **If No Historic Cost Reports are Available:** The payment rate shall be the average of the rates paid to other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce, with an adjustment for dental services since they are not provided by all FQHCs.
3. **If Neither Historic nor Budgeted Data Available:** If neither is available, the payment rate shall be the average of the rates paid to other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce, with an adjustment for dental services since they are not provided by all FQHCs.

D. **Change in Scope of Services**

To receive a APPS rate adjusted for a proposed increase or decrease in the scope of covered FQHC and dental services in a future fiscal year as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. At a minimum, this shall include a description of the change, budgeted expenditure, and change in total number of visits. In addition to change of scope, clinics will have the opportunity to submit a request to increase the APPS rate if costs exceed the APPS rate by 15% or more. Again, documentation must be provided to determine the case for reconsideration of the APPS rate. Any rate change would be implemented on the first of the month following the KDHE decision.

V. DETERMINATION OF REASONABLE COST

Reasonable cost consists of necessary and proper cost incurred in providing covered federally qualified health center services and dental services to all patients. Cost reimbursement principles, and coverage criteria set forth in K.A.R. 129-5-118, K.A.R. 129-5-118a, K.A.R. 129-5-118b, 42 CFR Part 405.2411 and 405.2446 through 405.2452. Medicaid state plan, Medicaid provider manual, 42 CFR Part 413, and Medicare Publications 10 & 27 shall be applied to the data submitted to Medicaid as tests of reasonableness.

A. **Review & Analysis of Reported Data**

Expenditures & income reported to Medicaid will be reconciled with the trial balance, financial statements prepared by the independent auditor, and the finalized Medicare cost report. Expenses reported as allowable, including overhead cost, will be analyzed to evaluate if they are accurate, reasonable, necessary, patient related, associated with covered services, and reported in appropriate cost centers. Revenue will be analyzed for

refunds received. Any findings will be deducted from reported expenses to yield total allowable cost. The encounter data will be analyzed for reasonableness, accuracy, inclusion of nursing assessments, and visits not meeting the definition of billable visits.

B. Revenue Offsets

Income will also be analyzed to confirm that Medicaid payments do not duplicate revenue received from other sources to cover specific programs or expenses, whether in part or whole. If such duplication is found, it will be offset before rate calculation. NOTE: Public Health Service Grants under section 329, 330, and 340 shall not be offset against expenses in determining allowable cost. To prevent such offset, the provider shall clearly identify these grants by name, not just numbers, in the supplemental data submitted with the cost report.

C. Total Reasonable FQHC & Dental Cost for the Facility

Allowable overhead (indirect) expense will be allocated to total allowable FQHC & Dental (direct) costs and total non-reimbursable (direct) expenses based on the proportion of each "direct" cost center to their summation. Post-allocation total FQHC & Dental expenses minus any revenue offsets shall be the total reasonable cost of covered FQHC and Dental services furnished to all patients, regardless of payer.

VI. SERVICES FURNISHED UNDER CONTRACT WITH MANAGED CARE ORGANIZATIONS (MCOs)

MCOs must reimburse providers using the higher rate between the PPS rate and the APPS rate. APPS rates will be re-evaluated at least every 5 years.