

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations (CMSO)

Ms. Elizabeth A. Johnson, Esq.
Commissioner
Department of Medicaid Services
Cabinet for Health and Family Services
275 East Main Street, 6W-A
Frankfort, KY 40621-0001

JUN 25 2009

RE: SPA 07-010

Dear Ms. Johnson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 07-010. Effective October 15, 2007 this amendment modifies the State's methodology for setting payment rates for inpatient hospital services. Specifically, the amendment provides for a rebasing of the diagnosis-related groups base rates and relative weights, adds a high volume per diem payment methodology based on Medicaid utilization, and deletes obsolete language.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of October 15, 2007. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332 or Venesa Day at (410) 786-8281.

Sincerely

Cindy Mann
Director

Center for Medicaid and State Operations (CMSO)

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
07-010

2. STATE
Kentucky

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 15, 2007

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Chapter 412, Chapter 413 and 447.200, 447.250, 447.271, and
447.272; 42 U.S.C. §1395ww(d), 42 U.S.C. §1396r-4(a).

7. FEDERAL BUDGET IMPACT:
a. FFY 2008 cost \$14,020,000
b. FFY 2009 cost \$14,020,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-A pages 1-38;
Delete Att. 4.19-A pages 7.1-7.8, 10.1, 12.1, 14.1; and
Delete Att. 4.19-A Exhibit A pages 100.01- 117.09

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Same

10. SUBJECT OF AMENDMENT:

This plan amendment changes inpatient reimbursement in response to several state regulation changes.

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED: Review delegated
to Commissioner, Department for Medicaid
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Shawn M. Crouch

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: December 28, 2007

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

6-25-09

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT 15 2007

20. SIGNATURE OF REGIONAL OFFICIAL:

Bill Lewin

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMSO

23. REMARKS:

(1) General Overview

- A. Beginning October 15, 2007, the Department will pay for inpatient hospital services in general acute care hospitals under a revised DRG-based methodology. The methodology is similar to the Medicare Prospective Payment System. The revised system will have hospital specific operating and capital base rates, and Kentucky specific relative weights. Hospital services not paid for using the DRG-based methodology will be paid for using per diem rates unless otherwise stated in this plan.

The following will be excluded from the DRG methodology:

1. Services provided in Critical access hospitals;
2. Services provided in Free-standing rehabilitation hospitals;
3. Services provided in Long-term acute care hospitals;
4. Psychiatric services in Acute care hospitals;
5. Services provided in Free-standing psychiatric hospitals;
6. Rehabilitation services in Acute care hospitals; and
7. Transplant services, other than kidney, pancreas, and cornea.

- B. Appeals and Review Process. Hospitals will be able to utilize the dispute resolution and appeals process described in 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative process, and sanctions. (Revised effective 12-19-2001).

1. An appeal shall comply with the review and appeal provisions established in 907 KAR 1:671, as previously cited.
2. An appeal shall not be allowable unless compliant with the terms and conditions shown in 907 KAR 1:671, as previously cited.
3. An administrative review shall specifically not be available for the following; this listing of exclusions is not to be considered exhaustive or complete:
 - a. A determination of the requirement, or the proportional amount, of a budget neutrality adjustment in the prospective payment rate; or
 - b. The establishment of:
 - 1) Diagnostic related groups;
 - 2) The methodology for the classification of an inpatient discharge within a DRG; or
 - 3) An appropriate weighting factor which reflects the relative hospital resources used with respect to a discharge within a DRG.

C. Adjustment of rates.

1. Final rates are not adjusted except for correction of errors, to make changes resulting from the dispute resolution or appeals process if the decision determines that rates were not established in accordance with the approved State Plan, Attachment 4.19-A (attachment), or to make changes resulting from Federal Court orders including to the extent necessary action to expand the effect of a Federal Court order to similarly situated facilities.
2. New rates may be set for each universal rate year, and at any point in the rate year when necessitated by a change in the applicable statute or regulation subject to a state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS).

D. Use of a Universal Rate Year

1. A universal rate year shall be established as July 1 through June 30 of the following year to coincide with the state fiscal year.
2. A hospital shall not be required to change its fiscal year to conform with a universal rate year.

E. Cost Reporting Requirements. The department follows the Medicare Principles of reimbursement found in 42 CFR 413 and the CMS Publication 15 to determine allowable cost. Additional cost report requirements are as follows:

1. An in-state hospital participating in the Medicaid program shall submit to the department a copy of a Medicare cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1 and the Supplemental Medicaid Schedule KMAP-4 as follows:
 - a. A cost report shall be submitted:
 - 1) For the fiscal year used by the hospital; and
 - 2) Within five (5) months after the close of the hospital's fiscal year; and
 - b. Except as follows, the department shall not grant a cost report submittal extension:
 - 1) If an extension has been granted by Medicare, the cost report shall be submitted simultaneously with the submittal of the Medicare cost report; or
 - 2) If a catastrophic circumstance exists, for example flood, fire, or other equivalent occurrence, the department shall grant a thirty (30) day extension.
2. If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a complete cost report is received.
3. A cost report submitted by a hospital to the department shall be subject to audit and review.
4. An in-state hospital shall submit to the department a final Medicare-audited cost report upon completion by the Medicare intermediary along with an electronic cost report file (ECR).

F. Unallowable Costs

1. The following shall not be allowable cost for Medicaid reimbursement unless otherwise noted:
 - a. A cost associated with a political contribution;
 - b. The allowability of legal fees is determined in accordance with the following:
 - 1) A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet for Health and Family Services is not allowable;
 - 2) A legal fee relating to a lawsuit against the Cabinet for Health and Family Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and
 - c. Cost associated with travel and related expenses must take into consideration the following:
 - 1) A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity is not allowable.
 - 2) A cost for a training or educational purpose outside the Commonwealth of Kentucky shall be allowable.
 - 3) If a meeting is not solely educational, the cost, excluding transportation, shall be allowable if an educational or training component is included.
2. A hospital shall identify an unallowable cost on the Supplemental Medicaid Schedule KMAP-1.
3. The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report.

G. Trending of an In-state Hospital's Cost Report Used for Non-DRG Rate Setting Purposes.

1. An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the department, either audited or un-audited, shall be trended from the midpoint of the cost report year to the beginning of the universal rate year to update an in-state hospital's Medicaid cost. This methodology applies for all rate setting throughout this attachment.
2. The trending factor to be used shall be the inflation factor prepared by GII (Global Insight, Incorporated, a market basket data indexing and forecasting firm referred to as GII) for the period being trended.

H. Indexing for Inflation of an In-state Hospital's Cost Report Used for Rate Setting Purposes.

1. After an allowable Medicaid cost has been trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost to the midpoint in the universal rate year. This methodology applies for all rate setting throughout this attachment.

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2. The department shall use the inflation factor prepared by GII (Global Insight, Incorporated) as the indexing factor for the universal rate year.

I. Cost Basis.

1. An allowable Medicaid cost shall:
 - a. Be a cost allowed after a Medicaid or Medicare audit;
 - b. Be in accordance with 42 C.F.R. Part 413;
 - c. Include an in-state hospital's provider tax; and
 - d. Not include a cost in the Unallowable Costs listed in Section (1)F of this attachment.
2. A prospective rate shall include both routine and ancillary costs.
3. A prospective rate shall not be subject to retroactive adjustment, except for:
 - a. A critical access hospital; or
 - b. A facility with a rate based on un-audited data.
4. An overpayment shall be recouped by the department as follows:
 - a. A provider owing an overpayment shall submit the amount of the overpayment to the department; or
 - b. The department shall withhold the overpayment amount from a future Medicaid payment due the provider.

J. Access to Subcontractor's Records. If a hospital has a contract with a subcontractor for services costing or valued at \$10,000 or more over a twelve (12) month period:

1. The contract shall contain a provision granting the department access:
 - a. To the subcontractor's financial information; and
 - b. In accordance with 907 KAR 1:672, published on January 4, 2008, Provider enrollment, disclosure, and documentation for Medicaid participation; and
2. Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

K. New Provider, Change of Owner or Merged Facility

1. A new provider.
 - a. Until a fiscal year end cost report is available, a newly constructed or newly participating hospital shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification.
 - b. During the projected rate year, the budget shall be adjusted if indicated and justified by the submittal of additional information.

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2. If a hospital undergoes a change of ownership, the new owner shall be reimbursed at the rate in place at the time of the ownership change.
 3. A merged facility of two or more entities.
 4. a. The merger of two per diem facilities shall:
 - 1.) Merge the latest available data used for rate setting.
 - 2.) Combine bed utilization statistics, creating a new occupancy ratio.
 - 3.) Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs.
 - 4.) If one (1) of the entities merging has disproportionate status and the other does not, retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid.
 - 5.) Recognize an appeal of the merged per diem rate in accordance with the state regulation on Conditions of Medicaid provider participation, withholding overpayments, administrative appeal process, and sanctions.
 - b. In the merger of two DRG facilities, the rate of the purchasing facility shall be applicable to the merged entity.
 - c. In the merger of a per diem facility and a DRG facility, the facility shall elect either a per diem style of reimbursement or a DRG style of reimbursement. Upon determination of the style, the rate shall be set in accordance with either Item a. or Item b. of this subsection.
 5. Cost report submission
 - a. Require each provider to submit a Medicaid cost report for the period ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end.
 - b. A Medicaid cost report for the period starting with the day of the merger and ending on the fiscal year end for the merged entity shall also be filed with the department in accordance with this attachment.
- L. Payment Not to Exceed Charges or the Upper Payment Limits.
1. The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges plus disproportionate share payments, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges, the state will recoup payments in excess of allowable charges plus disproportionate share payments.
 2. The state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement. Medicare upper payment limits as required by 42 CFR 447.272 will be determined in advance of the fiscal year from cost report and other applicable data from the most recent rate setting as compared to reimbursement for the same period. Cost data and reimbursement shall be trended forward to reflect current year upper payment limits. See Exhibit A for detail description and formula for UPL demonstration.

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- M. Public Process for Determining Rates for Inpatient Hospitals. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.
- N. The Hospital Provider Tax is described in Kentucky Revised Statute 142.303, revised June 26, 2007.
- (2) Acute Care Hospital Services
- A. DRG-Based Methodology
1. An in-state acute care hospital shall be paid for an inpatient acute care service on a fully-prospective per discharge basis.
 2. For an inpatient acute care service in an in-state acute care hospital, the total hospital-specific per discharge payment shall be the sum of:
 - a. A DRG base payment;
 - b. If applicable, a high volume per diem payment; and
 - c. If applicable, a cost outlier payment amount.
 3. For a rate effective on or after October 15, 2007, the department shall assign to the base year claims data as described in Item 5(c), DRG classifications from Medicare grouper version twenty-four (24) effective in the Medicare inpatient prospective payment system as of October 1, 2006.
 4. A DRG base payment shall be calculated for a discharge by multiplying the hospital specific base rate by the DRG relative weight.
 5. Calculating base rates.
 - a. The department shall determine a base rate by calculating hospital cost per discharge, adjusted for hospital case mix, outlier payments medical education costs and budget neutrality as described in subsections (5) through (11) of this section.
 - b. A hospital specific cost per discharge used to calculate a base rate shall be based on base year inpatient paid claims data.
 - c. For rates effective October 15, 2007, the base year claims data for calculating a hospital specific cost per discharge shall be state fiscal year 2006 inpatient Medicaid paid claims data.
 6. Calculating cost to charge ratios.
 - a. The department shall calculate hospital-specific cost to charge ratios for the fifteen (15) cost centers displayed in Table 1 below.
 - b. If a hospital lacks cost-to-charge information for a given cost center or if the hospital's cost-to-charge ratio is above or below three (3) standard deviations from the mean of a log distribution of cost-to-charge ratios, the department shall use the statewide geometric mean cost-to-charge ratio for the given cost center.
 - c. The department shall base cost center specific cost-to-charge ratios on cost and charge data extracted from the most recently submitted CMS Form 2552 Medicare cost report.

The costs used in the cost-to-charge ratios, which include operating and capital costs and exclude direct medical education costs, are extracted from Worksheet C, Part I, Column 5. The charges used in the cost-to-charge ratios are extracted from Worksheet C, Part I, Column 8.

Table 1. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk

<u>Table 1. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk</u>		
<u>Kentucky Medicaid Cost Center</u>	<u>Kentucky Medicaid Cost Center</u>	<u>Medicare Cost Report</u>
	<u>Description</u>	<u>Standard Cost Center</u>
<u>1</u>	<u>Routine Days</u>	<u>25</u>
<u>2</u>	<u>Intensive Days</u>	<u>26, 27, 28, 29, 30</u>
<u>3</u>	<u>Drugs</u>	<u>48, 56</u>
<u>4</u>	<u>Supplies or equipment</u>	<u>55, 66, 67</u>
<u>5</u>	<u>Therapy services excluding</u> <u>inhalation therapy</u>	<u>50, 51, 52</u>
<u>6</u>	<u>Inhalation therapy</u>	<u>49</u>
<u>7</u>	<u>Operating room</u>	<u>37, 38</u>
<u>8</u>	<u>Labor and delivery</u>	<u>39</u>
<u>9</u>	<u>Anesthesia</u>	<u>40</u>
<u>10</u>	<u>Cardiology</u>	<u>53, 54</u>
<u>11</u>	<u>Laboratory</u>	<u>44, 45</u>
<u>12</u>	<u>Radiology</u>	<u>41, 42</u>
<u>13</u>	<u>Other services</u>	<u>43, 46, 47, 57, 58, 59, 60,</u> <u>61, 62, 63, 63.5, 64, 65, 68</u>
<u>14</u>	<u>Nursery</u>	<u>33</u>
<u>15</u>	<u>Neonatal intensive days</u>	<u>30</u>

7. For hospitals with interns and residents cost-reported on Medicare cost report Worksheet B, Part I, Columns 22 and 23, the department shall multiply each of the hospital's cost-to-charge ratios by its indirect medical education adjustment factor. A hospital's indirect medical education adjustment factor shall be calculated as follows:

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- a. Compute the costs of interns and residents before the allocation of overhead costs to the patient service cost centers in Medicare cost report Worksheet B, Part I by summing the costs found in Column 0, Lines 22 and 23; and
 - b. Compute the costs of interns and residents after the allocation of overhead costs to the patient service cost centers in Medicare cost report Worksheet B, Part I by summing the costs found in Columns 22 and 23, Line 103; and
 - c. Compute the difference in costs of interns and residents after the allocation of overhead costs to the patient service cost centers in the Medicare cost report Worksheet B, Part I (as determined in (b) of this subsection) and before the allocation (as determined in (a) of this subsection); and
 - d. Divide the difference calculated in (c) of this subsection by total costs after allocation, found in Medicare cost report Worksheet B, Part I, Column 27, Line 103.
8. For an in-state acute care hospital, the department shall compile the number of patient discharges, patient days, and total charges by revenue code from the base year paid claims data. The department shall exclude from the rate calculation:
- a. Claims paid under a managed care program;
 - b. Claims for rehabilitation and psychiatric discharges reimbursed on a per diem basis;
 - c. Claims in hospital-based skilled nursing facilities or long-term care units;
 - d. Transplant claims other than kidney, pancreas, and cornea; and
 - e. Revenue codes not covered by the Medicaid Program; and
 - f. Claims with charges equal to zero (0).
9. The department shall calculate the Medicaid cost of a base year claim by multiplying the charges from each Medicaid covered revenue code by the corresponding cost center specific cost-to-charge ratio.
10. Using the base year Medicaid claims referenced in subsection (8) of this Section, the department shall compute an average hospital specific cost per discharge by dividing a hospital's Medicaid costs as determined in subsection 9 by its number of Medicaid discharges.
11. The department shall determine an in-state acute care hospital's DRG base payment rate by adjusting the hospital's average cost per discharge by the hospital's case mix index, expected outlier payments and budget neutrality factors.
- a. Case mix calculations.
 - 1) A hospital's case mix adjusted cost per discharge shall be calculated by dividing the hospital's average cost per discharge by its case mix index; and
 - 2) The hospital's case mix index shall be equal to the average of its DRG relative weights for acute care services for base year Medicaid discharges referenced in subsection 8 above.
 - b. Case mix adjustments.

- 1) A hospital's case mix adjusted cost per discharge shall be multiplied by an initial budget neutrality factor.
- 2) The initial budget neutrality factor for rates effective October 15, 2007 shall be 0.6962 for all hospitals.
- 3) When rates are rebased, the initial budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted for changes in patient volume and case mix.

c. Consideration of outliers.

- 1) Each hospital's case mix and initial budget neutrality adjusted cost per discharge shall be multiplied by a hospital-specific outlier payment factor.
- 2) A hospital-specific outlier payment factor shall be calculated using the following formula: $((\text{expected DRG non-outlier payments}) - (\text{expected proposed DRG outlier payments})) / (\text{expected DRG non-outlier payments})$.

d. Consideration of budget neutrality.

- 1) A hospital's case mix, initial budget neutrality and outlier payment adjusted cost per discharge shall be multiplied by a secondary budget neutrality factor.
- 2) The secondary budget neutrality factor for rates effective October 15, 2007 shall be 1.0744.
- 3) When rates are rebased, the secondary budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted for changes in patient volume and case mix.

12. High volume adjustments as of October 15, 2007.

- a. The department shall make a high volume per diem payment to an in-state acute care hospital for the rate year beginning October 15, 2007 in addition to the DRG base payment rate.
- b. To qualify for high volume per diem payments, a hospital must meet either the Kentucky Medicaid patient days criteria or the Kentucky Medicaid utilization percentage as shown in Table 2.
- c. A high volume per diem payment shall be equal to the applicable high volume per diem amount multiplied by the DRG's statewide arithmetic mean length-of-stay.
- d. The DRG statewide arithmetic mean length of stay shall be calculated using the base year claims described in section (2)A.5.c.
- e. The department shall pay the greater of the high volume per diem payment for estimated Kentucky Medicaid inpatient days or Kentucky Medicaid inpatient days utilization criteria established in Table 2 below:

<p>Table 2 – High Volume Adjustment Eligibility Criteria as of October 15, 2007</p>
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<u>Kentucky Medicaid Inpatient Days</u>		<u>Kentucky Medicaid Inpatient Days Utilization</u>	
<u>Days Range</u>	<u>Per Diem Payment</u>	<u>Medicaid Utilization Range</u>	<u>Per Diem Payment</u>
3,000 - 4,200 days	\$40 per day	19.3% - 20%	\$50 per day
4,200 - 5,600 days	\$60 per day	20.1% - 27.2%	\$115 per day
5,600 - 9,000 days	\$100 per day	27.3% - above	\$125 per day
9,000 - 20,000 days	\$125 per day		
20,000 and above days	\$205 per day		

f. Base year classification.

- 1) The department shall use base year claims data referenced in section (2)A.5.c to determine if a hospital qualifies for a high volume per diem add-on payment.
 - 2) As of October 15, 2007, the department shall determine Kentucky Medicaid inpatient days for a hospital by multiplying the DRG classification for each base year claim by the corresponding Kentucky DRG average length of stay.
- g. The department shall only change a hospital's classification regarding a high volume add-on payment or per diem amount during a rebasing year.

13. High volume adjustments as of November 15, 2007.

- a. The department shall make a high volume per diem payment to an in-state acute care hospital beginning November 15, 2007 in addition to the DRG base payment rate.
- b. To qualify for high volume per diem payments, a hospital must meet either the Kentucky Medicaid patient days criteria or the Kentucky Medicaid utilization percentage as shown in Table 3.
- c. A high volume per diem payment shall be equal to the applicable high volume per diem amount multiplied by the DRG's statewide arithmetic mean length-of-stay.
- d. The DRG statewide arithmetic mean length of stay shall be calculated using the base year claims referenced in section (2)A.5.c.
- e. The department shall pay the greater of the high volume per diem payment for covered Kentucky Medicaid inpatient days criteria or Kentucky Medicaid inpatient days utilization percent criteria established in Table 3 below:

<u>Table 3 - High Volume Adjustment Eligibility Criteria</u> <u>as of November 15, 2007</u>	
<u>Kentucky Medicaid Inpatient Days</u>	<u>Kentucky Medicaid Inpatient Days Utilization</u>

TN# 07-010
Supersedes
TN# 03-023

Approval Date: JUN 25 2009 Effective Date: 10/15/2007

<u>Days Range</u>	<u>Per Diem Payment</u>	<u>Medicaid Utilization Range</u>	<u>Per Diem Payment</u>
<u>0 - 3,499 days</u>	<u>\$0 per day</u>	<u>0.0% - 13.2%</u>	<u>\$0.00 per day</u>
<u>3,500 - 4,499 days</u>	<u>\$22.50 per day</u>	<u>13.3% - 16.1%</u>	<u>\$22.50 per day</u>
<u>4,500 - 7,399 days</u>	<u>\$45.00 per day</u>	<u>16.2% - 21.6%</u>	<u>\$45.00 per day</u>
<u>7,400 - 10,999 days</u>	<u>\$129.00 per day</u>	<u>21.7% - 27.2%</u>	<u>\$81.00 per day</u>
<u>11,000 - 19,999 days</u>	<u>\$172.00 per day</u>	<u>27.3% - 100.00%</u>	<u>\$92.75 per day</u>
<u>20,000 and above days</u>	<u>\$306.00 per day</u>		

- f. The department shall use base year claims data referenced in Item (2)A.5.c to determine if a hospital qualifies for a high volume per diem add-on payment.
- g. The department shall only change a hospital's classification regarding a high volume add-on payment or per diem amount during a rebasing year.

14. Cost outlier adjustments.

- a. The department shall make an additional cost outlier payment for an approved discharge paid under the DRG-based methodology, and meeting the Medicaid criteria for a cost outlier payment.
- b. A cost outlier shall be subject to QIO (Quality Improvement Organization) review and approval.
- c. A discharge shall qualify for an additional cost outlier payment if its estimated cost exceeds the DRG's outlier threshold.
- d. Outlier calculations.
- 1) The department shall calculate the estimated cost of a discharge, for purposes of comparing the discharge cost to the outlier threshold, by multiplying the sum of the hospital specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.
 - 2) A Medicare operating and capital-related cost-to-charge ratio shall be extracted from the CMS IPPS Pricer Program.
- e. Outlier thresholds.
- 1) The department shall calculate an outlier threshold as the sum of a hospital's DRG base payment or transfer payment, before outlier payments and excluding Medicaid high volume per diem payments, and the fixed loss cost threshold.
 - 2) The fixed loss cost threshold shall equal \$29,000.
- f. A cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

15. The department shall calculate Kentucky Medicaid-specific DRG relative weights by:

a. Relative weight factors.

- 1) Selecting Kentucky base year Medicaid inpatient paid claims, excluding those described in subsection (8) of this section;
- 2) For rates effective October 15, 2007, the department shall assign to the base year claims data the DRG assignment using the Medicare grouper version twenty-four (24) DRG classifications which were effective in the Medicare inpatient prospective payment system as of October 1, 2006;
- 3) For rates effective October 15, 2007, the cost for each base year claim calculated in accordance with subsections (5) through (11) of this section shall be used to calculate average cost per discharge for each DRG.

b. Calculating relative weight values for low volume DRGs by:

1) Consideration of DRG usage:

- a) Arraying DRGs with less than twenty-five (25) cases in the base year in order by the Medicare DRG relative weight in effect in the Medicare inpatient prospective payment system for the Medicare DRG grouper version twenty-four (24), published in the Federal Register, relied upon for Kentucky DRG classifications; and
 - b) For rates effective October 15, 2007, the department shall use the Medicare DRG relative weights which were effective for the Medicare inpatient prospective payment system as of October 1, 2006;
- 2) Grouping low volume DRGs, based on the Medicare DRG relative weight sort, into one (1) of five (5) categories resulting in each category having approximately the same number of Medicaid cases;
 - 3) Calculating DRG relative weights for each category; and
 - 4) Assigning the relative weight calculated for a category to each DRG included in the category;

c. Calculating relative weight values for DRGs with twenty-five (25) or more cases in the base year, by:

1) General considerations.

- a) Standardizing the labor portion of the cost of a claim for differences in Medicare wage indices and the full cost of a claim for differences in Medicare indirect medical education factors using Medicare rate components;
- b) For rates effective October 15, 2007, base year Medicare rate components shall equal Medicare rate components effective in the Medicare inpatient prospective payment system as of October 1, 2005; and
- c) Base year Medicare rate components used in the Kentucky inpatient prospective payment system include:
 - (i) Labor-related percentage and non-labor-related percentage;

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- (ii) Operating and capital cost-to-charge ratios;
 - (iii) Operating indirect medical education factors; and
 - (iv) Wage indices;
- 2) Cost factors.
- a) The department shall standardize costs using the following formula:
standard cost = $\frac{((\text{labor related percentage} \times \text{costs}) / \text{Medicare wage index}) + (\text{nonlabor related percentage} \times \text{costs})}{(1 + \text{Medicare operating indirect medical education factor})}$; and
 - b) For rates effective October 15, 2007, the labor related percentage shall equal sixty-two (62) percent and the nonlabor related percentage shall equal thirty-eight (38) percent;
- 3) Removing statistical outliers by deleting any claim that is:
- a) Above or below three (3) standard deviations from the mean cost per discharge for each DRG; and
 - b) Above or below three (3) standard deviations from the mean cost per day for each DRG;
- d. Computing an average standardized cost for all DRGs in aggregate and for each DRG or low volume DRG category, excluding statistical outliers;
- e. Computing DRG relative weights:
- 1) For a DRG with twenty-five (25) claims or more in the base year by dividing the average cost per discharge for each DRG by the statewide average cost per discharge; and
 - 2) For a DRG with less than twenty-five (25) claims in the base year by dividing the average cost per discharge for each of the five (5) low volume DRG categories by the statewide average cost per discharge; and
- f. Calculating, for the purpose of a transfer payment, Kentucky Medicaid geometric mean length of stay for each DRG and low volume DRG category based on the base year claims data used to calculate DRG relative weights.
16. The department shall:
- a. Separately reimburse for a mother's stay and a newborn's stay based on the DRG assigned to the mother's stay and to the newborn's stay;
 - b. Establish a unique set of DRGs and relative weights for in-state acute care hospitals identified by the department as qualifying as a level II neonatal center and for in-state acute care hospitals identified by the department as qualifying as a level III neonatal center as follows:
 - 1) The department shall reassign a claim that would have been assigned to a Medicare DRG 385-390 to a Kentucky-specific:
 - a) DRG 675-680 for an in-state acute care hospital with a level II neonatal center; and

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- b) DRG 685-690 for an in-state acute care hospital with a level III neonatal center;
- 2) The department shall assign a DRG 385-390 for a neonatal claim from a hospital which does not operate a level II or III neonatal center; and
 - 3) Computations and calculations.
 - a) The department shall compute a separate relative weight for a level II or III neonatal intensive care unit (NICU) neonatal DRG;
 - b) As of October 15, 2007, the department shall use base year claims from level II neonatal centers to calculate relative weights for DRGs 675-680.
 - c) As of November 15, 2007, the department shall use base year claims from level II neonatal centers, excluding claims from any high intensity level II neonatal center, to calculate relative weights for DRGs 675-680; and
 - d) The department shall use base year claims from level III neonatal centers to calculate relative weights for DRGs 685-690.
17. If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.
- a. For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.
 - 1) The department shall calculate an average daily rate by dividing the DRG base payment, excluding outlier payments and Medicaid high volume per diem payments, by the statewide Medicaid geometric mean length-of-stay for a patient's DRG classification.
 - 2) If a hospital qualifies for a high volume per diem add-on payment in accordance with Section (2)A.12 of this attachment under the DRG-based methodology, the department shall pay the hospital the applicable per diem add-on for the DRG average length-of-stay.
 - 3) Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.
 - b. For a hospital receiving a transferred patient, the department shall reimburse the DRG base payment, and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.
18. The department shall treat a transfer from an acute care hospital to a qualifying post-acute care facility for selected DRGs in accordance with paragraph (b) of this subsection as a post-acute care transfer.
- a. The following shall qualify as a post-acute care setting:
 - 1) A psychiatric, rehabilitation, children's hospital, long-term acute care hospital, or cancer hospital;
 - 2) A skilled nursing facility; or

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- 3) A home health agency.
 - b. A DRG eligible for a post-acute care transfer payment shall be in accordance with 42 U.S.C. 1395ww(d)(4)(C)(i).
 - c. The department shall pay each transferring hospital an average daily rate for each day of stay.
 - 1) A payment shall not exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.
 - 2) A DRG identified by CMS as being eligible for special payment shall receive fifty (50) percent of the full DRG payment plus the average daily rate for the first day of the stay and fifty (50) percent of the average daily rate for the remaining days of the stay, up to the full DRG base payment.
 - 3) The remaining DRGs as referenced in paragraph (b) of this subsection shall receive twice the per diem rate the first day and the per diem rate for each following day of the stay prior to the transfer.
 - d. The per diem amount shall be the base DRG payment allowed divided by the statewide Medicaid geometric mean length of stay for a patient's DRG classification.
19. The department shall reimburse for an intrahospital transfer to or from an acute care bed to or from a rehabilitation or psychiatric distinct part unit:
- a. The full DRG base payment allowed; and
 - b. The facility-specific distinct part unit per diem rate for each day the patient remains in the distinct part unit.
20. Transplant services.
- a. The department shall reimburse for a kidney, cornea, pancreas, or kidney and pancreas transplant on a prospective per discharge method according to the patient's DRG classification.
 - b. A transplant not referenced in paragraph (a) of this subsection, shall be reimbursed in accordance with 907 KAR 1:350 published on January 5, 2007, Coverage and payments for organ transplants.
21. A preadmission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:
- a. Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and
 - b. Exclude a service furnished by a home health agency, a skilled nursing facility or hospice unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.
22. Direct Graduate Medical Education Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs.

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- a. If federal financial participation for direct graduate medical education costs is not provided to the department, pursuant to 42 C.F.R. 447.201(c) or other federal regulation or law, the department shall not reimburse for direct graduate medical education costs.
 - b. If federal financial participation for direct graduate medical education costs is provided to the department, the department shall reimburse for the direct costs of a graduate medical education program approved by Medicare as follows
 - 1) A payment shall be made:
 - a) Separately from the per discharge and per diem payment methodologies; and
 - b) On an annual basis; and
 - 2) The department shall determine an annual payment amount for a hospital as follows:
 - a) The hospital-specific and national average Medicare per intern and resident amount effective for Medicare payments on October 1 immediately preceding the universal rate year shall be provided by each approved hospital's Medicare fiscal intermediary;
 - b) The higher of the average of the Medicare hospital-specific per intern and resident amount or the Medicare national average amount shall be selected;
 - c) The selected per intern and resident amount shall be multiplied by the hospital's number of interns and residents used in the calculation of the indirect medical education operating adjustment factor. The resulting amount is an estimate of total approved direct graduate medical education costs;
 - d) The estimated total approved direct graduate medical education costs shall be divided by the number of total inpatient days as reported in the hospital's most recently finalized cost report on Worksheet D, Part 1, to determine an average approved graduate medical education cost per day amount;
 - e) The average graduate medical education cost per day amount shall be multiplied by the number of total covered days for the hospital reported in the base year claims data, excluding services described in subsection (8), to determine the total graduate medical education costs related to the Medicaid Program; and
 - f) Medicaid Program graduate medical education costs shall then be multiplied by the budget neutrality factor.

23. Budget Neutrality Factors.

- a. When rates are rebased, estimated projected reimbursement in the universal rate year shall not exceed payments for the same services in the prior year adjusted for inflation using the inflation factor prepared by GII for the universal rate year and adjusted for changes in patient utilization and case mix.
- b. The estimated total payments for each facility under the reimbursement methodology in effect in the year prior to the universal rate year shall be estimated from base year claims.
- c. The estimated total payments for each facility under the reimbursement methodology in effect in the universal rate year shall be estimated from base year claims.

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- d. If the sum of all the acute care hospitals' estimated payments under the methodology used in the universal rate year exceeds the sum of all the acute care hospitals' adjusted estimated payments under the prior year's reimbursement methodology, each hospital's DRG base rate and per diem rates shall be multiplied by a uniform percentage to result in estimated total payments for the universal rate year being equal to total adjusted payments in the year prior to the universal rate year.
- e. When rates are rebased, the budget neutrality factors shall take into consideration the high volume adjustment payments.
24. Reimbursement Updating Procedures.
- a. The department shall annually, on July 1, use the inflation factor prepared by GII for the universal rate year to inflate a hospital-specific base rate for rate years between rebasing periods.
- b. The department shall rebase payment rates using the DRG reimbursement methodology every four (4) years. The first rebasing year under this provision shall be for the uniform rate year beginning on July 1, 2012.
25. Trending Medicaid Costs for DRG Re-basing Purposes.
- a. Estimated Medicaid costs used to calculate DRG relative weights and DRG base rates shall be trended to the midpoint of the universal rate year.
- b. The department shall use the inflation factor prepared by GII as the trending factor for the period being trended.
- c. On an annual basis, the DRG rates will be changed as stated in Item a. of this trending section unless it is higher than GII inflation factor found in Item b. of this section. If the GII trending factor is lower than the trending factor calculated in Item a. of this section, the GII trending factor will be used.
26. Readmissions.
- a. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.
- b. Reimbursement for a readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.
27. Intensity Operating Allowance Inpatient Supplement Payments.
- a. Beginning October 15, 2007, a State owned or operated University Teaching Hospital, including a hospital operated by a related party organization as defined at 42 CFR 413.17, which is operated as part of an approved School of Medicine, shall be based on the upper payment limits as required by 42 CFR 447.272 and will be determined prospectively each year based on the difference between the total payments made by Medicaid, excluding DSH, and the estimated Medicare payments for the same services. The Medicare payments will be determined based on the Medicare Principles of Reimbursement in accordance with 42 CFR 412 and 413.
- b. The detailed formula to determine the supplemental payments is described in Exhibit B incorporated as part of this attachment.

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- c. The prospective supplemental payments will be reconciled annually to the final cost report filed for the rate year or prospective payment period.
- d. Any payments made under subsection a of this section are subject to the payment limitations as specified in 42 CFR 447.271, whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.
- e. Payments made under this section shall be prospectively determined quarterly amounts, subject to a year-end reconciliation described in 2.a.
- f. In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Health Care Financing Administration, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.
- g. Pediatric Teaching Hospital

A state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

- 1) Calculated by determining the difference between Medicaid costs as stated on the audited cost report filed as of June 1 each year and payments received for the Medicaid recipients (i.e., Medicare, KMAP, TPL, and Medical Education); and including,
- 2) An additional quarterly payment of \$250,000 (\$1 million annually).

(Medicaid recipients shall not include recipients receiving services reimbursed through a Medicaid managed care contract.)

28. Supplemental Payments for DRG Psychiatric Access Hospitals

- a. For services provided on and after April 2, 2001 the Department shall provide supplemental payments to certain hospitals to assure access to psychiatric services for patients in rural areas of the Commonwealth. To qualify for psychiatric access payments a hospital must meet the following criteria:
- 1) The hospital is not located in a Metropolitan Statistical Area (MSA);
 - 2) The hospital provides at least 65,000 days of inpatient care as reflected in the Department's Hospital Rate data for Fiscal Year 1998-99;
 - 3) The hospital provides at least 20% of inpatient care to Medicaid eligible recipients as reflected in the Department's Hospital Rate data for State Fiscal Year 1998-99; and
 - 4) The hospital provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.
- b. Each qualifying hospital will receive a psychiatric access payment amount based on its proportion of the hospital's Medicaid psychiatric days to the total Medicaid psychiatric days for all qualifying hospitals applied to the total funds for these payments. Payments will be made on a quarterly basis in accordance with the following:

Medicaid patient days

Total Medicaid patient days X Fund = Payment

- c. Total Medicaid payments to a hospital from all sources shall not exceed Medicaid charges plus disproportionate share payments. A hospital's disproportionate share payment shall not exceed the sum of the payment shortfall for Medicaid services and the costs of the uninsured. The fund shall be an amount not to exceed \$6 million annually.

29. Appalachian Regional Hospital System supplemental payments.

All DRG hospitals operating in the Commonwealth of Kentucky that belong to the Appalachian Regional Hospital System will receive an adjusted payment equal to the difference between what Medicaid pays for inpatient services and what Medicare would pay for those same services to Medicaid eligible individuals or its proportionate share of \$7.5 million, whichever is lower. The Upper Payment Limit as defined in 42 CFR 447.272 will be applied on a facility-specific basis as described in Exhibit A. These payments will be made on a quarterly basis within 30 days of the end of the quarter.

30. Supplemental DRG Payments

a. In-state high intensity level II neonatal center.

- 1) The Department will make prospective supplemental payments to in-state hospitals for all DRGs 675 through 680 as referenced in Section (2)A.15.b.1 of this attachment to a hospital with a Level II neonatal intensive care unit that meets the following qualifications:

- a) Is licensed for a minimum of 24 neonatal level II beds;
- b) Has a minimum of 1,500 Medicaid neonatal level II patient days per year;
- c) Has a gestational age lower limit of twenty-seven (27) weeks; and
- d) Has a full-time perinatologist on staff.
- e) The payment will be an additional add-on per discharge for each of the above DRGs.

2) Before July 1, 2007, the add-on will be \$3,775;

3) From July 1, 2007 through October 14, 2007, the add-on will be \$9,853; and

4) On or after October 15, 2007, the add-on will be \$2,870.

- b. The Department will pay no more in the aggregate for inpatient hospital services than the inpatient Upper Payment Limit, as set forth in 42 CFR 447.253(b)(2) and 42 CFR 447.272. The Department will determine the inpatient Upper Payment Limit by estimating what would be paid for inpatient hospital services under the Medicare principles of reimbursement. The methodology used by the Department to calculate the inpatient Upper Payment Limits can be found in Attachment 4.19-A Exhibit A.
- c. An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility in accordance with applicable federal regulations.
- d. For the purpose of this attachment, Medicaid patient days shall not include days for a Medicaid recipient eligible to participate in the state's Section 1115 waiver as described

as the Demonstration project: Services provided through regional managed care partnerships 1115 Wavier.

- e. A payment made under the Supplemental DRG payments shall not duplicate a payment made via Item (8) Disproportionate share hospital distributions.
- B. Per Diem Methodology: Payment for Rehabilitation or Psychiatric Care in an In-State Acute Care Hospital.**
- 1. As of October 15, 2007, the department shall reimburse for rehabilitation or psychiatric care in an in-state acute care hospital that has a Medicare-designated rehabilitation or psychiatric distinct part unit:
 - a. On a facility specific per diem basis equivalent to the per diem cost reported for Medicare distinct part unit patients on the most recently Medicare cost report received prior to the rate year; and
 - b. In accordance with Reimbursement Limits and Updating Procedures section 24 of this attachment.
 - 2. As of October 15, 2007, the department shall reimburse for rehabilitation or psychiatric care provided in an in-state hospital that does not have a Medicare designated distinct part unit:
 - a. On a facility-specific per diem basis equivalent to its aggregate projected payments for DRG services divided by its aggregate projected Medicaid covered days; and
 - b. In accordance with the Reimbursement Limits and Updating Procedures section 24 of this attachment.
 - 3. As of November 15, 2007, the department shall reimburse for rehabilitation or psychiatric care in an in-state acute care hospital that has a Medicare-designated rehabilitation or psychiatric distinct part unit on a per diem basis as follows:
 - a. On a facility-specific per diem basis equivalent to the per diem cost reported for Medicare distinct part unit patients on the most recently received Medicare cost report prior to the rate year.
 - b. Reimbursement for an inpatient rehabilitation or psychiatric service shall be determined by multiplying a hospital's rehabilitation or psychiatric per diem rate by the number of allowed patient days.
 - c. A rehabilitation or psychiatric per diem rate shall be the sum of a rehabilitation or psychiatric operating per diem rate and a rehabilitation or psychiatric capital per diem rate, as appropriate.
 - 1) The rehabilitation or psychiatric operating cost-per-day amounts used to determine the rehabilitation or psychiatric operating per diem rate shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric cost basis (as appropriate), excluding capital costs and medical education costs, by the number of Medicaid rehabilitation or psychiatric patient days in the base year.
 - 2) The Medicaid rehabilitation or psychiatric cost basis and patient days shall be based on Medicaid claims for patients with a rehabilitation or psychiatric diagnosis (as appropriate) with dates of service in the base year. The rehabilitation or psychiatric operating per diem rate shall be adjusted for:

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- a) The price level increase from the midpoint of the base year to the midpoint of the universal rate year using the CMS Input Price Index; and
 - b) The change in the Medicare published wage index from the base year to the universal rate year.
- d. Computation of rates.
- 1) A rehabilitation or psychiatric capital per diem rate shall be facility-specific and shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric capital cost basis by the number of Medicaid rehabilitation or psychiatric patient days (as appropriate) in the base year.
 - 2) The Medicaid rehabilitation or psychiatric capital cost basis and patient days shall be based on Medicaid claims for patients with rehabilitation or psychiatric diagnoses (as appropriate) with dates of service in the base year.
 - 3) The rehabilitation or psychiatric capital per diem rate shall not be adjusted for inflation.
4. The department shall reimburse for rehabilitation or psychiatric care provided in an in-state hospital that does not have a Medicare-designated distinct part unit:
- a. On a projected payment basis using:
 - 1) A facility specific per diem basis equivalent to its aggregate projected payments for DRG services divided by its aggregate projected Medicaid paid days.
 - 2) Aggregate projected payments and projected Medicaid paid days shall be the sum of:
 - a) Aggregate projected payments and aggregate projected Medicaid paid days for non-per diem DRG services as calculated by the model established in section (2)A;
 - b) Actual prior year payments inflated by the inflation factor provided by GII; and
 - c) Per diem DRG service Medicaid days; and
 - e. In compliance with provisions for the use of a universal rate year and taking into consideration Medicaid policy with regard to unallowable costs as shown in (1)D and F of this attachment.
- (3) Payment for Long-term Acute Care Hospital Care, In-State Freestanding Psychiatric Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.
- A. The department shall reimburse for inpatient care provided to eligible Medicaid recipients in an in-state freestanding psychiatric hospital, in-state freestanding rehabilitation hospital, or LTAC hospital on a per diem basis.
 - B. The department shall calculate a per diem rate by:
 1. Using a hospital's fiscal year 2005 Medicare cost report, allowable cost and paid days to calculate a base cost per day for the hospital;
 2. Trending and indexing a hospital's specific cost, excluding capital cost, per day to the current state fiscal year;

3. Calculating an average base cost per day for hospitals within similar categories, for example rehabilitation hospitals, using the indexed and trended base cost per day;
 4. Assigning no hospital a base cost per day equaling less than ninety-five (95) percent of the weighted average trended and indexed base cost per day of hospitals within the corresponding category;
 5. Applying a parity factor equivalent to aggregate cost coverage established by the DRG reimbursement methodology described in the diagnostic related group hospital reimbursement portion of the state plan; and
 6. An additional amount of three (3) million dollars will be distributed on a pro-rata basis and applied to the per diem as calculated in paragraphs 1. through 5. of this subsection.
- C. From October 15, 2007 through November 14, 2007, the department shall reimburse the inpatient care provided to an eligible Medicaid recipient in an in-state psychiatric hospital previously designated as a primary referral and service resource for a child in the custody of the Cabinet for Health and Family Services at the median per diem rate paid of all freestanding psychiatric hospitals. Effective November 15, 2007, this provision is no longer relevant.
- D. In-State Hospital Minimum Occupancy Factor.
1. If an in-state hospital's minimum occupancy is not met, allowable Medicaid capital costs shall be reduced by:
 - a. Increasing the occupancy factor to the minimum factor; and
 - b. Calculating the capital costs using the calculated minimum occupancy factor.
 2. The following minimum occupancy factors shall apply:
 - a. A sixty (60) percent minimum occupancy factor shall apply to a hospital with 100 or fewer total licensed beds;
 - b. A seventy-five (75) percent minimum occupancy factor shall apply to a hospital with 101 or more total licensed beds; and
 - c. A newly-constructed in-state hospital shall be allowed one (1) full universal rate year before a minimum occupancy factor shall be applied.
- E. Reduced Depreciation Allowance. The allowable amount for depreciation on a hospital building and fixtures, excluding major movable equipment, shall be sixty-five (65) percent of the reported depreciation amount as shown in the hospital's cost reports.
- F. Payment to a Newly-participating In-State Freestanding Psychiatric Hospital, Freestanding Rehabilitation Hospital or a Long Term Acute Care Hospital.
1. The department shall reimburse a newly-participating in-state freestanding psychiatric hospital, freestanding rehabilitation hospital or long term acute care hospital the minimum per diem rate paid to hospitals in their category until the first fiscal year cost report submitted by the hospital has been finalized.
 2. Upon finalization of the first fiscal year cost report for a facility, the department shall reimburse the facility a per diem rate in accordance with Section (3)B of this attachment.

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- (4) Payment for Critical Access Hospital Care.
- A. The department shall pay a per diem rate to a critical access hospital equal to the hospital's Medicare rate.
 - B. A critical access hospital's final reimbursement for a fiscal year shall reflect any adjustment made by CMS.
 - C. Cost Report Requirements.
 - a. A critical access hospital shall comply with the cost reporting requirements established in Section (1)E of this attachment in the In-State Hospital Cost Reporting Requirements section.
 - b. A cost report submitted by a critical access hospital to the department shall be subject to audit and review.
 - D. An out-of-state critical access hospital shall be reimbursed under the same methodology as an in-state critical access hospital.
 - E. The department shall reimburse for care in a federally defined swing bed in a critical access hospital at the same rate as established by the Centers for Medicare and Medicaid Services for Medicare.
 - F. Reimbursement Limit. Total reimbursement to a hospital, other than to a critical access hospital, shall be subject to the limitation established in 42 C.F.R. 447.271.
- (5) In-State Psychiatric, Rehabilitation, and Long-term Acute Care Hospitals Reimbursement Updating Procedures.
- A. The department shall adjust an in-state hospital's per diem rate annually according to the following:
 - 1) The Healthcare Cost Review, a publication prepared by Global Insight (GI) is used to obtain to update trending and indexing factors. The most recently received first-quarter publication is used for rate-setting. For trending and indexing factors the Total %MOVAVG line from Table 6.1CY, Hospital Prospective Reimbursement Market Basket, is used. The second quarter column of the respective year being trended/indexed to is used.
 - 2) A capital per diem rate shall not be adjusted for inflation.
 - B. The department shall, except for a critical access hospital, rebase an in-state hospital's per diem rate every four (4) years.
 - C. Except for an adjustment resulting from an audited cost report, the department shall make no other adjustment, except for correction of error, as a result of a change resulting from a dispute resolution or appeal to the extent rates were not set in accordance with the State Plan, or Federal Court decision; or as a result of a properly promulgated policy change and approved by CMS through a State Plan amendment.
- (6) Reimbursement for Out-of-state Hospitals for Critical Access Care, Long Term Acute Care, Rehabilitation Care and Psychiatric Care.
- A. For inpatient psychiatric or rehabilitation care provided by an acute out-of-state hospital, the

department shall reimburse a per diem rate comprised of an operating per diem rate and a capital per diem rate.

1. As of October 15, 2007, the psychiatric or rehabilitation operating per diem rate shall be the median operating cost, excluding graduate medical education cost or any provider tax cost, per day for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 2. As of November 15, 2007, the psychiatric or rehabilitation operating per diem rate shall be the median psychiatric or rehabilitation operating per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 3. As of October 15, 2007, the psychiatric or rehabilitation capital per diem rate shall be the median psychiatric capital per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 4. As of November 15, 2007, the psychiatric or rehabilitation capital per diem rate shall be the median psychiatric or rehabilitation capital per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 5. An out-of-state hospital's per diem rate shall not include:
 - a. A provider tax adjustment; or
 - b. Graduate medical education costs.
- B. For care provided by an out-of-state freestanding long term acute care, critical access, or freestanding psychiatric hospital, the department shall reimburse a per diem rate comprised of an operating per diem rate and a capital per diem rate for each type of facility as appropriate.
1. The long term acute care, critical access, or psychiatric operating per diem rate shall equal the median operating cost, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding hospitals of the same type.
 2. The long term acute care, critical access, or psychiatric capital per diem rate shall be the median capital per diem rate for all in-state freestanding hospitals of the same type.
 3. An out-of-state hospital's per diem rate shall not include:
 - a. A provider tax adjustment; or
 - b. Graduate medical education costs.
- C. For care in an out-of-state rehabilitation hospital, the department shall reimburse a per diem rate equal to the median rehabilitation per diem rate for all in-state rehabilitation hospitals except that an out-of-state hospital's per diem rate shall not include:
1. A provider tax adjustment; or
 2. Graduate medical education costs.
- D. The department shall apply the requirements of 42 C.F.R. 447.271 to payments made pursuant to the plan provisions shown in this section of this attachment.

(7) Supplemental Payments for a Free-standing In-state Rehabilitation Hospital:

A state designated rehabilitation teaching hospital that is not state-owned or operated shall receive an annual rehabilitation teaching supplement payment, determined on a per diem basis, in an amount calculated by determining the difference between Medicaid costs as stated on the cost settled audited cost report each year, and payments received for the Medicaid patients (i.e., Medicare, KMAP, TPL, and Medical Education.)

(8) Disproportionate Share Hospital Provisions

A. Definition. A disproportionate share hospital or DSH means an in-state hospital that:

1. Has an inpatient Medicaid utilization rate of one (1) percent or higher; and
2. Meets the criteria established in 42 U.S.C. 1396r-4(d).
3. Has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.
4. Meets the requirements established in section 1923(d) of the Act.

B. Disproportionate Share Hospital Distribution General Provisions. A DSH distribution shall:

1. Be made to a qualified hospital;
2. Be based upon a hospital's proportion of inpatient and outpatient indigent care from the preceding state fiscal year;
3. Be a prospective amount. For example, a DSH distribution made to a hospital in October 2007 shall cover the state fiscal year beginning July 1, 2007 and ending June 30, 2008;
4. Not be subject to settlement or revision based on a change in utilization during the year to which it applies;
5. Be made on an annual basis;
6. Be made from a hospital's share of the allocated pool or total disproportionate share funds with the following allocation into three (3) pools: forty-three and ninety-two hundredths percent (43.92%) allocated to acute care hospitals; thirty-seven percent (37%) allocated to university hospitals; and nineteen and eight hundredths percent (19.08%) allocated to private psychiatric hospitals and state mental hospitals, or the maximum dollar cap from the annual federal allotment;
7. "Type I hospital" means an in-state disproportionate share hospital with 100 beds or less that participates in the Medicaid Program;
8. "Type II hospital" means an in-state disproportionate share hospital with 101 beds or more that participates in the Medicaid Program, except for a hospital that meets the criteria established in this administrative regulation for a Type III or Type IV hospital;
9. "Type III hospital" means an in-state disproportionate share state university teaching hospital, owned or operated by either the University of Kentucky or the University of Louisville Medical School; and

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10. "Type IV hospital" means an in-state disproportionate share hospital participating in the Medicaid Program that is a state-owned psychiatric hospital.
- C. Disproportionate Share Hospital Distribution to a DRG-Reimbursed Acute Care Hospital. The department shall determine a DSH distribution to a DRG-reimbursed acute care hospital by:
1. Determining a hospital's average reimbursement per discharge;
 2. Dividing the hospital's average reimbursement per discharge by Medicaid days per discharge;
 3. Multiplying the amount established in paragraph b by the hospital's total number of inpatient indigent care days for the most recently completed state fiscal year to establish the hospital's inpatient indigent care cost;
 4. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report;
 5. Combining the inpatient indigent care cost established in paragraph (c) with the outpatient indigent care cost established in paragraph (d) to establish a hospital's indigent care cost total; and
 6. Comparing the total indigent care cost for each DRG-reimbursed hospital to the indigent care costs of all hospitals receiving DSH distributions under the acute care pool pursuant to the following procedure to establish a DSH distribution on a pro rata basis:
 - a. The department shall calculate an indigent care factor for each hospital annually. The indigent care factor shall be determined by calculating the percentage of each hospital's annual indigent care costs toward the sum of the total annual indigent care cost for all hospitals within each respective pool. For purposes of this paragraph, "indigent care costs" means the hospital's inpatient and outpatient care as reported to the department multiplied by the hospital's Medicaid rate, or at a rate determined by the department in administrative regulation that, when multiplied by the hospital's reported indigent care, is equivalent to the amount that would be payable by the department under the fee-for-service Medicaid program for the hospital's total reported indigent care; and
 - b. Each hospital's annual distribution shall be calculated by multiplying the hospital's indigent care factor by the total fund allocated to the acute care pool, university hospital pool, and the private psychiatric pool.
- D. Disproportionate Share Hospital Distribution to a Critical Access Hospital, Rehabilitation Hospital or Long Term Acute Care Hospital. The department shall determine a DSH distribution to a critical access hospital, rehabilitation hospital, or long term acute care hospital:
1. For the period beginning state fiscal year beginning July 1, 2007 and ending June 30, 2008 by:
 - a. Multiplying the hospital's per diem rate in effect as of June 30, 2007 by its total number of inpatient indigent care days for the preceding state fiscal year (July 1, 2006 - June 30, 2007) to establish the hospital's inpatient indigent care cost;

- b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report;
 - c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and
 - d. Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to state regulations related to establishing a hospital's DSH distribution on a pro rata basis; and
2. For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:
 - a. Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection (2) of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and
 - b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report;
 - c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and
 - d. Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to state statute establishing a hospital's DSH distribution on a pro rata basis.
- E. Disproportionate Share Hospital Distribution to a Private Psychiatric Hospital. The department shall determine a DSH distribution to a private psychiatric hospital:
1. For the period beginning state fiscal year beginning July 1, 2007 and ending June 30, 2008 by:
 - a. Multiplying the hospital's per diem rate in effect as of June 30, 2007 by its total number of inpatient indigent care days for the preceding state fiscal year (July 1, 2006 - June 30, 2007) to establish the hospital's inpatient indigent care cost;
 - b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report hospital fee schedule or by establishing an inpatient equivalency;
 - c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and

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- d. Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis; and
2. For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:
 - a. Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection 2 of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and
 - b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge from the Medicare Cost Report fee schedule or by establishing an inpatient equivalency;
 - c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and
 - d. Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis.
- F. Disproportionate Share Hospital Distribution to a State Mental Hospital. The Department shall determine a DSH distribution to a state mental hospital by:
1. Comparing each state mental hospital's costs of services provided to individuals meeting the indigent eligibility criteria established in subsections H and I of this Section, minus any payment made by or on behalf of the individual to the hospital; and
 2. Using the DSH funding allocated to state mental hospitals to establish a state mental hospital's DSH distribution on a pro rata basis.
- G. Disproportionate Share Hospital Distribution to a University Hospital. The department's DSH distribution to a university hospital shall be based on the hospital's historical proportion of the costs of services to Medicaid recipients, minus reimbursement paid according to the regulation related to Diagnostic related group (DRG) inpatient hospital reimbursement, or the nondiagnostic related group inpatient hospital reimbursement and supplemental or IOA payments, plus the costs of services to indigent and uninsured patients minus any distributions made on behalf of indigent and uninsured patients; and
- H. Indigent Care Eligibility.
1. Prior to billing a patient and prior to submitting the cost of a hospital service to the department as uncompensated, a hospital shall use the indigent care eligibility form, DSH-001, Application for Disproportionate Share Hospital Program, to assess a patient's financial situation to determine if:
 - a. Medicaid or Kentucky Children's Health Insurance Program (KCHIP) may cover hospital expenses; or
 - b. A patient meets the indigent care eligibility criteria.
 2. An individual referred to Medicaid or KCHIP by a hospital shall apply for the referred

assistance, Medicaid or KCHIP, within thirty (30) days of completing the DSH-001, Application for Disproportionate Share Hospital Program, at the hospital.

I. Indigent Care Eligibility Criteria.

1. A hospital shall receive disproportionate share hospital funding for an inpatient or outpatient medical service provided to an indigent patient under the provisions of this attachment if the following apply:
 - a. The patient is a resident of Kentucky;
 - b. The patient is not eligible for Medicaid or KCHIP;
 - c. The patient is not covered by a third-party payor;
 - d. The patient is not in the custody of a unit of government that is responsible for coverage of the acute care needs of the individual;
 - e. The hospital shall consider all income and countable resources of the patient's family unit and the family unit shall include:
 - 1) The patient;
 - 2) The patient's spouse;
 - 3) The minor's parent or parents living in the home; and
 - 4) Any minor living in the home;
 - f. A household member who does not fall in one (1) of the groups listed in paragraph (e) of this subsection shall be considered a separate family unit;
 - g. Countable resources of a family unit shall not exceed:
 - 1) \$2,000 for an individual;
 - 2) \$4,000 for a family unit size of two (2); and
 - 3) Fifty (50) dollars for each additional family unit member;
 - h. Countable resources shall be reduced by unpaid medical expenses of the family unit to establish eligibility; and
 - i. The patient or family unit's gross income shall not exceed the federal poverty limits published annually in the Federal Register and in accordance with KRS 205.640.
2. Except as provided in subsection (3) of this section, total annual gross income shall be the lesser of:
 - a. Income received during the twelve (12) months preceding the month of receiving a service; or
 - b. The amount determined by multiplying the patient's or family unit's income, as applicable, for the three (3) months preceding the date the service was provided by four (4).
3. A work expense for a self-employed patient shall be deducted from gross income if:
 - a. The work expense is directly related to producing a good or service; and
 - b. Without it the good or service could not be produced.

4. A hospital shall notify the patient or responsible party of his eligibility for indigent care.
5. If indigent care eligibility is established for a patient, the patient shall remain eligible for a period not to exceed six (6) months without another determination.

J. Indigent Care Eligibility Determination Fair Hearing Process.

1. If a hospital determines that a patient does not meet indigent care eligibility criteria as established in subsections H and I of this Section, the patient or responsible party may request a fair hearing regarding the determination within thirty (30) days of receiving the determination.
2. If a hospital receives a request for a fair hearing regarding an indigent care eligibility determination, impartial hospital staff not involved in the initial determination shall conduct the hearing within thirty (30) days of receiving the hearing request.
3. A fair hearing regarding a patient's indigent care eligibility determination shall allow the individual to:
 - a. Review evidence regarding the indigent care eligibility determination;
 - b. Cross-examine witnesses regarding the indigent care eligibility determination;
 - c. Present evidence regarding the indigent care eligibility determination; and
 - d. Be represented by counsel.
4. A hospital shall render a fair hearing decision within fourteen (14) days of the hearing and shall provide a copy of its decision to:
 - a. The patient or responsible party who requested the fair hearing; and
 - b. The department.
5. A fair hearing process shall be terminated if a hospital reverses its earlier decision and notifies, prior to the hearing, the patient or responsible party who requested the hearing.
6. A patient or responsible party may appeal a fair hearing decision to a court of competent jurisdiction in accordance with state statute on judicial review of final order.

K. Indigent Care Reporting Requirements.

1. On a quarterly basis, a hospital shall collect and report to the department indigent care patient and cost data.
2. If a patient meeting hospital indigent care eligibility criteria is later determined to be Medicaid or KCHIP eligible or has other third-party payor coverage, a hospital shall adjust its indigent care report previously submitted to the department in a future reporting period.

L. Merged Facility. If two (2) separate entities merge into one (1) organization and one (1) of the merging entities has disproportionate status and the other does not, the department shall retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid.

M. Payment Limits: Limit on Amount of Disproportionate Share Payment to a Hospital.

1. Payments made under these provisions do not exceed the OBRA '93 limits described in 1923 (g) of the Social Security Act. This limit is the sum of the following two

measurements that determine uncompensated costs: (a) Medicaid shortfall; and (b) costs of services to uninsured patients less any payments received. Medicaid shortfall is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the non-disproportionate share hospital payment method under this state plan. The cost of services to the uninsured includes inpatient and outpatient services. Costs shall be determined by multiplying a hospital's cost to charge ratio by its uncompensated charges. Uninsured patients are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

- 2. Funds not distributed under the above provisions due to the limit in 1. may be redistributed to public hospitals who are located in the state's managed care region based on the following:

Medicaid Days

Total Medicaid Days X Remaining Funds = DSH Payment

Funds available for redistribution will be allocated to state teaching hospitals (Type III) to cover their uncompensated costs and then to public non-state providers (Type I and Type II). Medicaid days shall be based on the number of inpatient Medicaid days reported on the most recently completed cost report. Medicaid days shall include days provided under FFS and through a managed care entity.

- 3. Limit on Amount of Disproportionate Share Payment to a Hospital

- a. A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for Medicaid recipient services and the costs of uninsured patients. (Section 1923(g) of the Social Security Act.)
- b. Payment Shortfall for Medicaid Recipient Services. The payment shortfall for Medicaid recipient services is the amount by which the costs of inpatient and outpatient services provided Medicaid recipients exceed the payments made to the hospital for those services excluding disproportionate share payments.
- c. Unrecovered Cost of Uninsured/indigent Patients. The unrecovered cost of uninsured/indigent patients is the amount by which the costs of inpatient and outpatient services provided to uninsured/indigent patients exceed any cash payments made by or on behalf of them. An uninsured/indigent patient is an individual who has no health insurance and meets income standards established in state law.

- 4. The disproportionate share hospital payment shall be an amount that is reasonably related to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(9) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

- A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A
- B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in

licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

1. The PRTFs shall be paid a fixed per diem rate of \$230 which shall be adjusted upward each biennium by 2.22 percent or the usual and customary charge, if less. The payments shall not exceed prevailing charges in the locality for comparable services provided under comparable circumstances. The fixed rate (upper limit) is the state's best estimate of the reasonable and adequate cost of providing the services. This rate is determined in the following manner:
 - a. Facilities that provide services that meet the criteria for PRTFs are requested to submit their actual costs for covered services. These costs shall include all care and treatment, staffing, ancillary services (excluding drugs), capital, and room and board costs.
 - b. The actual costs submitted by the facilities are compared to the costs estimated to operate a model PRTF. The costs of the model facility and current facilities are analyzed on the basis of their being reasonable and adequate to meet the costs which would be incurred in order to provide quality services in an economic and efficient manner.
 - c. From this analysis and a consideration of the comments from the facilities, a uniform per diem rate is established for all participating facilities.
 - d. This per diem rate is then adjusted for inflation by 2.22 percent biennium. This inflation rate is based upon the historic rate of inflation as applied to these facilities and their necessary increases in costs of providing the services.
2. The fixed rate or usual and customary charge, if less, covers total facility costs for PRTF services including the following: all care and treatment costs, staffing, costs for ancillary services (except drugs), capital costs, and room and board costs. The rate is established to be fair and adequate compensation for services provided to Medicaid beneficiaries.

(10) Reimbursement for Out-of-state Hospitals.

- A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.
 1. The all-inclusive DRG payment amount:
 - a. Shall be based on the patients diagnostic category; and
 - b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
 2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:
 - 1) An adjustment for provider; and
 - 2) Graduate medical education.
 3. The out-of-state hospital DRG base rate shall be determined as follows:
 - a. For an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries

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- overlap Kentucky and a bordering state, the DRG base rate shall equal the average DRG all-inclusive base rate paid to in-state children's hospitals. Children's hospitals shall be defined as hospitals designated as Children's hospitals by CMS under the Medicare inpatient prospective payment system.
- b. For an out-of-state rural hospital, the DRG base rate shall equal the bottom quartile DRG all-inclusive base rate paid to in-state rural hospitals. Rural hospitals shall be defined as hospitals located in rural areas as designated by CMS in the Medicare inpatient prospective payment system.
 - c. For an out-of-state urban hospital, the DRG base rate shall equal the bottom quartile DRG all-inclusive base rate paid to in-state urban hospitals. Urban hospitals shall be defined as hospitals located in urban areas as designated by CMS in the Medicare inpatient prospective payment system.
3. An out-of-state provider shall not be eligible to receive high volume per diem add-on payments, indirect medical education reimbursement or disproportionate share hospital payments.
 4. The department shall make a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to Quality Improvement Organization review and approval.
 - a. The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim.
 - b. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.
 - c. The department shall use the Medicare operating the capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.
 - d. The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.
- B. As of November 15, 2007, the department shall reimburse an acute care out-of-state hospital, except for a children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and a bordering state, for inpatient care:
1. On a fully-prospective per discharge basis based on the patient's diagnostic category; and
 2. An all-inclusive rate.
- C. As of November 15, 2007, the all-inclusive rate referenced in subsection B.2 of this section shall:
1. Equal the facility-specific Medicare base rate multiplied by the Kentucky-specific DRG relative weights, except that the DRG relative weights shall exclude any provider tax adjustment for in-state hospitals;
 2. Exclude:

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- a. Medicare indirect medical education cost or reimbursement
 - b. Direct graduate medical education cost payment amounts;
 - c. High volume per diem add-on reimbursement;
 - d. Disproportionate share hospital distributions;
 - e. Any adjustment mandated for in-state hospitals; and
 - f. Graduate medical education costs; and
3. Include a cost outlier payment if the associated discharge meets the cost outlier criteria;
 - a. The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim;
 - b. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges;
 - c. The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year; and
 - d. The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.
- D. As of November 15, 2007, the department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, a DRG base rate equal to the average DRG base rate paid to in-state children's hospitals.
- E. An out-of-state provider shall not be eligible to receive high volume per diem add-on payments, indirect medical education reimbursement, direct graduate medical education cost payment amounts, or disproportionate share hospital payments.
- F. The department shall make a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to Quality Improvement Organization review and approval.
1. The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim.
 2. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.
 3. The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.

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4. The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.

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Kentucky Department for Medicaid Services Upper Payment Limit Methodology

This describes the methodology for calculating the Commonwealth of Kentucky's ("Commonwealth") inpatient hospital upper payment limits ("UPLs"). The Department's UPL methodology is in accordance with UPL guidance set forth by the Centers for Medicare and Medicaid Services ("CMS").

Overview of the Upper Payment Limit Methodology

The Commonwealth estimated the inpatient UPLs for the most recent state fiscal year by calculating a reasonable estimate of what would have been paid for Medicaid services using Medicare payment principles, by provider class. If the Medicaid payments for those services were equal to or less than the reasonable estimate of what would have been paid using Medicare payment principles, the Commonwealth met the UPL test.

For the inpatient hospital UPL analysis, the Commonwealth used various approaches to estimate what hospitals would have been paid using Medicare payment principles. These approaches are summarized as follows:

- *Private and non-state governmental owned acute hospitals*: Estimated payments under the Medicare Inpatient Prospective Payment System ("IPPS") payment methodology for the Federal Fiscal Year ("FFY") that most closely matches the UPL time period
- *Privately-owned psychiatric and rehabilitation distinct part units ("DPU")*: Estimated costs using the Medicare TEFRA approach (same approach as the outpatient analysis)
- *State-owned or operated inpatient hospitals*: Comparison of case-mix adjusted payment per discharge between Medicare and Medicaid for the UPL time period. These calculations have been made separately and are not included in this narrative.

Overview of Data Used for Analysis

The following data sources were used in the UPL calculations:

- Fee-for-service ("FFS") inpatient Medicaid claims data from the Medicaid Management Information System ("MMIS") for with dates of service that are within the UPL time period
- Most recently available Form CMS 2552 ("Medicare cost report") data extracted from the Healthcare Cost Report Information System ("HCRIS") dataset
- Supplemental Medicaid payment data from the Commonwealth as calculated in accordance with sections found in Attachment 4.19-A.

Development of UPL Analysis

The following summarizes the steps involved in the development of the UPL amounts for inpatient hospital services.

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

Step 1: Assigned Providers Into Provider Classes

Step 2: Calculated Reasonable Estimate of What Would Have Been Paid Under Medicare Payment Principles

Step 3: Determined Total Payments for Medicaid Services

Step 4: Compared Medicare Payments to Medicaid Payments for Each Provider Class

Each step is described in detail below.

Step 1: Assigned Providers Into Provider Classes

Per Federal UPL regulations, hospitals were placed into three provider classes:

- State-owned or operated
- Non-state government-owned or operated
- Privately-owned or operated

These provider class designations were determined via correspondence with staff from the Kentucky Office of the Inspector General, Division of Health Care Facilities and Services.

Kentucky Medicaid reimburses critical access hospitals, freestanding psychiatric hospitals and freestanding rehabilitation hospitals on a price basis using Medicare cost apportionment methodologies. As such, these providers have not been included in the UPL calculations.

Step 2: Calculated Reasonable Estimate of What Would Have Been Paid Under Medicare Payment Principles

Inpatient UPL analysis

There are several approaches to estimating Medicare payments for inpatient services, depending on the type of facility. These approaches are described as follows.

A. Non-state governmental and Privately-Owned Acute Hospitals

Kentucky Medicaid reimburses FFS acute inpatient hospital claims on a prospective basis using the Medicare Diagnosis Related Group ("DRG") Grouper. As such, it was reasonable to estimate what

**Kentucky Department for Medicaid Services
 Upper Payment Limit Methodology**

payments would have been under the Medicare Inpatient Prospective Payment System (“IPPS”) methodology for the same services paid by Medicaid during the UPL time period. The steps to estimating the Medicare IPPS payments are described as follows:

- 1) Medicare Rate Data: Medicare IPPS rate components were extracted from following sources (shown in Table 1):

Table 1: Medicare IPPS Rate Components

Medicare IPPS Rate Component	Source
<ul style="list-style-type: none"> • National Adjusted Operating Standardized Amounts, broken out by Labor and Non-Labor Components • Capital Standard Federal Payment Rates • Diagnosis Related (“DRG”) Classifications, Relative Weights and Geometric Mean Average Length of Stay (“GLOS”) • Post Acute Transfer DRGs 	<p>“Final Rule” Federal Register</p>
<ul style="list-style-type: none"> • Wage indices • Geographic Adjustment Factors (“GAF”) • Large Urban Add-ons (if applicable) • Intern-to-Bed Ratios • Full-time Residents to Average Daily Census Ratios • Total Hospital Beds • Supplemental Security Income (“SSI”) Ratios • Medicaid Ratios • Other Hospital (“HSP”) Factors • Medicare Hospital Aggregate Operating and Capital CCRs 	<p>CMS IPPS PRICER Program for an admit date of 10/1 and a discharge date of 10/2</p>
<ul style="list-style-type: none"> • Medicare Approved Per Intern and Resident Amounts • Intern and Resident Full-Time Equivalents (“FTEs”) 	<p>Hospital Fiscal Intermediaries Data Request for amounts</p>
<ul style="list-style-type: none"> • Quarterly Price Index Levels 	<p>CMS PPS Hospital Input Price Index Levels, published by GLOBAL INSIGHT</p>

**Kentucky Department for Medicaid Services
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- 2) Medicare IPPS Rates: Medicare payment rates were determined as follows:
- a) Acute Base Rates: Operating and capital acute base rates were calculated for each hospital. For operating, the labor portion of the National Adjusted Operating Standardized Amount was adjusted by facility wage index. For capital, the full Capital Standard Federal Payment Rate was adjusted by facility GAF and Large Urban Add-on (if applicable).
 - b) Indirect Medical Education ("IME") Factors: operating and capital IME factors were calculated for each teaching hospital. Operating IME factors were calculated using the Intern-to-Bed Ratio, while capital IME factors were calculated using the full-time residents to average daily census ratio.
 - c) Disproportionate Share Hospital ("DSH") Factors: operating and capital IME factors were calculated for each qualifying hospital. DSH factors were determined for each hospital based on the hospital DSH percentage and number of beds. The DSH percentage was calculated by adding the SSI ratio and the Medicaid ratio.
 - d) Hospital-Specific ("HSP") Factor: Operating HSP factors were extracted from the CMS IPPS PRICER Program for qualifying Sole Community Hospitals.
 - e) Hospital Outlier Thresholds: Operating and capital outlier thresholds were calculated for each hospital. Thresholds were calculated by splitting the outlier-fixed loss threshold into operating and capital based on hospital CCRs. For operating, the labor portion was adjusted by wage index. For capital, the full amount was adjusted by facility GAF and Large Urban Add-on (if applicable).
- 3) Development of Inpatient Paid Claims Database: Payments under the FFY 2006 IPPS methodology were calculated using Medicaid inpatient claims. Payments were calculated based on the assigned DRG classification, discharge status, submitted charges and length of stay from the claims data.
- a) Non-transfer claims: For claims where the patient was not discharged to another hospital, DRG payments were estimated by multiplying the DRG relative weight by the operating and capital base rates. For qualifying hospitals, IME, DSH and HSP payments were estimated by multiplying the respective factors by the operating and capital DRG payments.
 - b) Normal Transfer Claims: For claims where the patient was discharged to another hospital and the DRG was not designated as special post-acute transfer, payments were estimated based on the transfer adjustment.
 - i. The transfer adjustment was calculated as follows:
$$(\text{Length of stay} + 1) / (\text{DRG GLOS})$$

**Kentucky Department for Medicaid Services
Upper Payment Limit Methodology**

- ii. If the transfer adjustment was less than 1.0, payments were estimated by multiplying the total payment under the non-transfer claim methodology by the transfer adjustment
- iii. If the transfer adjustment was greater than or equal to 1.0, payments were estimated using the non-transfer claim methodology
- c) Special Post-Acute Transfer Claims: For claims where the patient was discharged to another hospital and the DRG was designated as a special post-acute transfer, payments were estimated based on the special transfer adjustment:
 - i. The special transfer adjustment was calculated as follows:
$$0.5 + [((\text{Length of stay} + 1) * 0.5) / (\text{DRG GLOS})]$$
 - ii. If the special transfer adjustment was less than 1.0, payments were estimated by multiplying the total payment under the non-transfer claim methodology by the special transfer adjustment
 - iii. If the special transfer adjustment was greater than or equal to 1.0, payments were estimated using the non-transfer claim methodology
- d) Outlier Claims: Outlier payments were calculated for all qualifying claims a claim qualified for an outlier payment if the total costs, estimated by multiplying Medicare hospital aggregate CCRs by submitted charges, exceeded the total outlier threshold. The total outlier threshold equaled the sum of the operating and capital hospital outlier thresholds and the full DRG payment, including IME and DSH payments. For transfer claims, the outlier thresholds were multiplied by the transfer adjustment.

If a claim qualified for an outlier payment, separate operating and capital outlier payments were calculated as follows:

 - i. Operating outlier payment:
$$[(\text{Operating Cost}) - (\text{Operating Outlier Threshold})] * (\text{Marginal Cost Factor})$$
 - ii. Capital outlier payment:
$$[(\text{Capital Cost}) - (\text{Capital Outlier Threshold})] * (\text{Marginal Cost Factor})$$
 - iii. Marginal cost factor: 90% for DRGs with an MDC of 22 (Burn) and 80% for all other DRGs
- e) Medicare payments were determined for every inpatient claim, resulting in an inpatient paid claims database

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- f) Using the inpatient paid claims database, Medicare payments by provider were determined.
- 4) Medicare IPPS Direct GME payments: Medicare reimburses teaching hospitals for the Direct GME costs related to the Medicare program. Medicare direct GME payments were estimated by determining the direct GME cost related to the Medicaid program. Direct GME payments were calculated as follows:
 - a) Total provider direct medical education costs were estimated by multiplying the Medicare Approved Per Intern and Resident Amounts by intern and resident FTEs
 - b) The Medicaid portion of the direct GME costs was estimated by multiplying the total direct medical education costs by the ratio of Medicaid days to total hospital days. Medicaid days were determined from the cost claims database and total hospital days were extracted from Medicare cost reports.

B. Psychiatric and Rehabilitation DPUs

Kentucky Medicaid reimburses all claims from psychiatric and rehabilitation DPUs on a per diem payment basis. As such, it was not reasonable to estimate payments under Medicare's Inpatient Psychiatric Facility Prospective Payment System ("IPF PPS") or Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS") Methodologies. In lieu of replicating Medicare's payment methodologies, the Commonwealth used estimated TEFRA costs as a reasonable proxy for Medicare payments for hospital DPU claims.

Inpatient services include both routine and ancillary costs. Routine costs were estimated by applying cost per diems to Medicaid claim routine revenue code patient days, while ancillary costs were estimated by applying cost-to-charge ratios to Medicaid claim ancillary revenue code charges.

- 1) Medicare Cost Report Data: Each psychiatric and rehabilitation DPU reported its routine costs in a subprovider cost center in the Medicare cost report. Subprovider routine costs and patient days and ancillary costs and charges were extracted from the most recently available Medicare cost report, as follows:
 - a) Worksheet B, Part I, Column 27: Total subprovider routine and ancillary costs were extracted from lines 31 through 68
 - b) Worksheet C, Part I, Column 5: Total hospital ancillary costs were extracted from the non-distinct part observation beds cost center (line 62)
 - c) Worksheet C, Part I, Column 6 and 7: Total hospital ancillary charges were extracted for each ancillary cost center

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Upper Payment Limit Methodology**

- d) Worksheet S-3, Part I, Column 6: Total hospital subprovider routine patient days were extracted from lines 14 and 14.01
 - e) Worksheet S-2, Line 20: Subprovider type (psychiatric or rehabilitation) was extracted for each subprovider cost center
- 2) Routine Cost Per Diems: Cost per diems were calculated for each DPU as follows:
- a) Each DPU's reported routine subprovider cost center from the HCRIS dataset was aligned into a standardized DPU cost center (Psych or Rehab) based on Medicare cost report Worksheet S-2
 - b) Costs and patient days were summed by provider, for each DPU
 - c) Cost per diems were calculated for each DPU by dividing costs by patient days
- 3) Cost-to-charge ratios ("CCRs"): CCRs were calculated for each ancillary cost center as follows:
- a) Each provider's reported ancillary cost centers from the HCRIS dataset were aligned into standardized cost centers. CMS includes documentation with the HCRIS dataset that crosswalks between reported cost centers and the standardized cost centers. This process involved aligning sub-scripted cost centers into standard cost centers (for example, aligned reported cost center 41.01 to 41 - Radiology/Diagnostic).
 - b) Costs and charges, by provider, were summed for each standardized Medicare cost center.
 - c) Cost-center specific CCRs were calculated for each provider by dividing costs by charges for each standardized cost center. Aggregate ancillary CCRs were calculated for each hospital by summing the costs and charges for all ancillary cost centers, and then dividing total ancillary costs by total ancillary charges. These aggregate ancillary CCRs were used when a cost-center specific CCR was not available.
- 4) Inflation Factors: inflation factors were developed for each hospital to inflate routine cost per diems to the UPL time period
- a) Price index levels were extracted from the CMS Prospective Payment System Hospital Input Price Index
 - b) The midpoint of each hospital Medicare cost report fiscal year was determined
 - c) Inflation factors were calculated based on the percentage change in Price Index Levels from the midpoint of each hospital's Medicare cost report to the midpoint of the UPL time period

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- 5) Development of DPU Inpatient Costed Paid Claims Database: DPU reasonable costs were estimated for inpatient claims
- a) Revenue codes from inpatient claims detail were crosswalked to a standardized cost center, except for non-covered revenue codes, which were excluded.
 - b) Routine costs at the claims detail level were estimated by multiplying the claims data variable "UNITS_OF_SERVICE" (which represents patient days) by the corresponding hospital cost center-specific routine cost per diem. Then multiply the result by 1.000 plus the corresponding routine inflation factor.
 - c) Ancillary costs were estimated at the claims' detail level by multiplying the claims' field "LI_SUBMITTED_CHARGE" (which represents ancillary service line item charges) by corresponding hospital cost center-specific CCR for the appropriate revenue code. If a cost center-specific CCR was not available, the hospital aggregate ancillary CCR was used as a proxy.
 - d) Estimated costs at the claims detail level were combined at the claims header level and added to the inpatient costed paid claims database
 - e) Using the DPU inpatient costed claims database, inpatient costs by DPU were determined.

Step 3: Determined Total Payments for Medicaid Services

For the inpatient hospital analyses, Medicaid FFS payments for each hospital were determined based on amounts reported in the MMIS for each claim in the FFS claims data. Other supplemental Medicaid payments amounts received from the Commonwealth were included in the inpatient UPL analysis. The Medicaid payments included in the UPL analysis are described detail below:

- A. FFS Medicaid Payments: Using the inpatient paid claims databases from the MMIS, total FFS Medicaid inpatient payments were calculated by summing the "REIMBURSEMENT_AMOUNT" and "THIRD_PARTY_PMT_AMT" fields for each hospital.
- B. Other Supplemental Inpatient Medicaid Payments:
 - 1) Settlement Payments: Based on lump sum Medicaid settlement payments to hospitals
 - 2) Direct GME Payments: Based on Medicaid direct graduate medical education payments.
 - 3) Intensity Operating Allowance ("IOA") Payments: Based on Medicaid IOA payments to teaching hospitals.
 - 4) Level II Neonatal Payment: Based on Medicaid Level II Neonatal payments to Central Baptist
 - 5) All other payments that may be made determined on a year by year basis.

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Step 4: Compared Medicare Payments to Medicaid Payments for Each Provider Class

After calculating Medicaid payments and a reasonable estimate of Medicare payments for each hospital, subtotals were calculated for each provider class. The remaining limit for each provider class was determined by subtracting total Medicaid payments from total estimated Medicare payments. If the difference was positive, there was remaining limit, and the provider class passed the UPL test. If the difference was negative, there was no remaining limit, and the provider class did not pass the UPL test.

State: Kentucky

University of Louisville Hospital and University of Kentucky Hospital
Upper Payment Limits Demonstration Calculations
FYE (Providers Fiscal Year End)

Step 1: Find Medicare per case rate with case mix removed

1. Portions of Medicare Payments for (Fiscal Year End) Subject to Case Mix Index
 - a. Other than Outlier payments (base rate)
(MCR Wksht. E Part A Line 1 (may be total of a number of lines))
 - b. IME Adjustment (MCR Wksht E Part A Line 3.24)
 - c. DSH Adjustment (MCR Wksht E Part A Line 4.04)
 - d. Capital Adjustment (MCR Wksht. E Part A Line 9)
 - e. Total Medicare Payments Subject to Case Mix Index (total lines 1a through 1d)
2. Adjustment for Case Mix Index
 - a. Medicare Case Mix Index-From Medicare annual PS&R Reports
 - b. Case Mix Adjusted Total Payments (ln 3e / ln 2a)
3. Medicare Payments for (Fiscal Year End) not subject to case mix index
 - a. Outlier adjustment (MCR Wksht E Part A Line 2.01)
 - b. GME adjustment (MCR Wksht E-3 Pt IV Line 23.01) - Excluding Medicare Part B
 - c. PPS Exempt Psych Unit (MCR Wksht E-3 Part 1 Ln 4)
 - d. New Technology & Organ Acquisition pass-thru (MCR Wksht E Part A Line 11.02 & 12)
 - e. Routine service pass-thru (Wksht E Part A Line 14)
 - f. Other ancillary other pass-thru (Wksht E Part A Lines 15 and E Part B Ln 1.07)
 - g. Total Medicare Payments Not Subject to Case Mix Index (total lines 3a through 3f)
4. Total Medicare payment with case mix removed (ln 2b + ln 3g)
5. Medicare Discharges (MCR Wksht. S-3 Part 1 line 12)-Reconciled to Medicare annual PS&R Reports

\$ #DIV/0!
\$ \$
\$ #DIV/0!

Step 2: Find Medicaid per case rate with case mix removed

6. Medicaid Payments for (Fiscal Year End) Subject to Case Mix Index
 - a. Medicaid Inpatient Payments subject to CMI-Reconciled to the annual Medicaid Paid Claims Listing
7. Adjustment for case mix
 - a. Medicaid Case Mix Index Using Medicare Weights (Internal Report)-Reconciled to the Medicaid MMIS.
 - b. Case Mix Adjusted Total Payments (ln 6a / ln7a)
8. Medicaid Payments not subject to case mix index-Reconciled to the annual Medicaid paid claims listing.

#DIV/0!

- a. Outlier adjustment
 - b. GME adjustment (Annual Payment)
 - c. PPS Exempt Psych Unit Payments
 - d. Transplants (Internal Reports Match to Medicaid Remittance)-reconciled to the Medicaid MMIS
 - e. Total Medicaid Payments Not Subject to Case Mix Index (total lines 8a thru 8d)
9. Total Medicaid payment with case mix removed (Ln 7b + Ln 8e) \$ #DIV/0!
10. Calculate Per Case Payment #DIV/0!
- a. Medicaid Discharges-Reconciled to the Medicaid MMIS.
 - b. Per case Medicaid rate with case mix removed (Ln 9 / Ln 10a)

Step 3: Calculate UPL Gap

- 11. Per Case Differential from Medicare payments subject to case mix (Ln 2b / Ln 5) - (Ln 7b / Ln 10a) #DIV/0!
- 12. Per Case Differential adjusted for Medicaid case mix using Medicare weights (Ln 11 x Ln 7a) #DIV/0!
- 13. Available Gap Under Case Mix Portion of UPL for UPL Payment (Ln 12 x Ln 10a) #DIV/0!
- 13.1. Per Case Differential from Medicare Payments, Not Subject to Case Mix (Ln 3g / Ln 5a) - (Ln 8e / Ln 10a) #DIV/0!
- 13.2. Available Gap Under Non-Case Mix Portion of UPL for UPL Payment (Ln 13.1 X Ln 10a) #DIV/0!
- 13.3. Available UPL Gap for UPL Payment (Ln 13 + Ln 13.2) #DIV/0!

Step 4: Inpatient Charges

- 14. Total Medicaid Inpatient Charges-Reconciled to the Medicaid MMIS. \$ -
- 15. Medicaid Inpatient Payments-Reconciled to the Medicaid MMIS. \$ -
- 16. Medicaid Charge Gap (Ln 14 - Ln 15)

Step 5: UPL Gap Available

- 17. Lesser of Charge Gap (Ln 16) or UPL Gap (Ln 13.3) #DIV/0!

Step 6: Calculate Federal Payment Available

- 18. Federal Matching Percentage \$ 1
- 19. Federal Incremental Payment (Ln 17 x Ln 18) #DIV/0!
- 20. State Match (Line 17 - Ln 19) #DIV/0!

NOTE:

TN# 07-010
Supersedes
TN# None

Approval Date: JUN 25 2009

Effective Date: 10/15/2007

State: Kentucky

1. This worksheet shall include all Medicare & Medicaid payments EXCEPT Medicaid DSH
2. All MCR reference are to the CMS 2552-96 cost report forms. In the event the cost report forms are revised all data will be from the applicable forms of the new cost report.
3. Medicaid discharges shall include 0 paid discharges.
4. Medicaid Management Information System.

TN# 07-010
Supersedes
TN# None

JUN 25 2009

Approval Date:

Effective Date: 10/15/2007

OS Notification

State/Title/Plan Number: KY 07-010

Type of Action: SPA Approval

Required Date for State Notification:

Fiscal Impact: FY 2008 \$ 14,020,000 Federal Share
FY 2009 \$ 14,020,000 Federal Share

Number of Services Provided by Enhanced Coverage, Benefits or Retained

Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:

Effective October 15, 2007 this amendment modifies the State's reimbursement methodology for setting payment rates for inpatient hospital services. Specifically, the amendment provides for a rebasing of the diagnosis-related groups base rates and relative weight, adds a high volume per diem payment methodology based on Medicaid utilization and deletes obsolete language.

Other Considerations: This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

We do not recommend the Secretary contact the governor.

**CMS Contact: Stanley Fields, NIRT 502-223-5332
Venesa Day, NIRT 410-786-8281**