

## XXXVI Specialty Intermediate Care Facility Clinic Payment Provisions

This plan provision defines the methodologies to be used by the Department in establishing individual licensed clinic interim reimbursement rates on July 1 of each year, and describes other policies relating to the rate setting and cost settlement process. The services provided at each licensed clinic are in compliance with 42 CFR 440.90 Clinic Services.

## 1. Cost Finding and Cost Reporting

- A. Each licensed clinic, physically located on the grounds of a state ICF facility which has an active state license and federal certification made by the state Office of Inspector General (the CMS designated entity responsible for conducting federal certification surveys), participating in the Kentucky Medicaid Program shall submit a combined (ICF-MR Inpatient, Clinic, and In-community Services) cost report modeled after the CMS-2552. The CMS-approved cost report will distinguish and separate inpatient (ICF-MR) from outpatient (Clinic) from In-Community (e.g., Home Health like). A legible copy will be submitted to the Department no later than four (4) calendar months after the close of the state fiscal year. The state may not modify the CMS-approved scope of cost or methods of allocating cost approved by CMS. Any modification to the scope of cost or cost allocation methodology requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.
- B. Projected cost shall be used to initiate this plan by allowing determination of the initial interim rates.
- C. Each licensed clinic physically located on the grounds of a state ICF facility is required to detail costs for its entire reporting year (which shall be the state fiscal year), making appropriate adjustments as required by this plan for determination of allowable costs. Interim rates shall be cost settled for the fiscal year. Cost settlement means that the single state agency takes all necessary actions to settle the interim payments to the provider with the actual value of services rendered as supported by the finalized cost report. As part of the cost settlement process, the state agency will use a reconciliation process on an needed basis so that provider reported cost report information is reconciled with data tracked by the agency's MMIS. The cost settlement process will include all necessary adjustments and recalculation of values so that the final retrospective settlement results in the agency paying reasonable, allowable cost for covered services provided to eligible Medicaid recipients.
- D. The cost report shall be prepared in accordance with the cost report instructions incorporated by reference in 907 KAR 3:225.
- E. A licensed clinic that does not file a legible and complete cost report within four (4) calendar months after the close of its reporting period may have its payments placed in escrow until the cost report is received.

- F. The Department shall retain all uniform cost reports submitted for a period of at least ten (10) years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of the Commonwealth's record retention requirements or federal requirements, whichever is longer. Access to submitted cost reports shall be in conformity with the Kentucky Open Records Act, KRS 61.870 *et seq.* and federal requirements.
- G. All cost reports submitted must include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Kentucky Medicaid Program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations. This cost report includes total computable cost incurred to provide Medicaid services"

2. Audits

All cost reports and related documents submitted by the providers shall be subject to reconciliation with a Paid Claims Listing, desk reviewed, desk audited, or field audited at the discretion of the Department

A. Description of the Department's Procedures for Audits – General

When audits are deemed necessary they shall be performed in accordance with the Government Auditing Standards as issued and periodically updated by the Comptroller General of the United States.

B. Retention

All audit reports issued by the Department shall be kept in accordance with Kentucky's record retention requirements for a minimum of ten (10) years and federal requirements, whichever is longer.

C. Overpayments and Underpayments

- 1) Any overpayments or underpayments for those years or partial years as determined by reconciliation, desk review, and/or desk or field audits, using approved State plans, shall be reimbursable to the provider or the Department as appropriate.
- 2) The terms of repayment shall be in accordance with 9907 KAR 1:671.
- 3) All overpayments shall be reported by the Department to the Center's for Medicare and Medicaid Services via established reporting practices.

- 4) Medicaid program sanctions and appeals shall be handled in accordance with 907 KAR 1:671.

3. Allowable Costs

Allowable costs for purposes of computing the encounter rate shall be determined using the CMS-approved cost report which incorporates Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413, and as contained in 907 KAR 3:225. These include:

- A. Cost incurred by a licensed clinic in meeting:
  - 1) The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610(c).
  - 2) Any other requirements for licensing under the State law which are necessary for providing the licensed services.
- B. A licensed clinic shall report its total cost in the cost report. However, only allowable health care service costs and the appropriate indirect overhead cost, as determined in the cost report, shall be cost settled. Non-allowable services cost and the inappropriate indirect overhead, as determined in the cost report, shall not be included in the cost settlement.
- C. Medicaid cost settlements shall be limited to an amount, if any, by which the cost for allowable claims exceeds the amount of a third party revenue recovery during the fiscal year and interim payments made by Medicaid. In addition, the reimbursement shall not exceed the amount according to 42 CFR 447.321.
- D. Under this plan, a licensed clinic shall be required to accept Medicaid reimbursement (interim payments and cost settlement) as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.

4. Standards

- A. Changes in individual licensed clinic interim rates shall be effective July 1<sup>st</sup> of each year.
- B. The most recent cost reports received by the Department as of March 15<sup>th</sup> of each year shall be used to establish the encounter rates for the following rate period.
- C. The individual licensed clinic's interim rates shall be adjusted only under the following circumstances:
  - 1) An error was made by the Department in the calculation of the licensed clinic's rate.

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- 2) A provider submits an amended cost report used to determine the rates in effect. An audited cost report may not be amended.
- 3) Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.
- D. Any interim rate adjustment or denial of a rate adjustment by the Department may be appealed by the provider in accordance with 907 KAR 1:671.
- E. A licensed clinic's reimbursable services are defined in Section II above. The services reimbursable under this plan include services rendered by the clinic's:
- physicians
  - dentists
  - physician assistants
  - nurse practitioners
  - registered nurses
  - psychologists
  - psychiatrists
  - pharmacists
  - audiologists
  - optometrists
  - dieticians
  - behavior specialists
  - certified behavior analysts
  - ophthalmologists
  - physical therapists
  - speech therapists
  - occupational therapists
  - physical therapist assistants
  - occupational therapist assistants
  - services and supplies incidental to any of the above listed individuals.
- F. Prescription drugs and immunization costs shall be reimbursed through the Pharmacy Program utilizing current fee schedules established for those services. These costs shall be reported in the cost report as non-allowable services. Medication consultation and medication management costs would be allowable and tracked separately in the appropriate cost centers.
- G. Costs relating to non-allowable clinic activities costs are to be excluded from the cost settlement and shall be separately reported in the cost report.

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5. Methods

A. Setting Individual Licensed Clinic Interim Procedure Rates.

- 1) Review and adjust each clinic's cost report available to the Department as of March 15.
- 2) Determine each clinic's interim rate by multiplying service specific charges by service specific cost-to-charge ratios, then dividing by the rate units applicable. (e.g., \$500,000 in cost times .95 CCR divided by 10,000 units = \$47.50 as an interim procedure rate.)

6. Payment Assurance

The Department shall pay each licensed clinic for services provided in accordance with the requirements of the Kentucky Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each clinic according to the standards and methods set forth in this Attachment.

7. Payment in Full

Participation in the Program shall be limited to licensed clinic's which accept payment in full for covered services in the amount paid in accordance with this plan.

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**9a. Specialty Intermediate Care Facility Clinic**

- A. Beginning on November 1, 2010, the Department shall reimburse for services described below provided at licensed clinics physically located on the grounds of a state intermediate care facility (ICF) with an active state license and federal certification (hereinafter referred to as "ICF clinics").
  
- B. Covered Services
  - 1. The Department shall reimburse ICF clinics for the following services provided onsite in accordance with the provisions of this State Plan:
    - (a) Dental services;
    - (b) Psychiatric services;
    - (c) Psychological services;
    - (d) Psychotropic medication management;
    - (e) Neurology;
    - (f) Epileptology;
    - (g) Preventative health care;
    - (h) Medical assessment and treatment;
    - (i) Occupational therapy;
    - (j) Physical therapy;
    - (k) Speech therapy;
    - (l) Nutritional/dietary consultation;
    - (m) Mobility evaluation/treatment;
    - (n) Behavioral support services
    - (o) Audiology;
    - (p) Ophthalmology;
    - (q) Pharmacy;
    - (r) Medication consultation;
    - (s) Medication management;
    - (t) Seizure management;
    - (u) Behavioral support services;
    - (v) Diagnostic services;
    - (w) Clinical laboratory services;
    - (x) Physician services; and
    - (y) Laboratory Services

C. Provider Participation

This plan is designed to assure adequate participation of licensed clinics in the Kentucky Medicaid Program, the availability of clinic services of high quality to recipients, and services which are comparable to those available to the general public. This is in accordance with 42 CFR 447.204.

D. Reimbursement Methodology is described in Attachment 4.19-B.

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