

907 KAR 3:230. Reimbursement policies and requirements for specialty intermediate care (IC) clinic services.

RELATES TO: KRS 205.520(3), 205.560(1), 42 C.F.R. Part 413, 42 C.F.R. 447.204, 42 C.F.R. 447.321

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), and 205.560(2)

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. This administrative regulation establishes the reimbursement policies and requirements for covered specialty intermediate care clinic services provided to a Medicaid recipient who is not enrolled with a managed care organization and optional policies for covered specialty IC clinic services provided to a Medicaid recipient who is enrolled with a managed care organization.

Section 1. Definitions.

- (1) "Bad debt" means accounts receivable which will likely remain uncollected.
- (2) "Department" means the Department for Medicaid Services or its designee.
- (3) "Federal financial participation" is defined in 42 C.F.R. 400.203.
- (4) "Government Auditing Standards" means the standards:
 - (a) For audits of government organizations, programs, activities, functions, and of government assistance received by contractors, nonprofit organizations, and other nongovernment organizations;
 - (b) Often referred to as generally accepted government auditing standards or GAGAS; and
 - (c) Accessible at the Web site of <http://www.gao.gov/govaud/ybk01.htm>.
- (5) "Medically necessary" means determined by the department to be needed in accordance with 907 KAR 3:130.
- (6) "Recipient" is defined by KRS 205.8451(9).
- (7) "Specialty intermediate care clinic" or "specialty IC clinic" means a clinic located on the grounds of a state-owned facility licensed pursuant to 902 KAR 20:086 as an intermediate care facility for individuals with an intellectual disability.

Section 2. Interim Reimbursement.

- (1)(a) Except for a specialty IC clinic's first fiscal year of operation, the department shall reimburse on an interim basis:
 1. For specialty intermediate care clinic services via an interim rate and utilizing a clinic-specific cost-to-charge ratio:
 - a. For each service;
 - b. Based on the clinic's most recently filed cost report, unless no cost report exists; and
 - c. Expressed as a percent of the clinic's charges; and
 2. During the course of a state fiscal year until the most recent full fiscal year cost report from the clinic has been finalized by the department.
- (b) The department shall use projected costs to establish interim rates for the first fiscal year of a specialty IC clinic's operation.
- (2) The department shall determine a:
 - (a) Clinic-specific cost-to-charge ratio for each service; and
 - (b) Specialty IC clinic's interim rate for a service by:

1. Multiplying the total charges for the service by the service-specific cost-to-charge ratio; and

2. Dividing the number established pursuant to subparagraph 1. of this paragraph by the applicable number of service units. For example, \$500,000 in total charges multiplied by a cost-to-charge ratio of 0.95 divided by 10,000 units equals an interim rate of forty-seven (47) dollars and fifty (50) cents.

(3) An interim rate for a fiscal year shall be effective on July 1 of a calendar year and remain in effect until close of business June 30 of the subsequent calendar year.

(4)(a) The department shall adjust an interim rate if:

1. The department miscalculated a specialty IC clinic's interim rate;

2. A specialty IC clinic submits an amended cost report which applies to the interim rate period; or

3. A further desk or on-site audit of a cost report used to establish the interim rate discloses a change in allowable costs.

(b) The department shall not adjust an interim rate for a reason not described in paragraph (a)1, 2, or 3 of this subsection.

(5) The department shall use the most recently received ICF-IID and Specialty Intermediate Care Clinic Cost Report as of March 15 to establish interim rates for a specialty IC clinic to be effective on July 1 of a given year.

Section 3. Final Reimbursement.

(1) After the most recent full fiscal year cost report for a specialty IC clinic has been finalized by the department, the department shall cost settle with the clinic to establish final reimbursement to the clinic for the corresponding fiscal year.

(2) A cost settlement between the department and a specialty IC clinic shall:

(a) Be limited to an amount, if any, by which the specialty IC clinic's allowable costs exceeds the amount of:

1. Any third party recovery during the fiscal year; and

2. Interim payments made to the specialty IC clinic; and

(b) Not exceed the federal upper payment limit in accordance with 42 C.F.R. 447.321.

(3)(a) The department's reimbursement to a specialty IC clinic shall be payment in full to the specialty IC clinic for services provided to recipients.

(b) A specialty IC clinic shall not bill a recipient for a service provided to a recipient.

(c) A bad debt shall not be:

1. An allowable cost; or

2. Reimbursable by the department.

Section 4. Cost Reporting Requirements.

(1)(a) A specialty IC clinic shall annually submit to the department a fully completed ICF-IID and Specialty Intermediate Care Clinic Cost Report within four (4) calendar months of the end of the prior state fiscal year.

(b) For example, an ICF-IID and Specialty Intermediate Care Clinic Cost Report covering the fiscal year ending June 30, 2013 shall be submitted to the department by close of business October 31, 2013.

(2) A specialty IC clinic shall complete an ICF-IID and Specialty Intermediate Care Clinic Cost Report in accordance with the ICF-IID and Specialty Intermediate Care Clinic Cost Report Instructions.

(3) Interim reimbursement for a specialty IC clinic which does not submit a legible and complete ICF-IID and Specialty Intermediate Care Clinic Cost Report to the department within the

time period referenced in subsection (1) of this section shall be placed in escrow by the department until the department receives a legible and completed ICF-IID and Specialty Intermediate Care Clinic Cost Report.

(4) After finalizing the first full fiscal year cost report submitted by a facility, the department shall establish an interim rate based on the first full year cost report.

(5) An ICF-IID and Specialty Intermediate Care Clinic Cost Report shall include the following statement immediately before the dated signature of the specialty IC clinic'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 statutes and administrative regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were reported in compliance with those statutes and administrative regulations. This cost report includes total computable cost incurred to provide Medicaid services."

(6) If a cost report indicates a payment is due by a specialty IC clinic to the department, the specialty IC clinic shall submit the amount due or submit a payment plan request with the cost report.

(7) If a cost report indicates a payment is due by a specialty IC clinic to the department and the specialty IC clinic fails to remit the amount due or request a payment plan, the department shall suspend future payment to the specialty IC clinic until the specialty IC clinics remits the payment or submits a request for a payment plan.

(8)(a) If it is determined that an additional payment is due by a specialty IC clinic after a final determination of cost has been made by the department, the additional payment shall be due by the specialty IC clinic to the department within sixty (60) days after notification.

(b) If a specialty IC clinic does not submit the additional payment within sixty (60) days, the department shall withhold future payment to the specialty IC clinic until the department has collected in full the amount owed by the specialty IC clinic to the department.

(9)(a) A specialty IC clinic shall report all of its costs, allowable costs, and unallowable costs on a cost report.

(b) The department shall not reimburse for or cost settle unallowable costs.

Section 5. Allowable and Unallowable Costs.

(1) An allowable cost shall:

- (a) Be allowable in accordance with 42 C.F.R. Part 413;
- (b) Be a cost allowed after an audit by the department; and
- (c) Include:

1. A cost incurred by a specialty IC clinic in meeting and maintaining health standards pursuant to 42 C.F.R. 431.610(c); and

2. Costs resulting from meeting Kentucky specialty clinic licensure requirements pursuant to 902 KAR 20:410.

(2) Reimbursable services shall be the specialty IC clinic services established in 907 KAR 3:225.

(3) Costs relating to unallowable clinic activities shall:

- (a) Be excluded from any cost settlement;
- (b) Not be reimbursable; and
- (c) Be reported separately on a cost report.

Section 6. Audits.

(1) An ICF-IID and Specialty Intermediate Care Clinic Cost Report and all related documents submitted to the department by a specialty IC clinic shall be subject to audit, review, and

reconciliation by the department.

(2) An audit, if performed, shall be performed in accordance with the most current Government Auditing Standards.

Section 7. Pharmacy, Medication, Immunization, and Other Costs Not Reimbursed at Cost.

(1) The department shall reimburse for:

(a) Prescription drug costs experienced by a specialty IC clinic through the department's pharmacy program in accordance with 907 KAR 23:020; or

(b) Immunization costs experienced by a specialty IC clinic through the department's physician program in accordance with 907 KAR 3:010.

(2) Medication:

(a) Consultation costs shall be allowable; and

(b) Management costs shall be allowable.

Section 8. Not Applicable to Managed Care Organizations.

(1) A managed care organization may elect to reimburse for specialty IC clinic services in accordance with this administrative regulation.

(2) The reimbursement policies established in this administrative regulation shall not apply to a managed care organization.

Section 9. Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies federal financial participation for the policy; or

(2) Disapproves the policy.

Section 10. Appeals.

(1) An interim rate adjustment or denial of an interim rate adjustment may be appealed in accordance with 907 KAR 1:671.

(2) A Medicaid program sanction or appeal shall be in accordance with 907 KAR 1:671.

Section 11. Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) "ICF-IID and Specialty IC Clinic Cost Report", March 2013 edition; and

(b) "ICF-IID and Specialty IC Clinic Cost Report Instructions", March 2013 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. (39 Ky.R. 2449; 40 Ky.R. 848; eff. 11-1-2013; TAM eff. 10-6-2017; Crt eff. 7-23-2018.)