

STATEMENT OF EMERGENCY

907 KAR 1:015E

- (1) This emergency administrative regulation is being promulgated to:
- (a) Curtail excessive and inappropriate utilization of care in emergency departments in accordance with KRS 205.8453 and 205.6310;
 - (b) Establish a flat rate of twenty-five (25) dollars for a screening of a lock-in recipient to determine if the lock-in recipient has an emergency medical condition; and
 - (c) Establish that the Department for Medicaid Services shall not reimburse for a non-emergency service provided to a lock-in recipient if the service is provided in an emergency department of a hospital or is provided by a hospital which is not the designated hospital for the lock-in recipient.
- (2) This action must be implemented on an emergency basis to ensure the availability of funding necessary for the continued operation of the Medicaid program; thus, protecting the health, welfare and safety of Medicaid recipients.
- (3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.
- (4) The ordinary administrative regulation is identical to this emergency administrative regulation.

Steven L. Beshear
Governor

Janie Miller, Secretary
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Healthcare Facilities Management

4 (Emergency Amendment)

5 907 KAR 1:015E. Payments for outpatient hospital services.

6 RELATES TO: KRS 205.520, 205.637, 216.380, 42 C.F.R. 400.203, 413.70, 440.2,
7 440.20(a), 447.321, 42 U.S.C. 1395l(h), 1396r-8(a)(7)

8 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560,
9 205.637(3), 205.6310, 205.8453, 42 U.S.C. 1396a, 1396b, 1396d[, ~~EO 2004-726~~]

10 NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9,~~
11 ~~2004, reorganized the Cabinet for Health and Family Services and placed the Depart-~~
12 ~~ment for Medicaid Services and the Medicaid Program under the Cabinet for Health~~
13 ~~and Family Services.~~ The Cabinet for Health and Family Services, Department for Me-
14 dicaid Services, has the responsibility to administer the Medicaid Program. KRS
15 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any re-
16 quirement that may be imposed, or opportunity presented, by federal law for the provi-
17 sion of medical assistance to Kentucky's indigent citizenry. This administrative regula-
18 tion establishes the method for determining amounts payable by the Medicaid Program
19 for outpatient hospital services.

20 Section 1. Definitions. (1) "Critical access hospital" or "CAH" means a hospital meet-
21 ing the licensure requirements established in 906 KAR 1:110 and KRS 216.380.

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

2 (3) "Emergency medical condition" is defined by 42 USC 1395dd(e)(1).

3 (4) "Federal financial participation" is defined in 42 C.F.R. 400.203.

4 (5)[(4)] "Finalized" means approved or final as determined by the Centers for Medi-
5 care and Medicaid Services (CMS).

6 (6) "Flat rate" means a set and final rate representing reimbursement in entirety with
7 no subsequent cost settling.

8 (7) "Lock-in recipient" means a recipient enrolled in the department's lock-in program
9 pursuant to 907 KAR 1:677.

10 (8) "Lock-in recipient's designated hospital" means the hospital designated to provide
11 nonemergency care for a lock-in recipient pursuant to 907 KAR 1:677.

12 (9) "Nonemergency" means that a condition or situation does not require an emer-
13 gency service pursuant to 42 CFR 447.53.

14 (10)[(5)] "Outpatient cost-to-charge ratio" means the ratio determined by dividing the
15 costs reported on Supplemental Worksheet E-3, Part III, Page 12 column 2, line 27 of
16 the cost report by the charges reported on column 2, line 20 of the same schedule.

17 (11) "Recipient" is defined by KRS 205.8451(9).

18 Section 2. In-State Outpatient Hospital Service Reimbursement. (1)(a) Except for
19 critical access hospital services, ~~and~~ outpatient hospital laboratory services, and a
20 service referenced in subsection (6) of this section, the department shall reimburse on
21 an interim basis for in-state outpatient hospital services at a facility specific outpatient
22 cost-to-charge ratio based on the facility's most recently filed cost report.

23 (b) An outpatient cost-to-charge ratio shall be expressed as a percent of the hospit-

1 al's charges.

2 (2) Except as established I subsection (6) of this section, a facility specific outpatient
3 cost-to-charge ratio paid during the course of a hospital's fiscal year shall be designed
4 to result in reimbursement, at the hospital's fiscal year end, equaling ninety-five (95)
5 percent of a facility's total outpatient costs incurred during the hospital's fiscal year.

6 (3) Except as established in subsection (4) and (6) of this section:

7 (a) Upon reviewing an in-state outpatient hospital's as submitted cost report for the
8 hospital's fiscal year, the department shall preliminarily settle reimbursement to the fa-
9 cility equal to ninety-five (95) percent of the facility's total outpatient costs, excluding la-
10 boratory services, incurred in the corresponding fiscal year; and

11 (b) Upon receiving and reviewing an in-state outpatient hospital's finalized cost report
12 for the hospital's fiscal year, the department shall settle final reimbursement, excluding
13 laboratory services, to the facility equal to ninety-five (95) percent of the facility's total
14 outpatient costs incurred in the corresponding fiscal year.

15 (4)(a) The department's total reimbursement for outpatient hospital services shall not
16 exceed the aggregate limit established in 42 C.F.R. 447.321.

17 (b) If projections indicate for a given state fiscal year that reimbursing for outpatient
18 hospital services at ninety-five (95) percent of costs would result in the department's
19 total outpatient hospital service reimbursement exceeding the aggregate limit estab-
20 lished in 42 C.F.R. 447.321, the department shall proportionately reduce the final out-
21 patient hospital service reimbursement for each hospital to equal a percent of costs
22 which shall result in the total outpatient hospital reimbursement equaling the aggregate
23 limit established in 42 C.F.R. 447.321.

1 (5) In accordance with 42 U.S.C. 1396r-8(a)(7), a hospital shall include the corres-
2 ponding healthcare common procedure coding (HCPC) code if billing a revenue code of
3 250 through 261 or 634 through 636 for an outpatient hospital service.

4 (6)(a) Except for a critical access hospital, the department shall reimburse a flat rate
5 of twenty-five (25) dollars for a screening of a lock-in recipient to determine if an emer-
6 gency medical condition exists.

7 (b) A hospital shall use revenue code 451 to bill for a service referenced in para-
8 graph (a) of this subsection.

9 (c) A service or reimbursement for a service referenced in subsection (a) of this sec-
10 tion, shall not be included:

11 1. With a hospital's costs for reimbursement purposes; and

12 2. In any cost settlement between the department and a hospital.

13 (7) In accordance with 907 KAR 1:014:

14 (a) Except for a service referenced in subsection (6) of this section, the department
15 shall not reimburse for a non-emergency service provided to a lock-in recipient if pro-
16 vided by a hospital other than the lock-in recipient's designated hospital; or

17 (b) The department shall not reimburse for a non-emergency service provided to a
18 lock-in recipient in an emergency department of a hospital.

19 Section 3. Out-of-State Outpatient Hospital Service Reimbursement. Excluding ser-
20 vices provided in a critical access hospital and laboratory services, reimbursement for
21 an outpatient hospital service provided by an out-of-state hospital shall be ninety-five
22 (95) percent of the average in-state outpatient hospital cost-to-charge ratio.

23 Section 4. Critical Access Hospital Outpatient Service Reimbursement. (1) The de-

1 department shall reimburse for outpatient hospital services in a critical access hospital as
2 established in 42 C.F.R. 413.70(b) through (d).

3 (2) A critical access hospital shall comply with the cost reporting requirements estab-
4 lished in Section 6 of this administrative regulation.

5 Section 5. Outpatient Hospital Laboratory Service Reimbursement. (1) The depart-
6 ment shall reimburse for an in-state or out-of-state outpatient hospital laboratory ser-
7 vice:

8 (a) At the Medicare-established technical component rate for the service in accor-
9 dance with 907 KAR 1:029 if a Medicare-established component rate exists for the ser-
10 vice; or

11 (b) By multiplying the facility's current outpatient cost-to-charge ratio by its billed la-
12 boratory charges if no Medicare rate exists for the service.

13 (2) Laboratory service reimbursement, in accordance with subsection (1) of this sec-
14 tion, shall be:

15 (a) Final; and

16 (b) Not settled to cost.

17 (3) An outpatient laboratory hospital laboratory service shall be reimbursed in accor-
18 dance with this section regardless of whether the service is performed in an emergency
19 room setting or in a nonemergency room setting.

20 Section 6. Cost Reporting Requirements. (1) An in-state outpatient hospital partici-
21 pating in the Medicaid program shall submit to the department a copy of the Medicare
22 cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental
23 Medicaid Schedule KMAP-1, the Supplemental Medicaid Schedule KMAP-4 and the

1 Supplemental Medicaid Schedule KMAP-6:

2 (a) A cost report shall be submitted:

3 1. For the fiscal year used by the hospital; and

4 2. Within five (5) months after the close of the hospital's fiscal year; and

5 (b) Except as provided in subparagraph 1 or 2 of this paragraph, the department
6 shall not grant a cost report submittal extension.

7 1. The department shall grant an extension if an extension has been granted by
8 Medicare. If an extension has been granted by Medicare, when the facility submits its
9 cost report to Medicare it shall simultaneously submit a copy of the cost report to the
10 department.

11 2. If a catastrophic circumstance exists, as determined by the department (for exam-
12 ple flood, fire, or other equivalent occurrence), the department shall grant a thirty (30)
13 day extension.

14 (2) If a cost report submittal date lapses and no extension has been granted, the de-
15 partment shall immediately suspend all payment to the hospital until a complete cost
16 report is received.

17 (3) If a cost report indicates payment is due by a hospital to the department, the hos-
18 pital shall submit the amount due or submit a payment plan request with the cost report.

19 (4) If a cost report indicates a payment is due by the hospital to the department and
20 the hospital fails to remit the amount due or request a payment plan, the department
21 shall suspend future payment to the hospital until the hospital remits the payment or
22 submits a request for a payment plan.

23 (5) An estimated payment shall not be considered payment-in-full until a final deter-

1 mination of cost has been made by the department.

2 (6) A cost report submitted by a hospital to the department shall be subject to de-
3 partmental audit and review.

4 (7) Within seventy (70) days of receipt from the Medicare intermediary, a hospital
5 shall submit to the department a printed copy of the final Medicare-audited cost report
6 including adjustments.

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

10 (b) If a hospital does not submit the additional payment within sixty (60) days, the
11 department shall withhold future payment to the hospital until the department has col-
12 lected in full the amount owed by the hospital to the department.

13 Section 7. Federal Financial Participation. A provision established in this administra-
14 tive regulation shall be null and void if the Centers for Medicare and Medicaid Services:

15 (1) Denies federal financial participation for the provision; or

16 (2) Disapproves the provision~~[shall be effective contingent upon the department's re-~~
17 ~~ceipt of federal financial participation for the respective provision].~~

18 Section 8. Appeals. A hospital may appeal a decision by the department regarding
19 the application of this administrative regulation in accordance with 907 KAR 1:671.

20 Section 9. Incorporation by Reference. (1) The following material is incorporated by
21 reference:

22 (a) "Supplemental Worksheet E-3, Part III, Page 12, May 2004 edition";

23 (b) "Supplemental Medicaid Schedule KMAP-1", May 2004 edition;

1 (c) "Supplemental Medicaid Schedule KMAP-4", May 2004 edition; and

2 (d) "Supplemental Medicaid Schedule KMAP-6", January 2007 edition.

3 (2) This material may be inspected, copied, or obtained, subject to applicable copy-
4 right law, at the Department for Medicaid Services, 275 East Main Street, Frankfort,
5 Kentucky 40601, Monday through Friday 8 a.m. to 4:30 p.m. (Recodified from 904 KAR
6 1:015, 5-6-86; Am. 15 Ky.R. 674; eff. 9-21-88; 17 Ky.R. 558; 1523; 1944; eff. 12-7-90;
7 28 Ky.R. 943; 1404; eff. 12-19-2001; 2274; 2592; eff. 6-14-02; 30 Ky.R. 725; 1525; eff.
8 1-5-2004; 35 Ky.R. 199; 943; 1473; eff. 1-5-2009.)

907 KAR 1:015E

REVIEWED:

Date

Elizabeth A. Johnson, Commissioner
Department for Medicaid Services

APPROVED:

Date

Janie Miller, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:015E

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Person: Jill Hunter (502) 564-5707, Darlene Burgess (502) 564-6511
or Stuart Owen (502) 564-4321

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes the reimbursement methodology for outpatient hospital services.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary in order to reimburse hospitals for the provision of outpatient services.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: The authorizing statutes of this administrative regulation grant the Department for Medicaid Services (DMS) the authority to reimburse hospitals for the provision of outpatient services.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation establishes the reimbursement methodology for outpatient hospital services.

- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: DMS is amending reimbursement by reimbursing a flat rate of twenty-five (25) dollars for a screening of a lock-in recipient to determine if the recipient has an emergency medical condition; by not reimbursing for a non-emergency service provided to a lock-in recipient in an emergency department of a hospital; and by not reimbursing for a non-emergency service (other than a screening to determine if an emergency medical condition exists) provided to a lock-in recipient if the hospital is not the lock-in recipient's designated hospital.
 - (b) The necessity of the amendment to this administrative regulation: This amendment is necessary to control excessive Medicaid utilization and to ensure the availability of funding necessary for the continued operation of the Medicaid program.
 - (c) How the amendment conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 205.8453 and KRS 205.6310 by curtailing excessive Medicaid emergency room utilization.
 - (d) How the amendment will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by KRS 205.8453 and KRS 205.6310 by curtailing excessive Medicaid emergency room utilization.

- (3) List the type and number of individuals, businesses, organizations, or state and

local government affected by this administrative regulation: This administrative regulation will affect all hospitals providing outpatient services.

- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
 - (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: In-state Hospitals will have to use revenue code 451 to bill for screenings for lock-in recipients.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): This amendment imposes no costs on regulated entities other than administrative costs associated with altering their billing practice for screenings for lock-in recipients.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Outpatient hospitals as a whole may benefit in that Medicaid funds which have been expended due to excessive utilization with lock-in recipients will be reduced; thus, preserving Medicaid funds for appropriate utilization and reimbursement.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: The Department for Medicaid Services (DMS) anticipates minimal administrative costs associated with Medicaid Management Information System (MMIS) programming to implement the amendment initially. DMS anticipates reducing expenditures by approximately \$100,000 (state and federal combined) annually by implementing the amendment.
 - (b) On a continuing basis: DMS anticipates reducing expenditures by approximately \$100,000 (state and federal combined) annually by implementing the amendment.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The amendment, including the amendment after comments, does not establish any fees, nor does it directly or indirectly increase any fees
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment, including the amendment after comments, does not establish or increase any fees.

- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Critical access outpatient hospital reimbursement differs from other outpatient hospital reimbursement as critical access hospital reimbursement is established in federal regulation. The rate for screening is applied to lock-in recipients only as they are recipients which have been identified as excessively and/or inappropriately utilizing Medicaid services.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 1:015E

Agency Contact Person: Jill Hunter (502) 564-5707, Darlene Burgess (502) 564-6511 or Stuart Owen (502) 564-4321

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

Yes X No _____

If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? All hospitals providing outpatient hospital services including the county and state owned are affected by this amendment.
3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 205.520, KRS 194A.030, 194A.050, 205.560, 205.6310, 205.8453, 42 USC 1396a(30), 42 CFR 440.20, and 42 CFR 447.321.
4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
 - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate additional revenue for state or local governments during the first year of implementation.
 - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment is not expected to generate additional revenue for state or local governments during subsequent years of implementation.
 - (c) How much will it cost to administer this program for the first year? DMS anticipates initial, minimal administrative cost associated with programming its Medicaid Management Information System (MMIS) to conform to the amendment. DMS anticipates reducing expenditures by approximately \$100,000 (state and federal combined) annually by implementing the amendment.
 - (d) How much will it cost to administer this program for subsequent years? DMS anticipates no future costs associated with the amendment. DMS anticipates reducing expenditures by approximately \$100,000 (state and federal combined) annually by implementing the amendment.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): _____

Expenditures (+/-): _____

Other Explanation: No additional expenditures are necessary to implement this amendment.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:015E

Agency Contact Person: Jill Hunter (502) 564-5707, Darlene Burgess (502) 564-6511 or Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. The amendment is not mandated, but 42 CFR 440.20 and 42 CFR 447.321 address outpatient hospital reimbursement. 42 CFR 400.203 establishes a provision regarding procedure coding.
2. State compliance standards. KRS 205.8453 charges Cabinet for Health and Family Services and the Department for Medicaid Services to institute "other measures necessary or useful in controlling fraud and abuse." KRS 205.560 addresses Medicaid reimbursement. KRS 205.637 addresses Medicaid reimbursement to county-owned and operated hospitals.

KRS 205.6310 states, "The Cabinet for Health and Family Services shall establish a system within the Medical Assistance Program to reduce unnecessary hospital emergency room utilization and costs by redefining and controlling hospital emergency utilization. The cabinet shall establish by promulgation of administrative regulations, pursuant to KRS Chapter 13A, the following:

- (1) Criteria and procedures, at least annually updated, that differentiate children and adults, and which conform to the Federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. sec. 1395dd), as amended, and any other applicable federal law or regulation for determining if a medical emergency exists;
- (2) Reimbursement rates that provide for nominal reimbursement of emergency room care for care that does not meet the criteria established for a medical emergency;
- (3) Reimbursement, at rates determined by the cabinet, for ancillary services which, based upon the symptoms of the patient, are medically appropriate to determine if a medical emergency exists;
- (4) Except for emergency room services rendered to children under the age of six (6), prohibition of reimbursement at hospital emergency room rates for diagnosis and treatment for a condition that does not meet the criteria established for a medical emergency; and
- (5) The provisions of this section shall apply to any managed care program for Medicaid recipients."

3. Minimum or uniform standards contained in the federal mandate. 42 USC 1396a(30)(A) requires a state to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care

and services are available to the general population in the geographic area.” Additionally, 42 CFR 447.321 establishes the upper payment limit for outpatient hospital reimbursement.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This amendment does not impose stricter than federal requirements.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The amendment does not impose stricter than federal requirements.