

CHAPTER 290 (SB 294)

AN ACT relating to Medicaid reimbursement for chiropractic services.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

Section 1. KRS 205.560 is amended to read as follows:

- (1) The scope of medical care for which the Cabinet for Health Services undertakes to pay shall be designated and limited by regulations promulgated by the cabinet, pursuant to the provisions in this section. Within the limitations of any appropriation therefor, the provision of complete upper and lower dentures to recipients of Medical Assistance Program benefits who have their teeth removed by a dentist resulting in the total absence of teeth shall be a mandatory class in the scope of medical care. Payment to a dentist of any Medical Assistance Program benefits for complete upper and lower dentures shall only be provided on the condition of a preauthorized agreement between an authorized representative of the Medical Assistance Program and the dentist prior to the removal of the teeth. The selection of another class or other classes of medical care shall be recommended by the council to the secretary for health services after taking into consideration, among other things, the amount of federal and state funds available, the most essential needs of recipients, and the meeting of such need on a basis insuring the greatest amount of medical care as defined in KRS 205.510 consonant with the funds available, including, but not limited to, the following categories, except where the aid is for the purpose of obtaining an abortion:
 - (a) Hospital care, including drugs, and medical supplies and services during any period of actual hospitalization;
 - (b) Nursing-home care, including medical supplies and services, and drugs during confinement therein on prescription of a physician, dentist, or podiatrist;
 - (c) Drugs, nursing care, medical supplies, and services during the time when a recipient is not in a hospital but is under treatment and on the prescription of a physician, dentist, or podiatrist;
 - (d) Physician, podiatric, and dental services;
 - (e) Optometric services for all age groups shall be limited to prescription services, services to frames and lenses, and diagnostic services provided by an optometrist, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses shall be provided only to children under age twenty-one (21);
 - (f) Drugs on the prescription of a physician used to prevent the rejection of transplanted organs if the patient is indigent;
 - (g) Nonprofit neighborhood health organizations or clinics where some or all of the medical services are provided by licensed registered nurses or by advanced medical students presently enrolled in a medical school accredited by the Association of American Medical Colleges and where the students or licensed registered nurses are under the direct supervision of a licensed physician who rotates his services in this supervisory capacity between two (2) or more of the nonprofit neighborhood health organizations or clinics specified in this paragraph;

- (h) Services provided by health-care delivery networks as defined in KRS 216.900; and (i) Services provided by midlevel health-care practitioners as defined in KRS 216.900.
- (2) Payments for hospital care, nursing-home care, and drugs or other medical, ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount of the payment to the cost of providing the services or supplies. It shall be one (1) of the functions of the council to make recommendations to the Cabinet for Health Services with respect to the bases for payment. In determining the rates of reimbursement for long-term-care facilities participating in the Medical Assistance Program, the Cabinet for Health Services shall, to the extent permitted by federal law, not allow the following items to be considered as a cost to the facility for purposes of reimbursement:
- (a) Motor vehicles that are not owned by the facility, including motor vehicles that are registered or owned by the facility but used primarily by the owner or family members thereof;
 - (b) The cost of motor vehicles, including vans or trucks, used for facility business shall be allowed up to fifteen thousand dollars (\$15,000) per facility, adjusted annually for inflation according to the increase in the consumer price index-u for the most recent twelve (12) month period, as determined by the United States Department of Labor. Medically equipped motor vehicles, vans, or trucks shall be exempt from the fifteen thousand dollar (\$15,000) limitation. Costs exceeding this limit shall not be reimbursable and shall be borne by the facility. Costs for additional motor vehicles, not to exceed a total of three (3) per facility, may be approved by the Cabinet for Health Services if the facility demonstrates that each additional vehicle is necessary for the operation of the facility as required by regulations of the cabinet;
 - (c) Salaries paid to immediate family members of the owner or administrator, or both, of a facility, to the extent that services are not actually performed and are not a necessary function as required by regulation of the cabinet for the operation of the facility. The facility shall keep a record of all work actually performed by family members;
 - (d) The cost of contracts, loans, or other payments made by the facility to owners, administrators, or both, unless the payments are for services which would otherwise be necessary to the operation of the facility and the services are required by regulations of the Cabinet for Health Services. Any other payments shall be deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health Services. Interest paid to the facility for loans made to a third party may be used to offset allowable interest claimed by the facility;
 - (e) Private club memberships for owners or administrators, travel expenses for trips outside the state for owners or administrators, and other indirect payments made to the owner, unless the payments are deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health Services; and
 - (f) Payments made to related organizations supplying the facility with goods or services shall be limited to the actual cost of the goods or services to the related organization, unless it can be demonstrated that no relationship between the facility and the supplier exists. A relationship shall be considered to exist when an individual, including brothers, sisters, father, mother, aunts, uncles, and in-laws, possesses a total of five percent (5%) or more of ownership equity in the facility and the supplying business.

An exception to the relationship shall exist if fifty-one percent (51%) or more of the supplier's business activity of the type carried on with the facility is transacted with persons and organizations other than the facility and its related organizations.

- (3) No vendor payment shall be made unless the class and type of medical care rendered and the cost basis therefor has first been designated by regulation.
- (4) The rules and regulations of the Cabinet for Health Services shall require that a written statement, including the required opinion of a physician, shall accompany any claim for reimbursement for induced premature births. This statement shall indicate the procedures used in providing the medical services.
- (5) The range of medical care benefit standards provided and the quality and quantity standards and the methods for determining cost formulae for vendor payments within each category of public assistance and other recipients shall be uniform for the entire state, and shall be designated by regulation promulgated within the limitations established by the Social Security Act and federal regulations. It shall not be necessary that the amount of payments for units of services be uniform for the entire state but amounts may vary from county to county and from city to city, as well as among hospitals, based on the prevailing cost of medical care in each locale and other local economic and geographic conditions, except that insofar as allowed by applicable federal law and regulation, the maximum amounts reimbursable for similar services rendered by physicians within the same specialty of medical practice shall not vary according to the physician's place of residence or place of practice, as long as the place of practice is within the boundaries of the state.
- (6) Nothing in this section shall be deemed to deprive a woman of all appropriate medical care necessary to prevent her physical death.
- (7) To the extent permitted by federal law, no medical assistance recipient shall be recertified as qualifying for a level of long-term care below the recipient's current level, unless the recertification includes a physical examination conducted by a physician licensed pursuant to KRS Chapter 311 or by an advanced registered nurse practitioner licensed pursuant to KRS Chapter 314 and acting under the physician's supervision.
- (8) If payments made to community mental health centers, established pursuant to KRS Chapter 210, for services provided to the mentally retarded exceed the actual cost of providing the service, the balance of the payments shall be used solely for the provision of other services to the mentally retarded through community mental health centers.
- (9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to recipients of medical assistance under Title XIX of the Social Security Act on July 15, 1986, shall deny admission of a person to a bed certified for reimbursement under the provisions of the Medical Assistance Program solely on the basis of the person's paying status as a Medicaid recipient. No person shall be removed or discharged from any facility solely because they became eligible for participation in the Medical Assistance Program, unless the facility can demonstrate the resident or the resident's responsible party was fully notified in writing that the resident was being admitted to a bed not certified for Medicaid reimbursement. No facility may decertify a bed occupied by a Medicaid recipient or may decertify a bed that is occupied by a resident who has made application for medical assistance.
- (10) Family-practice physicians practicing in geographic areas with no more than one (1) primary-care physician per five thousand (5,000) population, as reported by the United States

Department of Health and Human Services, shall be reimbursed one hundred twentyfive percent (125%) of the standard reimbursement rate for physician services.

- (11) The Cabinet for Health Services *shall*~~may~~ make payments under the Medical Assistance program for services which are within the lawful scope of practice of a chiropractor licensed pursuant to KRS Chapter 312, to the extent the Medical Assistance Program pays for the same services provided by a physician.

Approved April 3, 2000