

907 KAR 1:045. Reimbursement provisions and requirements regarding community mental health center services.

RELATES TO: KRS 205.520(3), 205.8451, 210.370-210.485, 42 C.F.R. 400.203, 413, 438.2, 447.325, 42 U.S.C. 1396n(c), 1396r-8(a)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6313, 42 U.S.C. 1396a

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. KRS 205.6313(4) requires the cabinet to promulgate administrative regulations to implement Medicaid reimbursement for primary care practitioners at community mental health centers. This administrative regulation establishes the reimbursement provisions and requirements regarding community mental health center services provided to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. Definitions. (1) "1915(c) home and community based waiver services provider" means a Kentucky Medicaid program established pursuant to, and in accordance with, 42 U.S.C. 1396n(c).

(2) "Allowable costs" means that portion of a facility's cost that may be allowed by the department for reimbursement purposes.

(3) "Community board for mental health or individuals with an intellectual disability" means a board established pursuant to KRS 210.380.

(4) "Community mental health center" or "CMHC" means a facility that meets the community mental health center requirements established in 902 KAR 20:091.

(5) "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(6) "Department" means the Department for Medicaid Services or its designee.

(7) "Enrollee" means a recipient who is enrolled with a managed care organization.

(8) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(9) "Federal indirect rate" means the rate approved by the United States Department for Health and Human Services (HHS) for grantee institutions to be used to calculate indirect costs as a percentage of direct costs.

(10) "Federal Register" means the official journal of the United States federal government that publishes government agency rules and public notices.

(11) "Healthcare Common Procedure Coding System code" means a billing code:

(a) Recognized by Medicare; and

(b) Monitored by the Centers for Medicare and Medicaid Services.

(12) "Interim reimbursement" means a reimbursement:

(a) In effect for a temporary period of time; and

(b) That does not represent final reimbursement for services provided during the period of time.

(13) "Kentucky-specific Medicare Physician Fee Schedule" means the list of current reimbursement rates for physician services established by the Centers for Medicare and Medicaid Services and available on the CMS Web site at www.cms.gov.

(14) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R.

438.2.

(15) "Medicaid allowable costs" means the costs:

(a) Associated with the Medicaid-covered services covered pursuant to 907 KAR 1:047 and 907 KAR 1:044:

1. Rendered to recipients who are not enrollees; and
 2. Not rendered as a 1915(c) home and community based waiver services provider; and
- (b) Determined to be allowable costs by the department.

(16) "Medical Group Management Association (MGMA) Physician Compensation and Production Survey Report" means a report developed and owned by the Medical Group Management Association that:

- (a) Highlights the critical relationship between physician salaries and productivity;
- (b) Is used to align physician salaries and benefits with provider production; and
- (c) Contains:

1. Performance ratios illustrating the relationship between compensation and production; and

2. Comprehensive and summary data tables that cover many specialties.

(17) "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(18) "Medicare Economic Index" means a measure of inflation:

- (a) Associated with the costs of physicians' practices; and
- (b) Published in the Federal Register.

(19) "Outreach services" means provider programs:

(a) Specifically designed to:

1. Engage recipients for the purposes of supporting Medicaid or Children's Health Insurance Program (CHIP) enrollment efforts;

2. Assist recipients with finding healthcare or coverage options; and

3. Promote preventive services for recipients; and

(b) That are directly assigned or allocated to a cost report line that is not cost settled by the department.

(20) "Payment plan request" means a request to pay an amount owed to the department over a period of time that is agreed to by the department.

(21) "Physician administered drug" or "PAD" means any rebateable covered outpatient drug that is:

(a) Provided or administered to a Medicaid recipient;

(b) Billed by a provider other than a pharmacy provider through the medical benefit, including providers who are physician offices or another outpatient clinical setting; and

(c) An injectable or noninjectable drug furnished incident to provider services that are billed separately to Medicaid.

(22) "Primary care services" means services covered as established in 907 KAR 1:047.

(23) "Provider" is defined by KRS 205.8451(7).

(24) "Rebateable" means a drug for which the drug manufacturer has entered into and has in effect a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).

(25) "Recipient" is defined by KRS 205.8451(9).

(26) "State fiscal year" means the period beginning on July 1 of a calendar year and ending on June 30 of the following calendar year.

Section 2. General Reimbursement Provisions. (1) The department shall reimburse a participating in-state community mental health center under this administrative regulation for services:

- (a) If the services are:
 - 1. Covered pursuant to:
 - a. 907 KAR 1:044; or
 - b. 907 KAR 1:047;
 - 2. Not provided by the CMHC acting as a 1915(c) home and community based waiver services provider, as those services are reimbursed based on the home and community based waiver;
 - 3. Provided to recipients who are not enrolled with a managed care organization; and
 - 4. Medically necessary; and
- (b) Based on the community mental health center's Medicaid allowable costs.
- (2) The department's reimbursement shall include reimbursing:
 - (a) On an interim basis during the course of a cost report period; and
 - (b) A final reimbursement for the state fiscal year that results from a reconciliation of the interim reimbursement amount paid to the CMHC compared to the CMHC's Medicaid allowable cost by cost center for the state fiscal year.

Section 3. Interim Reimbursement for Primary Care Services and PAD. (1) The department's interim reimbursement to a CMHC for primary care services shall depend upon the type of primary care service.

(2)(a) The department's interim reimbursement for services shall be the reimbursement established for the service on the current Kentucky-specific Medicare Physician Fee Schedule unless a reimbursement for the service does not exist on the current Kentucky-specific Medicare Physician Fee Schedule for the following:

- 1. Physician services;
- 2. Laboratory services;
- 3. Radiological services;
- 4. Occupational therapy;
- 5. Physical therapy; or
- 6. Speech-language pathology.

(b) If reimbursement for a given service listed in paragraph (a) of this subsection does not exist on the current Kentucky-specific Medicare Physician Fee Schedule, the department shall reimburse on an interim basis for the service as it reimburses for services pursuant to 907 KAR 3:010 or 907 KAR 8:045.

(3) The department's interim reimbursement for the cost of PAD in a CMHC shall be the reimbursement methodology established in 907 KAR 23:020.

Section 4. Interim Reimbursement for Behavioral Health Services. (1)(a) To establish interim rates for behavioral health services effective for dates of service through June 30, 2018, the department shall use the CMHC rates paid effective July 1, 2015.

(b) To establish interim rates for behavioral health services effective for dates of service July 1, 2018, and each subsequent July 1, the department shall use a CMHC's most recently submitted cost report that meets the requirements established in paragraph (c) of this subsection.

(c) The cost report shall comply with all requirements established in Section 5(1) of this administrative regulation.

(2) The department shall:

- (a) Review the cost report referenced in subsection (1)(b) of this section; and
- (b) Establish interim rates for Medicaid-covered behavioral health services:

- 1. To be effective July 1, 2018;
- 2. Based on Medicaid allowable costs as determined by the department through its review;

3. Intended to result in a reimbursement for Medicaid-covered behavioral health services:
 - a. Provided to recipients who are not enrollees; and
 - b. That equals the department's estimate of behavioral health services' costs for the CMHC for the period; and
 4. That shall be updated effective July 1, 2019, and each July 1 thereafter, based on the most recently received cost report referenced in subsection (1)(b) of this section.
- (3) Interim rates for behavioral health services effective July 1 each calendar year shall have been trended and indexed from the midpoint of the cost report period to the midpoint of the rate year using the Medicare Economic Index.
- (4) To illustrate the timeline referenced in subsection (2)(b)1. of this section, a cost report submitted by a CMHC to the department on December 31, 2017, shall be used by the department to establish behavioral health services' interim rates effective July 1, 2018.
- (5)(a) A behavioral health services interim rate shall not be subject to retroactive adjustment except as specified in this subsection.
- (b) The department shall adjust a behavioral health services interim rate during the state fiscal year if the rate that was established appears likely to result in a substantial cost settlement that could be avoided by adjusting the rate.
- (c)1. If the cost report from a CMHC has not been audited or desk-reviewed by the department prior to establishing interim rates for the next state fiscal year, the department shall use the cost report under the condition that interim rates shall be subject to adjustment as established in subparagraph 2. of this paragraph.
2. A behavioral health services interim rate based on a cost report that has not been audited or desk-reviewed shall be subject to adjustment when the audit or desk review is completed.
 3. An unaudited cost report shall be subject to an adjustment to the audited amount after the auditing has occurred.
- (d) Upon receipt of the cost report filed December 31, 2017, the department shall review the cost report to determine if the interim rates established in accordance with subsection (1)(a) of this section need to be revised to more closely reflect the costs of services for the interim period.

Section 5. Final Reimbursement Beginning with the State Fiscal Year that Begins July 1, 2018. (1)(a) For the state fiscal year spanning July 1, 2017, through June 30, 2018, and for subsequent state fiscal years, by December 31 following the end of the state fiscal year, a CMHC shall submit a cost report to the department:

1. In a format that has been approved by the Centers for Medicare and Medicaid Services;
2. That has been audited by an independent auditing entity; and
3. That states all of the:
 - a. CMHC's Medicaid allowable direct costs for:
 - (i) Medicaid-covered services rendered to eligible recipients during the cost report period; and
 - (ii) Medicaid-covered PAD rendered to eligible recipients during the cost report period;
 - b. CMHC's costs associated with:
 - (i) Medicaid-covered services rendered to enrollees during the cost report period; and
 - (ii) Medicaid-covered PAD rendered to enrollees during the cost report period;
 - c. Costs of the community board for mental health or individuals with an intellectual disability under which the CMHC operates for the cost report period; and
 - d. CMHC's costs associated with services rendered to individuals:
 - (i) That were reimbursed by an insurer or party other than the department or a managed care organization; and

(ii) During the cost report period.

(b) To illustrate the timeline referenced in paragraph (a) of this subsection, an independently audited cost report stating costs associated with services and PAD provided during the state fiscal year spanning July 1, 2017, through June 30, 2018, shall be submitted to the department by December 31, 2018.

(2) By October 1 following the department's receipt of a CMHC's completed cost report submitted to the department by the prior December 31, the department shall:

(a) Review the cost report referenced in subsection (1)(a) of this section; and

(b) Compare the Medicaid allowable costs to the department's interim reimbursement for Medicaid-covered services and PAD rendered during the same state fiscal year.

(3)(a) After the department compares a CMHC's interim reimbursement with the CMHC's Medicaid allowable costs for the period, if the department determines that the interim reimbursement:

1. Was less than the CMHC's Medicaid allowable costs for the period, the department shall send a payment to the CMHC equal to the difference between the CMHC's total interim reimbursement and the CMHC's Medicaid allowable costs; or

2. Exceeded the CMHC's Medicaid allowable costs for the period, the:

a. Department shall send written notification to the CMHC requesting the amount of the overpayment; and

b. CMHC shall, within thirty (30) calendar days of receiving the department's written notice, send a:

(i) Payment to the department equal to the excessive amount; or

(ii) Payment plan request to the department.

(b) A CMHC shall not implement a payment plan unless the department has approved the payment plan in writing.

(c) If a CMHC fails to comply with the requirements established in paragraph (a)2 of this subsection, the department shall:

1. Suspend payment to the CMHC; and

2. Recoup the amount owed by the CMHC to the department.

Section 6. Final Reimbursement for the Cost Report Period Spanning November 1, 2016, through June 30, 2017. The provisions established in Section 5 of this administrative regulation shall apply to final reimbursement for the period beginning November 1, 2016, through June 30, 2017, except that the cost report period shall begin November 1, 2016, and end June 30, 2017.

Section 7. New Services. (1) Reimbursement regarding a projection of the cost of a new Medicaid-covered service or expansion shall be made on a prospective basis in that the costs of the new service or expansion shall be considered when actually incurred as an allowable cost.

(2)(a) A CMHC may request an adjustment to an interim rate after reaching the mid-year point of the new service or expansion.

(b) An adjustment shall be based on actual costs incurred.

Section 8. Auditing and Accounting Records. (1)(a) The department shall perform a desk review of each cost report to determine if an audit is necessary and, if so, the scope of the audit.

(b) If the department determines that an audit is not necessary, the cost report shall be settled without an audit.

(c) A desk review or audit shall be used to verify costs to be used in setting the interim be-

behavioral health services rate, to adjust interim behavioral health services rates that have been set based on unaudited data, or for final settlement to cost.

(2)(a) A CMHC shall maintain and make available any records and data necessary to justify and document:

1. Costs to the CMHC;
2. Services provided by the CMHC;
3. The cost of PAD provided, if any, by the CMHC;
4. Cost allocations utilized including overhead statistics and supportive documentation;
5. Any amount reported on the cost report; and
6. Chart of accounts.

(b) The department shall have unlimited on-site access to all of a CMHC's fiscal and service records for the purpose of:

1. Accounting;
2. Auditing;
3. Medical review;
4. Utilization control; or
5. Program planning.

(3) A CMHC shall maintain an acceptable accounting system to account for the:

- (a) Cost of total services provided;
- (b) Charges for total services rendered; and
- (c) Charges for covered services rendered to eligible recipients.

(4) An overpayment discovered as a result of an audit or desk review shall be settled through recoupment or withholding.

Section 9. Allowable and Nonallowable Costs. (1) The following shall be allowable costs:

(a) Services' or drugs' costs associated with the services or drugs;

(b) Depreciation as follows:

1. A straight line method shall be used;
2. The edition of the American Hospital Association's useful life guidelines currently used by the Centers for Medicare and Medicaid Services' Medicare program shall be used;
3. The maximum amount for expensing an item in a single cost report shall be \$5,000; and
4. Only the depreciation of assets actually being used to provide services shall be recognized;

(c) Interest costs;

(d) Costs incurred for research purposes, which shall be allowable to the extent that the research costs are related to usual patient services and are not covered by separate research funding;

(e) Costs of motor vehicles used by management personnel up to \$25,000;

(f) Costs for training or educational purposes for licensed professional staff outside of Kentucky excluding transportation costs to travel to the training or education;

(g) Costs associated with any necessary legal expense incurred in the normal administration of the CMHC;

(h) The cost of administrative staff salaries, which shall be limited to the average salary for the given position as established for the geographic area on www.salary.com;

(i) The cost of practitioner salaries, which shall be limited to the median salary for the southern region as reported in the Medical Group Management Association (MGMA) Physician Compensation and Production Survey Report, if available.

1. A per visit amount using MGMA median visits shall be utilized.

2. The most recently available MGMA publication that relates to the cost report period shall

be used;

(j) Indirect costs, which shall be:

1. Calculated utilizing the approved federal indirect rate, if the provider has an approved federal indirect rate.

a. A provider shall include in indirect costs on line 1 of the cost report the same category of costs identified as indirect within the approved federal indirect rate supporting documentation.

b. Direct costs shall be those costs identified as direct within the approved federal indirect rate.

c. The federal indirect rate shall be applied to the same category of expenses identified as direct during the federal rate determination; or

2. If the provider does not have a federal indirect rate, those costs of an organization that are not specifically identified with a particular project, service, program, or activity but nevertheless are necessary to the general operation of the organization and the conduct of the activities it performs. The actual allowable cost of indirect services as reported on the cost report shall be allocated to direct cost centers based on accumulated cost if a federal indirect rate is not available; and

(k) Services provided in leased or donated space outside the walls of the facility.

(2) To be allowable, costs shall comply with reasonable cost principles established in 42 C.F.R. 413.

(3) The allowable cost for a service or good purchased by a facility from a related organization shall be in accordance with 42 C.F.R. 413.17.

(4)(a) The following shall not be allowable costs:

1. Bad debt;

2. Charity;

3. Courtesy allowances;

4. Political contributions;

5. Costs associated with an unsuccessful lawsuit against the department or the Cabinet for Health and Family Services;

6. Costs associated with any legal expense incurred related to a judgment granted as a result of an unlawful activity or pursuit;

7. The value of services provided by nonpaid workers;

8. Travel or related costs or expenses associated with nonlicensed staff attending:

a. A convention;

b. A meeting;

c. An assembly; or

d. A conference;

9. Costs related to lobbying;

10. Costs related to outreach services; or

11. Costs incurred for transporting recipients to services.

(b) Outreach services' costs shall either be directly assigned or allocated to a cost report line that is not cost-settled by the department.

(5) A discount or other allowance received regarding the purchase of a good or service shall be deducted from the cost of the good or service for cost reporting purposes, including in-kind donations.

(6)(a) Maximum allowable costs shall be the maximum amount that may be allowed as reasonable cost for the provision of a service or drug.

(b) To be considered allowable, a cost shall:

1. Be necessary and appropriate for providing services; and

2. Not exceed usual and customary charges.

(7) For direct and indirect personnel costs, 100 percent time reporting methods shall be utilized to group and report expenses to each cost category. Detailed documentation shall be available upon request.

Section 10. Units of Service. (1) Interim payments for behavioral health services, physician services, physical therapy services, occupational therapy services, speech-language pathology services, laboratory services, or radiological services shall be based on units of service.

(2) A unit for a behavioral health service, a physician service, a physical therapy service, a speech-language pathology service, an occupational therapy service, a laboratory service, or a radiological service shall be the amount indicated for the corresponding:

- (a) CPT code; or
- (b) Healthcare Common Procedure Coding System code.

Section 11. Reimbursement of Out-of-state Providers. Reimbursement to a participating out-of-state community mental health center shall be the lesser of the:

- (1) Charges for the service;
- (2) Facility's rate as set by the state Medicaid Program in the other state; or
- (3) The state-wide average of payments for in-state community mental health centers.

Section 12. Appeal Rights. A community mental health center may appeal a Department for Medicaid Services decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 13. Not Applicable to Managed Care Organization. A managed care organization shall not be required to reimburse for community mental health center services in accordance with this administrative regulation.

Section 14. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the reimbursement; and
- (2) Centers for Medicare and Medicaid Services' approval for the reimbursement. (2 Ky.R. 112; eff. 9-10-1975; 5 Ky.R. 276; eff. 12-6-1978; 7 Ky.R. 861; eff. 6-3-1981; 8 Ky.R. 534; 882; eff. 2-1-1982; 9 Ky.R. 268; eff. 9-8-1982; 10 Ky.R. 322; eff. 3-26-1984; 11 Ky.R. 290; eff. 9-11-1984; 1093; 1271; eff. 3-12-1985; 12 Ky.R. 378; eff. 10-8-1985; Recodified from 904 KAR 1:045, 5-2-1986; 13 Ky.R. 387; eff. 9-4-1986; 14 Ky.R. 312; eff. 9-10-1987; 15 Ky.R. 1980; eff. 3-15-1989; 16 Ky.R. 9-20-1989; 17 Ky.R. 574; eff. 10-14-1990; 18 Ky.R. 916; eff. 10-16-1991; 19 Ky.R. 323; eff. 8-28-1992; 20 Ky.R. 664; eff. 10-21-1993; Am 1364; eff. 2-16-2004; 31 Ky.R. 461; 717; eff. 11-5-2004; 32 Ky.R. 405; 685; eff. 10-14-2005; TAm 7-16-2013; 40 Ky.R. 1959; 2492; 2721; eff. 7-7-2014; 43 Ky.R. 1071, 1594, 1768; eff. 5-5-2017; 44 Ky.R. 382, 1033; eff. 1-5-2018.)