

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

JUL 05 2011



Center for Medicaid, CHIP, and Survey & Certification

JUN 29 2011

Mr. Neville Wise
Acting Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621

RE: State Plan Amendment 11-005

Dear Mr. Wise:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 11-005. Effective April 1, 2011 this amendment proposes to revise the inpatient hospital payment method for determining payments. Specifically, local government-owned hospitals will be paid based on a certified public expenditure method. Also, this amendment implements the requirements of 1923(j) of the Social Security Act and the final disproportionate share hospital rule effective January 19, 2009.

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 April 1, 2011. 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.

Sincerely


Cindy Mann
Director, CMCS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 11-005	2. STATE Kentucky
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE 02/01/2011 4/01/2011	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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)

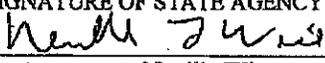
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 433.51	7. FEDERAL BUDGET IMPACT: a. FFY 2011 - \$2,936,586.00 828,908 b. FFY 2012 - \$3,054,049.44 1,648,992
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Page 4.19-A, Page 6 Page 4.19-A, Page 6.1 Page 4.19-A, Page 23 Att. 4.19-A, Exhibit C, Page 1-5 ATT 4.19A Exhibit D PAGES 1-5	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same New Same New

10. SUBJECT OF AMENDMENT

The purpose of this SPA is to allow the department to reimburse an in-state public government-owned hospital the full cost of inpatient care via a Certified Public Expenditure (CPE)

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Review delegated
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED to Commissioner, Department for Medicaid
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Services

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Department for Medicaid Services 275 East Main Street 6W Frankfort, Kentucky 40621
13. TYPED NAME: Neville Wise	
14. TITLE: Acting Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: March 23, 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 06-29-11
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2011	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMCS
23. REMARKS: Pen & ink change made per State request	

- 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.
- P. As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Department for Medicaid Services will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Beginning with Medicaid State Plan year 2011, DSH payments made to hospitals may be adjusted based on the results of the federally-mandated DSH audits as follows:

1. DSH payments found in the DSH audit process that exceed the hospital specific DSH limits will be recouped from hospitals to reduce their payments to their limit. Any payments that are recouped from hospitals as a result of the DSH audit will be redistributed to hospitals that are shown to have been paid less than their hospital-specific DSH limits. Redistribution of DSH payments will first be made to hospitals in the same ownership class (state owned, non-state government owned, and privately owned hospitals) These redistributions will occur proportionately to the original distribution of DSH funds not to exceed each hospital's specific DSH limit. If DSH funds cannot be fully redistributed within the same ownership class, due to the hospital specific limits, the excess funds will be redistributed to the other ownership class in proportion to the original DSH payments made by the state.
2. If the Medicaid program's original DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment will be retroactively paid to hospitals that are under their hospital-specific DSH limit are reflecting the potential redistributions in #1 above. These additional DSH payments will be made in proportion to the original DSH payments, and will be limited to each hospital's specific DSH limit.

(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 January 5, 2009, 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 on or after January 5, 2009, the base year claims data for calculating a hospital specific cost per discharge shall be calculated using 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.

share of the projected historical aggregate cost gap of the DRG hospitals, defined as the difference between costs and Medicaid payments for DRG services for the period July 1, 2004 through June 30, 2007, trended to the midpoint of the January 2009 through December 2010 payment period. The hospital's payment amount shall be divided into 36 equal units and paid on a descending balance basis as follows: first quarter, 8 units; second quarter, 7 units; third quarter, 6 units; fourth quarter, 5 units; fifth quarter, 4 units; sixth quarter, 3 units; seventh quarter, 2 units; and eighth quarter, 1 unit.

- 4) Hospitals receiving the Intensity Operating Allowance Supplement as established in this attachment shall not be eligible for the supplement payments described in this section since they are already receiving a supplement payment.
- 5) Any payments made under this supplement provision are subject to the upper payment limits specified in 42 CFR Part 447. See attached Exhibit A for the detailed methodology used to calculate the upper payment limits.

B. Certified Public Expenditures

The department shall reimburse an in-state public government-owned hospital the full cost of inpatient care via a Certified Public Expenditure (CPE) contingent upon approval by CMS

C. 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.

Certified Public Expenditures incurred in providing services to Medicaid and individuals with no source of third party insurance.

The Kentucky Medicaid Agency uses the CMS Form 2552 cost report for its Medicaid program and all acute care hospitals must submit this report each year. The Agency will utilize Worksheet Series S, B, C and D to determine the cost of services provided to Medicaid recipients and services to individuals with no source of third party insurance to be certified as public expenditures (CPE) from the CMS Form 2552 for inpatient services provided by hospitals. The Agency will use the protocol as described below.

Interim Payment

Interim payments will be made through the state Medicaid Management Information System (MMIS) and paid based on the approved Diagnosis Related Group (DRG) payment, per diem payments, fee schedule payments and/or dedicated on-demand payments through the state eMARS system.

Cost of Medicaid

1. **Interim Reconciliation of Interim Medicaid Inpatient Hospital Payment rate Post Reporting Year:** Upon completion of the State fiscal year, each hospital's interim payments and supplemental payments will be reconciled to its CMS Form 2552 cost report as filed to the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period. For hospitals that have a cost reporting period that differs from the State fiscal year end date of June 30th, the cost reports that overlap the State fiscal year will be used for the calculation. The reconciliation will occur upon receipt of the electronic CMS Form 2552 cost report that includes the June 30th fiscal year end of the State.

The State will apply the cost per diems calculated on the Medicare Worksheet D-1 Part II lines 38 and 42-47 to the respective routine days from Worksheet S-3, Part 1, Medicaid column, to determine Medicaid routine service cost for acute services. The cost per diem calculated on Medicare Worksheet D-1, Part II, line 38 for each subprovider will be applied to the respective days on worksheet S-3, Part 1, Medicaid column. Cost to charge ratios calculated on the Medicare Worksheet D-4 or D-3 will be applied to the Medicaid inpatient ancillary charges related to CMS ancillary service cost centers to determine Medicaid inpatient ancillary service cost. A calculation will be made to add back the cost of graduate medical education to the cost per diems and cost to charge ratios, if removed as a step-down adjustment on Worksheet B, Part I columns 22 and 23. The Medicaid days and charges are reconciled to MMIS paid claims data.

In addition to the cost calculated through application of cost per diems to routine service days and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures.

The Worksheet D-6 or D-4 series with the inclusion of medical education cost as stated above for each organ will be used to determine organ acquisition cost. The total amount of Medicaid organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 or D-4 Part III Line 53 or 61 divided by Total usable organs per Worksheet D-6 or D-4 Part III Line 54 or 62 times number of Medicaid organs (fee for service) transplanted during the year.

Total Medicaid inpatient cost therefore will be the sum of routine service cost, ancillary service cost, graduate medical education cost, and organ acquisition cost. Any Medicaid payments (other than the interim payments provided in this protocol) and third party and client responsibility payments are deducted from the total Medicaid inpatient cost to determine the certifiable amount. The State will compare the interim payments made to the interim Medicaid cost computed here for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

2. Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate Post Reporting Year: Upon issuance of a Notice of Program Reimbursement for CMS Form 2552 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period(s). For hospitals that have a cost reporting period that differs from the State fiscal year end date of June 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

The State will apply the cost per diems calculated on the Medicare Worksheet D-1 Part II lines 38 and 42-47 to the respective routine days from Worksheet S-3, Part 1, Medicaid column to determine Medicaid routine service cost for acute services. The cost per diem calculated on Medicare Worksheet D-1, Part II, line 38 for each subprovider will be applied to the respective days on Worksheet S-3, Part 1, Medicaid column. Cost to charge ratios calculated on the Medicare Worksheet D-4 or D-3 will be applied to the Medicaid inpatient ancillary charges related to CMS ancillary service cost centers to determine Medicaid inpatient ancillary service cost. A calculation will be made to add back the cost of graduate medical education to the cost per diems and cost to charge ratios, if removed as a step-down adjustment on Worksheet B, Part I columns 22 and 23. The Medicaid days and charges are reconciled to MMIS paid claims data.

In addition to the cost calculated through application of cost per diems to routine service and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures. The Worksheet D-6 or D-4 series with the inclusion of medical education cost as stated above for each organ will be used to determine organ acquisition cost. The total amount of Medicaid organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 or D-4 Part III Line 53 or 61 divided by Total usable

organs per Worksheet D-6 or D-4 Part III Line 54 or 62 times the number of Medicaid organs (fee for service) transplanted during the year.

Total Medicaid inpatient cost therefore will be the sum of routine service cost, ancillary service cost, graduate medical education cost, and organ acquisition cost. Any Medicaid payments other than the interim payments provided in this protocol and third party and client responsibility payments are deducted from the total Medicaid inpatient cost to determine the certifiable amount. The State will compare the final reconciliation to the interim reconciliation for each hospital. Any difference to the Medicaid cost will be recorded as an adjustment on the CMS 64 report.

Cost of the Uninsured - Interim

3. Calculation of Cost of Uninsured - Interim

The Department for Medicaid Services will utilize the computations noted below for costs to be certified for public expenditure.

A. Non State-Government Owned Acute Care Hospitals

- a. Providers will submit the DSH Data Collections form quarterly based on the state fiscal year to report data to be used in the indigent cost calculation. The provider will report inpatient days and charges.
- b. The inpatient indigent days submitted for each quarter are totaled and then multiplied by an inpatient average reimbursement per discharge rate to calculate the cost of the uncompensated services. The inpatient average reimbursement per discharge rate is calculated by dividing the hospitals average reimbursement per discharge by the Medicaid days per discharge based on a data bi-query from the MMIS claims system.
 1. For a critical access hospital, rehabilitation, or long term acute care hospital the Medicaid inpatient per diem rate paid as of August 1st in the SFY period for which the DSH payment is made will be multiplied by inpatient indigent care days to calculate inpatient indigent costs.

4. **Interim Reconciliation:** Upon completion of the State fiscal year, each hospital's interim rate and supplemental payments will be reconciled to its CMS Form 2552 cost report as filed to the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period. For hospitals that have a cost reporting period that differs from the State fiscal year end date of June 30th, the cost reports that overlap the State fiscal year will be used for the calculation. The reconciliation will occur upon receipt of the electronic CMS Form 2552 cost report that includes the June 30th fiscal year end of the State.

Each hospital will supply the State with detailed uninsured inpatient routine days and ancillary charges information for services provided to uninsured individuals.

The State will apply the cost per diems calculated on the Medicare Worksheet D-1 Part II lines 38 and 42-47 to the respective routine uninsured days submitted by the provider to determine uninsured routine service cost for acute services. The cost per diem calculated on Medicare Worksheet D-1, Part II, line 38 for each subprovider will be applied to the respective uninsured days submitted by the provider. Cost to charge ratios calculated on the Medicare Worksheet D-4 or D-3 will be applied to the inpatient uninsured ancillary service charges submitted by the provider to determine uninsured inpatient ancillary service cost. A calculation will be made to add back the cost of graduate medical education to the cost per diems and cost to charge ratios, if removed as a step-down adjustment on Worksheet B, Part I columns 22 and 23. The uninsured inpatient days and charges are reconciled to the provider submitted uninsured data.

In addition to the cost calculated through application of cost per diems to routine service days and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures.

The Worksheet D-6 or D-4 series with the inclusion of medical education cost as stated above for each organ will be used to determine organ acquisition cost. The total amount of uninsured organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 or D-4 Part III Line 53 or 61 divided by Total usable organs per Worksheet D-6 or D-4 Part III Line 54 or 62 times number of uninsured organs (fee for service) transplanted during the year.

Total uninsured inpatient cost therefore will be the sum of routine service cost, ancillary service cost, graduate medical education costs, and organ acquisition cost. Uninsured payments related to the charges submitted are deducted from the total uninsured inpatient cost to determine the certifiable amount. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of services for individuals with no source of third party insurance. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

5. Cost of the Uninsured - Final

Upon issuance of a Notice of Program Reimbursement for CMS Form 2552 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period(s). For hospitals that have a cost reporting

period that differs from the State fiscal year end date of June 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

If necessary, each hospital will supply the State with updated detailed inpatient routine days and ancillary charges information for services provided to uninsured individuals.

The State will apply the cost per diems calculated on the Medicare Worksheet D-1 Part II lines 38 and 42-47 to the respective routine uninsured days submitted by the provider to determine uninsured routine service cost for acute services. The cost per diem calculated on Medicare Worksheet D-1, Part II, line 38 for each subprovider will be applied to the respective uninsured days submitted by the provider. Cost to charge ratios calculated on the Medicare Worksheet D-4 or D-3 will be applied to the inpatient uninsured ancillary service charges submitted by the provider to determine uninsured inpatient ancillary service cost. A calculation will be made to add back the cost of graduate medical education to the cost per diems and cost to charge ratios, if removed as a step-down adjustment on Worksheet B, Part I columns 22 and 23. The uninsured inpatient days and charges are reconciled to the provider submitted uninsured data.

In addition to the cost calculated through application of cost per diems to routine service and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures. The Worksheet D-6 or D-4 series with the inclusion of medical education cost as stated above for each organ will be used to determine organ acquisition cost. The total amount of organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 or D-4 Part III Line 53 or 61 divided by Total usable organs per Worksheet D-6 or D-4 Part III Line 54 or 62 times the number of organs (fee for service) transplanted during the year

Total uninsured inpatient cost therefore will be the sum of routine service cost, ancillary service cost, graduate medical education costs, and organ acquisition cost. Uninsured payments related to the charges submitted are deducted from the total uninsured inpatient cost to determine the certifiable amount. Any Medicaid payments made in excess of Medicaid cost will be used to offset uncompensated care of services for individuals with no source of third party coverage. . Any difference to the cost will be recorded as an adjustment on the CMS 64 report.