Revised Submission 6.10.13

KANSAS MEDICAID STATE PLAN

Attachment 3.1A
#2b

3.1-A Limitation

#2b Rural Health Clinic Services

Rural Health Centers (RHC) are defined in section 1905(a)(2)(B) of the Social Security Act. RHC 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. RHC 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 RHC are the same limitations as defined for those services in the state plan.

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Effective January 1, 2001, rural health clinics 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. A RHC will be reimbursed at the greater rate between the PPS rate and the alternative methodology rate. Under both options, reimbursement for services covered by Medicare shall be made through an all-inclusive encounter rate determined by the Medicare intermediary for each qualified encounter.

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

I. ENCOUNTER BILLING

A. Billable Visit or Encounter

A rural health clinic "visit" means a face-to-face encounter between a clinic patient and a clinic health care professional including a physician, physician assistant (PA), advanced practice registered nurse (APRN), nurse-midwife, 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 care professional or multiple encounters with the same health professional on the same day shall constitute a single visit.

B. More Than One Encounter on the Same Day

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 RHC visit.

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F. Exclusions

Services & supplies, both direct and indirect, not related to patient care and not reasonable & necessary for the efficient delivery of health care services for diagnosis & treatment of clinic patients are not covered. These should neither be billed as RHC visits nor reported on the cost report as allowable RHC expenditure. In addition, the following are not covered as RHC benefit:

1. All services furnished by the auxiliary health care staff who are not employed by the clinic.
2. Services provided by the RHC's auxiliary health care employees without direct supervision of a clinic practitioner.
3. Technical components of Radiology and EKG.
4. Clinic diagnostic laboratory services including the six required lab tests for RHC certification.
5. Health care services performed by outside entities, including those entities which are owned by the clinic's owner or staff. These include but are not limited to Lab, Radiology, EKG, pharmacy, PT, and psychotherapy. The state plan requires that providers of these services bill Medicaid directly.

II. REIMBURSEMENT METHODS

Effective January 1, 2001, the Kansas Medicaid Program will implement the prospective payment system (PPS) for rural health clinics to conform with BIPA 2000. There will be no retroactive cost settlements under this system. Effective January 1, 2013 as an alternative to the PPS, providers will be offered the opportunity for reimbursement under a Alternative Prospective Payment System (APPS) that will be calculated based on the two most recent facility final cost reports of 2008, 2009 or 2010. The RHCs will be reimbursed at the higher rate of PPS rate or APPS rate.

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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 rural health clinic.
4. **Cost-Based Rate or Payment** – Based on the Medicare cost report.
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** – Derives from the Medicare cost report for 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 – Two latest facility fiscal years of 2008, 2009, or 2010 where final Medicare cost reports were submitted.
12. **Re-Base Years or RFY1 and RFY2** – New Providers – Two facility fiscal years subsequent to the first year of business as a rural health clinic.

B. **Cost Reports**

RHC providers shall be required to submit cost reports to Medicaid. The providers will submit to the agency finalized cost reports received from Medicare intermediaries.

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F. **Adjustment for Laboratory**

Effective July 1, 2002, clinical diagnostic lab services furnished by a clinic are no longer within the scope of RHC services under the Kansas Medicaid Program. A RHC 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 date that facilitates identification of these expenditures.

G. **Change in Scope of Services**

To receive a PPS rate adjusted for a proposed increase or decrease in the scope of covered RHC 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 expenditures, 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 PAYMENT METHODOLOGY – "ALTERNATIVE PROSPECTIVE PAYMENT SYSTEM" (APPS)

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

A. **Determination of APPS Rate**

1. Methodology – Determined by two most recent available cost reports of 2008, 2009, or 2010, as follows:
   (i) Two Re-Base Years 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.

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D. **Baseline Rate for New Providers**

1. **If Historic Cost Reports Are Available:** If the facility is an established RHC, 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 RHC will be excluded.
2. **If No Historic Cost Reports Are Available:** The payment rate shall be the average of the rates paid to other RHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce.

E. **Change in Scope of Services**

To receive a APPS rate adjusted for a proposed increase or decrease in the scope of covered RHC 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.

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V. 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.

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(Reserved for future use)