Summary Report

Insurance Billing for Sensitive Health Services

STATUTORY AND REGULATORY ANALYSIS USING LAWATLAS

Health care facilities providing sensitive health services for free are an essential part of the American healthcare system.[1] Such facilities treat individuals with limited means of payment and those suffering from illnesses that can be associated with stigma, such as sexually transmitted diseases (STDs).[2] The effective prevention and control of STDs requires an understanding of the legal landscape facing publicly funded free health facilities that provide these services. This series of LawAtlas legal datasets seeks to provide greater availability of information about the laws and regulations that impede or facilitate STD prevention efforts with a particular attention to barriers to billing private insurance for services. There was a special focus on the unique situations that arise when legal provisions mandate free health care services. For purposes of this research, health care facilities that accept nominal fees and/or donations were considered *free* health care facilities.[3]

Four major areas related to insurance billing practices for sensitive health services are summarized in this report: legal limitations on the ability of free health care facilities to bill for care, immunity from civil liability for the health care provider and/or clinic who provides free treatment, confidentiality protections for insured dependents accessing free health care facilities, and the ability of the health care facility to retain funds received.[4]

For publicly funded health care facilities, the ability or inability to bill either a third-party payor or the patient themselves for services rendered is a hugely important issue[5] examined in the first dataset. This is especially true as the Affordable Care Act (ACA) continues to change the landscape for insurance and billing throughout the country. The laws and regulations that bear on the current state of affairs for free health care facilities, by dictating whether they must provide free services, or must allow billing by private insurers for these services were researched, analyzed, and coded into the resulting dataset.[6]

The second dataset focuses on immunity from civil liability for the healthcare provider and/or the clinic.[7] Many states have provisions which limit the liability of healthcare providers and/or facilities providing free health services. A determination of whether or not immunity is granted by the law necessarily leads to

---

[1] http://rwjf.org/content/dam/farm/toolkits/2009/rwjf50923
[2] Golden MR, Kerndt PR. Improving Clinical OperationsL Can We and Should We Save Our STD Clinics? Sex Transm Disn 2010; 37:264-5.
[3] All future instances of **free** in this report may include a facility where nominal fees and/or donations are accepted.
[4] The ability of the healthcare facility to retain funds received is summarized in this report and does not appear on LawAtlas.org.
[5] http://www.ncsddc.org/sites/default/files/media/finalbillingguide.pdf
[6] http://lawatlas.org/preview?dataset=public-health-clinics-billing-for-care-limits-on-3rd-party-billing-2 [Accessed on January 27, 2014]
[7] http://lawatlas.org/preview?dataset=public-health-clinics-billing-for-care-provider-immunity [Accessed on January 27, 2014]

an examination of the requirements to obtain the immunity, and any factors that may limit the protection or cause it to disappear entirely. The dataset addresses whether such immunity existed, and whether it would be limited or revoked by the acceptance of compensation by clinics or providers.

Spouses and other dependents covered under another payor's insurance, such as minors and young adults on their parents' health insurance plans may be especially concerned about protection from disclosure to the payor when it comes to sensitive health services.[8]

The third dataset concerns plan communications requirements for insured dependents.[9] If individuals with private insurance use public clinics because they are concerned with the confidentiality issue with their private insurer, then it is important to understand the legal landscape with regards to billing private insurers considering this is the direction many clinics are headed.[10] Health care providers, facilities, and departments, also have an interest in whether or not there is a heightened level of confidentiality for these types of services. The dataset analyzes state laws and regulations bearing on privacy in insurance plan communications. It is anticipated to be released in early 2014.

Finally, the remittance of funds bears on the three aforementioned legal datasets. It is important for publicly funded health facilities and departments to understand where any collected monies may or must be directed, whether the funds must be retained or transferred elsewhere, and for what they can be used. This is an important area of the law for health departments and free treatment facilities. This information is not part of a LawAtlas dataset; however, a summary of the law appears in this report along with full text of the law where available in the appendix to this report.

---

[8] Hyden C, Allegrante JP, Cohall AT. HIV testing Sites' Communication About Adolescent Confidentiality: Potential Barriers and Facilitators to Testing. Health Promot. Pract. 2013; http://hpp.sagepub.com/content/early/2013/08/20/1524839913499347.full.pdf

[9] This dataset will be available on LawAtlas.org in early 2014.

[10] Celum CL, Bolan G, Krone M, et al. Patients attending STD clinics in an evolving health care environment. Sex Transm Dis 1997; 244(10);599-605.

INSURANCE BILLING FOR SENSITIVE HEALTH SERVICES: LIMITS ON THIRD-PARTY BILLING

In anticipation of the ACA, a major policy issue facing STD prevention and control efforts is the ability of health care facilities and health departments to bill for the services that they provide. The provision of free testing and treatment is widely perceived as being legally required. Thus, the limits of this free care - whether the state law authorizes the department to provide free services, or expressly prohibits third-party billing for STD services - is a question of growing importance. Some states have or plan to close their STD testing and treatment facilities due to budget restraints. However, individuals seek services from STD treatment facilities for non-financial and financial reasons, such as stigma, confidentiality and expertise.[11]

The varied landscape of this area of the law often stems from how a state defines "free." An analysis of the law proves that the general belief that a provision for free health care services exists in the law is accurate in the vast majority of states.[12] Most often, state laws authorize free care, although they neither require nor do they contain an express prohibition against charging either the patient or a third-party payor for the services.[13] Despite the fact that 46 states and the District of Columbia explicitly mention "free health care" in their legal text, only 15 states expressly prohibit charging a patient for services,[14] and 12 states expressly prohibit the charging a third-party payor for the services.[15] Finally, 8 states have laws or regulations that require the state, or any department of the state or local government, to provide free treatment specifically for STDs.[16]

INSURANCE BILLING PRACTICES FOR SERVICES: LIMITS ON THIRD-PARTY BILLING

	The state has a law that explicitly addresses "free" health care services. Jurisdictions: All (except NH, RI, VT, WV)
	No express prohibition against charging the patient or payor for services. Jurisdictions: 9 (AK, AL, AZ, DC, IN, ME, OR, RI, SD)
	Expressly prohibits the charging of the patient for services. Jurisdictions: 15 (AR, CA, DE, FL, IA, MA, NJ, NV, NY, OK, SC, TN, TX, VA, WI)
	Expressly prohibits the clinic or facility from charging third- party payors. Jurisdictions: 12 (DE, FL, IA, MA, NJ, NV, OK, SC, TN, TX, VA, WI)
	Requires the state, or any department of the state or local government, to provide free treatment specifically for STDs. Jurisdictions: 8 (MA, MI, NC, NJ, NY, PA, SC, VA)

Center for
Public Health Law
Research

INSURANCE BILLING FOR SENSITIVE HEALTH SERVICES: PROVIDER CIVIL IMMUNITY

Many states provide immunity to providers and facilities that provide free healthcare services. Thus, for clinics and providers that enjoy such legal protection, an important consideration in the implementation of a billing system is the potential loss of liability protections. The general legal question in this area is whether or not the state grants immunity from civil liability to licensed health care professionals that provide free health care services. Some states may also have provisions which limit the liability of volunteer health care providers or establish mechanisms for free or reduced cost professional malpractice insurance. Establishing whether these policies are affected by the acceptance of compensation by clinics or providers is vital to determining the role of increased insurance coverage in funding the operation of free treatment facilities.

Thirty-eight states provide for civil immunity for health care professionals who provide free services.[17] Again, the implications of the word "free" become important, as its definition may dictate whether or not this immunity applies.[18] Thirty-three states define free from the perspective of the provider, stipulating that the grant of immunity is dependent on the provider's lack of receipt of compensation for the services provided.[19] In addition, immunity is conditioned on whether the provider or the health care facility meets certain guidelines. For example, Florida, Georgia, Iowa, Kansas, Oklahoma, and Washington require that there be a contract or agreement between the government and the health care professional in order for the immunity to apply.[20] In Alabama, Florida, Illinois, Louisiana and North Carolina the law requires that an explanation of the immunity be conspicuously posted for the liability protection to be afforded.[21] Finally, there are several instances where immunity protections will be lost, including but not limited to acceptance of compensation, willful misconduct, gross negligence, and the location services take place.

INSURANCE BILLING PRACTICES FOR SERVICES: PROVIDER CIVIL IMMUNITY

	Health care professionals who provide "free" services immune from civil liability. Jurisdictions: 38 (AK, AL, AR, AZ, CO, DC. DE, FL, GA, HI, IA, ID, IL, IN, KS, LA, MD, ME, MI, , MS, MT, NC, ND, NE,
	Immunity lost upon acceptance of compensation by the provider. Jurisdictions: 33 (AK, AL, AR, AZ, CO, DC, FL, GA, IA, ID, IL, IN, LA, MD, MS, MT, NC, ND, NE, NH, NV, NY, OH, OK, SC, SD, TN, TX, UT, VA, WA, WY)
	Immunity contingent on a contract or agreement between the government and the health care professional. Jurisdictions: 6 (FL, GA, IA, KS, OK, WA)
	Immunity contingent on explanation of the immunity conspicuously posted. Jurisdictions: 5 (AL, FL, IL, LA, NC)
	No express prohibition resulting in the loss of immunity protection. Jurisdictions: 4 (CA, CT, KS, MN)

INSURANCE BILLING FOR SENSITIVE HEALTH SERVICES: PLAN COMMUNICATIONS REQUIREMENTS FOR INSURED DEPENDENTS

Patients often seek services from such publically funded health care facilities because they are presumed to be subject to a heightened level of confidentiality.[22] Health care providers, facilities, and health departments need to know whether or not there is an actual heightened level of confidentiality for these types of services. Further, because the patient may not be the payor on a policy, it is important to know if there are any state laws and regulations that authorize health insurance plan communications with policyholders, allow insureds to make requests to limit these communications, or explicitly prohibit disclosure of confidential health information by providers and/or health insurers. ***It is anticipated this dataset will be released in the second quarter of 2014.***

Center for
Public Health Law
Research

INSURANCE BILLING FOR SENSITIVE HEALTH SERVICES: RETENTION OF FUNDS

When providing care, funds may be collected by health care facilities. Where such funds, received by the department, must be directed is an important question for state and local health departments. While a LawAtlas dataset was not completed for this area, we researched statutes and regulations related to whether funds must be remitted to the state treasury, and if those funds must be used for a stated purpose. 35 states and the District of Columbia had statues and/or regulations specifically addressing the retention of funds for state and local health departments. In 15 states, no relevant statutes were found using our search terms. All the legal text collected in this area appears as an appendix to this report.

VIEW DATA ON LAWATLAS

Insurance Billing Practices for Sensitive Health Services: Provider Civil Immunity – http://lawatlas.org/preview?dataset=public-health-clinics-billing-for-care-provider-immunity **Insurance Billing Practices for Sensitive Health Services: Limits on Third-Party Billing** – http://lawatlas.org/preview?dataset=public-health-clinics-billing-for-care-limits-on-3rd-party-billing-2
Communicable Disease Intervention Protocol – http://lawatlas.org/preview?dataset=communicable-disease-intervention-protocol

This report gives an overview of the data collected in each Insurance Billing for Sensitive Health Services dataset. You can build more queries and view the legal text by visiting the dataset pages on LawAtlas.org.

To build a query, make selections from the menu of options to the left of the map. When you select a featured criterion, the map and table will display the states that have a law that meets that criteria.

Hovering your mouse over a feature will produce a pop-up “tool-tip” that describes the feature in more detail. You can select multiple features for your query or if you are only interested in seeing the law for one state, just click the state on the map.

PROJECT SUPPORT

This project is supported by Cooperative Agreement Number 93.283 from the Centers for Disease Control and Prevention to the National Network of Public Health Institutes (NNPHI). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or NNPHI.

Insurance Billing for Sensitive Health Services

STATUTORY AND REGULATORY ANALYSIS USING LAWATLAS

APPENDIX

State Laws Concerning remittance of Agency Funds to the State Treasury

Researchers used the search terms below to find any statutes or regulations that may concern remittance of agency funds to the state treasury by a health facility that offers free services or health department.

Search Terms:

money, moneys, monies, collected, state, department, treasury, credit, state agency, commissions, deposited, collecting, monies, remit

adv: "health clinic" & money, moneys, monies, collected, state, department, treasury, credit, state agency, commissions, deposited, collecting, monies, remit

health /10 clinic /10 free health /10 clinic

/10 fun! health clinic

remit!

Alabama

Ala. Admin. Code r. 560-X-60-.11

Unallowable Expenses. (January 12, 1994)

(1) General

(a) All payments to providers for services rendered must be based on the reasonable cost of such services covered by the Alabama State Plan. It is the intent of the program that providers will be reimbursed the reasonable costs which must be incurred in providing quality patient care. Implicit in the intent that reasonable costs be paid are the expectations that the provider seeks to minimize costs and that costs do not exceed what a prudent and cost-conscious buyer pays for a given item of service or product. If costs are determined to exceed the level that prudent buyers incur in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not allowable.

(b) Costs related to patient care include necessary and proper costs involved in developing and maintaining the efficient operation of patient care facilities. Necessary and proper costs related to patient care are those which are usual and accepted expenses of similar providers.

(2) Overhead costs which will not be allowed are listed below. This listing is not intended to be all inclusive. Other overhead costs which violate the prudent buyer concept or are not related to patient care will not be reimbursed by the Alabama Medicaid Agency.

(a) Management Fees. Management firms, individuals and consultants which duplicate services already provided, or in a clinic in which a full-time administrator is employed. Excluded from this rule are those management contracts required incident to a bond issue for a valid business purpose.

(b) Director's Fees

(c) Compensation to owners and other personnel not performing necessary functions (d) Salaries which are paid to personnel performing overlapping or duplicate functions (e) Legal Fees and Expenses

1. Retainers

2. Relating to informal conferences and fair hearings

3. Relating to issuance and sale of capital stock and other securities

4. Relating to creation of corporations or partnerships

5. Relating to business reorganization

6. Services for benefits of stockholders

7. Acquisition of clinics or other business enterprises

8. Relating to sale of clinics and other enterprises

9. In connection with criminal actions resulting in a finding of guilt or equivalent action or plea

10. Other legal services not related to patient care

(f) Outside Accounting and Audit Fees and Expenses

1. Personal tax returns

2. Retainers

3. Relating to informal conferences and fair hearings

4. Relating to issuance and sale of capital stock and other securities

5. Relating to creation of corporations or partnerships

6. Relating to business reorganization

7. Services for the benefits of stockholders

8. Acquisition for clinics or other business enterprises

9. Relating to sale of clinics and other enterprises

10. In connection with participation in criminal actions resulting in guilt or equivalent action or plea

11. Other accounting services not related to patient care

(g) Taxes

1. Personal income

2. Property not related to patient care

3. Corporate income tax

4. Vehicle tag & tax

(h) Dues

1. Club

2. Civic

3. Social

4. Professional organization dues for individuals

5. Non-patient care related organization

(i) Insurance

1. Life

2. Personal property not used in patient care

3. On real estate not used in providing patient care

4. Group life and health insurance premiums which favor owners of a clinic or are for personnel not bona fide employees of the clinic

(j) Special assessments from Health Care Association

(k) Bad debts and associated collection expenses

(l) Employees relocation expenses

(m) Penalties

1. Late Tax

2. Late payment charges. (None: If a clinic can fully document that a late payment, charge is directly due to late Medicaid payments, the amount of the late payment charge will be an allowable cost.)

3. Bank overdraft

4. Fines

(n) Certain Real Estate Expenses

1. Appraisals obtained in connection with the sale or lease of a clinic (unless required by Medicaid)

2. Costs associated with real estate not related to patient care

(o) Interest Expense

1. Interest associated with real estate in excess of clinic needs or real estate not related to patient care.

2. Interest expenses applicable to penalties

3. Construction Interest (must be capitalized)

4. Interest paid to a related party

5. Interest on personal property not related to patient care

6. Interest on loans not associated with patient care

7. Imputed interest

(p) Licenses

1. Consultants

2. Professional personnel

(q) Donations and Contributions

(r) Accreditation Surveys

(s) Telephone Services

1. Mobile telephones, beepers, telephone call relays, automated dialing services

2. Long distance telephone calls of a personal nature

(t) Any costs associated with corporate stock records maintenance

(u) Any expenses associated with political activities or lobbying efforts are not allowable

(3) Prior Period Costs and Accounts Payable

(a) The Medicaid reimbursement rate is calculated to provide adequate funds to pay business expenses in a timely manner. Costs incurred in prior periods but not paid must be accrued and reported in that period during which the costs were incurred. Payment of prior period cost in the current year is not an allowable cost. Exceptions will be allowed, based on reasonableness, for small invoices which, in total, do not exceed $500.00 per fiscal period. These invoices must be as a result of no fault of the provider. Any pattern of abuse will cause the costs in question to be automatically disallowed by the Agency.

(b) Short-term liabilities must be paid within ninety (90) days from the date of invoice; otherwise, the expense will not be allowed unless the provider can establish to the satisfaction of Medicaid that the payment was not made during the 90 days for a valid business reason.

(c) Actual payment must be made by cash or negotiable instrument. For this purpose, an instrument to be negotiable must be in writing and signed, must contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and must be payable to order of or to bearer. All voided instruments, whether voided in fact or by devise, are considered void from inception.
(d) A provider who files for and is awarded protection under Chapter 11 of the Federal Bankruptcy Code may be given consideration in a current year cost report for actual payment of prior period allowable costs which have been disallowed in prior period cost reports due to failure to make actual payment of the cost claimed. In order for payment of these prior year allowable costs to be considered under a current year cost report, they must have been paid pursuant to a court approved plan for reorganization under Chapter 11 of the Federal Bankruptcy Code. The allowable costs will not include any interest or penalty incurred for failure to make payment in prior year. The Agency will not reimburse interest expense generated from loans incurred to pay any such allowable prior period costs. Any such (untrended) allowable cost shall be added to the encounter rate after the normal rate setting process. It will be subject to the 80th percentile ceiling, thus the providers cost must be below the ceiling rate for any possible reimbursement of these prior period costs to occur.

(4) Bad Debts. Bad debts resulting from beneficiaries' failure to pay are to be treated as noncovered costs. Hence, such bad debts cannot be included in allowable costs.

(5) Research Costs

(a) Costs, incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

(b) There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many Federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and clinic research needs

(6) Luxury Items or Services

(a) Where clinic operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

(b)Luxury items or services are those that are substantially in excess of or more expensive than the usual items or services rendered within a clinic's operation to the majority of patients.

Alaska

Alaska Admin. Code tit. 7, § 140.215

Health clinic services and payment conditions (February 1, 2010)

(a) The department will pay a health clinic for providing services under (b) - (e) of this section rendered to a patient of the clinic by an employee or a contract worker of the clinic. Except as otherwise provided in this section, the department will pay a provider for services under this section in accordance with the payment rate established in 7 AAC 145.700.

(b) The department will pay for primary care services provided by a physician, a physician assistant, or an advanced nurse practitioner acting within the scope of that individual's license to practice. The department will not pay for services that the department determines to be incidental to primary care services, including laboratory services, x-ray services, and supplies.

(c) The department will pay for ambulatory services under 7 AAC 105 - 7 AAC 160, including

(1) vision services under 7 AAC 110.705;

(2) speech-language pathology services under 7 AAC 115.410; (3) hearing services under 7 AAC 115.520 and 7 AAC 115.530;

(4) EPSDT screening and EPSDT services under 7 AAC 110.205 and 7 AAC 110.210; (5) podiatry services under 7 AAC 110.505;

(6) nutrition services under 7 AAC 110.275 and 7 AAC 110.280; (7) private-duty nursing services under 7 AAC 110.525;

(8) hospice services under 7 AAC 140.275 and 7 AAC 140.280; (9) family planning services under 7 AAC 110.230;

(10) physical therapy services under 7 AAC 115.310;

(11) occupational therapy services under 7 AAC 115.110; (12) chiropractic services under 7 AAC 110.120; and

(13) nonprimary care services that are provided in a hospital by a rural health clinic physician, physician assistant, or advanced nurse practitioner acting within the scope of that individual's license to practice.

(d) The department will separately pay a health clinic for dental services covered under 7 AAC 110.145 - 7 AAC 110.160 provided by a dentist who is enrolled separately under 7 AAC 110.140.

(e) The department will pay the established encounter rate to a health clinic for the behavioral health services identified in Table I-1. Procedure Codes: Mental Health Services of the Federally Qualified Health Center/Rural Health Clinic Services section of the Alaska Provider Billing Manual, adopted by reference in 7 AAC 160.900, if those services are provided to a recipient by a psychologist or a clinical social worker acting within the scope of that individual's license to practice. Behavioral health services covered under this subsection include

(1) psychiatric diagnostic interview procedures;

(2) psychological testing and examination services;

(3) individual psychotherapy;

(4) group psychotherapy;

(5) family psychotherapy; and

(6) health and behavior assessment and intervention services.

(f) The department will separately pay a health clinic for labor and delivery services provided by a physician, a physician assistant, or an advanced nurse practitioner, including a nurse midwife, who has separately enrolled under 7 AAC 105 - 7 AAC 160. The department will pay a provider under this subsection in accordance with the relevant fee schedule established under 7 AAC 145.050.

(g) The department will separately pay a health clinic for pharmacy services and for prescription drugs provided by the health clinic under 7 AAC 120.110 if the health clinic is enrolled as a dispensing provider in accordance with 7 AAC 120.100. The department will pay a provider under this subsection in accordance with the rates established in 7 AAC 145.400 and 7 AAC 145.410.

(h) The department will not pay for

(1) services or supplies that a health clinic routinely provides to individuals other than Medicaid-eligible recipients;

(2) services or supplies that the health clinic routinely furnishes for free or without regard to the recipient's ability to pay; or

(3) services provided off-site of the health clinic, except as provided in 7 AAC 140.220.

Alaska Admin. Code tit. 7, § 145.710

Calculating total health clinic visits.

(a) For the purposes of calculating a rate under 7 AAC 145.700(c) for a rural health clinic, the department will consider the total number of visits to be the sum of the following:

(1) the total number of visits for all recipients provided services by a full-time equivalent physician employed by the clinic; the department will calculate this figure by using the greater of the actual number of visits or a number that represents the minimum rural health clinic productivity standard, as follows:

(A) at least 2,100 visits per year per full-time equivalent physician employed by the clinic;

(B) 50 percent of the number set out in (A) of this paragraph, for a rural health clinic's first year of enrollment, and 75 percent of that number for a rural health clinic's second year of enrollment;

(2) the total number of visits for all recipients provided services by a full-time equivalent physician assistant or advanced nurse practitioner employed by the clinic; the department will calculate this figure by using the greater of the actual number of visits or a number that represents the minimum rural health clinic productivity standard, as follows:

(A) at least 1,050 visits per year per full-time equivalent physician assistant or advanced nurse practitioner employed by the clinic;

(B) 50 percent of the number set out in (A) of this paragraph, for a rural health clinic's first year of enrollment, and 75 percent of that number for a rural health clinic's second year of enrollment.

(b) For purposes of calculating a rate under 7 AAC 145.700(c) for a federally qualified health center, the department will consider the total number of visits to be the sum of the following:

(1) the total number of visits for all recipients provided services by a full-time equivalent physician employed by the center; the department will calculate this figure by using the greater of the actual number of visits or a number that represents the minimum federally qualified health center productivity standard, as follows:

(A) at least 3,050 visits per year per full-time equivalent physician employed by an urban federally qualified health center;

(B) at least 2,100 visits per year per full-time equivalent physician employed by a rural federally qualified health center;

(C) 50 percent of the number set out in (A) or (B) of this paragraph, as applicable, for a federally qualified health center's first year of enrollment, and 75 percent of that number for a federally qualified health center's second year of enrollment;

(2) the total number of visits for all recipients provided services by a full-time equivalent midlevel practitioner employed by the center; the department will calculate this figure by using the greater of the actual number of visits or a number that represents the minimum federally qualified health center productivity standard, as follows:

(A) at least 1,550 visits per year per full-time equivalent midlevel practitioner employed by an urban federally qualified health center;

(B) at least 1,050 visits per year per full-time equivalent midlevel practitioner employed by a rural federally qualified health center;

(C) 50 percent of the number set out in (A) or (B) of this paragraph, as applicable, for a federally qualified health center's first year of enrollment, and 75 percent of that number for a federally qualified health center's second year of enrollment.

(c) For the purposes of this section, a federally qualified health center is

(1) an urban federally qualified health center if it is located within a metropolitan statistical area as determined by the United States Office of Management and Budget;

(2) a rural federally qualified health center if it is located outside a metropolitan statistical area as determined by the United States Office of Management and Budget.

(d) In this section, “midlevel practitioner” means

(1) a physician assistant licensed under AS 08.64.107;

(2) an advanced nurse practitioner licensed under AS 08.68.100;

(3) a clinical psychologist licensed under AS 08.86.130; or

(4) a clinical social worker licensed under AS 08.95.110.

Arizona

No statutes or regulations found using the search terms.

Arkansas

No statutes or regulations found using the search terms.

California

Cal. Welf. & Inst. Code § 14132.01

Community clinics, free clinics, or intermittent clinics; Medi-Cal and Family PACT Waiver Program billing for cost of drugs and supplies; reimbursement reductions; discount drug program implications (January 1, 2006)

(a) Notwithstanding any other provision of law, a community clinic or free clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code or an intermittent clinic operating pursuant to subdivision (h) of Section 1206 of the Health and Safety Code, that has a valid license pursuant to Article 13 (commencing with Section 4180) of Chapter 9 of Division 2 of the Business and Professions Code shall bill and be reimbursed, as described in this section, for drugs and supplies covered under the Medi-Cal program and Family PACT Waiver Program.

(b)(1) A clinic described in subdivision (a) shall bill the Medi-Cal program and Family PACT Waiver Program for drugs and supplies covered under those programs at the lesser of cost or the clinic's usual charge made to the general public.

(2) For purposes of this section, “cost” means an aggregate amount equivalent to the sum of the actual acquisition cost of a drug or supply plus a clinic dispensing fee not to exceed twelve dollars ($12) per billing unit as identified in either the Family PACT Policies, Procedures, and Billing Instructions Manual, or the Medi-Cal Inpatient/Outpatient Provider Manual governing outpatient clinic billing for drugs and supplies, as applicable. For purposes of this section, “cost” for a take-home drug that is dispensed for use by the patient within a specific timeframe of five or less days from the date medically indicated means actual acquisition cost for that drug plus a clinic dispensing fee, not to exceed seventeen dollars ($17) per prescription. Reimbursement shall be at the lesser of the amount billed or the Medi-Cal reimbursement

rate, and shall not exceed the net cost of these drugs or supplies when provided by retail pharmacies under the Medi-Cal program.

(c) A clinic described in subdivision (a) that furnishes services free of charge, or at a nominal charge, as defined in subsection (a) of Section 413.13 of Title 42 of the Code of Federal Regulations, or that can demonstrate to the department, upon request, that it serves primarily low-income patients, and its customary practice is to charge patients on the basis of their ability to pay, shall not be subject to reimbursement reductions based on its usual charge to the general public.

(d) Federally qualified health centers and rural health clinics that are clinics as described in subdivision

(a) may bill and be reimbursed as described in this section, upon electing to be reimbursed for pharmaceutical goods and services on a fee-for-service basis, as permitted by subdivision (k) of Section

14132.100.

(e) A clinic that otherwise meets the qualifications set forth in subdivision (a), that is eligible to, but that has elected not to, utilize drugs purchased under the 340B Discount Drug Program for its Medi-Cal patients, shall provide notification to the Health Resources and Services Administration's Office of Pharmacy Affairs that it is utilizing non-340B drugs for its Medi-Cal patients in the manner and to the extent required by federal law.

Colorado

Colo. Rev. Stat. Ann. § 25-1.5-103

Health facilities--powers and duties of department--limitations on rules promulgated by department (August 7, 2013)

(1) The department has, in addition to all other powers and duties imposed upon it by law, the powers and duties provided in this section as follows:

(a)(I)(A) To annually license and to establish and enforce standards for the operation of general hospitals, hospital units as defined in section 25-3-101(2), psychiatric hospitals, community clinics, rehabilitation hospitals, convalescent centers, community mental health centers, acute treatment units, facilities for persons with developmental disabilities, nursing care facilities, hospice care, assisted living residences, dialysis treatment clinics, ambulatory surgical centers, birthing centers, home care agencies, and other facilities of a like nature, except those wholly owned and operated by any governmental unit or agency.

(B) In establishing and enforcing such standards and in addition to the required announced inspections, the department shall, within available appropriations, make additional inspections without prior notice to the health facility, subject to sub-subparagraph (C) of this subparagraph (I). Such inspections shall be made only during the hours of 7 a.m. to 7 p.m.

(C) The department shall extend the survey cycle or conduct a tiered inspection or survey of a health facility licensed for at least three years and against which no enforcement activity has been taken, no

patterns of deficient practices exist, as documented in the inspection and survey reports issued by the department, and no substantiated complaint resulting in the discovery of significant deficiencies that may negatively affect the life, health, or safety of consumers of the health facility has been received within the three years prior to the date of the inspection. The department may expand the scope of the inspection or survey to an extended or full survey if the department finds deficient practice during the tiered inspection or survey. The department, by rule, shall establish a schedule for an extended survey cycle or a tiered inspection or survey system designed, at a minimum, to: Reduce the time needed for and costs of licensure inspections for both the department and the licensed health facility; reduce the number, frequency, and duration of on-site inspections; reduce the scope of data and information that health facilities are required to submit or provide to the department in connection with the licensure inspection; reduce the amount and scope of duplicative data, reports, and information required to complete the licensure inspection; and be based on a sample of the facility size. Nothing in this sub-subparagraph (C) limits the ability of the department to conduct a periodic inspection or survey that is required to meet its obligations as a state survey agency on behalf of the centers for medicare and medicaid services or the department of health care policy and financing to assure that the health facility meets the requirements for participation in the medicare and medicaid programs.

(D) In connection with the renewal of licenses issued pursuant to this subparagraph (I), the department shall institute a performance incentive system pursuant to section 25-3-105(1)(a)(I)(C).

(E) The department shall not cite as a deficiency in a report resulting from a survey or inspection of a licensed health facility any deficiency from an isolated event identified by the department that can be effectively remedied during the survey or inspection of the health facility, unless the deficiency caused harm or a potential for harm, created a life- or limb-threatening emergency, or was due to abuse or neglect.

(F) Sections 24-4-104, C.R.S., and 25-3-102 govern the issuance, suspension, renewal, revocation, annulment, or modification of licenses. All licenses issued by the department must contain the date of issue and cover a twelve-month period. Nothing contained in this paragraph (a) prevents the department from adopting and enforcing, with respect to projects for which federal assistance has been obtained or is requested, higher standards as may be required by applicable federal laws or regulations of federal agencies responsible for the administration of applicable federal laws.

(II) To establish and enforce standards for the operation and maintenance of the health facilities named in subparagraph (I) of this paragraph (a), wholly owned and operated by the state or any of its political subdivisions, and no such facility shall be operated or maintained without an annual certificate of compliance; (b) To suspend, revoke, or refuse to renew any license issued to a health facility pursuant to subparagraph (I) or (II) of paragraph (a) of this subsection (1) if such health facility has committed abuse of health insurance pursuant to section 18-13-119, C.R.S., or if such health facility has advertised through newspapers, magazines, circulars, direct mail, directories, radio, television, or otherwise that it will perform any act prohibited by section 18-13-119(3), C.R.S., unless the health facility is exempted from section 18- 13-119(5), C.R.S.;

(c)(I) To establish and enforce standards for licensure of community mental health centers and acute treatment units.

(II) The department of public health and environment has primary responsibility for the licensure of community mental health centers and acute treatments units. The department of human services has primary responsibility for program approval at these facilities. In performing their respective responsibilities pursuant to this subparagraph (II), both departments shall take into account changes in

health care policy and practice incorporating the concept and practice of integration of services and the development of a system that commingles and integrates health care services.

(2) For purposes of this section, unless the context otherwise requires:

(a) “Acute treatment unit” means a facility or a distinct part of a facility for short-term psychiatric care, which may include substance abuse treatment, and which provides a total, twenty-four-hour therapeutically planned and professionally staffed environment for persons who do not require inpatient hospitalization but need more intense and individual services than are available on an outpatient basis, such as crisis management and stabilization services.

(a.5) “Community clinic” has the same meaning as set forth in section 25-3-101 and does not include:

(I) A federally qualified health center, as defined in section 1861(aa)(4) of the federal “Social Security Act”, 42 U.S.C. sec. 1395x(aa)(4);

(II) A rural health clinic, as defined in section 1861(aa)(2) of the federal “Social Security Act”, 42 U.S.C. sec. 1395x(aa)(2).

(b) “Community mental health center” means either a physical plant or a group of services under unified administration and including at least the following: Inpatient services; outpatient services; day hospitalization; emergency services; and consultation and educational services, which services are provided principally for persons with mental illness residing in a particular community in or near which the facility is situated.

(b.5) “Enforcement activity” means the imposition of remedies such as civil money penalties; appointment of a receiver or temporary manager; conditional licensure; suspension or revocation of a license; a directed plan of correction; intermediate restrictions or conditions, including retaining a consultant, department monitoring, or providing additional training to employees, owners, or operators; or any other remedy provided by state or federal law or as authorized by federal survey, certification, and enforcement regulations and agreements for violations of federal or state law.

(c) “Facility for persons with developmental disabilities” means a facility specially designed for the active treatment and habilitation of persons with developmental disabilities or a community residential home, as defined in section 27-10.5-102(4), C.R.S., which is licensed and certified pursuant to section 27-10.5-109, C.R.S.

(d) "Hospice care" means an entity that administers services to a terminally ill person utilizing palliative care or treatment.

(3)(a) In the exercise of its powers pursuant to this section, the department shall not promulgate any rule, regulation, or standard relating to nursing personnel for rural nursing care facilities, rural intermediate care facilities, and other rural facilities of a like nature more stringent than the applicable federal standards and regulations.

(b) For purposes of this subsection (3), "rural" means:

(I) A county of less than fifteen thousand population; or

(II) A municipality of less than fifteen thousand population which is located ten miles or more from a municipality of over fifteen thousand population; or

(III) The unincorporated part of a county ten miles or more from a municipality of fifteen thousand population or more.

(c) A nursing care facility which is not rural as defined in paragraph (b) of this subsection (3) shall meet the licensing requirements of the department for nursing care facilities. However, if a registered nurse hired pursuant to department regulations is temporarily unavailable, a nursing care facility may use a licensed practical nurse in place of a registered nurse if such licensed practical nurse is a current employee of the nursing care facility.

(3.5)(a)(I) The department of public health and environment may establish life safety code and physical plant requirements for an occupancy that is contiguous with an acute treatment unit if the occupancy is operated by the acute treatment unit licensee and the services provided by the occupancy are outpatient services certified in accordance with article 65 of title 27, C.R.S., to determine appropriate placement or detoxification services licensed by the department of human services. The services provided by the occupancy shall benefit acute treatment unit clients, although the occupancy may also provide such services to other populations. It shall be at the discretion of the acute treatment unit licensee to either construct the necessary fire safety separations between the occupancy and the acute treatment unit or to assume fiscal and administrative responsibility for assuring that the occupancy meets the life safety code requirements as specified and verified by the department of public health and environment.

(II) The state board of health may promulgate rules authorizing the department of public health and environment to assess a penalty of up to one hundred dollars per day if the department finds that an occupancy does not comply with life safety code requirements. The department shall only assess the penalty after the acute treatment unit licensee has had an opportunity to correct the noncompliance. (III) Nothing in this subsection (3.5) shall be construed to extend the life safety code authority of the department of public health and environment to an occupancy that is not subject to licensure by the department and that has the appropriate fire safety separations between the occupancy and the acute treatment unit.

(b) A licensee that is subject to life safety code oversight of one or more occupancies pursuant to paragraph (a) of this subsection (3.5) shall pay a fee or fees in accordance with rules promulgated by the state board of health.

(c) Any moneys collected pursuant to this subsection (3.5) shall be transmitted to the state treasurer, who shall credit the same to the health facilities general licensure cash fund created in section 25-3-103.1.

(4) In the exercise of its powers, the department shall not promulgate any rule, regulation, or standard that limits or interferes with the ability of an individual to enter into a contract with a private pay facility concerning the programs or services provided at the private pay facility. For the purposes of this subsection (4), "private pay facility" means a skilled nursing facility or intermediate care facility subject to the requirements of section 25-1-120 or an assisted living residence licensed pursuant to section 25-27-105 that is not publicly funded or is not certified to provide services that are reimbursed from state or federal assistance funds.

<Text of subsec. (5) effective July 1, 2013, upon notification by the division of fire safety> (5)(a) This subsection (5) applies to construction, including substantial renovation, and ongoing compliance with article 33.5 of title 24, C.R.S., of a health care facility building or structure on or after July 1, 2013. All health facility buildings and structures shall be constructed in conformity with the standards adopted by the director of the division of fire prevention and control in the department of public safety. (b) Except as provided in paragraph (c) of this subsection (5) but notwithstanding any other provision of law to the contrary, the department shall not issue or renew any license under this article unless the department has received a certificate of compliance from the division of fire prevention and control certifying that the building or structure of the health facility is in conformity with the standards adopted by the director of the division of fire prevention and control.

(c) The department has no authority to establish or enforce standards relating to building or fire codes. All functions, personnel, and property of the department as of June 30, 2013, that are principally directed to the administration, inspection, and enforcement of any building or fire codes or standards shall be transferred to the health facility construction and inspection section of the division of fire prevention and control pursuant to section 24-33.5-1201(5), C.R.S.

(d) Notwithstanding any provision of law to the contrary, all health facilities seeking certification pursuant to the federal insurance or assistance provided by title XIX of the federal "Social Security Act", as amended and commonly known as "medicaid", or the federal insurance or assistance provided by title XVIII of the federal "Social Security Act", as amended and commonly known as "medicare", or any successor code adopted or promulgated by the appropriate federal authorities, shall continue to meet such certification requirements.

(e) Nothing in this subsection (5) divests the department of the authority to perform health survey work or prevents the department from accessing related funds.

C.R.S.A. § 25.5-1-109

Department of health care policy and financing cash fund (July 1, 2006)

All moneys collected by the state department as fees or otherwise shall be transmitted to the state treasurer, who shall credit the same to the department of health care policy and financing cash fund, which fund is hereby created in the state treasury. Moneys in the fund shall be subject to annual

appropriation by the general assembly for the direct and indirect costs of the state department's duties as provided by law.

Colo. Rev. Stat. Ann. § 25.5-3-112

Health care services fund--creation--state plan amendment--primary care special distribution fund (June 3, 2011)

(1)(a) There is hereby created in the state treasury the Colorado health care services fund, referred to in this section as the " fund". The fund shall consist of moneys credited thereto pursuant to this section.

(b) In fiscal year 2005-06, the general assembly shall appropriate fourteen million nine hundred sixty-two thousand four hundred eight dollars from the general fund to the fund. Of the moneys in the general fund exempt account created in section 24-77-103.6(2), C.R.S., the following amounts shall be appropriated by the general assembly to the fund:

(I) In fiscal year 2007-08, fifteen million dollars; and

(II) In fiscal year 2008-09, twelve million nine hundred eighteen thousand seven hundred fifty dollars.
(III) Deleted by Laws 2010, Ch. 48, § 1, eff. March 29, 2010.

(b.5) In fiscal year 2009-10, the general assembly shall appropriate ten million three hundred ninety thousand dollars from the general fund to the fund.

(b.6) In fiscal year 2011-12, the treasurer shall transfer one million dollars from the general fund to the fund.

(c) All moneys appropriated to the fund shall be used as provided in this section and shall not be deposited in or transferred to the general fund of this state or to any other fund. Notwithstanding any provision of section 24-36-114, C.R.S., to the contrary, all interest derived from the deposit and investment of moneys in the fund shall be credited to the fund.

(1.5) Notwithstanding any provision of subsection (1) of this section to the contrary, on April 20, 2009, the state treasurer shall deduct five hundred thousand dollars from the fund and transfer such sum to the general fund.

(2) In fiscal year 2006-07, and each of the two fiscal years thereafter, notwithstanding the requirements of section 25.5-3-108(8)(b), the moneys deposited into the fund shall be appropriated as follows:

(a) Of the moneys appropriated pursuant to this subsection (2), eighteen percent of the moneys annually appropriated shall be to Denver health and hospitals as the community health clinic provider for the city and county of Denver.

(b)(I) For fiscal year 2006-07, eighty-two percent of the moneys remaining after the appropriation pursuant to paragraph (a) of this subsection (2) shall be appropriated to community health clinics to provide primary care services pursuant to this article.

(II) For fiscal year 2006-07, eighteen percent of the moneys remaining after the appropriation pursuant to paragraph (a) of this subsection (2) shall be appropriated to primary care clinics operated by a licensed or certified health care facility to provide primary care services pursuant to this article.

(III) For fiscal years 2007-08 and 2008-09, the allocation of the moneys remaining after the appropriation pursuant to paragraph (a) of this subsection (2) shall be determined based on prior utilization as specified in rule by the state board.

(2.5) In fiscal year 2009-10, notwithstanding the requirements of section 25.5-3-108(8)(b), the moneys deposited into the fund shall be appropriated as follows:

(a) Twenty percent of the moneys shall be appropriated to the state department for distribution to Denver health and hospitals as the community health clinic provider for the city and county of Denver;

(b) Eighty percent of the moneys shall be appropriated to the state department for distribution to community health clinics based upon prior utilizations as determined by the state department to mitigate reductions the clinics experience due to reductions in moneys available from the primary care fund created pursuant to section 24-22-117(2)(b), C.R.S.

(2.7) In the 2010-11 fiscal year, notwithstanding the requirements of section 25.5-3-108(8)(b), the moneys deposited into the fund shall be appropriated to the state department for distribution to Denver health and hospitals, as the community health clinic for the city and county of Denver, and to community health clinics. The state department shall develop a distribution formula specifying the distributions based upon prior utilizations and, to the extent possible, mitigation of the reductions in funding that the clinics experience due to reductions in moneys available from the primary care fund established pursuant to section 24-22-117(2)(b), C.R.S.

(2.8) In the 2011-12 fiscal year, notwithstanding the requirements of section 25.5-3-108(8)(b), the moneys deposited into the fund shall be appropriated to the state department for distribution to Denver health and hospitals, as the community health clinic for the city and county of Denver, to community health clinics, and to federally qualified health centers. The state department shall develop a distribution formula specifying the distributions based upon prior utilizations and, to the extent possible, mitigation of the reductions in funding that the clinics experience due to reductions in moneys available from the primary care fund established pursuant to section 24-22-117(2)(b), C.R.S.

(3)(a) The state department shall submit a state plan amendment for federal financial participation for moneys appropriated to primary care clinics operated by a licensed or certified health care facility. Upon approval of the state plan amendment, the state department is authorized to receive and expend all available federal moneys without a corresponding reduction in spending authority from the fund.

(b) To the extent possible under federal law, the state department shall pursue available federal financial participation for moneys appropriated to community health clinics.

(4) Repealed by Laws 2010, Ch. 213, § 3, eff. July 1, 2012.

10 Colo. Code Regs. § 2505-10

RURAL HEALTH CLINICS

8.740.1 DEFINITIONS

Rural Health Clinic means a clinic or center that:

1.Has been certified as a Rural Health Clinic under Medicare.

2. Is located in a rural area, which is an area that is not delineated as an urbanized area by the Bureau of the Census.

3. Has been designated by the Secretary of Health and Human Services as a Health Professional Shortage Area (HPSA) through the Colorado Department of Public Health and Environment.

4. Is not a rehabilitation facility or a facility primarily for the care and treatment of mental diseases. Visit means a face-to-face encounter between a clinic client and any health professional providing the services set forth in 8.740.4.

8.740.2 REQUIREMENTS FOR PARTICIPATION

8.740.2.A. A Rural Health Clinic shall be certified under Medicare.

8.740.2.B. A Rural Health Clinic providing laboratory services shall be certified as a clinical laboratory in accordance with 10 C.C.R 2505-10, Section 8.660.

8.740.3 CLIENT CARE POLICIES

8.740.3.A. The Rural Health Clinic's health care services shall be furnished in accordance with written policies that are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the group shall not be a member of the Rural Health Clinic staff.

8.740.3.B. The policies shall include:

1. A description of the services the Rural Health Clinic furnishes directly and those furnished through agreement or arrangement. See section 8.740.4.A.4.

2. Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or client referral, the maintenance of health care records and procedures for the

periodic review and evaluation of the services furnished by the Rural Health Clinic.

3. Rules for the storage, handling and administration of drugs and biologicals.

8.740.4 SERVICES

8.740.4.A. The following services may be provided by a certified Rural Health Clinic:

1. General services

a. Outpatient primary care services that are furnished by a physician assistant, clinical psychologist, clinical social worker, nurse practitioner or nurse midwife as defined in their respective practice acts. b. Part-time or intermittent visiting nurse care.

c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under 8.740.4.A.1.a and b.

2. Laboratory services. Rural Health Clinics furnish basic laboratory services essential to the immediate diagnosis and treatment of the client.

3. Emergency services. Rural Health Clinics furnish medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures.

4. Services provided through agreements or arrangements. The Rural Health Clinic has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including inpatient hospital care; physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the Rural Health Clinic.

8.740.5 PHYSICIAN RESPONSIBILITIES

8.740.5.A. A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on client referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.740.6 ALLOW ABLE COSTS

8.740.6.A. The following types and items of cost shall be included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician who owns, is employed by, or furnishes services under contract to a Rural Health Clinic.

2. Compensation for the duties that a supervising physician is required to perform.

3. Costs of services and supplies incident to the services of a physician, physician assistant, clinical psychologist, clinical social worker, nurse practitioner, or nurse-midwife.

4. Overhead costs, including clinic or center administration, costs applicable to use and maintenance of the entity and depreciation costs.

5. Costs of services purchased by the Rural Health Clinic.

8.740.7 REIMBURSEMENT

8.740.7.A. The Department shall reimburse Rural Health Clinics a per visit encounter rate. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

8.740.7.B. The encounter rate shall be the higher of:

1. The Prospective Payment System (PPS), as defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, BIPA is incorporated herein by reference. No amendments or later editions are incorporated. The Acute Care Benefits Section Manager at the Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of BIPA, or the materials may be examined at any publications depository library.

2. The Medicare rate.

a. The Medicare rate for hospital based Rural Health Clinics with less than 50 beds shall be based on actual costs.

b. The Medicare rate for all other Rural Health Clinics is the Medicare upper payment limit for Rural Health Clinics.

Connecticut

Conn. Gen. Stat. Ann. § 17b-349

Adjustment of rates of payment to community health centers and free-standing medical clinics participating in Medicaid program (July 1, 2013)

(a) The rates paid by the state to community health centers and free-standing medical clinics participating in the Medicaid program may be adjusted annually on the basis of the cost reports submitted to the Commissioner of Social Services, except that rates effective July 1, 1989, shall remain in effect through June 30, 1990. The Department of Social Services shall distribute funding, within available appropriations, to federally qualified health centers based on cost reports submitted to the Commissioner of Social Services, until an alternative payment methodology is approved by the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. (1) Beginning with the one-year rate period commencing on October 1, 2012, and annually thereafter, the Commissioner of Social Services may add to a community health center's rates, if applicable, a capital cost rate adjustment that is equivalent to the center's actual or projected year-to-year increase in total allowable depreciation and interest expenses associated with major capital projects divided by the projected service visit volume. For the purposes of this subsection, "capital costs" means expenditures for land or building purchases, fixed assets, movable equipment, capitalized financing fees and capitalized construction period interest and "major capital projects" means projects with costs exceeding two million dollars. The commissioner may revise such capital cost rate adjustment retroactively based on actual allowable depreciation and interest expenses or

actual service visit volume for the rate period. (2) The commissioner shall establish separate capital cost rate adjustments for each Medicaid service provided by a center. (3) The commissioner shall not grant a capital cost rate adjustment to a community health center for any depreciation or interest expenses associated with capital costs that were disapproved by the federal Department of Health and Human Services or another federal or state government agency with capital expenditure approval authority related to health care services. (4) The commissioner may allow actual debt service in lieu of allowable depreciation and interest expenses associated with capital items funded with a debt obligation, provided debt service amounts are deemed reasonable in consideration of the interest rate and other loan terms.

(5) The commissioner shall implement policies and procedures necessary to carry out the provisions of this subsection while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt such regulations is published in the Connecticut Law Journal not later than twenty days after implementation. Such policies and procedures shall be valid until the time final regulations are effective.

(b) For the fiscal year ending June 30, 1998, any grant awards made to a community health center or its successor for the purpose of supporting the community health center infrastructure services to the uninsured or expansion initiative projects shall be equivalent to base grant awards made in the fiscal year ending June 30, 1997, provided, if any portion of the amount is not required by a given community health center, the differential shall be distributed among all the other health centers according to their share of total funding.

(c) For the fiscal year ending June 30, 1999, any grant awards made to a community health center or its successor for the purpose of supporting the community health center infrastructure services to the uninsured or expansion initiative projects shall be equivalent to base grant awards made in the fiscal year ending June 30, 1997, provided, if any portion of the amount is not required by a given community health center, the differential shall be distributed among all the other health centers according to their share of total funding.

(d) For the fiscal year ending June 30, 2000, any grant awards made to a community health center or its successor for the purpose of supporting the community health center infrastructure services to the uninsured or expansion initiative projects shall be equivalent to base grant awards made in the fiscal year ending June 30, 1999, provided, if any portion of the amount is not required by a given community health center, the differential shall be distributed among all the other health centers according to their share of total funding.

(e) For the fiscal year ending June 30, 2001, any grant awards made to a community health center or its successor for the purpose of supporting the community health center infrastructure services to the uninsured or expansion initiative projects shall be equivalent to base grant awards made in the fiscal year ending June 30, 1999, provided, if any portion of the amount is not required by a given community health center, the differential shall be distributed among all the other health centers according to their share of total funding.

(f) For the fiscal year ending June 30, 2002, any grant awards made to a community health center or its successor for the purpose of supporting the community health center infrastructure services to the

uninsured or expansion initiative projects shall be in the same proportion to its grant award made in the fiscal year ending June 30, 2001, as the total appropriation for such grant awards for the fiscal year ending June 30, 2002, is to the total appropriation for such grant awards for the prior fiscal year, provided, if any portion of the amount is not required by a given community health center, the differential shall be distributed among all the other health centers according to their share of total funding.

(g) For the fiscal year ending June 30, 2003, any grant awards made to a community health center or its successor for the purpose of supporting the community health center infrastructure services to the uninsured or expansion initiative projects shall be in the same proportion to its grant award made in the fiscal year ending June 30, 2002, as the total appropriation for such grant awards for the fiscal year ending June 30, 2003, is to the total appropriation for such grant awards for the prior fiscal year, provided, if any portion of the amount is not required by a given community health center, the differential shall be distributed among all the other health centers according to their share of total funding.

(h) For the fiscal year ending June 30, 2004, any grant awards made to a community health center or its successor for the purpose of supporting the community health center infrastructure services to the uninsured or expansion initiative projects shall be in the same proportion to its grant award made in the fiscal year ending June 30, 2003, as the total appropriation for such grant awards for the fiscal year ending June 30, 2004, is to the total appropriation for such grant awards for the prior fiscal year, provided, if any portion of the amount is not required by a given community health center, the differential shall be distributed among all the other health centers according to their share of total funding.

(i) For the fiscal year ending June 30, 2005, any grant awards made to a community health center or its successor for the purpose of supporting the community health center infrastructure services to the uninsured or expansion initiative projects shall be in the same proportion to its grant award made in the fiscal year ending June 30, 2004, as the total appropriation for such grant awards for the fiscal year ending June 30, 2005, is to the total appropriation for such grant awards for the prior fiscal year, provided, if any portion of the amount is not required by a given community health center, the differential shall be distributed among all the other health centers according to their share of total funding.

Delaware

No statutes or regulations found using the search terms.

District of Columbia

D.C. Code § 44-731

Fees for clinical services. (Mar. 15, 1985)

(a) A fee, based on rates to be established by the Mayor, shall be charged to each person who is not indigent for all clinical services provided at District of Columbia health clinics. The Mayor's authority to set such fees at D.C. General Hospital and for those services provided at the Ambulatory Health Care

Administration community health clinics shall terminate on the date that the Board of Directors of the District of Columbia Health and Hospitals Public Benefit Corporation has its first meeting in accordance with § 44-1102.04(h).

(b) The following clinical health services shall be provided by the Mayor at District of Columbia health clinics, including the outpatient clinic at the D.C. General Hospital, through contractual arrangements with private agencies or providers, or through other alternative arrangements:

(1) Screening services: (A) Hypertension;

(B) Sickle cell anemia; and

(C) Asbestosis, cancer of the stomach, cancer of the colon, rectal cancer, and other diseases resulting from prolonged exposure to asbestos. Free screening services for these diseases shall be provided only to those persons who have been identified as having a high risk of asbestos related disease and who do not have any form of health insurance in accordance with recommendations of the Task Force on Asbestos Abatement and rules and regulations issued by the Mayor.

(2) Screening and treatment services:

(A) Drug addiction; (B) Lead poisoning; (C) Venereal disease;

(D) Tuberculosis outpatient care; and

(E) Forensic psychiatry.

(3) Immunization services:

(A) Communicable disease in adults and children; and

(B) Rabies in animals.

(c)(1) The Mayor may determine that certain services will be provided without charge to all patients, because such a policy is determined to be in the public interest on the basis of any of the following health factors:

(A) Threat of communicable disease; (B) Danger to the public health; or

(C) Mortality and morbidity related to a specific disease.

(2) All clinical health services shall be provided, without charge, at District of Columbia health clinics, including the outpatient clinic at the D.C. General Hospital, to persons who are receiving assistance under subchapter VII of Chapter 2 of Title 4, and who do not receive assistance under Medicaid.

(d) At the beginning of each fiscal year, the Mayor shall cause to be published in the District of Columbia Register a list of those services, if any, rendered free of charge by city clinics and by the D.C. General Hospital in the public interest.

(e) For purposes of this subchapter, the term "clinical services" shall include all health services rendered by the District in an ambulatory setting, including mental health, alcoholism, and drug treatment services.

D.C. Mun. Regs. tit. 29, § 809

AUDITS AND REVIEWS (Jan. 15, 1982)

809.1 Federal laws and regulations governing the Medicaid program mandate the ongoing conduct of audits and reviews by the state agency to detect and deter provider fraud and Medicaid patient misutilization and abuse. For the Department of Human Services, the Medical Assistance Division shall carry out these responsibilities.

809.2 The Surveillance and Utilization Review Branch (SUR) of the Medical Assistance Division, shall perform ongoing audits, on-site visits, and reviews to ensure that Medicaid payments are consistent with efficiency, economy, and quality of care.

809.3 The review process shall be routinely conducted to determine, by scientific sampling, the appropriateness of services rendered and billed to Medicaid.

809.4 The SUR shall conduct routine onsite audits and reviews of each participating FSMHC to ensure that the FSMHC records fully, accurately, and properly document the provision of appropriate services to Medicaid patients that were billed to Medicaid during the period covered by the audit.

809.5 Using a scientifically acceptable sampling technique, the SUR shall examine the medicaid patient records to determine whether or not services billed to Medicaid were appropriate and properly documented in the patient record. Questionable billings found shall be reviewed and discussed with the appropriate FSMHC staff for possible clarification and acceptance.

809.6 If SUR determines that billings are to be denied, the Department of Human Services shall recoup, by the most expeditious means available, those monies erroneously paid to the FSMHC for denied billings.

809.7 The recoupment amounts shall be determined by a formula by which a percentage shall be arrived at representing the relationship between the total billings from the FSMHC during the period being audited and the number of denied billings resulting from the audited sample which shall be applied to the total Medicaid dollars paid the FSMHC during the period covered by the audit and shall determine the dollar amount to be recouped. For example, if one hundred (100) records are audited in which one thousand (1,000) were billed to Medicaid and ten (10) of those billed services are denied for reimbursement, this represents a one percent (1%) denial rate. If during the period being audited, Medicaid paid the FSMHC ten thousand dollars ($10,000), one percent (1%), or one hundred dollars ($100) would be recouped.

809.8 A participating FSMHC shall agree to facilitate audits and reviews by maintaining the required records and by cooperating with the authorized personnel assigned to perform audits and reviews. These personnel are bound by law to fully respect and abide by all protections of the law regarding confidentiality.

809.9 All prospective FSMHC providers shall be informed that because there is federal financial participation in Medicaid payment, penalties on substantiated fraudulent activities are twenty-five thousand dollars ($25,000) fines, imprisonment up to five (5) years, or both.

Florida

West's F.S.A. § 17.58

Deposits of public money outside the State Treasury; revolving funds (June 26, 2003)

(1) All moneys collected by state agencies, boards, bureaus, commissions, institutions, and departments shall, except as otherwise provided by law, be deposited in the State Treasury. However, when the volume and complexity of collections so justify, the Chief Financial Officer may give written approval for such moneys to be deposited in clearing accounts outside the State Treasury in qualified public depositories pursuant to chapter 280. Such deposits shall only be made in depositories designated by the Chief Financial Officer. No money may be maintained in such clearing accounts for a period longer than approved by the Chief Financial Officer or 40 days, whichever is shorter, prior to its being transmitted to the Chief Financial Officer or to an account designated by him or her, distributed to a statutorily authorized account outside the State Treasury, refunded, or transmitted to the Department of Revenue. All depositories so designated shall pledge sufficient collateral to be security for such funds as provided in chapter 280.

(2) Revolving funds authorized by the Chief Financial Officer for all state agencies, boards, bureaus, commissions, institutions, and departments may be deposited by such agencies, boards, bureaus, commissions, institutions, and departments in qualified public depositories designated by the Chief Financial Officer for such revolving fund deposits; and the depositories in which such deposits are made shall pledge collateral security as provided in chapter 280.

(3) Notwithstanding the foregoing provisions, clearing and revolving accounts may be established outside the state when necessary to facilitate the authorized operations of any agency, board, bureau, commission, institution, or department. Any of such accounts established in the United States shall be subject to the collateral security requirements of chapter 280. Accounts established outside the United States may be exempted from the requirements of chapter 280 as provided in chapter 280; but before

any unsecured account is established, the agency requesting or maintaining the account shall recommend a financial institution to the Chief Financial Officer for designation to hold the account and shall submit evidence of the financial condition, size, reputation, and relative prominence of the institution from which the Chief Financial Officer can reasonably conclude that the institution is financially sound before designating it to hold the account.

(4) Each department shall furnish a statement to the Chief Financial Officer, on or before the 20th of the month following the end of each calendar quarter, listing each clearing account and revolving fund within that department's jurisdiction. Such statement shall report, as of the last day of the calendar quarter, the cash balance in each revolving fund and that portion of the cash balance in each clearing account that will eventually be deposited to the State Treasury as provided by law. The Chief Financial Officer shall show

the sum total of state funds in clearing accounts and revolving funds, as most recently reported to the Chief Financial Officer by various departments, in his or her monthly statement to the Governor, pursuant to s. 17.55.

Georgia

No statutes or regulations found using the search terms.

Hawaii

Haw. Rev. Stat. § 346-53.62

Federally qualified health centers and rural health clinics; reconciliation of managed care supplemental payments

<For contingent effect, see Laws 2008, 1st Sp. Sess., ch. 8, § 9.>

(a) Federally qualified health centers or rural health clinics that provide services under a contract with a medicaid managed care organization shall receive estimated quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payments the federally qualified health center or rural health clinic receives from medicaid managed care organizations and payments the federally qualified health center or rural health clinic would have received under the Benefits Improvement and Protection Act of 2000 prospective payment system methodology. Not more than one month following the beginning of each calendar quarter and based on the receipt of federally qualified health center or rural health clinic submitted claims during the prior calendar quarter, federally qualified health centers or rural health clinics shall receive the difference between the combination of payments the federally qualified health center or rural health clinic receives from estimated supplemental quarterly payments and payments received from medicaid managed care organizations and payments the federally qualified health center or rural health clinic would have received under the Benefits Improvement and Protection Act of 2000 prospective payment system methodology. Balances due from the federally qualified health center shall be recouped from the next quarter's estimated supplemental payment.

(b) The federally qualified health center or rural health clinic shall file an annual settlement report summarizing patient encounters within one hundred fifty days following the end of a calendar year in which supplemental payments are received from the department. The total amount of supplemental and medicaid managed care organization payments received by the federally qualified health center or rural health clinic shall be reviewed against the amount that the actual number of visits provided under the federally qualified health center's or rural health clinic's contract with the medicaid managed care organization would have yielded under the prospective payment system. The department shall also receive financial records from the medicaid managed care organization. As part of this review, the department may request additional documentation from the federally qualified health center or rural health clinic and the medicaid managed care organization to resolve differences between medicaid

managed care organization and provider records. Upon conclusion of the review, the department shall calculate a final payment that is due to or from the participating federally qualified health center or rural health clinic. The department shall notify the participating federally qualified health center or rural health clinic of the balance due to or from the federally qualified health center or rural health clinic. The notice of program reimbursement shall include the department's calculation of the balance due to or from the federally qualified health center or rural health clinic.

(c) For the purposes of this section, the payments received from medicaid managed care organizations exclude payments for non-prospective payment system services, managed care risk pool accruals, distributions, or losses, or any pay-for-performance bonuses or other forms of incentive payments such as quality improvement recognition grants and awards.

(d) An alternative supplemental managed care payment methodology other than the one set forth herein may be implemented as long as the alternative payment methodology is consented to in writing by the federally qualified health center or rural health clinic to which the methodology applies.

HRS § 40-81

Report by agencies receiving special moneys (April 30, 2010)

All state officers, departments, boards, bureaus, commissions, or agencies collecting or receiving any moneys not required by law to be deposited in the state treasury shall report to the comptroller all receipts and disbursements on account thereof for each quarterly period of the calendar year not later than the fifteenth day following the end of each quarterly period on such forms and under such rules as may be prescribed by the comptroller; provided that with respect to all moneys held outside the state treasury by the University of Hawaii until June 30, 2016, or the department of education until June 30, 2011, pursuant to the authority granted to the university and the department of education by this chapter, the University of Hawaii and the department of education shall report to the comptroller all transactions for each quarterly period not later than the fifteenth day following the end of each quarterly period on such forms and under such rules as may be prescribed by the comptroller.

Idaho

No statutes or regulations found using the search terms.

Illinois

Ill. Admin. Code tit. 89, § 140.463

Clinic Service Payment (October 22, 2007)

a) Definitions

"Behavioral Health Services", for the purposes of this Section, means services provided by a licensed clinical psychologist, licensed clinical social worker or licensed clinical professional counselor. "Center", for the purposes of this Section, means both a federally qualified health center and a rural health clinic. "Federally Qualified Health Center" or "FQHC" means a health care provider that receives a grant under Section 330 of the Public Health Service Act (Public Law 78-410) (42 USC 1395x(aa)(3)) or has been determined to meet the requirements for receiving such a grant by the Health Resources and Services Administration, U.S. Department of Health and Human Services.

"Rural Health Clinic" or "RHC" means a health care provider that has been designated by the Public Health Service, U.S. Department of Health and Human Services, or by the Governor, and approved by the Public Health Service, in accordance with the Rural Health Clinics Act (Public Law 95-210) (42 USC 1395x(aa)(2)) to be an RHC.

b) Reimbursement

The Center will be reimbursed under a prospective payment system for 100 percent of the average of the costs that are reasonable and related to the cost of furnishing such services by the Center in accordance with the provisions of federal law (42 USC 1396a(aa)). Baseline payment rates will be determined individually for each enrolled Center. Once determined, the baseline payment rate will be adjusted annually using the Medicare Economic Index (MEI). Payment for services provided on or after January 1, 2001, shall be made using specific rates for each Center as specified in this Section.

1) Baseline Payment Rates

A) For each Center, the Department will calculate a baseline medical encounter rate and, for each Center that is enrolled with the Department to provide Behavioral Health Services or dental services, the Department will calculate a baseline Behavioral Health Services or dental encounter rate, using the methodology specified in this subsection (b).

i) The cost basis for the baseline rates shall be drawn from individual Center cost reports for Center fiscal years ending in 1999 and 2000 or, in the instance of a Center that did not operate during the entirety of those periods, cost reports that cover the portions of those periods during which the Center was in operation.

ii) Pending federal approval, for dates of service provided by an FQHC on or after January 1, 2006, the cost basis for the baseline rates shall be the greater of an encounter rate using the criteria under subsection (b)(1)(A)(i) of this Section, or the same criteria that uses the Center's cost reports ending in 2002 and 2003 in place of cost reports ending in 1999 and 2000.

B) The baseline payment rates shall be based upon allowable costs, reported by the Center, that are determined by the Department to be reasonable and efficient. The method for determining allowable cost factors is similar to that used for Medicare (42 USC 1395g), with the following significant differences. The Department's methodology shall:

i) Consider costs associated with services not covered under Medicare (e.g., pharmacy, patient transportation, medical case management, health education, nutritional counseling).

ii) Apply reasonable constraints on allowable cost, as described in subsection (b)(10) of this Section. iii) Apply reasonable constraints on the total cost per encounter.

C) The baseline payment rates for a Center shall be the average (arithmetic mean) of the annual reasonable costs per encounter, calculated separately for each of the fiscal years for which cost report data must be submitted using the methodology specified in subsections (b)(2), (3) and (4) of this Section for the medical encounter rate, dental encounter rate, and Behavioral Health Services encounter rate, respectively.

2) Annual Reasonable Cost Per Medical Encounter

A) The annual reasonable cost per medical encounter shall be the lesser of:

i) The annual cost per encounter, as calculated in subsection (b)(2)(D) of this Section; or

ii) The reasonable cost of providing a medical encounter, which shall be 105 percent of the Statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

B) The core services component.

The core services component is the sum of the following two components:

i) The allowable direct cost per encounter, which is the quotient of the allowable direct cost, as defined in subsection (b)(1)(B) of this Section, for core services divided by the greater of the number of encounters reported by direct staff (e.g., staff specified in subsection (b)(10)(A) and, for the determination of encounter payment rates effective prior to January 1, 2002, subsection (b)(10)(C)); or the number of encounters resulting from the application of the minimum efficiency standards found in subsections (b)(10)(A) and (b)(10)(C); and

ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor. C) Supplemental services component.

The supplemental services component is the sum of the following two components:

i) The allowable supplemental cost per encounter, which is the quotient of the cost of services (e.g., pharmacy, patient transportation, medical case management, health education, nutritional counseling), excepting core services, dental services and, effective January 1, 2002, Behavioral Health Services, provided by the Center, divided by the greater of the number of encounters reported by direct staff; or the number of encounters resulting from application of the minimum productivity standards found in subsections (b)(10)(A) and (b)(10)(C) of this Section; and

ii) The allowable overhead cost per encounter, which is the product of the allowable supplemental cost per encounter multiplied by the Center's allowable overhead rate factor.

D) Annual cost per encounter.

The annual cost per medical encounter is the sum of the core services component, as determined in subsection (b)(2)(B) of this Section, and the supplemental services component, as determined in subsection (b)(2)(C).

3) Annual Reasonable Cost Per Dental Encounter

A) The annual reasonable cost per dental encounter shall be the lesser of:

i) The annual cost per encounter, as calculated in subsection (b)(3)(B) of this Section; or

ii) The reasonable cost of providing a dental encounter, which shall be 105 percent of the Statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

B) Annual cost per encounter.

The annual cost per encounter is the sum of the following two components:

i) The allowable direct cost per encounter, which is the quotient of the allowable direct dental cost, as defined in subsection (b)(1)(B), divided by the greater of the number of encounters reported by direct dental staff; or the number of encounters resulting from the application of the minimum efficiency standard found in subsection (b)(10)(B); and

ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

4) Annual Reasonable Cost Per Behavioral Health Service Encounter

Effective for services provided on or after January 1, 2002, a separate annual reasonable cost per Behavioral Health Service encounter shall be determined.

A) The annual reasonable cost per Behavioral Health Service encounter shall be the lesser of the following:

i) The annual cost per encounter, as calculated in subsection (b)(4)(B) of this Section.

ii) The reasonable cost of providing a Behavioral Health Service encounter, which shall be 105 percent of the Statewide median of the calculated annual cost per encounter for FQHCs or RHCs, as the case may be.

B) Annual cost per encounter.

The annual cost per encounter is the sum of the following two components:

i) The allowable direct cost per encounter, which is the quotient of the allowable direct cost for Behavioral Health Services, as defined in subsection (b)(1)(B) of this Section, divided by the greater of the number of encounters reported by direct behavioral health staff; or the number of encounters resulting from the application of the minimum efficiency standard found in subsection (b)(10)(C); and

ii) The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

5) For any individual eligible under the medical assistance programs, a Center may bill only one medical encounter, one dental encounter, and one behavioral health encounter per day. A Center will be reimbursed for a service only if it has enrolled with the Department to provide that service.

6) Claims submitted to the Department must identify all services provided during the encounter.

7) Cost Basis

Each Center must annually complete a cost report, in a format specified by the Department, for the Center's fiscal year. Each FQHC must also annually submit a copy of financial statements audited by an independent Certified Public Accountant. The cost report and audited financial statements must be filed with the Department within 180 days after the close of the Center's fiscal year, except for cost reports and audited financial statements for Center fiscal years 1999 and 2000 which, in the case of FQHCs, must be filed with the Department no later than November 30, 2001, and in the case of RHCs, must be filed no later than March 30, 2002. Except for the first year during which the Center begins operations, the cost report must cover a full fiscal year ending on June 30 or other fiscal year that has been approved by the Department. Payments will be withheld from any Center that has not submitted the cost report by the applicable filing date, and no payments will be made until such time as the reports or audited statements are received and approved by the Department.

8) Establishment of Initial Year Payment Amount for a New Center

For any Center that begins operation on or after January 1, 2001, the payment rate per encounter shall be the median of the payment rates per encounter of neighboring FQHCs or RHCs with similar caseloads, as determined by the Department. If the Department determines that there are no such comparable Centers, then the rate per encounter shall be the median of the payment rates per encounter

Statewide for all FQHCs or RHCs, as the case may be.

9) Rate Adjustments

A) Initial rate determinations.

i) On or about January 1, 2002, the Department shall determine the medical and dental encounter rates for each participating FQHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted and adjudicated prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected FQHC.

ii) On or about January 1, 2003, the Department shall determine the medical and dental encounter rates for each participating RHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted and adjudicated prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected RHC.

B) Annual adjustment.

i) Beginning January 1, 2002, and annually thereafter, except as specified in subsection (b)(9)(B)(ii) of this Section, the Department will adjust baseline rates by the most recently available MEI. The adjusted rates shall be paid for services provided on or after the date of adjustment.

ii) In the instance of a Center that provided Behavioral Health Services prior to January 1, 2002, for the purpose of applying the January 1, 2002, adjustment by the most recently available MEI, the baseline medical services encounter rate applicable for services provided from January 1, 2001, through December 31, 2001, shall be redetermined after removal of costs and encounters attributable to Behavioral Health Services.

C) Scope of service adjustment.

If a Center significantly changes its scope of services, the Center may request that new baseline encounter rates be determined. Adjustments to encounter rates will be made only if the change in the scope of services results in the inclusion of Behavioral Health Services or dental services or a difference of at least five percent from the Center's current rate. The Department may initiate a rate adjustment, based on audited financial statements or cost reports, if the scope of services has been modified to include Behavioral Health Services or dental services or would otherwise result in a change of at least five percent from the Center's current rate.

10) Reasonable Cost Considerations

The following minimum efficiency standards will be applied to determine reasonable cost: A) Medical direct care productivity.

The Center must average 4,200 encounters annually per full-time equivalent (FTE) for physicians and 2,100 encounters per FTE for mid-level health care staff (i.e., physician assistants, nurse practitioners, specialized nurse practitioners and nurse midwives).

B) Dental direct care productivity.

The Center must average 1.5 encounters per hour per FTE for dentists. C) Behavioral health direct care productivity.

The Center must average 2,100 annual encounters per FTE for licensed clinical psychologists, licensed clinical social workers and licensed clinical professional counselors.

D) Guideline for non-physician health care staff.

The maximum ratio of staff is four FTE non-physician health care staff for each FTE staff subject to the direct care productivity standards in subsections (b)(10)(A) and (B) of this Section.

E) Allowable overhead.

The maximum Medicaid allowable overhead cost is 35 percent of allowable total cost.

11) Adjustments for Medical Services Paid for by a Managed Care Organization (MCO)

The Department shall make payment adjustments to a Center if it provides care through a contractual arrangement with a Medicaid MCO and is reimbursed an amount, reported to the Department, that is less than the minimum payment required in 42 USC 1396a(aa). The amount of any such payment adjustment shall be at a fixed annual rate as determined by the Department. For each Center so eligible, a payment adjustment shall take into consideration the total payments made by the MCO to the Center (including all

payments made on a service-by-service, encounter or capitation basis). In the event that Center cost data related to MCO services are unavailable to the Department, an estimate of such costs may be used that takes into consideration other relevant data. Adjustments will be made, at least quarterly, only for Medicaid eligible services. All such services must be defined in a contract between the Center and the MCO. Such contracts must be made available to the Department.

12) Audits

All cost reports will be audited by the Department. The Center will be advised of any adjustment resulting from these audits.

13) Alternate Payment Methodology for Government-Operated Centers

A) A Center operated by a State or local government agency may elect to be reimbursed under the alternate payment methodology described in this subsection (b)(13).

B) The State or local government agency shall enter into an interagency or intergovernmental agreement, as appropriate, with the Department that specifies the responsibilities of the two parties with respect to services provided by the Center and the funding of those services.

C) The Center operated by a State or local government agency shall be reimbursed by the Department on a per encounter basis according to the provisions of subsections (b)(1) through (11) of this Section. D) The State or local government agency shall certify the expenditure of public funds in excess of reimbursement received from the Department, under subsection (b)(13)(C) of this Section, and any reimbursement from other payers (e.g., an insurance company, a managed care organization) for services provided to individuals eligible for medical assistance programs administered by the Department, provided the funds were not derived from a federal funding source or were not otherwise used as a State or local match for federal funds. The certification shall be in the form and format specified by the Department. The certification shall be filed within 30 days after the submission of the annual cost report. The certification shall compare expenditures within that cost reporting period to payments received or receivable for that same period.

E) The certified expenditures shall be used by the Department to claim federal financial participation. Federal funds resulting from the claiming of the certified expenditures shall be distributed, according to the provisions of the agreement referenced in subsection (b)(13)(B) of this Section, to the State or the government agency that operates the Center that provided the services.

14) Alternate Payment Methodology for Certain Qualifying Centers

A) No later than 30 days after the initial rate determination specified in subsection (b)(9)(A) of this Section, the Department shall determine the eligibility of each Center for this alternative payment methodology. A Center will qualify for this alternative payment methodology if the Department's estimate of the total amount to be paid to the Center for services provided during the 12-month period ending December 31, 2001, under the reimbursement policy and rates in effect prior to the initial rate

determination, is greater than the total amount that will be paid for those same services under the initial rates. The Department shall notify each qualifying Center, in writing, of the result of this determination.

B) A qualifying Center may, for services provided from January 1, 2002 through December 31, 2002, elect to be reimbursed under the alternate payment methodology described in this subsection (b)(14). A qualifying Center must notify the Department, in writing, no later than 30 days after the date of the written notification from the Department, of its election to be reimbursed under this alternative payment methodology.

C) A Center electing this alternative payment system shall be reimbursed by the Department on a per encounter basis according to the provisions of subsections (b)(1) through (11) of this Section, except the medical encounter payment rate shall be increased by an amount equal to twice the quotient resulting from the Department's estimate of the difference between the total amount to be paid to the Center for services provided during the 12-month period ending December 31, 2001, under the initial rates as determined in subsection (b)(9)(A); and the total amount that would have been paid under the payment rates in effect prior to the initial rate determination, divided by the Department's estimate of total medical encounters during the 12-month period ending December 31, 2001.

15) Alternate Behavioral Health Payment Methodology for Certain Qualifying Centers Centers that are certified by the Department of Human Services-Division of Mental Health, or the Department of Children and Family Services to provide Behavioral Health Services may elect an alternate payment methodology for their Behavioral Health Services. An election of this alternate payment methodology will allow the Centers to be reimbursed under the provisions of 59 Ill. Adm. Code 132 for Behavioral Health Services provided. A qualifying Center must notify the Department in writing, no later than 30 days after the date of the written notification from the Department, of its election to be reimbursed under this alternate payment methodology.

16) All service sites operated by a Center shall be reimbursed using the Center's established encounter rates, except in the instance where the site submitted separate cost reports and separate baseline rates were determined for the site.

c) Rate Appeals Process

1) All appeals of audit adjustments or rate determinations must be submitted in writing to the Department. Appeals must be submitted within 60 calendar days after the notification of such adjustments or rate determinations. If upheld, the revised audit adjustment or rate determination shall be made effective as of the beginning of the rate period.

2) To be accepted for review, the written appeal shall include the following:

A) The current approved reimbursement rate, allowable costs, and the additional reimbursable costs sought through the appeal.

B) A clear, concise statement of the basis for the appeal.

C) A detailed statement of financial, statistical, and related information in support of the appeal, indicating the relationship between the additional reimbursable costs as submitted and the circumstances creating the need for increased reimbursement.

D) A statement by the Center's chief executive officer or financial officer that the application of the rate appeal and information contained in the Center's reports, schedules, budgets, books, and records submitted are true and accurate.

3) Rate appeals may be considered for the following reasons:

A) Mechanical or clerical errors committed by the provider in reporting historical expenses used in the calculation of allowable costs.

B) Mechanical or clerical errors committed by the Department in auditing historical expenses as reported and/or in calculating reimbursement rates.

4) The Department shall rule on all appeals within 120 calendar days after receipt of the complete appeal, except that, if additional information is required from the facility, the period shall be extended until such time as the information is provided.

5) Appeals shall be submitted to the Department's Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763-0002.

Ill. Admin. Code tit. 77, § 230.200

Costs and Fees

a) The Department may charge a fee to any health care facility or program applying to be certified to participate in the Medicare program or in the Medicaid program to cover the costs associated with the application, inspection and survey of the facility or program and processing of the application, including personnel costs. The Department's decision to charge a fee will be based on whether the inspection and survey and processing costs are reimbursed to the State by the federal government. (Section 55.82 of the Act)

b) The costs associated with conducting health care facility or program initial certification inspections shall be calculated based on the following:

1) Number of hours to conduct survey for facility or program type, i.e., long-term care facility, home health agency, rural health clinic, end-stage renal dialysis center, hospice program, hospital, physical or occupational therapist in independent practice, occupational therapy, speech therapy, outpatient physical therapy, ambulatory surgical treatment center, portable x-ray unit;

2) Personnel costs (i.e., average salaries of surveyors and retirement, insurance, and social security benefits);

3) Travel costs;

4) Processing of the application. (Section 55.82 of the Act)

c) The fee charged to a health care facility or program for an initial certification inspection shall be determined by the actual average cost for conducting surveys for that type of program or facility during the previous 12 months.

d) If a fee is charged, it shall be reduced by the amount reimbursed to the State by the federal government for surveys for that type of program or facility during the previous quarter of the federal fiscal year.

e) The Department shall notify the applicant of the amount of any fee to be charged within 30 calendar days after receiving a completed application.

f) The fee shall be paid by the facility or program before the application is processed. (Section 55.82 of the Civil Administrative Code of Illinois) If the applicant does not submit the fee to the Department within 30 calendar days after receipt of the notice, the applicant shall be considered to have declined the certification inspection.

g) The Department shall not refund initial certification inspection fees.

h) If unforeseen circumstances affecting the facility or program occur after the fee has been paid, the Department shall postpone the inspection and shall not charge an additional fee. Such circumstances may include, but not be limited to, a natural disaster or a loss of essential services.

Ill. Admin. Code tit. 89, § 140.462

Covered Services in Clinics (April 29, 2013)

Payment shall be made to clinics for the following types of services when provided by, or under the direction of, a physician:

a) Hospital-Based Organized Clinics

1) With respect to those hospital-based organized clinics that qualify as Maternal and Child Health clinics, as described in Section 140.461(f)(1), covered services are those described in subsection (e), as appropriate.

2) With respect to all other hospital-based organized clinics, covered services are those described in 89 Ill. Adm. Code 148.

3) Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C). b) Encounter Rate Clinics

1) With respect to those encounter rate clinics that qualify as Maternal and Child Health providers, as described in Section 140.924(a)(2)(B), covered services are those described in Section 140.922.

2)With respect to all other encounter rate clinics, covered services are medical services that provide for the continuous health care needs of persons who elect to use this type of service, including dental services that will be billed as separate encounters for dates of service on or after January 1, 2011.

3) Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C). c) Rural Health Clinics

Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's Services, including covered services of nurse practitioners, nurse midwives and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

2) Other services for which a separate encounter may be billed include dentist and behavioral health services as defined in Section 140.463(a).

3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice that have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include:

A) medical case management; B) laboratory services;

C) occupational therapy; D) patient transportation; E) pharmacy services;

F) physical therapy; G) podiatric services;

H) speech and hearing services; I) x-ray services;

J) health education; K) nutrition services;

L) optometric services.

4) A rural health clinic (RHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service provided.

5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing prior to billing for the services.

6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any RHC services with the exception of services identified in subsections (c)(7) and (c)(8).

7) Effective July 1, 2012 through June 30, 2013, a physician or APN may submit fee-for-service billings for implantable contraceptive devices administered in an RHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;

B) The RHC must be listed as the payee on the claim;

C) Reimbursement shall be made at the RHC 's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

D) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.

8) Effective July 1, 2013, an RHC may submit fee-for-service billings for implantable contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the RHC's actual acquisition cost;

B) Reimbursement shall be made at the RHC 's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

C) This reimbursement shall be separate from any encounter payment the RHC may receive for implanting the device.

d) Federally Qualified Health Centers

Those core services for which the clinic or center may bill an encounter as described in 42 CFR 440.90 (2000) are as follows:

1) Physician's services, including covered services of nurse midwives, nurse practitioners and physician-supervised physician assistants. Group psychotherapy services must meet the guidelines set forth in Section 140.413(a)(4)(C).

2) Other services for which separate encounters may be billed include dentists and behavioral health services as defined in Section 140.463(a).

3) Medically-necessary services and supplies furnished by or under the direction of a physician or dentist within the scope of licensed practice have been included in the cost report but neither fee-for-service nor encounter billings may be billed. Some examples of these services include: A) medical case management;

B) laboratory services;

C) occupational therapy; D) patient transportation; E) pharmacy services;

F) physical therapy; G) podiatric services; H) optometric services;

I) speech and hearing services; J) x-ray services;

K) health education; L) nutrition services.

4) A federally qualified health center (FQHC) that adds behavioral health services or dental services on or after October 1, 2001, must notify the Department in writing. These services are to be billed as an encounter with a procedure code that appropriately identifies the service.

5) Any service that is no longer provided on or after October 1, 2001, or any new service added on or after October 1, 2001, must be communicated to the Department in writing.

6) Effective January 1, 2001, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) precludes fee-for-service billings for any FQHC services provided with the exception of services identified in subsections (d)(7) and (d)(8).

7) Effective July 1, 2012 through June 30, 2013, a physician or APN may submit fee-for-service billings for implantable contraceptive devices administered in an FQHC. Reimbursement for the implantable contraceptive devices shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;

B) The FQHC must be listed as the payee on the claim;

C) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

D) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.

8) Effective July 1, 2013, an FQHC may submit fee-for-service billings for implantable contraceptive devices. Reimbursement for the implantable contraceptive device shall be made in accordance with the following:

A) To the extent that the implantable device was purchased under the 340B Drug Pricing Program, the device must be billed at the FQHC's actual acquisition cost;

B) Reimbursement shall be made at the FQHC's actual acquisition cost or the rate on the Department's practitioner fee schedule, whichever is applicable;

C) This reimbursement shall be separate from any encounter payment the FQHC may receive for implanting the device.

e) Maternal and Child Health Clinics

Payment shall be made to the Maternal and Child Health clinics identified in Section 140.461(f)(1) for the following services when provided by, or under the direction of, a physician:

1) In the case of clinics described in Section 140.461(f)(1)(A) and (f)(1)(B), primary care services delivered by the clinic, which must include, but are not necessarily limited to:

A) Early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;

B) Childhood risk assessments to determine potential need for mental health and substance abuse assessment and/or treatment;

C) Regular immunizations for the prevention of childhood diseases;

D) Follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as a result of an EPSDT screening;

E) Routine prenatal care, including risk assessment, for pregnant women; and

F) Specialty care as medically needed.

2) In the case of clinics described in Section 140.461(f)(1)(C), primary care and specialty services delivered by the clinic, which must include, but are not necessarily limited to:

A) Prenatal care, including risk assessment (one risk assessment per pregnancy);

B) All ambulatory treatment services deemed medically necessary, recommended, or prescribed by a physician as the result of the assessment; and

C) Services to pregnant women with diagnosed substance abuse or addiction problems.

3) In the case of clinics described in Section 140.461(f)(1)(D): A) Comprehensive medical and referral services.

B) Primary care services, which must include, but are not necessarily limited to:

i) early, periodic, screening, diagnostic, and treatment (EPSDT) services as defined in Section 140.485;

ii) regular immunizations for the prevention of childhood diseases; and

iii) follow-up ambulatory medical care deemed necessary, recommended, or prescribed by a physician as the result of an EPSDT screening.

C) Pediatric specialty services, which must include, at a minimum, necessary treatment for:

i) asthma,

ii) congenital heart disease, iii) diabetes, and

iv) sickle cell anemia.

D). Ambulatory treatment for other medical conditions as specified in the center's certificate application and as approved by the Department.

f) School Based/Linked Health Clinics (Centers)

Covered services are the following services, when delivered in a school based/linked health center setting as described in Section 140.461(g):

1) Basic medical services: well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance;

immunizations; EPSDT services; diagnosis and treatment of acute illness and injury; basic laboratory tests; prescriptions and dispensing of commonly used medications for identified health conditions, in accordance with Medical Practice and Pharmacy Practice Acts; and acute management and on-going monitoring of chronic conditions, such as asthma, diabetes and seizure disorders.

2) Reproductive health services: gynecological exams; diagnosis and treatment of sexually transmitted diseases; family planning; prescribing and dispensing of birth control or referral for birth control services; pregnancy testing; treatment or referral for prenatal and postpartum care; and cancer screening.

Indiana

No statutes or regulations found using the search terms.

Iowa

I.C.A. § 8A.503

Rules--deposit of departmental moneys

The director shall prescribe by rule the manner and methods by which all departments and agencies of the state who collect money for and on behalf of the state shall cause the money to be deposited with the treasurer of state or in a depository designated by the treasurer of state. All such moneys collected shall be deposited at such times and in such depositories to permit the state of Iowa to deposit the funds in a manner consistent with the state's investment policies. All such moneys shall be promptly deposited, as directed, even though the individual amount remitted may not be correct. If any individual amount remitted is in excess of the amount required, the department or agency receiving the same shall refund the excess amount. If the individual amount remitted is insufficient, the person, firm, or corporation concerned shall be immediately billed for the amount of the deficiency.

I.C.A. § 12.10

Deposits by state officers

Except as otherwise provided, all elective and appointive state officers, boards, commissions, and departments shall, within ten days succeeding the collection, deposit with the treasurer of state, or to the credit of the treasurer of state in any depository designated by the treasurer of state, ninety percent of all fees, commissions, and moneys collected or received. The balance actually collected in cash, remaining in the hands of any officer, board, or department shall not exceed the sum of five thousand dollars and money collected shall not be held more than thirty days. This section does not apply to the state fair board, the state board of regents, the utilities board of the department of commerce, the director of the department of human services, the Iowa finance authority or to the funds received by the state racing and gaming commission under sections 99D.7 and 99D.14.

Kansas

K.S.A. 75-4215

Remittance of state moneys; fee agency accounts; reports; post audit

(a) All moneys collected by any state agency shall be remitted daily to the state treasurer unless otherwise authorized by the board to remit less frequently.

(b) If a state agency is authorized by the board to maintain a fee agency account pursuant to K.S.A. 75-4214, and amendments thereto, any moneys collected by the state agency shall be deposited daily in the fee agency account. Fee agency account balances shall be remitted daily or less often if authorized by the board, to the state treasurer by such agency drawing on such fee agency account all moneys therein except for any balances required for direct refunds of tuition, fees or charges from such fee agency account authorized under K.S.A. 76-738, and amendments thereto. When requested, such agency shall file with the board a detailed and verified report with each deposit showing the sources from which such moneys were received. The board shall have the authority to limit specific types of moneys that can be deposited in a fee agency account.

(c) Fee agency accounts and moneys to be deposited therein shall be subject to post audit under article 11 of chapter 46 of Kansas Statutes Annotated.

Kentucky

Ky. Rev. Stat. Ann. § 216B.131

Use of moneys (July 13, 1990)

(1) All moneys derived from applicants seeking certificates of need or licenses or from any other sources connected with this chapter shall be promptly paid over to the State Treasurer, who shall deposit such moneys in a special fund which, in addition to appropriated funds, shall be used to carry out the purposes of this chapter and for no other purpose.

(2) Any fine imposed for the violation of this chapter shall, when collected, be paid into the Kentucky nursing incentive scholarship fund.

902 Ky. Admin. Regs. 20:145

Operations and services; rural health clinics (October 17, 2001)

Section 1. Location and Requirement to Provide Services. (1) A health facility shall not be licensed or relicensed as a rural health clinic unless it:

(a) Is located in an area designated by the United States Public Health Service, Division of Shortage Designation as a:

1. Health professional shortage area; or

2. Medically-underserved area; and

(b) Complies with the requirements established in Sections 2 and 3 of this administrative regulation.

(2) The rural health clinic may be freestanding, or may be a subordinate part of a licensed health facility, or health service.

Section 2. Administration and Operation. (1) The licensee shall be legally responsible for the operation of the clinic and for compliance with federal, state, and local law pertaining to the operation of the clinic.

(2) The rural health clinic shall be under the medical direction of a physician.

(3) The licensee shall establish written policies and lines of authority, and shall designate the person who shall be principally responsible for the daily operation of the clinic.

(4) The licensee shall develop patient care policies with the advice of a group of professional personnel that includes one (1) or more physician, and one (1) or more advanced practice registered nurse or physician assistant. At least one (1) member shall not be an employee of the rural health clinic. The policies shall include:

(a) A description of the services provided directly by the rural health clinic and those provided through agreement;

(b) Guidelines for the medical management of health problems which include the conditions requiring medical consultation and patient referral, and the maintenance of health records;

(c) Procedures to be followed in the storage, handling, and administration of drugs and biologicals; and

(d) Procedures for an annual review and evaluation of the services provided by the clinic.

(5) Personnel. The rural health clinic shall have a staff that includes at least one (1) physician and at least one (1) advanced practice registered nurse or physician assistant. The clinic shall employ other staff or ancillary personnel necessary to provide the services essential to the clinic's operation.

(a) The physician shall:

1. Be responsible for all medical aspects of the center and shall provide direct medical services in accordance with the Medical Practice Act, KRS Chapter 311;

2. Provide medical direction, supervision, and consultation to the staff;

3. In conjunction with the advanced practice registered nurse(s) or physician assistant(s), participate in developing, executing, and periodically reviewing the rural health clinic's written policies and services;

4. Periodically review the rural health clinic's patient records;

5. Provide medical orders and medical care services to patients of the rural health clinic; and

6. Be physically present for weekly consultation;

7. Be available within one (1) hour, through direct telecommunication, for consultation, assistance with medical emergencies, or patient referral.

(b) The advanced practice registered nurse or physician assistant shall:

1. Participate in the development, execution and periodic review of the written policies governing the services the rural health clinic provides;

2. Participate with the physician in periodic review of patient health records;

3. Provide services in accordance with rural health clinic policies, established protocols; and a. For an advanced practice registered nurse, the Nurse Practice Act, KRS Chapter 314, and administrative regulations relating to the practice of an advanced practice registered nurse; or

b. For a physician assistant, KRS 311.565 and administrative regulations relating to the practice of a physician assistant:

4. Arrange for, or refer a patient to, a needed service that is not provided at the rural health clinic; and

5. Assure that adequate patient health records are maintained and transferred when a patient is referred.

(6) The rural health clinic shall have a linkage agreement or an arrangement for patient referral with each of the following:

(a) Inpatient hospital care;

(b) Physician services in a hospital, patient's home, or long term care facility;

(c) Additional and specialized diagnostic and laboratory services that are not available at the rural health clinic;

(d) Home health agency;

(e) Local health department;

(f) Emergency medical services; and

(g) Pharmacy services.

(7) The rural health clinic shall maintain a clinical record system in accordance with written policies and procedures. A member of the professional staff shall be designated to be responsible for maintaining the records and for insuring that the records are systematically organized, readily accessible and accurately documented.

(8) For a patient receiving health care services, the rural health clinic shall maintain a record that includes, as applicable:

(a) Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient for each contact;

(b) Reports of physical examinations, diagnostic and laboratory test results, and consultative findings; (c) All orders, reports of treatments rendered and medications given and other pertinent information necessary to monitor the patient's progress;

(d) Signature of the physician or other health care professional on each order written or treatment provided.

(9) The rural health clinic shall maintain the confidentiality of medical record information and shall safeguard against loss, destruction, or unauthorized use. Written policies and procedures shall govern the use and removal of records from the clinic and the condition for release of information.

(10) Medical records shall be retained for a minimum of five (5) years or in the case of a minor, three (3) years after the patient reaches the age of majority under state law, whichever is the longer.

(11) The rural health clinic shall carry out or arrange for an annual evaluation of its total program, consider the findings of the evaluation, and take corrective action, if necessary. The evaluation shall include:

(a) The utilization of clinic services including at least the number of patients served and the volume of services;

(b) A representative sample of both active and closed clinical records; (c) The rural health clinic's health care policies.

Section 3. Services. (1) The rural health clinic shall develop and maintain written protocols that: (a) Are signed by a staff physician;

(b) Explicitly direct the step-by-step collection of subjective and objective medical data from a patient; (c)

Direct explicit medical action depending on the medical data collected; and

(d) Include:

1. Standing orders;

2. Rules of practice; and

3. Medical directives.

(2) The rural health clinic staff shall furnish diagnostic and therapeutic services and supplies commonly furnished in a physician's office, or at the entry point into the health care delivery system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions.

(3) The rural health clinic shall provide basic laboratory services essential to the immediate diagnosis and treatment of the patient, including:

(a) Chemical examinations of urine by stick or tablet methods, or both, including urine ketones; (b) Hemoglobin or hematocrit;

(c) Glucose;

(d) Examination of stool specimens for occult blood; (e) Pregnancy tests; and

(f) Primary culturing for transmittal to a hospital laboratory or licensed laboratory.

(4) The rural health clinic shall provide medical emergency procedures as a first response to common life-threatening injuries and acute illness, and shall have available the drugs and biologicals commonly used in lifesaving procedures, such as analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids.

(5) The clinic shall post in a conspicuous area at the entrance, visible from the outside of the clinic, the hours that emergency medical services will be available in the clinic, and where emergency medical services not provided by the clinic can be obtained during and after the clinic's regular scheduled hours of operation.

907 Ky. Admin. Regs. 1:055

Payments for primary care center, federally-qualified health center, and rural health clinic services (October 16, 2002)

Section 1. Definitions. (1) “Allowable costs” means costs that are incurred by a center or clinic that are reasonable in amount and proper and necessary for the efficient delivery of services.

(2) “Audit” means an examination, which may be full or limited in scope, of a clinic's or center's financial transactions, accounts, and reports as well as its compliance with applicable Medicare and Medicaid regulations, manual instructions, and directives.

(3) “Center” means a federally-qualified health center or a primary care center.

(4) “Change in scope of service” means a change in the type, intensity, duration, or amount of service. (5) “Clinic” means a rural health clinic.

(6) “Department” means the Department for Medicaid Services or its designated agent. (7) “Federally-qualified health center” or “FQHC” is defined in 42 C.F.R. 405.2401.

(8) “Health care provider” means:

(a) A licensed physician;

(b) A licensed osteopathic physician; (c) A licensed podiatrist;

(d) A licensed optometrist;

(e) A licensed and certified advanced registered nurse practitioner; (f) A licensed dentist or oral surgeon;

(g) A certified physician assistant; or

(h) For an FQHC:

1. A licensed clinical social worker; or

2. A licensed clinical psychologist.

(9) “Interim rate” means a reimbursement fee established by the department to pay a FQHC, RHC, or primary care center for covered services prior to the establishment of a PPS rate.

(10) “Medically necessary” or “medical necessity” means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(11) “Medicare Economic Index” or “MEI” means the economic index referred to in 42 U.S.C. 1395u(b)(3)(L).

(12) “PCC” or “primary care center” means an entity that has met the licensure requirements established in 902 KAR 20:058.

(13) “Percentage increase in the MEI” is defined in 42 U.S.C. 1395u(i)(3). (14) “PPS” means prospective payment system.

(15) “Rate year” means the twelve (12) month period beginning July 1 of each year for which a rate is established for a center or clinic under the prospective payment system.

(16) “Reasonable cost” means a cost as determined by the applicable Medicare cost reimbursement principles set forth in 42 C.F.R. Part 413, 45 C.F.R. 74.27, and 48 C.F.R. Part 31.

(17) “RHC” or “rural health clinic” is defined in 42 C.F.R. 405.2401(b).

(18) “Visit” means a face-to-face encounter between a patient and a health care provider during which a FQHC, RHC, or PCC service is delivered.

Section 2. Provider Participation Requirements. (1) A participating center or clinic shall be enrolled in the Kentucky Medicaid Program.

(2) An FQHC shall be enrolled as a primary care center.

(3) A participating center or clinic and staff shall comply with all applicable federal, state, and local regulations concerning the administration and operation of a PCC, FQHC, or an RHC.

(4) A center or clinic performing laboratory services shall meet the requirements established in 907 KAR 1:028 and 907 KAR 1:575.

Section 3. Reimbursement. (1) For services provided on and after July 1, 2001, the department shall reimburse a PCC, FQHC, or RHC an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS) as required by 42 U.S.C. 1396a(aa).

(2) The department shall calculate a PPS base rate for:

(a) An existing center or clinic in accordance with Section 4 of this administrative regulation; or

(b) A new center or clinic in accordance with Section 5 of this administrative regulation. (3) The department shall adjust a PPS rate per visit:

(a) By fifty (50) percent of the percentage increase in the MEI applicable to primary care services on January 1, 2002;

(b) By the percentage increase in the MEI applicable to primary care services on July 1 of each year, beginning July 1, 2002; and

(c) In accordance with Section 6 of this administrative regulation:

1. Upon request and documentation by a center or clinic that there has been a change in scope of services; or

2. Upon review and determination by the department that there has been a change in scope of services.

(4) A rate established in accordance with this administrative regulation shall not be subject to an end of the year cost settlement.

Section 4. Establishment of a PPS Base Rate for an Existing Provider. (1) The department shall establish a PPS base rate to reimburse an existing PCC, FQHC, and RHC 100 percent of its average allowable cost of providing Medicaid-covered services during a center's or clinic's fiscal years 1999 and 2000. A center's or clinic's fiscal year that ends on January 31 shall be considered ending the prior year.

(2) A center or clinic shall complete MAP 100601 annually and submit it to the department by the last calendar day of the third month following the center's or clinic's fiscal year end.

(3) The department shall:

(a) Use a center's or clinic's desk reviewed or audited cost reports for fiscal years ending February 1999 through January 2000 and February 2000 through January 2001;

(b) Trend the cost from the second base year forward to July 1, 2001 by the percentage of increase as measured by the HCFA hospital market basket index; and

(c) Calculate the average cost by dividing the total cost associated with FQHC, PCC, and RHC services by the total visits associated with the FQHC, PCC, and RHC services.

(4) If a center or clinic has only one (1) full year of cost report data, the department shall calculate a PPS base rate using a single-audited cost report.

(5) The department shall adjust a PPS base rate determined in accordance with this section to account for an increase or decrease in the scope of services provided during fiscal year 2001 in accordance with Section 6 of this administrative regulation.

(6) Until the establishment of a PPS base rate by the department, a center or clinic shall be paid for services at an interim rate.

(7) Except for a center that has been receiving an incentive payment, the interim rate shall be the rate on file on June 30, 2001.

(8) A center that has been receiving an incentive payment shall have an interim rate based upon the average costs of providing services for fiscal years 1999 and 2000. The average shall be calculated in accordance with this section using unaudited cost report data.

(9) A center shall not be eligible for an incentive payment for services provided on and after July 1, 2001.
(10)(a) A center or clinic shall have thirty (30) days from the date of notice by the department of its PPS rate to request an adjustment based on a change in scope of services; and

(b) The department shall have thirty (30) days to review the request prior to establishing a final PPS rate that shall be subject to appeal in accordance with Section 9 of this administrative regulation.

Section 5. Establishment of a PPS Base Rate for a New Provider. (1) The department shall establish a PPS base rate to reimburse a new PCC, FQHC, and RHC 100 percent of its reasonable cost of providing Medicaid covered services during a center's or clinic's base year.

(2) Reasonable costs shall be determined by the department based on a center's or clinic's cost report used by the department to establish the PPS rate.

(3) Until a center or clinic submits a Medicaid cost report containing twelve (12) full months of operating data for a fiscal year, the department shall make payments to the center or clinic based on an interim rate.

(4) A new center or clinic shall submit a budget that sets forth:

(a) Estimates of Medicaid allowable costs to be incurred by the center or clinic during the initial reporting period of at least twelve (12) months; and

(b) The number of Medicaid visits a center or clinic expects to provide during the reporting period.

(5) An interim payment shall be based on an annual budgeted or projected average cost per visit that shall be subject to reconciliation after a Medicaid cost report with twelve (12) months of actual operating data has been received.

Section 6. Adjustments to a PPS Rate. (1) If a center or clinic changes its scope of services after the base year, the department shall adjust a center's or clinic's PPS rate by dividing a center's or clinic's total Medicaid costs by total Medicaid visits. A provider shall submit MAP 100501 to request a rate adjustment after a change in service.

(2) Total Medicaid costs shall be determined in accordance with the following:

(a) The Medicaid costs of existing services shall be determined by multiplying a center's or clinic's current Medicaid PPS rate by the number of Medicaid visits used to calculate the base Medicaid PPS rate; and

(b) The Medicaid costs of a new service shall be determined by:

1. Adding:

a. The projected annual direct cost of a new service as determined from a center's or clinic's budgeted report; and

b. The administrative cost of a new service which shall be equal to the ratio of administrative costs to direct costs determined from the base-year cost reports multiplied by a center's or clinic's projected direct cost of a new service; and

2. Multiplying the sum derived in subparagraph 1 of this paragraph by a center's or clinic's projected Medicaid utilization percentage for the change in service.

(3) The amount determined in subsection (2)(a) of this section shall be added to the amount determined in subsection (2)(b) of this section.

(4) The amount determined in subsection (3) of this section shall be divided by total visits to derive a center's or clinic's new PPS rate.

(5) Total Medicaid visits shall include:

(a) The annual number of Medicaid visits used in the calculation of the PPS base rate; and

(b) The projected annual number of Medicaid visits for a new service.

(6) The department shall adjust the PPS rate determined under this section to a final rate upon completion of:

(a) A Medicaid comprehensive desk review of a center's or clinic's cost report;

(b) A Medicaid audit of a center's or clinic's cost report in accordance with 45 C.F.R. 74.27 and 48 C.F.R.

Part 31; or

(c) A Medicare audit that has been reviewed and accepted by Medicaid of a center's or clinic's cost report. Section 7. Limitations. (1) Except for a case in which a patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment, an encounter with more than one (1) health care provider and multiple encounters with the same health care provider which take place on the same day and at a single location shall constitute a single visit.

(2) A vaccine available without charge to a FQHC, RHC, or PCC through the Vaccines for Children Program and the administration of the vaccine shall not be reported as a cost to the Medicaid Program. Section 8. Out-of-State Providers. Reimbursement to an out-of-state FQHC or RHC shall be the rate on file with their state Medicaid agency.

Section 9. Appeal Rights. (1) An appeal of a negative action taken by the department regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

(2) An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) A FQHC, PCC, or RHC may appeal department decisions as to the application of this administrative regulation as it impacts the facility's reimbursement rate in accordance with 907 KAR 1:671.

Section 10. Incorporation by Reference. (1) The following material is incorporated by reference: (a) “MAP 100501, Prospective Payment System Rate Adjustment, November, 2001 edition”; and (b) “MAP 100601, Scope of Services Survey Baseline Documentation, November, 2001 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 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

Louisiana

La. Const. art. VII, § 10.9

Louisiana Fund (July 1, 2001)

A. The Louisiana Fund is established in the state treasury as a special fund. After allocation of money to the Bond Security and Redemption Fund as provided in Article VII, Section 9(B) of this constitution, the treasurer shall deposit in and credit to the Louisiana Fund all remaining monies received as a result of the Settlement Agreement after deposits into the Millennium Trust as provided in Section 10.8 of this Article, and all interest income on the investment of monies in the Louisiana Fund. Monies in the Louisiana Fund shall be invested by the treasurer in the same manner as the state general fund.

B. Appropriations from the Louisiana Fund shall be restricted to the following purposes:

(1) Initiatives to ensure the optimal development of Louisiana's children through enhancement of educational opportunities and the provision of appropriate health care, which shall include but not be limited to:

(a) Early childhood intervention programs targeting children from birth through age four, including programs to reduce infant mortality.

(b) Support of state programs for children's health insurance.

(c) School-based health clinics, rural health clinics, and primary care clinics.

(2) Initiatives to benefit the citizens of Louisiana with respect to health care through pursuit of innovation in advanced health care sciences, provision of comprehensive chronic disease management services, and expenditures for capital improvements for state health care facilities.

(3) Provision of direct health care services for tobacco-related illnesses.

(4) Initiatives to diminish tobacco-related injury and death to Louisiana's citizens through educational efforts, cessation assistance services, promotion of a tobacco-free lifestyle, and enforcement of the requirements of the Settlement Agreement by the attorney general.

C. Each appropriation from the Louisiana Fund shall include performance expectations to ensure accountability in the expenditure of such monies. Any unexpended and unencumbered monies in each fund at the end of a fiscal year shall remain in the respective fund.

Maine

No statutes or regulations found using the search terms.

Maryland

COMAR 10.09.02.07

Payment Procedures

A. The provider shall submit the request for payment on the form designated by the Department.

B. The Department reserves the right to return to the provider, before payment, all invoices not properly signed, completed, and accompanied by properly completed forms required by the Department.

C. Physicians shall charge the Program their usual and customary charge to the general public for similar services, except for injectable drugs, the provision of diagnostic or therapeutic radiopharmaceuticals, and dispensed medical supplies, in which case, physicians shall charge the Program their acquisition cost.

D. The Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, Revision July-December 2011, is contained in the Medical Assistance Provider Fee Manual, dated October 1986. All the provisions of this document, unless specifically excepted, are incorporated by reference.

E. The Department will pay for covered services at the lower of: (1) Physician's customary charge or acquisition cost;

(2) The Department's fee schedule.

F. The Program reserves the right to negotiate and establish a different fee for a physician or a group of physicians under contract to a hospital to provide services when a portion of the cost of the contract is paid as the hospital's cost, provided this fee does not exceed limitations set forth in §E of this regulation.

G. Supplemental payments on Medicare claims are made subject to the following provisions:

(1) Deductible insurance will be paid in full;

(2) Beginning with August 1, 2010 dates of service, and subject to the limitations of the State budget, coinsurance, shall be paid:

(a) In full for the following: (i) Mental health services;

(ii) CPT codes that are priced by report; (iii) Claims for anesthesia services;

(iv) Claims from a federally qualified health center; and

(v) HCPCS codes beginning with A through W; and

(b) For all other claims, at the lesser of:

(i) 100 percent of the coinsurance amount; or

(ii) The balance remaining after the Medicare payment is subtracted from the Medicaid rate; and

(3) Services not covered by Medicare are payable according to §E of this regulation. H. Payments on Medicare claims are authorized if the:

(1) Provider accepts Medicare assignments;

(2) Medicare makes direct payment to the provider;

(3) Medicare has determined that services were medically justified; (4) Services are covered by the Program;

(5) Initial billing is made directly to Medicare according to Medicare guidelines. I. The provider may not bill the Department or the recipient for:

(1) Completion of forms and reports; (2) Broken or missed appointments;

(3) Professional services rendered by mail or telephone;

(4) Services which are provided at no charge to the general public; and

(5) Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of the recipient.

J. The Program will make no direct payment to recipients.

K. The Program will reimburse the provider for dispensed drugs at rates established in COMAR 10.09.03. The provider shall bill the Program in accordance with COMAR 10.09.03 using the Pharmacy Invoice.

L. The program will reimburse the provider for injectable drugs at rates promulgated by the fee schedule under §D of this regulation.

M. The Program will reimburse the provider for dispensed medical supplies at actual cost or at rates established by COMAR 10.09.12, whichever is less.

N. Billing time limitations for claims submitted pursuant to this chapter are set forth in COMAR 10.09.36.

O. Providers shall bill the Program in the following manner:

(1) A physician whose laboratory is not required to be registered pursuant to Health-General Article, Title 17, Subtitles 2 and 3, Annotated Code of Maryland, shall bill the Program for laboratory services in accordance with procedures required under these regulations;

(2) A physician whose laboratory is registered as a medical laboratory pursuant to Health-General Article, Title 17, Subtitles 2 and 3, Annotated Code of Maryland, shall bill the Program for laboratory services in accordance with procedures required under COMAR 10.09.09.

P. Reimbursement.

(1) The Program shall reimburse providers for all laboratory and other diagnostic services performed by a physician, or by authorized personnel under that physician's supervision, for that physician's patients.

(2) Reimbursement shall be according to all applicable provisions of COMAR 10.10.06 and fees established under COMAR 10.09.02.

(3) Maximum reimbursement may not exceed the Medicare laboratory fee established by the Maryland Medicare carrier recognized by the Program.

(4) The Program shall reimburse providers for mental health services performed by a physician according to the fees established under COMAR 10.21.25 and the requirements of this chapter.

Q. The Program will reimburse the provider for the provision of diagnostic and therapeutic radiopharmaceuticals at actual cost.

Massachusetts

No statutes or regulations found using the search terms.

Michigan

No statutes or regulations found using the search terms.

Minnesota

Minn. Stat. Ann. § 256L.11

Provider payment (July 21, 2011)

Subdivision 1. Medical assistance rate to be used. (a) Payment to providers under sections 256L.01 to 256L.11 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to 6.

(b) Effective for services provided on or after July 1, 2009, total payments for basic care services shall be reduced by three percent, in accordance with section 256B.766. Payments made to managed care and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

(c) Effective for services provided on or after July 1, 2009, payment rates for physician and professional services shall be reduced as described under section 256B.76, subdivision 1, paragraph (c). Payments made to managed care and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

Subd. 2. Payment of certain providers. Services provided by federally qualified health centers, rural health clinics, and facilities of the Indian health service shall be paid for according to the same rates and conditions applicable to the same service provided by providers that are not federally qualified health centers, rural health clinics, or facilities of the Indian health service.

Subd. 2a. Payment rates; services for families and children under the MinnesotaCare health care reform waiver. Subdivision 2 shall not apply to services provided to families with children who are eligible according to section 256L.04, subdivision 1, paragraph (a).

Subd. 3. Inpatient hospital services. Inpatient hospital services provided under section 256L.03, subdivision 3, shall be paid for as provided in subdivisions 4 to 6.

Subd. 4. Definition of medical assistance rate for inpatient hospital services. The “medical assistance rate,” as used in this section to apply to rates for providing inpatient hospital services, means the rates established under sections 256.9685 to 256.9695 for providing inpatient hospital services to medical assistance recipients who receive Minnesota family investment program assistance.

Subd. 5. Enrollees younger than 18. Payment for inpatient hospital services provided to MinnesotaCare enrollees who are younger than 18 years old on the date of admission to the inpatient hospital shall be at the medical assistance rate.

Subd. 6. Enrollees 18 or older. Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the $10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5. Inpatient services paid directly by the commissioner under this paragraph do not include chemical dependency hospital-based and residential treatment.

Subd. 7. Critical access dental providers. Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2007, through August 31, 2011, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 50 percent above the payment rate that would otherwise be paid to the provider. Effective for dental services provided on or after September 1, 2011, the commissioner shall increase the payment rate by 30 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

Mississippi

Miss. Code Ann. § 7-7-15

Receipt of money

Every state department, division, officer, board, commission, institution or other agency owned or controlled by the state, collecting or receiving public funds or monies from any source whatever to be deposited in the State Treasury for the use of the state or any state agency, shall pay such monies to the State Fiscal Officer, who shall issue his warrant or certificate of receipt therefor, specifying the amount and the particular account on which such payment is to be made.

Missouri

Mo. Code Regs. Ann. tit. 15, § 50-1.010

Function and Organization (October 15, 1986)

PURPOSE: This rule describes the general organization and functions of the Missouri state treasurer's office to comply with the requirements of section 536.023, RSMo (1986).

(1) The primary function of the state treasurer's office is to perform the duties as defined in Article IV, Section 15, Missouri Constitution and chapter 30, RSMo (1986). In general, these duties include: to be custodian of all state funds; to invest state moneys not needed for current operating expenses; and to disburse state moneys not needed for current operating expenses; and to disburse state moneys as provided by law.

(2) The office of state treasurer operates in three (3) major functional areas-receipts and accounting; investments; and disbursements, tabulating and records.

(A) The receipts and accounting function involves posting receipts from the Department of Revenue and disbursement from the Office of Administration to the cash ledger; maintaining ledger controls on fund balances and appropriations to assure no check is issued that exceeds appropriated balances; and maintaining control of receipts of state moneys collected by state agencies and their agents and deposited in local banks throughout the state.

(B) The investment area invests state moneys not needed for current operating expenses in time deposits, bearing interest, in Missouri banking institutions selected by the state treasurer and approved by the governor and state auditor or in short-term United States government securities and repurchase agreements.

(C) The disbursements, tabulating and records area tabulates state checks, verifies daily expenditures as certified by the Office of Administration, generates a check register, affixes the facsimile signature of the state treasurer to checks, tracks the outstanding status of checks, reconciles bank accounts, controls and processes outlawed and replacement checks and maintains cancelled checks and other records.

(3) The offices of the state treasurer are located in the State Capitol Building and the Truman State Office Building, 301 West High, Jefferson City, MO 65102. Any information requested by the public can be obtained by writing to the Missouri State Treasurer,

Montana

Mont. Admin. R. 37.86.4407

RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, RECORD KEEPING AND REPORTS (June 17, 2005)

(1) A provider must meet the record keeping and other requirements of ARM 37.85.414 in addition to the requirements of this rule.

(2) A provider must make and maintain adequate financial and statistical records in accordance with generally accepted accounting principles, as defined by the American institute of certified public accountants. The provider's records must be sufficient to allow the department and its agents to determine payment for the RHC or FQHC services provided to medicaid recipients and to provide a record that may

be audited using generally accepted auditing standards. Such records must be maintained for a period of six years, three months after a cost report is filed with respect to the period covered by such records or until such cost report is finally settled, whichever is later.

(3) The records described in (2) must be available at the provider facility at all reasonable times and shall be subject to inspection, review and audit by the department or its agents, the United States department of health and human services, the general accounting office, the Montana legislative auditor, and other governmental agencies as authorized by law.

(4) Upon failure or refusal of the provider to make available and allow access to such records, or to report an increase or decrease in scope of services, the department may recover in full all payments made to the provider during the reporting period to which such records relate and may suspend any further payments to the provider until such time as the provider fully complies with this rule.

(5) No later than 30 days prior to the beginning of its initial reporting period as a new provider or following a change in ownership, a provider must submit to the department or its agent an estimate of budgeted costs and visits for RHC or FQHC services for the reporting period in the form and detail required by the department and such other information as the department may require to establish a rate as provided at ARM 37.86.4413.

Mont. Admin. R. 37.86.4412

RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, REIMBURSEMENT(June 17, 2005)

(1) This Sub-Chapter specifies requirements applicable to provision of and reimbursement for RHC and FQHC services. These rules are in addition to requirements generally applicable to medicaid providers as otherwise provided in state and federal statute, rules, regulations and policies.

(2) Unless otherwise provided in these rules, this Sub-Chapter applies to rate years beginning on or after January 1, 2001. Reimbursement and other substantive RHC and FQHC requirements for earlier periods are subject to the laws, regulations, rules and policies then in effect. Procedural and other non- substantive provisions of these rules are effective upon adoption.

(3) All RHCs and FQHCs will be reimbursed on a prospective payment system beginning January 1, 2001 and each succeeding calendar year. The prospective payment system will apply equally to provider based and independent RHCs and FQHCs.

(4) On January 1 of each succeeding calendar year, the rate for the preceding year must be adjusted by the percentage increase in the medicare economic index (MEI) applicable to primary care services for that calendar year.

(5) The department will reimburse the RHC or FQHC for the rate change in (4) retroactive to the effective date of January 1 of the calendar year, beginning with January 1, 2002.

(6) For clinics or centers that had their initial medicaid prospective system base visit rate calculated in 2001 or starting with the third fiscal year (for "new" clinics or centers as defined at ARM 37.86.4413), the prospective payment per visit rate may be adjusted to take into account any increase or decrease in the scope of service.

(a) The department will determine the new rate according to the following formula: NR= (R x PV) + C/(PV + CV)

(i) "NR" represents the new reimbursement rate adjusted for the increase or decrease in the scope of service;

(ii) "R" represents the present outpatient prospective payment system (OPPS) medicaid rate;

(iii) "PV" represents the present number of total visits which is the total number of visits for the RHC or FQHC during the 12-month time period prior to the change in scope of service;

(iv) "C" represents the expected change in costs due to the change in scope of service; and

(v) "CV" represents the expected change in the number of visits due to the change in scope of service.

Nebraska

Neb. Admin. R. & Regs. Tit. 471, Ch. 34, § 004

Payment for Rural Health Clinic Services:

NMAP will pay for services provided by Rural Health Clinics in compliance with Section 1902 (bb) of the Social Security Act. The Department assures that payments to all RHCs will result in a payment to the clinic in the amount which is at least equal to the Prospective Payment System.

34-004.01 Definitions means the following definitions apply within this chapter:

Encounter means a face-to-face visit between a Medicaid-eligible patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which an FQHC service is rendered. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment. Encounter Payments means PPS rate paid to the RHC by the Department multiplied by the number of encounters billed.

Encounter Rate means the all-inclusive PPS rate that the Department reimburses the RHC for an encounter.

Independent Rural Health Clinic means A clinic that is free standing with no association to a hospital, nursing facility, or home health agency.

Medicare Cost Report means the report filed by each RHC provider with its Medicare intermediary as required by Chapter 9 of the Medicare Rural Health Clinic and Federal Qualified Health Center Manual. Prospective Payment System (PPS) means the payment system where in a reimbursement rate is paid for services provided.

Provider-Based Rural Health Clinic means a rural health clinic that is an integral part of a hospital, nursing facility, or home health agency that is participating in Medicare and is licensed, governed and supervised by the facility.

Nevada

No statutes or regulations found using the search terms.

New Hampshire

N.H. Rev. Stat. § 6:11

Payments to Treasurer

I. The treasurer shall establish deposit procedures for all state departments and institutions receiving money for the state. Such procedures shall include, but shall not be limited to, deposits to a department's or institution's bank accounts, related transfers to treasury bank accounts, electronically collecting state moneys, and concurrence of the treasurer for the opening of department and institution bank accounts.

II. If more than $500 is in the possession of any state department or institution such funds shall be on deposit in the related department's bank account or in a treasury bank account. The treasurer shall transfer moneys from state departments and institutions to the treasurer's account in the most expeditious manner possible, including, but not limited to, the use of electronic transfers. If any facility of any state department or institution is in a location where there is no bank or other depository institution within 10 miles of that facility, that state department or institution shall make deposits at least on a weekly basis or when funds remitted total $1,500 or more.

III. All state departments and institutions, except the university system of New Hampshire, the building projects revolving fund of the state board of education, and the supreme court for the purposes of the escrow account for court facility improvements under RSA 490:26-c, receiving money for the state shall deposit the full amount of all such moneys into a state treasurer's bank account or into a state department's bank account from which the treasurer shall collect funds by automated means, unless the treasurer determines that such means cannot be implemented or concurs with department procedures for deposits and collection.

IV. All state departments and institutions, except those state departments and institutions which are exempted in RSA 6:11, III, which are not depositing directly into a treasury bank account or which are not included in a treasury electronic collection system may deposit state moneys into a department's bank account and shall either:

(a) Remit to treasury daily all moneys in excess of an amount established by each department with the concurrence of the treasurer; or

(b) Deposit all moneys at the department of treasury daily in accordance with rules established under RSA 6:3-a, I.

V. All state departments and institutions, except those state departments and institutions which are exempted in RSA 6:11, III, depositing moneys directly into a treasury bank account shall prepare and submit to treasury the appropriate accounting documentation. Such departments and institutions shall make every effort to ensure that the documentation is received by treasury on the same day as the day of deposit.

VI. All state departments and institutions depositing moneys into a department's bank account shall, in a timely manner, prepare and submit to treasury the appropriate accounting documentation related to treasury's daily automated collections as provided in RSA 6:11, III or a department's remittances as provided in RSA 6:11, IV(a).

VII. All payments due to the state of New Hampshire for services provided shall be paid for in United States dollars. Any payment received in any other currency shall be returned to the payor. All outstanding obligations are subject to the terms and conditions of said payment. Exceptions to the provisions of this paragraph are subject to the approval of the treasurer.

New Jersey

N.J.S.A. 52:18A-8

State revenues; depositories; reports; accounting

All State revenue collected by any department, institution, commission, board, committee or official of this State shall, except as otherwise provided by law, be deposited, in the method prescribed by the director of the Division of Budget and Accounting, to the credit of the State of New Jersey in such depositories as the State Treasurer shall designate. A report of such moneys collected shall be submitted to such director and the State Treasurer in such form as the director shall prescribe. Such reports shall be submitted not later than the tenth day of the month following that during which such moneys were received. The director of the Division of Budget and Accounting, upon receiving such report, shall audit and register all amounts contained therein and make proper accounting thereof.

New Mexico

N. M. S. A. 1978, § 6-10-3

Payment of state money into treasury; suspense funds (July 1, 2011)

All public money in the custody or under the control of any state official or agency obtained or received by any official or agency from any source, except as in Section 6-10-54 NMSA 1978 provided, shall be

paid into the state treasury. It is the duty of every official or person in charge of any state agency receiving any money in cash or by check, draft or otherwise for or on behalf of the state or any agency thereof from any source, except as in Section 6-10-54 NMSA 1978 provided, to forthwith and before the close of the next succeeding business day after the receipt of the money to deliver or remit it to the state treasurer; provided, however, that:

A. the money collected by the state parks division of the energy, minerals and natural resources department and the state monuments division of the cultural affairs department shall be deposited into the state treasury no later than ten days following collection;

B. county treasurers shall remit all money received for taxes for state purposes or that are by law required to be remitted to the department on or before the tenth day of the next succeeding month following the receipt or collection thereof;

C. every official or person in charge of any state agency receiving any money, except as in Section 6-10-54 NMSA 1978 provided, in cash or by check or draft, on deposit, in escrow or in evidence of good faith to secure the performance of any contract or agreement with the state or with any department, institution or agency of the state, which money has not yet been earned so as to become the absolute property of the state, shall deliver or remit to the state treasury within the times and in the manner as in this section provided, which money shall be deposited in a suspense account to the credit of the proper official, person, board or bureau in charge of any state agency so receiving the money; and

D. all money held by the commissioner of public lands on deposit, in escrow or in evidence of good faith to secure the performance of any contract or agreement with the state shall be delivered or remitted to the state treasury within six months from the date this act is approved and at those times, in the amounts and from the various banks in which it is deposited as may be directed by the state board of finance.

<u>New York</u>

McKinney's Public Health Law § 2807

Hospital reimbursement provisions; generally

1. Valid operating certificate requirement. No government agency and no corporation organized and operating in accordance with article forty-three of the insurance law and no health maintenance organization organized and operating in accordance with article forty-four of this chapter, shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health-related service, unless, at the time the service was provided, the hospital possessed a valid operating certificate authorizing such service. No government agency shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health-related service that has been determined by the commissioner of health to be unauthorized for payment under the medical assistance program pursuant to section twenty-eight hundred three of this article.

2. (a) Rate approvals. Payments for hospital service and health-related service made by government agencies or for services provided prior to January first, nineteen hundred ninety-seven by organizations

operating in accordance with the provisions of article forty-four of this chapter shall be at rates approved by the state director of the budget in the case of government agencies and approved by the commissioner in the case of plans, organized and operating under the provisions of article forty-four of this chapter, under which such payments are made by agencies other than government agencies or corporations organized and operating in accordance with article forty-three of the insurance law. Payments for hospital service and health-related service by corporations organized and operating in accordance with article forty-three of the insurance law for services provided prior to January first, nineteen hundred ninety-seven shall be at rates approved by the commissioner of health.

(a-1) Notwithstanding any inconsistent provision of law, rates of payment by governmental agencies for the operating cost component of general hospital out-patient and emergency services, and for the operating cost component of treatment or diagnostic center services shall not require a certification by the commissioner that they are reasonably related to the costs of efficient production of such services nor that they are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

(b) During the period October first, nineteen hundred ninety-four through September thirtieth, nineteen hundred ninety-five and for each twelve month rate period commencing on October first thereafter, rates of payment by governmental agencies for the operating cost component of treatment or diagnostic center services shall be based on operating costs in the base year cost report adjusted by a trend factor determined in accordance with rules and regulations promulgated pursuant to paragraph (b) of subdivision two of section twenty-eight hundred three of this article; provided, however, that prior to such adjustment, allowable operating costs shall be established by the commissioner after taking into account the cost of services provided in facilities offering similar services and regional economic factors, plus the addition of the capital cost per visit. The capital cost per visit shall be based on the base year cost report except that the capital cost per visit may be adjusted for major outpatient capital expenditures, incurred subsequent to the reporting year, when such expenditures have received the requisite approvals and the facility has provided the commissioner with a certified statement of expenditures. The base year for the rate period commencing on October first, nineteen hundred ninety-four shall be nineteen hundred ninety- two and shall be advanced one year thereafter for each subsequent rate period.

(c) Repealed. (d) Repealed.

(e) [Expired April 1, 2011, pursuant to L.1989, c. 753, § 11.] Notwithstanding any inconsistent provisions of this subdivision or any other law, payments made by governmental agencies for ambulatory surgical services provided by a hospital, including general hospitals and diagnostic and treatment centers, during the period June first, nineteen hundred eighty-nine through December thirty-first, nineteen hundred eighty-nine and the period January first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety and every twelve month rate period thereafter shall be at case based rates of reimbursement established by the commissioner and approved by the state director of the budget. Ambulatory surgical services case based rates of payment shall be established prospectively and shall include operating costs and capital costs. Factors considered in establishing such case based rates shall include, but not be limited to: a classification of procedures with individual or combined rates established for each services classification; operating and capital costs of ambulatory surgical services efficiently and

economically provided, considering regional economic factors, trended to the rate period; and the need for incentives to improve services and institute economies.

(f)(i) [Expired Dec. 31, 1996, pursuant to L.1990, c. 884, § 11.] During the period July first, nineteen hundred ninety through March thirty-first, nineteen hundred ninety-one, the rate periods during the period April first, nineteen hundred ninety-one through September thirtieth, nineteen hundred ninety-four and for each fiscal year period commencing on October first thereafter, comprehensive clinic rates of payment b y governmental agencies established in accordance with paragraph (b) of this subdivision, applicable for services provided to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law for voluntary non-profit or publicly sponsored diagnostic and treatment centers providing a comprehensive range of primary health care services which can demonstrate, on forms provided by the commissioner, losses from a disproportionate share of bad debt and charity care during a base year period established by regulation may include an allowance determined in accordance with this paragraph to reflect the needs of the diagnostic and treatment center for the financing of losses resulting from bad debt and the costs of charity care. Losses resulting from bad debt and the costs of charity care shall be determined by the commissioner considering, but not limited to, such factors as the losses resulting from bad debt and the costs of charity care provided by the diagnostic and treatment center and the availability of other financial support, including state and local assistance public health aid, to meet the losses resulting from bad debt and the costs of charity care of the diagnostic and treatment center.

The bad debt and charity care allowance for a diagnostic and treatment center for a rate period shall be determined by the commissioner in accordance with rules and regulations adopted by the council and approved by the commissioner, and shall be consistent with the purposes for which such allowances are authorized for general hospitals pursuant to the provisions of article twenty-eight of this chapter and rules and regulations promulgated by the commissioner. A diagnostic and treatment center applying for a bad debt and charity care allowance pursuant to this paragraph shall provide assurances satisfactory to the commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third party insurance payors, governmental payors and self-paying patients. To be eligible for an allowance pursuant to this paragraph, a diagnostic and treatment center must provide a comprehensive range of primary health care services and must demonstrate that a minimum of fifteen percent of total clinic visits reported during the applicable base year period were to uninsured individuals. The commissioner may retrospectively reduce the bad debt and charity care allowance of a diagnostic and treatment center if it is determined that provider management actions or decisions have caused a significant reduction for the rate period in the delivery of comprehensive primary health care services to bad debt and charity care residents of the community.

(ii) The total amount of funds to be allocated and distributed for bad debt and charity care allowances to eligible voluntary and nonprofit diagnostic and treatment centers for a rate period in accordance with this paragraph shall be limited to an annual aggregate amount of seven million three hundred thousand dollars. The total amount of funds to be allocated and distributed for bad debt and charity care allowances to

eligible publicly sponsored diagnostic and treatment centers for a rate period in accordance with this paragraph shall be limited to an annual aggregate amount of seven million seven hundred thousand dollars; provided, however, that twenty percent of the amount of funds allocated for distribution to eligible publicly sponsored diagnostic and treatment centers shall be available for clinics operating under the auspices of the Health and Hospitals Corporation. Notwithstanding the foregoing and any other provision of this chapter municipalities which received state aid, pursuant to article two of the public health law and prior to the effective date of this chapter, in support of non-hospital based free-standing or local health department operated general medical clinics, shall receive a bad debt and charity care allowance of not less than the amount received in the nineteen hundred eighty-nine--nineteen hundred ninety state fiscal year for general medical clinics, plus the applicable local share for medical assistance expenditures under title XIX of the federal social security act. Funds to be distributed pursuant to this subparagraph shall be based on losses associated with the delivery of bad debt and charity care excluding the amount of such losses determined in accordance with subparagraph (ix) of this paragraph as the incremental loss basis for a supplemental allowance for a diagnostic and treatment center designated as a preferred primary care provider.

(iii) No diagnostic and treatment center may receive a bad debt and charity care allowance in accordance with this paragraph in an amount which exceeds its need for the financing of losses associated with the delivery of bad debt and charity care.

(iv) A nominal payment amount for the financing of losses associated with the delivery of bad debt and charity care will be established for each eligible diagnostic and treatment center. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of bad debt and charity care for percentage increases in the relationship between base year period eligible bad debt and charity care clinic visits and base year period total clinic visits according to the following scale:

% of eligible bad debt and charity care

% of nominal financial clinic visits to total visits loss coverage up to 15%

50%

15 - 30%

75%

30%+

100%

If the sum of the nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers or for all eligible public diagnostic and treatment centers is less than the amount allocated for bad debt and charity care allowances pursuant to subparagraph (ii) or (ix) respectively of this paragraph for such diagnostic and treatment centers respectively, the nominal coverage percentages of base year period losses associated with the delivery of bad debt and charity care pursuant to this scale may be increased to not more than one hundred percent for voluntary non-profit diagnostic and treatment centers or for public

diagnostic and treatment centers in accordance with rules and regulations adopted by the council and approved by the commissioner.

(v) The bad debt and charity care allowance for each eligible voluntary non-profit diagnostic and treatment center shall be based on the dollar value of the result of the ratio of total funds allocated for bad debt and charity care allowances for voluntary non-profit diagnostic and treatment centers pursuant to subparagraph (ii) of this paragraph to the total statewide nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers determined in accordance with subparagraph (iv) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(vi) The bad debt and charity care allowance for each eligible public diagnostic and treatment center shall be based on the dollar value of the result of the ratio of total funds allocated for bad debt and charity care allowances for public diagnostic and treatment centers pursuant to subparagraph (ii) of this paragraph to the total statewide nominal payment amounts for all eligible public diagnostic and treatment centers determined in accordance with subparagraph (iv) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(vii) Diagnostic and treatment centers shall furnish to the department such reports and information as may be required by the commissioner to assess the cost, quality, access to, effectiveness and efficiency of bad debt and charity care provided. The council shall adopt rules and regulations, subject to the approval of the commissioner, to establish uniform reporting and accounting principles designed to enable diagnostic and treatment centers to fairly and accurately determine and report bad debt and charity care visits and the costs of bad debt and charity care. In order to be eligible for an allowance pursuant to this paragraph, a diagnostic and treatment center must be in compliance with bad debt and charity care reporting requirements.

(viii) Of the funds allocated and distributed for bad debt and charity care allowances to eligible voluntary and non-profit diagnostic and treatment centers for a rate period in accordance with subparagraph (ii) of this paragraph, an annual aggregate amount not to exceed three million eight hundred thousand dollars within a rate period shall be paid by or on behalf of diagnostic and treatment centers into a primary care initiative pool established by the commissioner. Such funds shall be distributed to diagnostic and treatment centers in accordance with the provisions of subdivisions one through six of section twenty-eight hundred seven-b of this article.

(ix) During the period January first, nineteen hundred ninety-four through September thirtieth, nineteen hundred ninety-four and for each twelve month rate period commencing on October first thereafter, to the extent of funds available therefor, a diagnostic and treatment center which is approved as a preferred primary care provider pursuant to subdivision twelve of section twenty-eight hundred seven of this article and meets the requirements of this paragraph may be eligible for a supplemental allowance determined in accordance with this paragraph. The supplemental allowance shall be based on losses associated with the delivery of bad debt and charity care incurred by a preferred primary care provider to the extent such losses exceed any losses associated with the delivery of bad debt and charity care incurred for nineteen hundred ninety-three or, if later, the year immediately preceding the year in which the diagnostic and treatment center is first designated a preferred primary care provider.

(x) This paragraph shall be effective if, and as long as, federal financial participation is available for expenditures made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allowances determined in accordance with this paragraph.

(xi) Notwithstanding any inconsistent provision of this paragraph, adjustments to rates of payment for diagnostic and treatment centers determined in accordance with subparagraphs (i) through (x) of this paragraph shall apply only for services provided on or before December thirty-first, nineteen hundred ninety-six.

(g)(i) During the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four and for each calendar year rate period commencing on January first thereafter, rates of payment by governmental agencies for the operating cost component of general hospital outpatient services shall be based on the operating costs reported in the base year cost report adjusted by the trend factor applicable to the general hospital in which the services were provided; provided, however, that the maximum payment for the operating cost component of outpatient services shall be sixty-seven dollars and fifty cents plus the addition of the capital cost per visit. The capital cost per visit shall be based on the base year cost report except that the capital cost per visit may be adjusted for major outpatient capital expenditures incurred subsequent to the reporting year, when such expenditures have received the requisite approvals and the facility has provided the commissioner with a certified statement of the expenditures. The base year for the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four shall be nineteen hundred ninety-two and shall be advanced one year thereafter for each subsequent calendar year rate period. Further, the provisions of subdivision seven of this section shall not apply. The commissioner may waive the maximum allowable payment and limitations on the rate of payment as prescribed herein to provide for the reimbursement of offering and arranging services eligible for ninety percent federal funds as set forth in section nineteen hundred three of the federal social security act,1 and to provide for the reimbursement of specialized services having separately identifiable costs and statistics, including but not limited to hemodialysis services and surgical services provided on an outpatient basis. Such waiver shall be granted only when the commissioner finds that the services are being provided efficiently and at minimum cost. The commissioner shall promptly promulgate rules and regulations necessary to identify such services. Among the criteria which the commissioner shall consider in the case of specialized services are whether the services require highly specialized staff, equipment or facilities, thereby generating a cost that substantially exceeds that of more routine diagnostic or treatment services; whether the facility in which the services are provided is presently providing the services to the population in need; and, whether the services may be provided safely and effectively on an outpatient basis at a lower cost than through inpatient admission. In addition the commissioner shall provide for a waiver of the maximum allowable payment for those outpatient services medically necessary which include surgical procedures where delay in surgical intervention would substantially increase the medical risk associated with such surgical intervention. Where the commissioner waives the maximum allowable payment for any specified service he may, in accordance with the foregoing criteria and such other criteria as he deems appropriate, establish a maximum allowable payment for such specified service.

(ii) During the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four and for each calendar year rate period commencing on January first thereafter, rates

of payment by governmental agencies for the operating cost component of general hospital emergency services shall be based on the operating costs reported in the base year cost report adjusted by the trend factor applicable to the general hospital in which the services were provided, and in addition shall include that portion of the reasonable incremental emergency service operating costs incurred by such hospital in excess of emergency service costs reported in the nineteen hundred eighty-eight cost report, after application of the trend factor, attributable to meeting additional quality of care standards for emergency services that became effective on or after January first, nineteen hundred eighty-nine; provided, however, that the maximum payment for the operating component shall be ninety-five dollars, provided further, however, that for the period January first, two thousand seven through December thirty-first, two thousand seven the maximum payment for the operating component shall be one hundred twenty-five dollars, and during the period January first, two thousand eight through December thirty-first, two thousand eight, the maximum payment for the operating component shall be one hundred forty dollars; and during the period January first, two thousand nine through December thirty-first, two thousand nine and for each calendar year thereafter, the maximum payment for the operating component shall be one hundred fifty dollars. A capital cost per visit shall be based on the base year cost report except that the capital cost per visit may be adjusted for the major outpatient capital expenditures incurred subsequent to the report year, when such expenditures have received the requisite approvals and the facility has provided the commissioner with a certified statement of expenditures. The base year for the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four shall be nineteen hundred ninety-two and shall be advanced one year thereafter for each subsequent calendar year rate period. Further, the provisions of subdivision seven of this section shall not apply prior to January first, two thousand seven.

(h) Notwithstanding any inconsistent provisions of this subdivision or any other law, except as provided in section 43.02 of the mental hygiene law, the commissioner may, in accordance with rules and regulations adopted by the council and approved by the commissioner, establish rates of reimbursement for payments made by governmental agencies, subject to the approval of the state director of the budget, for services provided on an outpatient basis by a general hospital or diagnostic and treatment center designated as a preferred primary care provider pursuant to subdivision twelve of this section or providing specialty services including hemo and peritoneal dialysis, outpatient rehabilitative and psychiatric services, methadone maintenance, and other organized outpatient or clinic services which are structured to address extensive and complex medical needs for patients with chronic or infectious medical conditions based on factors other than those prescribed by paragraph (b) or subparagraph (i) of paragraph (g) of this subdivision or subdivision three of this section provided, however, that the use of such an alternative approach will not result in any increase to other rates of reimbursement established pursuant to this article. During the initial rate period such rates of payment for preferred primary care providers shall be at least equal to the average rate of payment per visit which would otherwise be provided pursuant to subparagraph (i) of paragraph (g) or paragraph (b) of this subdivision. Factors used to establish rates shall include a reasonable classification of medical procedures with individual or combined rates established for each service classification group which will be prospectively determined based upon an estimate of the costs of such outpatient services efficiently and economically provided by general hospitals and diagnostic and treatment centers, considering regional economic factors and the need for incentives to improve services and institute economies. Notwithstanding any inconsistent provisions of law, rates of

payment by governmental agencies for outpatient services provided by a general hospital or diagnostic and treatment center, shall not require a certification by the commissioner that they are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

2-a. Notwithstanding any provision of which is inconsistent with or contrary to the structure established by this subdivision and subdivision thirty-three of section twenty-eight hundred seven-c of this article, and subject to the availability of federal financial participation, rates of payment by governmental agencies, established pursuant to this article, for general hospital outpatient services, general hospital emergency services, ambulatory surgical services provided by a hospital as defined by subdivision one of section twenty-eight hundred one of this article, and diagnostic and treatment center services, but excepting any facility whose reimbursement is governed by subdivision eight of this section or any payments made on behalf of persons enrolled in Medicaid managed care or in the family health plus program, shall be in accordance with the following:

(a)(i) for the period December first, two thousand eight through November thirtieth, two thousand nine, seventy-five percent of such rates of payment for each general hospital's outpatient services shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and twenty-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(ii) for the period December first, two thousand nine through December thirty-first, two thousand ten, fifty percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and fifty percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(iii) for the period January first, two thousand eleven through December thirty-first, two thousand eleven, twenty-five percent of such rates shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility for the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and seventy-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision; and

(iv) for periods on and after January first, two thousand twelve, one hundred percent of such rates of payment shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision.

(v) This paragraph shall be effective the later of: (i) December first, two thousand eight, or (ii) after the commissioner receives final approval of federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act2 for the rate methodology

established pursuant to subparagraph (i) of paragraph (a) of subdivision thirty-three of section twenty-eight hundred seven-c of this article.

(b)(i) for the period September first, two thousand nine through November thirtieth, two thousand nine, seventy-five percent of such rates of payment for services provided by each diagnostic and treatment center and each free-standing ambulatory surgery center shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and twenty-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(ii) for the period December first, two thousand nine through December thirty-first, two thousand ten, fifty percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and fifty percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(iii) for the period January first, two thousand eleven through December thirty-first, two thousand eleven, twenty-five percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and seventy-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision; and

(iv) for periods on and after January first, two thousand twelve, one hundred percent of such rates of payment shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision.

(c) for periods on and after December first, two thousand eight, such rates of payment for ambulatory surgical services provided by general hospitals shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision, provided however, that the capital cost component for such rates shall be separately computed in accordance with regulations promulgated in accordance with paragraph (e) of this subdivision.

(d) for periods on and after January first, two thousand nine, the operating cost component of such rates of payment for general hospital emergency services shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision and shall not reflect any maximum payment amount as otherwise provided for in subparagraph (ii) of paragraph (g) of subdivision two of this section.

(e)(i) notwithstanding any inconsistent provisions of this subdivision, the commissioner shall promulgate regulations establishing, subject to the approval of the state director of the budget, methodologies for

determining rates of payment for the services described in this subdivision. Such regulations shall reflect utilization of the ambulatory patient group (APG) methodology, in which patients are grouped based on their diagnosis, the intensity of the services provided and the medical procedures performed, and with each APG assigned a weight reflecting the projected utilization of resources. Such regulations shall provide for the development of one or more base rates and the multiplication of such base rates by the assigned weight for each APG to establish the appropriate payment level for each such APG. Such regulations may also utilize bundling, packaging and discounting mechanisms.

If the commissioner determines that the use of the APG methodology is not, or is not yet, appropriate or practical for specified services, the commissioner may utilize existing payment methodologies for such services or may promulgate regulations, and may promulgate emergency regulations, establishing alternative payment methodologies for such services.

(ii) Notwithstanding this subdivision and any other contrary provision of law, the commissioner may incorporate within the payment methodology described in subparagraph (i) of this paragraph payment for services provided by facilities pursuant to licensure under the mental hygiene law, provided, however, that such APG payment methodology may be phased into effect in accordance with a schedule or schedules as jointly determined by the commissioner, the commissioner of mental health, the commissioner of alcoholism and substance abuse services, and the commissioner of mental retardation and developmental disabilities.

(iii) Regulations issued pursuant to this paragraph may incorporate quality related measures limiting or excluding reimbursement related to potentially preventable conditions and complications; provided however, such quality related measures shall not include any preventable conditions and complications not identified for Medicare nonpayment or limited payment.

(f)(i) The commissioner shall periodically measure the utilization and intensity of services provided to medical assistance recipients in ambulatory settings. Such analysis shall include, but not be limited to: measurement of the shift of surgical procedures from the inpatient hospital setting to the ambulatory setting including measurement of the impact of any such shift on quality of care and outcomes; changes in the utilization and intensity of services provided in the outpatient hospital department and in diagnostic and treatment centers; and the change in the utilization and intensity of services provided in the emergency department.

(ii) notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, for periods on and after January first, two thousand nine, the following services provided by general hospital outpatient departments and diagnostic and treatment centers shall be reimbursed with rates of payment based entirely upon the ambulatory patient group methodology as described in paragraph (e) of this subdivision, provided, however, that the commissioner may utilize existing payment methodologies or may promulgate regulations establishing alternative payment methodologies for one or more of the services specified in this subparagraph, effective for periods on and after March first, two thousand nine:

(A) services provided in accordance with the provisions of paragraphs (q) and (r) of subdivision two of section three hundred sixty-five-a of the social services law; and

(B) all services, but only with regard to additional payment amounts, as determined in accordance with regulations issued in accordance with paragraph (e) of this subdivision, for the provision of such services during times outside the facility's normal hours of operation, as determined in accordance with criteria set forth in such regulations; and

(C) individual psychotherapy services provided by licensed social workers, in accordance with licensing criteria set forth in applicable regulations, to persons under the age of twenty-one and to persons requiring such services as a result of or related to pregnancy or giving birth; and

(D) individual psychotherapy services provided by licensed social workers, in accordance with licensing criteria set forth in applicable regulations, at diagnostic and treatment centers that provided, billed for, and received payment for these services between January first, two thousand seven and December thirty-first, two thousand seven;

(E) services provided to pregnant women pursuant to paragraph (s) of subdivision two of section three hundred sixty-five-a of the social services law and, for periods on and after January first, two thousand ten, all other services provided pursuant to such paragraph (s) and services provided pursuant to paragraph (t) of subdivision two of section three hundred sixty-five-a of the social services law;

(F) wheelchair evaluation services and eyeglass dispensing services; and

(G) immunization services, effective for services rendered on and after June tenth, two thousand nine.

(f-1) Notwithstanding any inconsistent provision of this section or any other contrary provision of law, the commissioner may with the approval of the director of the budget, for periods prior to two thousand twelve, establish rates of payments for selected patient service categories that are based entirely upon the ambulatory patient groups methodology as authorized pursuant to paragraph (e) of this subdivision.

(g) for the purposes set forth in paragraphs (a) and (b) of this subdivision, rates described as in effect for the two thousand seven calendar year shall mean those rates which are in effect for that year on the date this subdivision becomes effective and such rates shall not thereafter, for the purposes set forth in such paragraphs (a) and (b), be subject to further adjustment.

(h)(i) To the degree that rates of payment computed in accordance with paragraphs (a) and (d) of this subdivision reflect utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision for purposes of computing the operating component of such rates, the computation of the capital cost component of such rates shall remain subject to the provisions of subparagraphs (i) and (ii) of paragraph (g) of subdivision two of this section, provided, however, that this subparagraph shall not be understood as applying to those portions of rates of payment computed pursuant to paragraph (a) of this subdivision which are based on average Medicaid payments per claim.

(ii) To the degree that rates of payment computed in accordance with paragraph (b) of this subdivision reflect utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision for purposes of computing the operating component of such rates, the computation of the capital cost component of such rates shall, for diagnostic and treatment centers, remain subject to

the provisions of paragraph (b) of subdivision two of this section and shall, for free-standing ambulatory surgery centers, be separately computed in accordance with regulations promulgated in accordance with paragraph (e) of this subdivision, provided, however, that this subparagraph shall not be understood as applying to those portions of rates of payment which are based on average Medicaid payments per claim.

(i) Notwithstanding any provision of law to the contrary, rates of payment by governmental agencies for general hospital outpatient services, general hospital emergency services and ambulatory surgical services provided by a general hospital established pursuant to paragraphs (a), (c) and (d) of this subdivision shall result in an aggregate increase in such rates of payment of fifty-six million dollars for the period December first, two thousand eight through March thirty-first, two thousand nine and one hundred seventy-eight million dollars for periods after April first, two thousand nine, through March thirty-first, two thousand thirteen, and one hundred fifty-three million dollars for state fiscal year periods on and after April first, two thousand thirteen, provided, however, that for periods on and after April first, two thousand nine, such amounts may be adjusted to reflect projected decreases in fee-for-service Medicaid utilization and changes in case-mix with regard to such services from the two thousand seven calendar year to the applicable rate year, and provided further, however, that funds made available as a result of any such decreases may be utilized by the commissioner to increase capitation rates paid to Medicaid managed care plans and family health plus plans to cover increased payments to health care providers for ambulatory care services and to increase such other ambulatory care payment rates as the commissioner determines necessary to facilitate access to quality ambulatory care services.

3. Commissioner rate certification, governmental payments. Prior to the approval of such rates, as provided in subdivision two of this section, the commissioner shall determine, and in the case of approvals by the state director of the budget, certify to such official that the proposed rate schedules for payments to hospitals for hospital and health-related services are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital is located, the rate of increase or decrease of the economy in the area in which the hospital is located, costs of hospitals of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economies and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of in-hospital service, including, but not limited to, obstetrical, pediatric, laboratory, training, radiology, pharmacy, laundry, purchasing, preadmission, nursing home, ambulatory or home care services. The commissioner shall exclude costs for research and those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service, and allowances for costs which are not specifically identified except for allowances authorized under section twenty-eight hundred seven-a or twenty-eight hundred seven-c of this article. In determining and certifying to the state director of the budget rates of payment, including rates of payment for residential health care facilities, the commissioner shall take into consideration the different levels of care authorized to be provided in such hospital or health-related service and determine and certify distinct rates of payment for each such level of care. If the modification of an operating certificate of a hospital pursuant to subdivision six of section twenty-eight hundred six of this article requires the establishment of a rate for a level of service not previously provided in such hospital during

the rate period existing at the time of such modification, a new rate period for that portion of the hospital reclassified as a result of such modification may be established upon sixty days' prior notice.

4. Commissioner rate certifications, payments pursuant to the provisions of the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law and the comprehensive motor vehicle insurance reparations act.3 For the rate years commencing January first, nineteen hundred eighty-six and January first, nineteen hundred eighty-seven the commissioner shall submit to the chairman of the workers' compensation board a schedule of hospital inpatient reimbursement rates computed in accordance with subdivision two of section twenty-eight hundred seven-a of this article or as revised pursuant to subdivisions eleven and fourteen of section twenty-eight hundred seven-a of this article. Beginning with the rate period commencing January first, nineteen hundred eighty-eight the commissioner shall submit, and beginning with the rate period January first, nineteen hundred ninety-seven and certify, to the chairman of the workers' compensation board for an established rate period a schedule of hospital inpatient reimbursement rates computed in accordance with subdivision one of section twenty-eight hundred seven-c of this article for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law and the comprehensive motor vehicle insurance reparations act and beginning with the rate year commencing January first, nineteen hundred ninety-one including payments pursuant to the volunteer ambulance workers' benefit law.

5. Audit authority. The commissioner shall make available to the commissioner of social services, in a mutually satisfactory manner, all information necessary to conduct or have conducted, on a cost sharing basis among payors, an appropriate review or audit of the fiscal and statistical records of a hospital necessary to implement the provisions of this article.

6. Consideration of economic status in certain cases. Notwithstanding the provisions of this section, the commissioner, in determining and certifying rates of payment for services provided by a party to a contract entered into pursuant to the provisions of subdivision three of section twenty-eight hundred three of this article, shall take into consideration the economic status of the patients receiving such services.

7. Reimbursement rate promulgation. The commissioner shall notify each hospital and health-related service of its approved rates of payment which shall be used in reimbursing for services provided to persons eligible for payments made by state governmental agencies at least sixty days prior to the beginning of an established rate period for which the rate is to become effective. Notification shall be made only after approval of rate schedules by the state director of the budget. The sixty and thirty day notice provisions, herein, shall not apply to rates issued following judicial annulment or invalidation of any previously issued rates, or rates issued pursuant to changes in the methodology used to compute rates which changes are promulgated following the judicial annulment or invalidation of previously issued rates. Notwithstanding any provision of law to the contrary, nothing in this subdivision shall prohibit the recalculation and payment of rates, including both positive and negative adjustments, based on a reconciliation of amounts paid by residential health care facilities beginning April first, nineteen hundred ninety-seven for additional assessments or further additional assessments pursuant to section twenty-eight hundred seven-d of this article with the amounts originally recognized for reimbursement purposes.
7-a. Notwithstanding any inconsistent provision of law, with regard to a general hospital the provisions of subdivisions four and seven of this section and the provisions of section eighteen of chapter two of the

laws of nineteen hundred eighty-eight relating to the requirement of prior notice and the time frames for notice, approval or certification of rates of payment, maximum rates of payment or maximum charges where not otherwise waived pursuant to law shall be applicable only to such rates of payment or maximum charges prospectively established for an annual rate period and such provisions shall not be applicable to a general hospital with regard to prospective adjustments or retrospective adjustments of established rates of payment or maximum charges for or during an annual rate period based on correction of errors or omissions of data or in computation, rate appeals, audits or other rate adjustments authorized by law or regulations adopted pursuant to section twenty-eight hundred three of this article.

7-b. Notification of diagnostic and treatment center approved rates. (a) For rate periods or portions of rate periods beginning on or after October first, nineteen hundred ninety-four, the commissioner shall notify each diagnostic and treatment center of its approved rates of payment, which shall be used in the reimbursement for services provided to persons eligible for payments made by state governmental agencies at least thirty days prior to the beginning of the period for which such rates are to become effective.

(b) Notwithstanding any contrary provision of law, all diagnostic and treatment centers certified on or before September second, nineteen hundred ninety-seven shall, not later than September second, nineteen hundred ninety-seven, notify the commissioner whether they intend to maintain all books and records utilized by the diagnostic and treatment center for cost reporting and reimbursement purposes on a calendar year basis or, commencing on July first, nineteen hundred ninety-six, on a July first through June thirtieth basis, and shall thereafter maintain all books and records on such basis. All diagnostic and treatment centers certified after September second, nineteen hundred ninety-seven shall notify the commissioner at the time of certification whether they intend to maintain all books and records on a calendar year basis or on or a July first4 through June thirtieth basis, and shall thereafter maintain all books and records on such a basis.

(c) The books and records maintained pursuant to paragraph (b) of this subdivision shall be utilized and made available to the commissioner in promulgating rates of payment for annual rate periods beginning on or after October first, nineteen hundred ninety-seven.

(d) Notwithstanding any provision of the law to the contrary, rates of payment established in accordance with paragraph (b) as amended, and paragraph (f) of subdivision two of this section for the rate period beginning April first, nineteen hundred ninety-three shall continue in effect through September thirtieth, nineteen hundred ninety-four, and applicable trend factors shall be applied to that portion of such rates of payment for the rate period which begins April first, nineteen hundred ninety-four.

8. Rates for federally qualified health centers and rural health centers. Notwithstanding section four of chapter eighty-one of the laws of nineteen hundred ninety-five, as amended by section twenty-seven of chapter one of the laws of nineteen hundred ninety-nine, and any other law, rule or regulation to the contrary, for periods on and after January first, two thousand one, rates of payment made by governmental agencies for services provided by diagnostic and treatment centers or general hospital outpatient clinics licensed under this article to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law which are also designated, in accordance with 42 USC §

1396a(aa), as federally qualified health centers or rural health centers shall be established in accordance with the following:

(a) For periods on and after January first, two thousand one, and prior to October first, two thousand one, such rates of payment shall be computed in accordance with paragraph (b) of subdivision two of this section, provided, however, that the operating and capital cost components of such rates and the applicable ceilings on allowable operating costs shall reflect an average of nineteen hundred ninety-nine and two thousand base year costs as reported to the department.

(b) For each twelve month period following September thirtieth, two thousand one, the operating cost component of such rates of payment shall reflect the operating cost component in effect on September thirtieth of the prior period as increased by the percentage increase in the Medicare Economic Index as computed in accordance with the requirements of 42 USC § 1396a(aa)(3) and as adjusted pursuant to applicable regulations to take into account any increase or decrease in the scope of services furnished by the facility.

(c) Rates of payments to facilities which first qualify as federally qualified health centers or rural health centers on or after October first, two thousand shall be computed in accordance with the provisions of paragraph (b) of subdivision two of this section, provided, however, that the operating cost component of such rates shall reflect an average of the operating cost component of rates of payments issued to other facilities subject to this subdivision during the same rate period, located in the same geographic region and with a similar case load, and further provided that the capital cost component of such rates shall reflect the most recently available capital cost data as reported to the department. For each twelve month period following the rate period in which such facilities commence operation, the operating cost component of rates of payment for such facilities shall be computed in accordance with paragraph (b) of this subdivision. In calculating the operating cost component of such rates for facilities which first qualify as federally qualified health care centers on or after October first, two thousand, the counties comprising the geographic region known as downstate shall be the same as the counties comprising the downstate region for purposes of reimbursing diagnostic and treatment centers under ambulatory patient groups, which counties are specified in the regulations adopted by the commissioner implementing section 18 of part C of chapter fifty-eight of the laws of two thousand eight.

(d) Subject to receipt of all necessary federal approvals, rates of payment computed in accordance with this subdivision may be further adjusted in accordance with the provisions of subdivision seventeen of this section, provided, however, that such adjustments shall not be subject to trend adjustments as provided in paragraph (b) of this subdivision.

(e) Diagnostic and treatment centers eligible for rates of payment computed pursuant to paragraphs (a) and (b) of this subdivision, which were, on December thirty-first, two thousand, receiving rates of payment as preferred primary care providers computed pursuant to paragraph (h) of subdivision two of this section, may elect to continue to receive rates of payment computed in accordance with such

paragraph (h), provided that in no event shall such rates of payment be less than the rates of payment computed pursuant to paragraphs (a) and (b) of this subdivision.

(f) For any rate periods after March thirty-first, two thousand eight, subject to the availability of federal financial participation, the commissioner may prospectively adjust rates of payment for facilities otherwise subject to this subdivision to reflect alternative rate-setting methodologies, provided, however, that such alternative rate-setting methodologies must: (i) be authorized by applicable state law, (ii) be agreed to by the commissioner and each facility to which they are applied and (iii) in no event result in rates that are, in aggregate, less than the rates of payment otherwise provided for in this subdivision.

9. Payments under this section not to preclude other lawful payments. Any payments made under the authority of this section or section twenty-eight hundred seven-c of this article shall not preclude payments under any other section of law.

10. Notwithstanding the provisions of this article, the commissioner may waive, subject to the approval of the state director of the budget, the requirements of any provisions of this section, section twenty-eight hundred seven-a or twenty-eight hundred seven-c of this article to permit the development and/or continuation of limited pilot reimbursement programs to provide additional knowledge and experience in different types of reimbursement mechanisms for general hospitals.

11. [Expires April 1, 2014, pursuant to L.1986, c. 600, § 2.] Notwithstanding the provisions of this article, the commissioner may waive, subject to the approval of the state director of the budget, the requirements of any provision of this section, section twenty-eight hundred seven-a or twenty-eight hundred seven-c of this article to permit the development, implementation and operation of limited pilot reimbursement programs for general hospital outpatient services and diagnostic and treatment center services that would be prospective and associated to the resource use patterns in rendering ambulatory care services.

12. (a) Notwithstanding any inconsistent provision of this article or any other law, for the purpose of improving access to and availability of comprehensive primary health care to persons receiving medical assistance pursuant to title eleven of article five of the social services law, the commissioner, upon application by a health care provider, may designate such provider as a preferred primary care provider in accordance with the provisions of this subdivision.

(b) Health care providers designated as preferred primary care providers pursuant to this subdivision shall meet such requirements as may be established by the commissioner in regulation, including, but not limited to:

(i) access by the medically indigent and medicaid eligible to ambulatory services; (ii) provision, to the maximum extent practicable, of continuity of care;

(iii) arrangements for specialty physician care and necessary ancillary services; (iv) reasonably accessible hours of operation;

(v) services which are accessible to medically underserved populations and communities including, to the maximum extent feasible, offering such services within the medically underserved community; and

(vi) participation in local social services district managed care programs established pursuant to section three hundred sixty-four-j of the social services law, provided that the commissioner, in consultation with the commissioner of social services, may exempt a health care provider from such participation for good cause. Good cause shall include but not be limited to geographic inaccessibility to managed care programs, inability to coordinate services of managed care programs, or that participation in the managed care program would significantly affect the provider's financial ability to provide services.

(c) For the purposes of this subdivision, a health care provider eligible to be designated as a preferred primary care provider shall mean a general hospital, a diagnostic and treatment center, a private physician, a nurse practitioner, a midwife, a professional corporation or a group of physicians or nurse practitioners. The designation of any general hospital or a diagnostic and treatment center as a preferred primary care provider shall apply only to the specific site where the entity provides comprehensive primary health care services.

13. [Expires July 1, 2014, pursuant to L.1993, c. 731, § 76(1)(b).] Subject to the availability of funds, the commissioner shall authorize health occupation development and workplace demonstration programs pursuant to the provisions of section two thousand eight hundred seven-h of this article for diagnostic and treatment centers, and the commissioner is hereby directed to make rate adjustments to cover the cost of such programs.

14. [Eff. through March 31, 2011, pursuant to L.1995, c. 81, § 246, subd. 5.] Notwithstanding any inconsistent provision of law or regulation, for purposes of establishing rates of payment by governmental agencies for diagnostic and treatment centers for services provided on or after April first, nineteen hundred ninety-five, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this subdivision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses provided by this subdivision shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the commissioner for each diagnostic and treatment center with base year administrative and general costs exceeding the average.

15. Notwithstanding any inconsistent provision of law, including subdivision fourteen of this section, the facility-specific impact of eliminating the statewide cap on administrative and general costs, as imposed pursuant to subdivision fourteen of this section, for the period April first, nineteen hundred ninety-nine through June thirtieth, nineteen hundred ninety-nine pursuant to a chapter of the laws of nineteen hundred ninety-nine, shall be included in rates of payment for facilities affected by such elimination for the period October first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety- nine. In addition, rates for diagnostic and treatment centers for the period October first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine shall include, in the aggregate, the sum of fourteen million dollars which shall be added to rates of payment established in accordance with paragraphs (b) and (h) of subdivision two of this section based on an apportionment of such amount

using a ratio of each individual provider's estimated medicaid expenditures to total estimated medicaid expenditures for diagnostic and treatment centers, as determined by the commissioner, for the October first, nineteen hundred ninety-nine through September thirtieth, two thousand rate period.

16. Notwithstanding any inconsistent provision of law, payment for drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law provided to persons receiving medical assistance pursuant to title eleven of article five of the social services law by any non-hospital based diagnostic and treatment center licensed under this article in existence on the effective date of this subdivision providing comprehensive primary medical care services and registered by the state board of pharmacy pursuant to section sixty-eight hundred eight of the education law shall be on a fee-for-service basis and shall not be included in any comprehensive clinic rate paid to such facility by governmental agencies established in accordance with paragraph (b) of subdivision two of this section.

17. (a) Notwithstanding any contrary provision of law or regulation, the commissioner shall, subject to the availability of federal financial participation, adjust medical assistance rates of payment established pursuant to paragraph (b) of subdivision two of this section for free-standing diagnostic and treatment centers licensed pursuant to this article and which are: a “covered provider” as defined in subdivision one of section three hundred sixty-four-j-two of the social services law; or eligible for an allocation under paragraph (a-1) of subdivision two of section three hundred sixty-four-j-two of the social services law; or which provides services to individuals with developmental disabilities as their principal mission, in accordance with paragraphs (b) and (c) of this subdivision for purposes of improving recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility in the following aggregate amounts for the following periods:

(i) for the period April first, two thousand two through December thirty-first, two thousand two, thirteen million dollars;

(ii) for the period January first, two thousand three through December thirty-first, two thousand three, thirteen million dollars;

(iii) for the period January first, two thousand four through December thirty-first, two thousand four, thirteen million dollars;

(iv) for the period January first, two thousand five through December thirty-first, two thousand five, thirteen million dollars;

(v) for the period January first, two thousand six through December thirty-first, two thousand six, thirteen million dollars;

(vi) for the period January first, two thousand seven through June thirtieth, two thousand seven, six million five hundred thousand dollars;

(vii) for the period July first, two thousand seven through March thirty-first, two thousand eight, nine million seven hundred fifty thousand dollars; and

(viii) thirteen million dollars for the period April first, two thousand eight through March thirty-first, two thousand nine;

(ix) thirteen million dollars for the period April first, two thousand nine through March thirty-first, two thousand ten; and

(x) thirteen million dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven.

(b) Such adjustments to rates of payments shall be allocated proportionally based on each diagnostic and treatment center's total annual gross salary and fringe benefit costs, as reported in each such diagnostic and treatment center's nineteen hundred ninety-nine cost report as submitted to the department prior to November first, two thousand one, provided, however, that for periods on and after July first, two thousand seven, such adjustments to rates of payment shall be allocated proportionally, based on each such diagnostic and treatment center's total reported medicaid visits, as reported in each such diagnostic and treatment center's two thousand four cost report as submitted to the department prior to January thirty-first, two thousand seven, to the total of such medicaid visits for all diagnostic and treatment centers.

(c) Rate adjustments made pursuant to this subdivision shall not be subject to subsequent adjustment or reconciliation.

(d) Diagnostic and treatment centers which have their rates adjusted pursuant to this subdivision shall use such funds for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Each such diagnostic and treatment center shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. The commissioner is authorized to audit each such diagnostic and treatment center to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

18. (a) Notwithstanding any contrary provision of law or regulation, the commissioner shall, subject to the provisions of paragraph (c) of this subdivision and to the availability of federal financial participation, increase medical assistance rates of payment established pursuant to paragraph (b) of subdivision two of this section for eligible diagnostic and treatment centers by three percent for services provided on and after December first, two thousand two for purposes of improving recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility.

(b) For the purposes of this subdivision, “eligible diagnostic and treatment center” shall mean a voluntary, not-for-profit diagnostic and treatment center licensed under this article that received medical assistance rates of payment reflecting assignment to limited primary care or drug free peer groups as established pursuant to applicable rate-setting regulations and that provides primary health care services to a patient population primarily comprised of substance abuse patients and that is ineligible for an adjustment to medical assistance rates of payment under subdivision seventeen of this section.

(c) Diagnostic and treatment centers which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purpose of recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Each such diagnostic and treatment center shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. The commissioner is authorized to audit each such diagnostic and treatment center to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

19. (a) Notwithstanding any provision of law, rule or regulation to the contrary and subject to the provisions of paragraph (b) of this subdivision and to the availability of federal financial participation, the commissioner shall increase medical assistance rates of payment by three percent for services provided on and after December first, two thousand two by freestanding methadone maintenance service and program providers issued operating certificates pursuant to this article and section 32.09 of the mental hygiene law for the purposes of improving recruitment and retention of methadone maintenance workers.

(b) Freestanding methadone maintenance services and program providers which are eligible for rate adjustments pursuant to this subdivision and which are also eligible for rate adjustments pursuant to subdivision seventeen of this section, shall, on or before July first, two thousand two, submit, in a form and manner determined by the commissioner, amendments to designated sections of their AHCF-1 cost report segregating wages and fringe benefit costs associated with methadone maintenance services from all other services for the purposes of determining awards made pursuant to subdivision seventeen of this section for rate periods ending in two thousand three and in two thousand four.

(c) Freestanding methadone maintenance service and program providers which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purpose of recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Each such methadone maintenance service and program provider shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers at such programs or any worker with direct patient care responsibility. The commissioner is authorized to audit each such methadone maintenance service and program provider to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

20. Notwithstanding any contrary provision of law and subject to the receipt of all necessary federal approvals and the availability of federal financial participation, the commissioner is authorized to enter into agreements with SUNY downstate medical center, other public general hospitals, and/or with the sponsoring local governments of such other public general hospitals, under which such facilities and/or

such local government shall, by intergovernmental transfer, fund the non-federal share of Medicaid funds made available for Delivery System Reform Incentive Payments ("DSRIPS") to such facilities. Such non-federal share payments shall be deemed voluntary and, further, such payments shall be excluded from computations made pursuant to section one of part C of chapter fifty-eight of the laws of two thousand five, as amended. In addition, the facilities, and/or the sponsoring local governments of such facilities or the state may, by written notification to the other parties to the agreement, cancel such agreement at any time prior to the payment of the DSRIP funds.

21. Notwithstanding any contrary provision of law and subject to the receipt of all necessary federal approvals and the availability of federal financial participation, the commissioner is authorized to enter into agreements with SUNY downstate medical center, other public general hospitals, and/or with the sponsoring local governments of such other public general hospitals, under which such facilities and/or such local government shall, by intergovernmental transfer, fund the non-federal share of Medicaid funds made available for implementation of Medicaid Redesign Team initiatives. Such non-federal share payments shall be deemed voluntary and, further, such payments shall be excluded from computations made pursuant to section one of part C of chapter fifty-eight of the laws of two thousand five, as amended. In addition, the facilities, and/or the sponsoring local governments of such facilities or the state may, by written notification to the other parties to the agreement, cancel such agreement at any time prior to the payment of the Medicaid Redesign Team initiatives funds.

North Carolina

No statutes or regulations found using the search terms.

North Dakota

N.D. Cent. Code Ann. § 50-06-06.2

Clinic services--Provider qualification--Utilization of federal funds

Within the limits of legislative appropriation therefor and in accordance with rules established by the department, the department may defray the costs of preventive diagnostic, therapeutic, rehabilitative, or palliative items or services furnished medical assistance eligible individuals by regional human service centers. Within the limits of legislative appropriations and to the extent permitted by state and federal law and regulations established thereunder, it is the intent of the legislative assembly that federal funds available under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] be utilized to defray the costs of identifiable mental health clinic services furnished eligible individuals in regional human service centers and that federal funds available under title XX of the Social Security Act [42 U.S.C. 1397 et seq.] be utilized to defray the costs of identifiable social services furnished eligible individuals by county social service boards and regional human service centers.

Ohio

Ohio Rev. Code Ann. § 9.38

Deposit of public moneys (November 2, 1999)

As used in this section and section 9.39 of the Revised Code:

(1) "Color of office," "public office," and "public official" have the same meanings as in section 117.01 of the Revised Code.

(2) "Legislative authority" means a board of county commissioners, a board of township trustees, the legislative authority of a municipal corporation, or the board of education of a school district.

A person who is a state officer, employee, or agent shall pay to the treasurer of state all public moneys received by that person as required by rule of the treasurer of state adopted pursuant to section 113.09 of the Revised Code. A person who is a public official other than a state officer, employee, or agent shall deposit all public moneys received by that person with the treasurer of the public office or properly designated depository on the business day next following the day of receipt, if the total amount of such moneys received exceeds one thousand dollars. If the total amount of the public moneys so received does not exceed one thousand dollars, the person shall deposit the moneys on the business day next following the day of receipt, unless the public office of which that person is a public official adopts a policy permitting a different time period, not to exceed three business days next following the day of receipt, for making such deposits, and the person is able to safeguard the moneys until such time as the moneys are deposited. The policy shall include provisions and procedures to safeguard the public moneys until they are deposited. If the public office of which the person is a public official is governed by a legislative authority, only the legislative authority may adopt such a policy; in the case of a board of county commissioners, the board may adopt such a policy with respect to public offices under the board's direct supervision and the offices of the prosecuting attorney, sheriff, coroner, county engineer, county recorder, county auditor, county treasurer, or clerk of the court of common pleas. If a person who is a public official receives public moneys for a public office of which that person is not a public official, that person shall, during the first business day of the next week, pay to the proper public official of the proper public office the moneys so received during the current week.

Ohio Rev. Code Ann. § 113.09

Deposits credited to general revenue fund; illegal warrants; disposition of investment earnings (December 1, 2006)

Except as provided in section 113.10 of the Revised Code, all moneys deposited with the treasurer of state, the disposition of which is not otherwise provided for by law, shall be credited to the general revenue fund, which is hereby created in the state treasury. If a warrant for the payment of money from the state treasury has been illegally or improperly issued, or the amount of a warrant exceeds the sum that should have been named therein, and payment of such warrant or excess has been made by the treasurer of state, the director of budget and management shall, unless the account of the appropriation from which it was paid has been closed, credit the amount collected to such appropriation; but, if such account has

been closed, the director shall credit the amount so collected to the fund on which the warrant was originally drawn.

All investment earnings on moneys deposited in the state treasury shall be credited to the general revenue fund unless:

(A) The disposition of the earnings is otherwise provided for by law;

(B) The director has provided in the plan approved under section 131.36 of the Revised Code that a different fund is entitled to the earnings.

Ohio Rev. Code Ann. § 113.10 Contingent fund (July 1, 1985)

There is hereby created the treasurer of state's contingent fund, which shall not be a part of the state treasury. Money received by the treasurer of state that is provisional in nature or the disposition of which cannot be determined immediately shall, in accordance with rules adopted by the treasurer of state, be credited to this fund until a determination is made as to the final disposition of the money. The treasurer of state shall establish by rule the form and manner of deposits into and disbursements from the fund and the circumstances under which deposits may be made into and disbursements may be made from the fund. All income earned on money credited to this fund shall be credited to the general revenue fund.

Oklahoma

73 Okl.St.Ann. § 163.2

Deposit of funds

Monies collected from private tenants in the State Office Building in Tulsa, Oklahoma, through June 30, 1976, or monies collected from lease agreement with state agencies entered into subsequent to the date of this act, except the State Department of Agriculture, the Supreme Court, the Commissioner of Narcotics and Dangerous Drugs Control, the Human Rights Commission, the Indian Affairs Commission, the Water Resources Board, the Oklahoma Educational Television Authority, the Oklahoma Department of Commerce, the Department of Mental Health and Substance Abuse Services, the Department of Labor, the University of Oklahoma and the board of county commissioners of Tulsa County, shall be paid to the State Treasurer for deposit to the General Revenue Fund. Monies collected from any agency or institution of the government of the United States are exempted from payment to the State Treasurer for deposit to the General Revenue Fund.

Oregon

Or. Admin. R. 410-147-0500

Total Encounters for Cost Reports (July 1, 2007)

(1) Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs) are required to report the total number of encounters for furnishing services outlined in 42 USC 1396d(a)(2)(C) and 1396d(a)(2)(B), respectively.

(2) In general, the Division of Medical Assistance Programs (DMAP) calculates a FQHC or RHC's Prospective Payment System (PPS) encounter rate by dividing the total costs incurred by a clinic for furnishing services as defined in 42 USC 1396d(a)(2)(B) or (C) by the total number of all clinic visits, or "encounters." The intent of PPS is to calculate the average cost of an encounter, and not the average cost of a Medicaid billable encounter.

(3) This rule provides guidance for cost reporting of all encounters. It is the responsibility of the FQHC and RHC to report all encounters, except when expressly directed not to elsewhere in this rule. FQHCs and RHCs are required to include ALL:

(a) Encounters for all clients regardless of payor;

(b) Encounters for FQHC or RHC services that are not covered by Medicaid, Medicare, Third Party Payor or other party, but otherwise have an associated cost for providing the service whether billed to the client (e.g. uninsured, signed waiver on file) or absorbed by the clinic; and;

(c) Encounters regardless of line placement on the Health Services Commission's Prioritized List of Health Services. For the purpose of reporting encounters according to this rule, encounters are not subject to the HSC Prioritized List, or service limitations and benefit reductions implemented by the Division of Medical Assistance Programs (DMAP).

(4) FQHCs and RHCs must report all encounters furnished to all client populations irrespective of coverage or payor source. Examples of client populations include, but are not limited to:

(a) Oregon Health Plan (OHP) clients (includes both fee-for-service and prepaid health plan (PHP) clients). Refer to OAR 410-147-0120 for more information regarding OHP encounters;

(b) Citizen/Alien-Waived Emergency Medical (CAWEM) clients. Refer also to OAR 410-120-1210(3)(f).
(c) Family Planning Expansion Program (FPEP) Title X, clients;

(d) Uninsured and/or self-pay clients; (e) Medicare clients;

(f) Third party or private pay insurance clients;

(g) County- and/or clinic-pay clients (services paid or funded by the county or clinic); and

(h) Clients funded by federal, state, local or other grants.

(5) FQHCs and RHCs must exclude from the total number of reported encounters: (a) Encounters attributed to non-allowable costs:

(A) Services performed under the auspices of a Women, Infant and Children (WIC) program or a WIC contract;

(B) Services performed and reimbursed under separate enrollment. e.g. Targeted Case Management; (C) Services provided by patient advocates/ombudsmen and Outstationed Outreach Workers, employed by or under contract with the FQHC or RHC, for the primary purpose of providing outreach and/or group education sessions;

(D) Provider participation in a community meeting or group session that is not designed to provide clinical services. This includes, and is not limited to, information sessions for prospective Medicaid beneficiaries, and information presentations about available health services at the FQHC or RHC; and

(E) Health services provided as part of a large-scale “free to the public“ or “nominal fee“ effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair);

(b) Encounters for specific services outlined in 42 USC 1396d(a)(2)(B) and (C), that do not meet the criteria of a valid encounter when furnished as a stand-alone service. Costs for furnishing these services is an allowed administrative program cost and should be reported on a clinic's cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Costs Statement (DMAP 3027) Instructions. Examples include, but are not limited to:

(A) Case management services for coordinating health care for a client;

(B) Enabling services, including but not limited to, sign language and oral interpreter services;

(C) Supportive, rehabilitation services including, but not limited to, environmental intervention, and supported housing and employment; skills training and activity therapy to promote community integration and job readiness;

(D) Laboratory and radiology services, including venipuncture and tuberculosis (TB) tests (the initial visit for the TB test administered to the epidermis);

(E) Prescription refills; and

(F) Services provided without the client present, except for telephone contacts as specified in this rule section (6)(c).

(6) FQHCs and RHCs are required to include encounters for services furnished by practitioners recognized by DMAP in OAR 410-147-0120(6). Examples of encounters that may be overlooked but should be included are:

(a) Encounters below the funding line on the Health Services Commission's Prioritized List of Health Services. All encounters are to be reported regardless of line placement;

(b) Encounters outside of the clinic by primary care practitioners (e.g. services furnished in a hospital or residential treatment setting);

(c) Telephone contacts as provided for in the Tobacco Cessation, OAR 410-130-0190; and Maternity Case Management (MCM), 410-130-0595, programs. See also 410-120-1200(2)(y); (d) Medication management-only encounters by a behavioral health practitioner;

(e) Encounters by Registered and Licensed Practical Nurses:

(A) Home encounters in an area in which the Secretary of the Health Resources and Services Administration, Health and Human Services, has determined that there is a shortage of home health agencies (OAR 410-147-0120(10));

(B) Administration of immunizations/vaccinations encounters;

(C) “99211“ encounters; and

(D) Maternity Case Management (MCM) encounters.

(7) Global procedures require attention for accurate reporting of encounters:

(a) Obstetrics procedures: Each antepartum, delivery and postpartum encounter included in a global procedure for maternity and delivery services should be reported as a separate encounter;

(b) Dental procedures: Multiple contacts for global dental procedures should be reported as a single encounter. Refer to OAR 410-147-0040(5) ICD-9-CMm Diagnosis and CPT/HCPCs Procedure Codes, for more information;

(c) Surgical procedures: Refer to OAR 410-147-0040(5), ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes, for more information:

(A) Services within a surgical package and “included“ in a given CPT surgical code are reported as a single encounter. Refer to OAR 410-130-0380, Surgical Guidelines, for more information; and

(B) The initial consultation or evaluation of the problem by the provider to determine the need for surgery, and separate from a preoperative appointment, is a separate encounter.

(8) A surgical procedure furnished to an OHP client and provided by more than one surgeon employed by the FQHC or RHC does not count as multiple encounters. The exception to this rule is major surgery, including a cesarean delivery, furnished to a CAWEM client. Services provided by the primary surgeon and the assistant surgeon, when both are employed with the FQHC or RHC, may be eligible as multiple encounters if medically necessary.

(9) When two or more services are provided on the same date of service:

(a) With distinctly different diagnoses, a clinic should report multiple encounters when the criteria in OAR 410-147-0140, Multiple Encounters, is met; or

(b) With similar diagnoses, a clinic must report one encounter.

(10) Clinics must maintain, for no less than five years, all documentation relied upon by the clinic to calculate the number of encounters reported on the cost statement (DMAP 3027):

(a) All documentation supporting the number of encounters reported on the cost statement must be sufficient to withstand an audit; and

(b) The total number of encounters calculated from all sources of documentation must reconcile to the total number of encounters reported on the cost statement, and subtotaled encounters must reconcile to each documentation source relied upon.

Pennsylvania

PA ST 35 P.S. § 10227.111

Community-Based Health Care Program (August 19, 2013)

(a) Establishment.--The Community-Based Health Care Program is established within the department to provide grants to community-based health care clinics to:

(1) Expand and improve health care access and services, such as preventive care, chronic care and disease management, prenatal, obstetric, postpartum and newborn care, dental treatment, behavioral health and pharmacy services.

(2) Reduce unnecessary utilization of hospital emergency services by providing an effective alternative health care delivery system.

(3) Encourage collaborative relationships among community-based health care clinics, hospitals and other health care providers.

(b) Grant award methodology.--A methodology for the allocation of grant awards shall be developed by the department based on the following distribution:

(1) Not more than 50% for the expansion of an existing or the development of a new community-based health care clinic using criteria that include:

(i) The actual and projected number of total patients, new patients and patient visits for all patients served or to be served, specifically delineating the number of low-income and uninsured patients, who fall below 200% of the Federal poverty income guidelines.

(ii) The addition or expansion of ancillary health care services, such as dental, behavioral health and pharmacy.

(iii) The development or enhancement of preventive and chronic care and disease management techniques.

(2) Not more than 25% for improvements in prenatal, obstetric, postpartum and newborn care.

(3) Not more than 20% for improved access and services, including patient transportation, intended to reduce unnecessary emergency room utilization.

(4) Not more than 5% for the establishment of collaborative relationships among community-based health care clinics, hospitals and other health care providers.

(5) Not more than 15% of the funds made available for the program authorized by this section may be awarded to applicants within any one city, town, borough or township of this Commonwealth.

(b.1) Limitation.--No more than 25% of the grants awarded under subsection (b) may go to federally qualified health centers as defined in section 1905(l)(2)(B) of the Social Security Act (49 Stat. 620, 42

U.S.C. § 1396d(l)(2)(B)) or federally qualified health center look-alikes.

(c) Distribution.--Funds shall be distributed in a manner that improves access and expands services in all geographic areas of this Commonwealth.

(d) Reallocation.--The department shall reallocate funds among the categories described in subsections

(b) and (b.1) if sufficient qualified grant requests are not received to use all the funds available in a specific category.

(e) Amount of grants.--A grant under this subsection shall require a matching commitment of 25% of the grant, which can be in the form of cash or equivalent in-kind services.

(f) Federal funds.--The department shall seek any available Federal funds, as well as any available grants and funding from other sources, to supplement amounts made available under this subchapter to the extent permitted by law.

PA ST 35 P.S. § 10227.113

Hospital health clinics (August 19, 2013)

(a) Program.--The Department of Public Welfare shall, in cooperation with the department, be responsible for administering the program as it relates to hospital health clinics in accordance with the requirements of this act and shall have the following additional duties:

(1) To develop an application and collect such data and information as may be necessary to determine the eligibility of hospital health clinics for payments under this section using the criteria set forth in section 111(a) and (b).1

(2) To review an application and make a final determination regarding a hospital health clinic's eligibility for funding within 90 days of receipt.

(3) To make payments to hospital health clinics in accordance with the payment calculation set forth in subsection (e).

(b) Submission of application.--In order to qualify for funding under this section, a hospital health clinic shall submit the required application to the Department of Public Welfare no later than 90 days after the effective date of this act.

(c) Funding.--

(1) For each fiscal year, upon Federal approval of an amendment to the Medicaid State plan, the Department of Public Welfare shall annually distribute any available funds obtained under this act for hospital health clinics through disproportionate share payments to hospitals to provide financial assistance that will assure readily available and coordinated comprehensive health care to the citizens of this Commonwealth.

(2) The Secretary of Public Welfare shall determine the funds available and make appropriate adjustments based on the number of qualifying hospitals with hospital health clinics.

(d) Maximization.--The Department of Public Welfare shall seek to maximize any Federal funds, including funds obtained under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.).

(e) Payment calculation.--

(1) Thirty percent of the total amount available shall be allocated to eligible hospital health clinics of hospitals located in counties of the first and second class. The total amount available for each hospital health clinic at a hospital in these counties shall be allocated on the basis of each hospital's percentage of medical assistance and low-income hospital health clinic visits compared to the total number of medical assistance and low-income hospital health clinic visits for all hospitals in the first and second class counties.

(2) Fifty percent of the total amount available shall be allocated to eligible hospital health clinics of hospitals located in counties of the third, fourth and fifth class. The total amount available for each hospital health clinic at a hospital in these counties shall be allocated on the basis of each hospital's percentage of medical assistance and low-income hospital health clinic visits compared to the total number of medical assistance and low-income hospital health clinic visits for all hospitals in the third, fourth and fifth class counties.

(3) Twenty percent of the total amount available shall be allocated to eligible hospital health clinics of hospitals located in counties of the sixth, seventh and eighth class. The total amount available for each hospital health clinic at a hospital in these counties shall be allocated on the basis of each hospital's percentage of medical assistance and low-income hospital health clinic visits compared to the total number of medical assistance and low-income hospital health clinic visits for all hospitals in the sixth, seventh and eighth class counties.

(4) Any hospital that has reached its disproportionate share limit under Title XIX of the Social Security Act shall receive its share of the State funds available under this act.

55 Pa. Code § 1129.51

General payment policy. (December 24, 1983)

(a) Payment will be made for rural health clinic services rendered at the clinic, at a hospital or at the place of residence of the patient.

(b) Payment for rural health clinic services will be made on the basis of an all-inclusive visit fee established by the Medicare carrier. When the cost for a service provided by the clinic is included in the established visit fee, the practitioner rendering the service shall not bill the MA Program for it separately.

(c) An adjustment to the all-inclusive visit fee will be made when the Medicare carrier determines the difference, if any, between the total payment due the clinic and the total payment made during the reported period. The adjustment will be made as follows:

(1) If the clinic has been underpaid, the Department will make a lump sum payment for the amount due.

(2) If the clinic has been overpaid, the clinic shall make a lump sum payment to the Department for the amount due. A repayment plan not to exceed 1 year will be arranged by the Department at the request of the clinic if the Department is satisfied that a lump sum payment would impose severe financial hardship on the clinic.

Rhode Island

No statutes or regulations found using the search terms.

South Carolina

S.C. Code Ann. § 44-15-80

Powers and duties of Department.

In addition to the powers and duties already conferred by law, the Department of Mental Health shall: (1) Promulgate rules and regulations governing the eligibility of community mental health programs to receive State grants, prescribing standards for qualification of personnel and quality of professional service and for in-service training and educational leave programs for personnel;

(2) Govern eligibility for service so that no person will be denied service on the basis of inability to pay and so that anyone who cannot afford to pay for necessary treatment at the rate customarily charged in available private practice shall be eligible to receive services from the community mental health clinic;
(3) Provide for establishment of fee schedules and reduction of balance due which shall be based upon ability to pay;

(4) Regulate fees for consultation and diagnostic services, which services may be provided to anyone without regard to his financial status when such person is referred by the courts, schools, health or welfare agencies;

(5) Promulgate such other rules and regulations as it deems necessary to carry out the purposes of this article;

(6) Review and evaluate local programs and the performance of all personnel and make recommendations thereon to community mental health boards and program administrators;

(7) Provide consultative staff service to communities to assist in ascertaining local needs and in planning and establishing community mental health programs; and

(8) Employ personnel, certified by the merit system as classified according to existing job classifications, including a State Director of Community Mental Health Services, to be under the supervision of the Director of the Department of Mental Health, to implement the provisions of this article.

(9) Require reports from the directors of community mental health programs relating to the intake, examination, diagnosis and file closing of any patient or client.

S.C. Code Ann. § 44-23-1110

Charges for maintenance, care and services.

The Department of Mental Health shall establish the charges for maintenance and medical care for patients, other than beneficiary, of State mental health facilities. These charges shall be based upon the per capita costs per day of the services rendered, which may include costs of operation, costs of depreciation, and all other elements of cost, which may be adjusted from time to time as the Department of Mental Health considers advisable. It shall establish a reasonable scale of fees to be charged patients, other than beneficiary, served by the mental health clinics and shall retain these fees for use in defraying the expenses of the clinics.

South Dakota

S.D. Admin. R. 67:16:44:05

Required cost reports (January 5, 1997)

A provider must submit to the Department of Social Services, Office of Provider Reimbursement and Audits, a completed copy of the provider's cost report showing the actual costs incurred during the reporting period and the total number of visits for the services furnished as required in chapter 5, § 500 of the Medicare Rural Health Clinic and Federally Qualified Health Center Manual (HCFA Pub. 27), as specified in § 67:16:44:04. The provider must submit the required cost report to the department within five months after the provider's fiscal year ends.

S.D. Admin. R. 67:16:44:07

Payment limitations (June 24, 2013)

Payments to a center or a clinic are subject to the following limitations:

(1) Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day constitute a single visit;

(2) Payment is limited to two visits a day. The second visit is payable only if, after the first visit, the patient suffers illness or injury which requires additional diagnosis or treatment;

(3) Payment is limited to those covered services provided by a physician, physician assistant, nurse practitioner, nurse midwife, or visiting nurse; and

(4) Payment for mental health services are limited to those providers and services covered under the provisions of chapter 67:16:41.

Tennessee

Tenn. Code Ann. § 9-4-301

Duty of immediate deposit; cash management policy; effect of deposit on liability (July 9, 2012) (a) It is the duty of every department, institution, office and agency of the state and every officer and employee of state government, including the state treasurer, collecting or receiving state funds, to deposit them immediately into the state treasury or to the account of the state treasurer in a bank designated as a state depository or to the appropriate departmental account if authorized by § 9-4-302. The state funding board has the authority to establish a cash management policy to govern the cash management and deposit practices of every department, institution, office and agency of state government. The board is authorized to review cash management practices and make recommendations to appropriate state officials regarding modifications to current practices as well as the cash processing equipment needs of various state agencies.

(b) Notwithstanding any other law to the contrary, and notwithstanding any written comment on the payment instrument or any other verbal or written comment, whenever any official deposits state funds in accordance with subsection (a), in any form or description, including, but not limited to, checks, drafts or warrants, that deposit shall in no manner relieve the person or organization submitting the amount of any liability which has or is subsequently determined to be owed to the state except to the extent that the amount deposited discharges the amount owed to the state. When an instrument is tendered by such person or organization and is deposited by the state for an amount which is less than the full amount owed, the remaining liability is enforceable in the same manner as the original amount owed to the state.

(c) Such deposit shall be made without any deductions on account of salaries, fees, costs, charges, expenses, refunds, claims, or demands of any description whatsoever.

(d) Unless otherwise provided by law, all county and other officials collecting moneys for the use and benefit of the state shall remit the same to the commissioner of revenue in accordance with procedures established by the commissioner of finance and administration and approved by the state treasurer and the comptroller of the treasury.

Tenn. Code Ann. § 63-1-203

Compensation and reimbursement; donations and gifts (August 11, 2010)

A medical practitioner or a free health clinic may not receive any compensation for services rendered including, but not limited to, reimbursement from an individual or from any third party payor.

Reimbursement may not be accepted from any insurance policy, health plan or federal or state benefits program. A clinic may receive donations and gifts.

Texas

V.T.C.A., Health & Safety Code § 85.064

Funding

(a) The department may accept and use local, state, and federal funds and private donations to fund the program.

(b) State, local, and private funds may be used to qualify for federal matching funds if federal funding becomes available.

(c) A hospital district, local health department, public or nonprofit hospital or clinic, or nonprofit community organization may participate in the program by sending funds to the department for the purpose of providing assistance to clients for the purchase of HIV medication. A hospital district may send funds obtained from any source, including taxes levied by the district.

(d) The department shall deposit money received under this section in the state treasury to the credit of the HIV medication fund and to the credit of a special account in that fund that shall be established for each entity sending funds under this section.

(e) Funds received from a hospital district, local health department, public or nonprofit hospital or clinic, or nonprofit community organization under this section may be used only to provide assistance to clients of that entity. The funds may be supplemented with other funds available for the purpose of the program.

(f) Funds appropriated by the General Appropriations Act may not be transferred from other line items for the program.

Utah

Utah Code Ann. § 26-9-4

Rural Health Care Facilities Account--Source of revenues--Interest--Distribution of revenues--Expenditure of revenues--Unexpended revenues lapse into the General Fund (March 29, 2010) (1)

As used in this section:

(a) “Emergency medical services” is as defined in Section 26-8a-102.

(b) “Federally qualified health center” is as defined in 42 U.S.C. Sec. 1395x. (c) “Fiscal year” means a one-year period beginning on July 1 of each year. (d) “Freestanding urgent care center” is as defined in Section 59-12-801.

(e) “Nursing care facility” is as defined in Section 26-21-2.

(f) “Rural city hospital” is as defined in Section 59-12-801.

(g) “Rural county health care facility” is as defined in Section 59-12-801.

(h) “Rural county hospital” is as defined in Section 59-12-801.

(i) “Rural county nursing care facility” is as defined in Section 59-12-801.

(j) “Rural emergency medical services” is as defined in Section 59-12-801.

(k) “Rural health clinic” is as defined in 42 U.S.C. Sec. 1395x.

(2) There is created a restricted account within the General Fund known as the “Rural Health Care Facilities Account.”

(3)(a) The restricted account shall be funded by amounts appropriated by the Legislature. (b) Any interest earned on the restricted account shall be deposited into the General Fund.

(4) Subject to Subsections (5)and (6), the State Tax Commission shall for a fiscal year distribute money deposited into the restricted account to each:

(a) county legislative body of a county that, on January 1, 2007, imposes a tax in accordance with Section 59-12-802; or

(b) city legislative body of a city that, on January 1, 2007, imposes a tax in accordance with Section 59-12-804.

(5)(a) Subject to Subsection (6), for purposes of the distribution required by Subsection (4), the State Tax Commission shall:

(i) estimate for each county and city described in Subsection (4) the amount by which the revenues collected from the taxes imposed under Sections 59-12-802 and 59-12-804 for fiscal year 2005-06 would have been reduced had:

(A) the amendments made by Laws of Utah 2007, Chapter 288, Sections 25 and 26, to Sections 59-12-802 and 59-12-804 been in effect for fiscal year 2005-06; and

(B) each county and city described in Subsection (4) imposed the tax under Sections 59-12-802 and 59-12-804 for the entire fiscal year 2005-06;

(ii) calculate a percentage for each county and city described in Subsection (4) by dividing the amount estimated for each county and city in accordance with Subsection (5)(a)(i) by $555,000; and

(iii) distribute to each county and city described in Subsection (4) an amount equal to the product of: (A) the percentage calculated in accordance with Subsection (5)(a)(ii); and

(B) the amount appropriated by the Legislature to the restricted account for the fiscal year.

(b) The State Tax Commission shall make the estimations, calculations, and distributions required by Subsection (5)(a) on the basis of data collected by the State Tax Commission.

(6) If a county legislative body repeals a tax imposed under Section 59-12-802 or a city legislative body repeals a tax imposed under Section 59-12-804:

(a) the commission shall determine in accordance with Subsection (5) the distribution that, but for this Subsection (6), the county legislative body or city legislative body would receive; and

(b) after making the determination required by Subsection (6)(a), the commission shall:

(i) if the effective date of the repeal of a tax imposed under Section 59-12-802 or 59-12-804 is October 1: (A)(I) distribute to the county legislative body or city legislative body 25% of the distribution determined in accordance with Subsection (6)(a); and

(II) deposit 75% of the distribution determined in accordance with Subsection (6)(a) into the General Fund; and

(B) beginning with the first fiscal year after the effective date of the repeal and for each subsequent fiscal year, deposit the entire amount of the distribution determined in accordance with Subsection (6)(a) into the General Fund;

(ii) if the effective date of the repeal of a tax imposed under Section 59-12-802 or 59-12-804 is January 1: (A)(I) distribute to the county legislative body or city legislative body 50% of the distribution determined in accordance with Subsection (6)(a); and

(II) deposit 50% of the distribution determined in accordance with Subsection (6)(a) into the General Fund; and

(B) beginning with the first fiscal year after the effective date of the repeal and for each subsequent fiscal year, deposit the entire amount of the distribution determined in accordance with Subsection (6)(a) into the General Fund;

(iii) if the effective date of the repeal of a tax imposed under Section 59-12-802 or 59-12-804 is April 1: (A)(I) distribute to the county legislative body or city legislative body 75% of the distribution determined in accordance with Subsection (6)(a); and

(II) deposit 25% of the distribution determined in accordance with Subsection (6)(a) into the General Fund; and

(B) beginning with the first fiscal year after the effective date of the repeal and for each subsequent fiscal year, deposit the entire amount of the distribution determined in accordance with Subsection (6)(a) into the General Fund; or

(iv) if the effective date of the repeal of a tax imposed under Section 59-12-802 or 59-12-804 is July 1, beginning on that effective date and for each subsequent fiscal year, deposit the entire amount of the distribution determined in accordance with Subsection (6)(a) into the General Fund.

(7)(a) Subject to Subsection (7)(b), a county legislative body shall distribute the money the county legislative body receives in accordance with Subsection (5) or (6):

(i) for a county of the third, fourth, or fifth class, to fund rural county health care facilities in that county; and

(ii) for a county of the sixth class, to fund:

(A) emergency medical services in that county;

(B) federally qualified health centers in that county; (C) freestanding urgent care centers in that county;

(D) rural county health care facilities in that county; (E) rural health clinics in that county; or

(F) a combination of Subsections (7)(a)(ii)(A) through (E).

(b) A county legislative body shall distribute a percentage of the money the county legislative body receives in accordance with Subsection (5) or (6) to each center, clinic, facility, or service described in Subsection (7)(a) equal to the same percentage that the county legislative body distributes to that center, clinic, facility, or service in accordance with Section 59-12-803 for the calendar year ending on the December 31 immediately preceding the first day of the fiscal year for which the county legislative body receives the distribution in accordance with Subsection (5) or (6).

(c) A center, clinic, facility, or service that receives a distribution in accordance with this Subsection (7) shall expend that distribution for the same purposes for which money generated by a tax under Section 59-12-802 may be expended.

(8)(a) Subject to Subsection (8)(b), a city legislative body shall distribute the money the city legislative body receives in accordance with Subsection (5) or (6) to fund rural city hospitals in that city.

(b) A city legislative body shall distribute a percentage of the money the city legislative body receives in accordance with Subsection (5) or (6) to each rural city hospital described in Subsection (8)(a) equal to the same percentage that the city legislative body distributes to that rural city hospital in accordance with Section 59-12-805 for the calendar year ending on the December 31 immediately preceding the first day of the fiscal year for which the city legislative body receives the distribution in accordance with Subsection (5) or (6).

(c) A rural city hospital that receives a distribution in accordance with this Subsection (8) shall expend that distribution for the same purposes for which money generated by a tax under Section 59-12-804 may be expended.

(9) Any money remaining in the Rural Health Care Facilities Account at the end of a fiscal year after the State Tax Commission makes the distributions required by this section shall lapse into the General Fund.

Vermont

No statutes or regulations found using the search terms.

Virginia

No statutes or regulations found using the search terms.

Washington

Wash. Rev. Code Ann. § 43.01.050

Daily remittance of moneys to treasury--Undistributed receipts account—Use (July 26, 2009)

Each state officer or other person, other than county treasurer, who is authorized by law to collect or receive moneys which are required by statute to be deposited in the state treasury shall transmit to the state treasurer each day, all such moneys collected by him or her on the preceding day: PROVIDED,

That the state treasurer may in his or her discretion grant exceptions where such daily transfers would not be administratively practical or feasible. In the event that remittances are not accompanied by a statement designating source and fund, the state treasurer shall deposit these moneys in an account hereby created in the state treasury to be known as the undistributed receipts account. These moneys shall be retained in the account until such time as the transmitting agency provides a statement in duplicate of the source from which each item of money was derived and the fund into which it is to be transmitted. The director of financial management in accordance with RCW 43.88.160 shall promulgate regulations designed to assure orderly and efficient administration of this account. In the event moneys are deposited in this account that constitute overpayments, refunds may be made by the remitting agency without virtue of a legislative appropriation.

West Virginia

W. Va. Code Ann. § 16-2-11

Local board of health; powers and duties (May 30, 2000)

(a) Each local board of health created, established and operated pursuant to the provisions of this article shall:

(1) Provide the following basic public health services and programs in accordance with state public health performance-based standards:

(i) Community health promotion including assessing and reporting community health needs to improve health status, facilitating community partnerships including identifying the community's priority health

needs, mobilization of a community around identified priorities and monitoring the progress of community health education services;

(ii) Environmental health protection including the promoting and maintaining of clean and safe air, water, food and facilities and the administering of public health laws as specified by the commissioner as to general sanitation, the sanitation of public drinking water, sewage and wastewater, food and milk, and the sanitation of housing, institutions, and recreation; and

(iii) Communicable or reportable disease prevention and control including disease surveillance, case investigation and follow-up, outbreak investigation, response to epidemics, and prevention and control of rabies, sexually transmitted diseases, vaccine preventable diseases, HIV/AIDS, tuberculosis and other communicable and reportable diseases;

(2) Appoint a local health officer to serve at the will and pleasure of the local board of health with approval of the commissioner;

(3) Submit a general plan of operation to the commissioner for approval, if it receives any state or federal money for health purposes. This program plan shall be submitted annually and comply with provisions of the local board of health standards administrative rule;

(4) Provide equipment and facilities for the local health department that are in compliance with federal and state law;

(5) Permit the commissioner to act by and through it, as needed. The commissioner may enforce all public health laws of this state, the rules and orders of the secretary, any county commission orders or municipal ordinances of the board's service area relating to public health, and the rules and orders of the local board within the service area of a local board. The commissioner may enforce these laws, rules and orders when, in the opinion of the commissioner, a public health emergency exists or when the local board fails or refuses to enforce public health laws and rules necessary to prevent and control the spread of a communicable or reportable disease dangerous to the public health. The expenses incurred shall be charged against the counties or municipalities concerned;

(6) Deposit all moneys and collected fees into an account designated for local board of health purposes. The moneys for a municipal board of health shall be deposited with the municipal treasury in the service area. The moneys for a county board of health shall be deposited with the county treasury in the service area. The moneys for a combined local board of health shall be deposited in an account as designated in the plan of combination: Provided, That nothing contained in this subsection is intended to conflict with the provisions of article one, chapter sixteen of this code;

(7) Submit vouchers or other instruments approved by the board and signed by the local health officer or designated representative to the county or municipal treasurer for payment of necessary and reasonable expenditures from the county or municipal public health funds: Provided, That a combined local board of health shall draw upon its public health funds account in the manner designated in the plan of combination;

(8) Participate in audits, be in compliance with tax procedures required by the state and annually develop a budget for the next fiscal year;

(9) Perform public health duties assigned by order of a county commission or by municipal ordinance consistent with state public health laws; and

(10) Enforce the public health laws of this state and any other laws of this state applicable to the local board.

(b) Each local board of health created, established and operated pursuant to the provisions of this article may:

(1) Provide primary care services, clinical and categorical programs, and enhanced public health services;

(2) Employ or contract with any technical, administrative, clerical or other persons, to serve as needed and at the will and pleasure of the local board of health. Staff and any contractors providing services to the board shall comply with applicable West Virginia certification and licensure requirements. Eligible staff employed by the board shall be covered by the rules of the division of personnel under section six, article ten, chapter twenty-nine of this code. However, any local board of health may, in the alternative and with the consent and approval of the appointing authority, establish and adopt a merit system for its eligible employees. The merit system may be similar to the state merit system and may be established by the local board by its order, subject to the approval of the appointing authority, adopting and making applicable to the local health department all, or any portion of any order, rule, standard, or compensation rate in effect in the state merit system as may be desired and as is properly applicable;

(3) Adopt and promulgate and from time to time amend rules consistent with state public health laws and the rules of the West Virginia state department of health and human resources, that are necessary and proper for the protection of the general health of the service area and the prevention of the introduction, propagation and spread of disease. All rules shall be filed with the clerk of the county commission or the clerk or the recorder of the municipality or both and shall be kept by the clerk or recording officer in a separate book as public records;

(4) Accept, receive and receipt for money or property from any federal, state or local governmental agency, from any other public source or from any private source, to be used for public health purposes or for the establishment or construction of public health facilities;

(5) Assess, charge and collect fees for permits and licenses for the provision of public health services: Provided, That permits and licenses required for agricultural activities may not be assessed, charged or collected: Provided, however, That a local board of health may assess, charge and collect all of the expenses of inspection of the physical plant and facilities of any distributor, producer or pasteurizer of milk whose milk distribution, production or pasteurization facilities are located outside this state but who sells or distributes in the state, or transports, causes or permits to be transported into this state, milk or milk products for resale, use or consumption in the state and in the service area of the local board of health. A local board of health may not assess, charge and collect the expenses of inspection if the physical plant and facilities are regularly inspected by another agency of this state or its governmental subdivisions or by an agency of another state or its governmental subdivisions certified as an approved inspection agency by the commissioner. No more than one local board of health may act as the regular inspection agency of the physical plant and facilities; when two or more include an inspection of the

physical plant and facilities in a regular schedule, the commissioner shall designate one as the regular inspection agency;

(6) Assess, charge and collect fees for services provided by the local health department: Provided, That fees for services shall be submitted to and approved by the commissioner;

(7) Contract for payment with any municipality, county or board of education for the provision of local health services or for the use of public health facilities. Any contract shall be in writing and permit provision of services or use of facilities for a period not to exceed one fiscal year. The written contract may include provisions for annual renewal by agreement of the parties; and

(8) Retain and make available child safety car seats, collect rental and security deposit fees for the expenses of retaining and making available child safety car seats, and conduct public education activities concerning the use and preventing the misuse of child safety car seats: Provided, That this subsection is not intended to conflict with the provisions of section forty-six, article fifteen, chapter seventeen-c of this code: Provided, however, That any local board of health offering a child safety car seat program or employee or agent of a local board of health is immune from civil or criminal liability in any action relating to the improper use, malfunction or inadequate maintenance of the child safety car seat and in any action relating to the improper placement, maintenance or securing of a child in a child safety car seat.

(c) The local boards of health are charged with protecting the health and safety, as well as promoting the interests of the citizens of West Virginia. All state funds appropriated by the Legislature for the benefit of local boards of health shall be used for provision of basic public health services.

W. Va. Code Ann. § 16-4-19

Voluntary submission to examination and treatment; charges; disposition of money collected Any resident of the State may at any time report to any municipal or county health officer having jurisdiction of the case, and voluntarily submit himself to all tests and examination as are necessary to ascertain whether in fact the person submitting himself for examination is infected with a venereal disease; and said health officer to whom any party has applied as above for tests and examination shall provide for making all such tests and examinations as are necessary to ascertain whether in fact said party so applying be so infected with a venereal disease. If such tests and examinations show said party so applying to be so infected, then said party shall elect whether he will take treatment of a private physician, or whether he will take treatment to be provided by the health officer through a clinic or otherwise, and if he elects to take treatment through the local health officer's arrangement, he may be required to pay for such treatment at a charge which shall in no case exceed the sum of five dollars for each dose of “neo” or arsphenamine administered for syphilis, and at a nominal cost for other medicines used; but if the patient is unable to pay anything, he shall be treated free of charge under the direction of the local health officer, at a clinic or otherwise. All proper charges for such examination and treatment as may be necessary hereunder shall be a proper charge against the municipality or county, as the case may be, whether said party so taking treatment lived in or out of a municipal corporation. And whether said person proposing to take treatment as provided hereunder elect to take from a private physician or elect to take treatment under the direction of the local health officer, he shall first sign the agreement

required to be signed by persons about to be released from detention or quarantine, and shall observe all its provisions, and so long as such person so signing shall so observe these provisions he need not be detained or quarantined pending treatment, except that no person who is known as a prostitute, or as a person associating with such, or as a person who resides in any house having the reputation of being a house of prostitution, or who frequents the same, shall be allowed at liberty if infected with a venereal disease in an infectious stage, even though he does voluntarily submit for examination and treatment and does take treatment under the provisions of this section.

All money collected under this section shall be paid into a clinic fund, if one is provided, and if not then into the county or city treasury, as the case may be; and the local health officer having jurisdiction shall collect and account for such funds collected hereunder.

W. Va. Code R. § 64-51-9

Fees for Services Provided by Local Boards of Health.

9.1. Services for Which a Local Board of Health May Propose Fees -- Except as provided in subsection

9.2. of this section, a local board of health may propose fees for all its services, including but not limited to professional health services, screenings, injections, assessments, counseling done for health-related issues, classes which teach healthy habits, lifestyles, or maintenance of health when there is a preexisting disease condition present, case management on behalf of patients whether in the home, clinic or through written and oral communications by letter or phone, and inspections.

9.2. Exception from Local Board of Health Fees -- The public health mission to provide first for general community safety means that fees for service will not be charged to individuals in the following circumstances:

9.2.1. In the case of a community epidemic, natural disaster, civil upheaval, toxic contamination, and other like situations where common good is at issue;

9.2.2. In the case of individuals seeking medical evaluation, treatment or epidemiologic follow-up, including administrative costs, associated with sexually transmitted disease and tuberculosis; or

9.2.3. In the case where the exemption from fees provision of subsection 4.2. of this rule applies.

9.3. Basis for Fees -- Local board of health maximum fees may be based on the actual cost of service delivery plus administrative overhead. Administrative overhead may include but is not limited to:1) salaries and wages; 2) other direct costs; and 3) that portion of the general and administrative costs, to include the administrator, secretaries, clerks, financial management and other overhead expenses, which contribute to the delivery of the service.

9.4. Fee Proposals By Local Boards of Health -- A local board of health proposing to charge fees under this rule shall approve an annual program plan and budget for the current fiscal year which includes:

9.4.1. Proposed health programs as defined in subsection 3.26. of this rule;

9.4.2. An accounting of fee collections in the previous fiscal year and in the current fiscal year, and projected fee collections in the remainder of the current fiscal year and during the next fiscal year;

9.4.3. A proposed schedule of fees; and

9.4.4. A proposed sliding fee scale to be implemented by the local board. The sliding fee scale may be based on annual federal poverty level guidelines as published by the Bureau for Public Health for other programs or on an alternative system proposed by a local board of health for providing services at a reduced fee based on an individual's ability to pay.

9.5. Posting of Proposed Fees -- After a local board of health's adoption of a proposed schedule of fees and sliding fee scale, the board shall post, publish or otherwise inform the public living in the area served by the board of the proposal and allow for a thirty (30) day comment period.

9.6. Submission of Proposal for Approval -- A local board of health proposing to charge fees shall submit to the Commissioner of the Bureau for Public Health:

9.6.1. A budget and program plan including the information required in subsection 9.4. of this rule;

9.6.2. A copy of the posted notice of the proposed fees and a description of the public notice process;

9.6.3. A copy of comments received on the proposed fees; and

9.6.4. A response to the comments.

9.7. Emergency Fees -- Establishment of fees other than in accordance with subsection 9.6. of this rule may be accomplished only upon petition by the local board of health to the Commissioner in response to an emergency.

9.8. Approval or Rejection of Fees of Local Boards of Health by the Commissioner of Public Health - The Commissioner shall approve or reject a local board of health's proposed budget and program plan and fees. If there is a rejection, the local board of health may propose a revision. Upon approval by the Commissioner of the proposed fees, the local board of health shall file the approved fee schedule with the clerk of all the county commissions or municipalities of which the board is a part, or in the case of a combined board of health, the filings shall be with the clerks or recorders of all the participating county commissions and municipalities. After the local board of health has made all the required filings, it may charge the approved fees.

9.9. Notice of Uncompensated Care -- Signs shall be prominently displayed in a public health clinic in as many languages as a substantial number of patients speak, as well as signs in pictures for those who do not read, that inform the public that services related to sexually transmitted disease and tuberculosis, and other health care services in the public health clinic may not be denied for inability to pay.

9.10. Local Board of Health Account -- All local board of health fees collected together with accounting documentation shall be deposited into an account designated for local board of health purposes. The monies for a municipal board of health shall be deposited with the municipal treasury in the service area. The monies for a county board of health shall be deposited with the county treasury in the service area.

The monies for a combined local board of health shall be deposited in an account as designated in the plan of combination.

9.11. Annual Audits -- Local boards of health are subject to annual audits and must be in compliance with tax procedures required by the state and shall annually develop a budget for the next fiscal year under W. Va. Code § 6-9-7.

W. Va. Code R. § 112-1-1 General (July 8, 1981)

1.1. Scope. -- These rules implement the provisions of section two, article two, chapter twelve of the Code of West Virginia, 1931, as amended. The general purpose of these rules is to establish a system whereby moneys received by state agencies, officials and employees on behalf of the State of West Virginia will be: (1) Deposited in the State Treasurer's Office within twenty-four (24) hours; (2) immediately and properly accounted for; and (3) immediately available for investment by the state rather than lying idle in cash or demand deposits. Such general purpose is in keeping with the legislative findings and purpose set forth in section one, article one, chapter twelve of the Code, wherein the state Board of Investments and the Treasurer are authorized to develop and maintain modern systems, consistent with sound financial practices, for the collection, disbursement, management and investment of public moneys. These rules also are specifically directed toward implementing the Legislature's intent in section two, article one, chapter twelve of the Code wherein state officers and employees are prohibited from making or causing deposits of state funds to be made in any bank not designated as a depository by the State Board of Investments.

<u>Wisconsin</u>

Wis. Stat. Ann. § 49.45

Medical assistance; administration (July 1, 2012)

…

(59) Health maintenance organization payments to hospitals. (a) The department shall, from the appropriation accounts under s. 20.435(4)(xc) and (xe), pay each health maintenance organization with which it contracts to provide medical assistance a monthly amount that the health maintenance organization shall use to make payments to hospitals under par. (b).

(b) Health maintenance organizations shall pay all of the moneys they receive under par. (a) to eligible hospitals, as defined in s. 50.38(1), within 15 days after receiving the moneys. The department shall specify in contracts with health maintenance organizations to provide medical assistance a method that health maintenance organizations shall use to allocate the amounts received under par. (a) among eligible hospitals based on the number of discharges from inpatient stays and the number of outpatient visits for which the health maintenance organization paid such a hospital in the previous month for enrollees who are recipients of medical assistance, except enrollees who receive medical assistance under s. 49.45(23).

Payments under this paragraph shall be in addition to any amount that a health maintenance organization is required by agreement between the health maintenance organization and a hospital to pay the hospital for providing services to the health maintenance organization's

Wyoming

No statutes or regulations found using the search terms.