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

Financial Management Group

MAY 04 2016

Mr. Stephen P. Miller
Commissioner
Commonwealth of Kentucky
Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6 W-A
Frankfort, KY 40621

RE: State Plan Amendment (SPA) 15-006

Dear Mr. Miller:

We have reviewed the proposed amendment to Attachments 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 15-006. Effective October 1, 2015 this amendment modifies the state's reimbursement methodology for setting payment rates for hospital services. Specifically, this amendment will revise the state's current prospective DRG method to the Medicare DRG methodology including the use of the base rate for both operating and capital and the MS DRG grouper.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 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 1, 2015. 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,

Kristin Fan
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 15-006

2. STATE: Kentucky

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 1, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 ~~$2 million~~ $1,764,894
b. FFY 2017 $2 million $1,764,894

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-A, Page 1 – Page 39
Att. 4.19-A, Exhibit A, Page 1 – 7
Att. 4.19-A, Exhibit B, Page 1 – 3
Att. 4.19-A, Exhibit D – Page 1 - 3

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

10. SUBJECT OF AMENDMENT:
The purpose of this SPA is to revise KY's hospital reimbursement.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL: Nicolle F Wiel for

13. TYPED NAME: Lisa D. Lee

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 9/30/15

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: MAY 04 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL: Kristin Fan

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FMG

23. REMARKS:
Pen & Ink Change to block #7 to include $1,764,894 for FFY 2016 and 2017

FORM HCFA-179 (07-92)

1 General Overview

A. Effective for discharges on or after October 1, 2015, the Department will pay for acute care inpatient hospital services provided to a Medicaid recipient who is not enrolled with a managed care organization under a diagnosis related group (DRG) based methodology using the CMS Medicare Severity Diagnosis Related Grouper (MS-DRG) grouper. The methodology will be the Medicare Inpatient Prospective Payment System as described in this State Plan. The revised system will utilize the hospital specific Medicare operating and capital base rates, and the Medicare-established relative weights. Hospital services not paid for using the DRG-based methodology will be paid for using per diem rates or as otherwise stated in this plan.

The following will be excluded from the DRG methodology:

1) Services provided in Critical access hospitals. Reimbursement procedures are described in section 4, beginning on page 22 of this document;
2) Services provided in Free-standing rehabilitation hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
3) Services provided in Long-term acute care hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
4) Psychiatric services, including substance abuse, in Acute care hospitals. Reimbursement procedures are described in section 2(Z), beginning on page 18 of this document;
5) Services provided in Free-standing psychiatric hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
6) Rehabilitation services in Acute care hospitals. Reimbursement procedures are described in section 2(Z), beginning on page 18 of this document; and

B. Appeals and Review Process.

1) Matters Subject to an Appeal. A hospital may appeal whether the Medicare data specific to the hospital that was extracted by the Department in establishing the hospital's reimbursement was the correct data.

2) Appeal Process.

a. An appeal shall comply with the requirements and provisions established in this section.
b. (1) A request for a review of an appealable issue shall be received by the department within sixty (60) calendar days of the date of receipt by the provider of the department's notice of rates set under Regulation 907 KAR 10:830, revised 9/4/2015.
(2) The request referenced in paragraph (1) of this subsection shall:
(a) Be sent to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, 6th Floor, Frankfort, Kentucky 40621-0002; and
(b) Contain the specific issues to be reviewed with all supporting documentation necessary for the departmental review.
c. (1) The department shall review the material referenced in subsection (b) of this section and notify the provider of the review results within 30 days of its receipt except as established in paragraph (2) of this subsection.

1 Overview (continued)

B. Appeals and Review Process (continued)

(2) If the provider requests a review of a non-appealable issue under 907 KAR 10:830 (revised 9/4/2015), the department shall:
(a) Not review the request; and
(b) Notify the provider that the review is outside of the scope of 907 KAR 10:830 (revised 9/4/2015).

d. (1) A provider may appeal the result of the department's review, except for a notification that the review is outside the scope of 907 KAR 10:830 (revised 9/4/2015), by sending a request for an administrative hearing to the Division for Administrative Hearings (DAH) within thirty (30) days of receipt of the department's notification of its review decision.
(2) A provider shall not appeal a notification that a review is outside of the scope of 907 KAR 10:830 (revised 9/4/2015).

e. (1) An administrative hearing shall be conducted in accordance with KRS Chapter 13B.
(2) Pursuant to KRS 13B.030, the Secretary of the Cabinet for Health and Family Services delegates to the Cabinet for Health and Family Services, Division for Administrative Hearings (DAH) the authority to conduct administrative hearings under 907 KAR 10:830 (revised 9/4/2015).
(3) A notice of the administrative hearing shall comply with KRS 13B.050.
(4) The administrative hearing shall be held in Frankfort, Kentucky no later than ninety (90) calendar days from the date the request for the administrative hearing is received by the DAH.
(5) The administrative hearing date may be extended beyond the ninety (90) calendar days by:
(a) A mutual agreement by the provider and the department; or
(b) A continuance granted by the hearing officer.
(6) (a) If the prehearing conference is requested, it shall be held at least thirty (30) calendar days in advance of the hearing date.
(b) Conduct of the prehearing conference shall comply with KRS 13B.070.
(7) If a provider does not appear at the hearing on the scheduled date, the hearing officer may find the provider in default pursuant to KRS 13B.050(3)(h).
(8) A hearing request shall be withdrawn only under the following circumstances:
(a) The hearing officer receives a written statement from a provider stating that the request is withdrawn; or
(b) A provider makes a statement on the record at the hearing that the provider is withdrawing the request for the hearing.
(9) Documentary evidence to be used at the hearing shall be made available in accordance with KRS 13B.090.
(10) The hearing officer shall:
(a) Preside over the hearing; and
(b) Conduct the hearing in accordance with KRS 13B.080 and 13B.090.
(11) The provider shall have the burden of proof concerning the appealable issues under 907 KAR 10:830 (revised 9/4/2015).

1 Overview (continued)

B. Appeals and Review Process (continued)

(12) (a) The hearing officer shall issue a recommended order in accordance with KRS 13B.110.
(b) An extension of time for completing the recommended order shall comply with the requirements of KRS 13B.110 (2) and (3).
(13) (a) A final order shall be entered in accordance with KRS 13B.120.
(b) The cabinet shall maintain an official record of the hearing in compliance with KRS 13B.130.
(c) In the correspondence transmitting the final order, clear reference shall be made to the availability of judicial review pursuant to KRS 13B.140, 13B.150, and KRS 13B.160.

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, 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 shall 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), if applicable.

D. Use of a Universal Rate Year

1) A universal rate year shall be established for rates in this attachment as follows:
a. For DRG rates, excluding non-distinct part unit (non-DPU) psychiatric and rehabilitation hospital rates, the universal rate year shall be October 1 through September 30 of the following year.
b. For Psychiatric Residential Treatment Facility (PRTF) rates, the universal rate year shall be November 1 through October 31 of the following year.
c. For all other hospital rates referenced in this attachment, the universal rate year shall be July 1 through June 30 of the following year, or as specifically stated throughout this attachment.

2) A hospital shall not be required to change its fiscal year to conform with a universal rate year.

E. Cost Reporting Requirements.

1) 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 Overview (continued)

E. Cost Reporting Requirements (continued)

2) An in-state hospital participating in the Medicaid program shall submit to the department a copy of a Medicare cost report form CMS 2552-10 it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1, the Supplemental Medicaid Schedule KMAP-4, and the Supplemental Medicaid Schedule KMAP-6 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.

3) 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.

4) A cost report submitted by a hospital to the department shall be subject to audit and review.

5) 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 Overview (continued)

F. Unallowable Costs (continued)

(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.

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.

1 Overview (continued)

I. Cost Basis. (continued)

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) The Department shall reimburse a new acute care hospital based on the Medicare IPPS Final Rule Data Files and Tables inputs in effect at the time of the hospital's enrollment with the Medicaid program as described in section (2) of this attachment. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

2) If no applicable rate information exists in the Medicare IPPS Final Rule Data Files and Tables for a given period for an in-state acute care hospital, the Department shall use, for the in-state acute care hospital, the average of all in-state acute care hospitals for the operating rate, capital rate, and outlier cost-to-charge ratio, excluding any adjustments made for sole community hospitals or Medicare dependent hospitals.

3) 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.

1 Overview (continued)

K. New Provider, Change of Owner or Merged Facility (continued)

4) A merged facility of two or more entities.

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 on Conditions of Medicaid provider participation, withholding overpayments, administrative appeal process, and sanctions.

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.

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.

1 Overview (continued)

O. 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 the Medicaid State Plan year 2011 DSH audit, 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 for a given state fiscal year that exceed the hospital specific uncompensated care cost (UCC) 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. Redistributions will occur proportionately to the original distribution of DSH funds not to exceed each hospital's specific UCC DSH limit. If DSH funds cannot be fully redistributed within the original distribution pool , due to the hospital specific limits, the excess funds will be redistributed to the other distribution pools 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 state fiscal year, the remaining DSH allotment will be retroactively paid to hospitals that are under their hospital-specific DSH limit 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 eligible in-state acute care hospital shall be paid for all covered inpatient acute care services on a fully-prospective per discharge basis.

B. Effective for discharges on or after October 1, 2015, the department's reimbursement shall equal ninety-five (95) percent of a hospital's Medicare DRG payment excluding the following Medicare reimbursement components:
   1) A Medicare low-volume hospital payment;
   2) A Medicare end stage renal disease payment;
   3) A Medicare new technology add-on payment;
   4) A Medicare routine pass-through payment;
   5) A Medicare ancillary pass-through payment;
   6) A Medicare value-based purchasing payment or penalty;
   7) A Medicare readmission penalty in accordance with Item "M" below;
   8) A Medicare hospital-acquired condition penalty in accordance with Item "M" below;
   9) Any type of Medicare payment implemented by Medicare after October 1, 2015; or
   10) Any type of Medicare payment not described below.

C. 1) For covered inpatient acute care services, in an in-state acute care hospital, the total hospital-specific per discharge payment shall be the sum of:
      a. A DRG base payment; and
      b. If applicable, a cost outlier payment.
   2) The resulting payment shall be limited to ninety-five (95) percent of the calculated value.
   3) If applicable, a transplant acquisition fee payment shall be added pursuant to Item "L" below.

D. 1) The department shall assign a DRG classification to each unique discharge billed by an acute care hospital.
   2) a. The DRG assignment shall be based on the most recent Medicare Severity DRG (MS-DRG) grouping software released by the Centers for Medicare and Medicaid Services beginning with version 32 on October 1, 2015 unless CMS releases version 33 on October 1, 2015.
      b. If CMS releases version 33 on October 1, 2015, the department shall make interim payments for dates of service beginning October 1, 2015 based on version 32 and then retroactively adjust claims for dates of service beginning October 1, 2015 using version 33.
      c. The grouper version shall be updated in accordance with the Reimbursement Updating Procedures outlined below in Item R.

2. Acute Care Hospital Services

3) In assigning a DRG for a claim, the department shall exclude from consideration any secondary diagnosis code associated with a never event.

E. 1) A DRG base payment shall be the sum of the Medicare operating base payment and the capital base payment calculated as described in paragraphs 3) and 4) below.

2) All calculations in this subsection shall be subject to special rate-setting provisions for sole community hospitals found in Item O and Medicare dependent hospitals found in Item P.

3) a. The Medicare operating base payment shall be determined by multiplying the hospital-specific operating rate by the DRG relative weight.

b. If applicable, the resulting product of subparagraph "a." of this paragraph shall be multiplied by the sum of one (1) and a hospital-specific operating indirect medical education (IME) factor determined in accordance with subparagraph "g." below.

c. Beginning October 1, 2015, the hospital-specific operating rate referenced in subparagraph "a." above shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS as described in subparagraphs "d." through "g." below. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

d. The Medicare IPPS standard amount established for operating labor costs from Table 1 shall be multiplied by the wage index from Table 3 associated with the final Core Based Statistical Area (CBSA) assigned to the hospital by Medicare, inclusive of any Section 505 adjustments applied by Medicare, as reported in the IPPS impact file.

e. The resulting product of subparagraph "d." shall be added to the Medicare IPPS standard amount for non-labor operating costs.

f. The operating rate shall be updated in accordance with Item "R" below.

g. (1) Beginning October 1, 2015, the hospital-specific operating IME factor shall be taken from the Federal Fiscal Year 2016 Medicare Inpatient Prospective Payment System (IPPS) Final Rule Data Files and Tables published by CMS.

(2) The operating IME factor shall be updated in accordance with Item "R" below.

4) a. The capital base payment shall be determined by multiplying the hospital-specific capital rate by the DRG relative weight.

b. If applicable, the resulting product of subparagraph "a." above shall be multiplied by the sum of one (1) and a hospital-specific capital indirect medical education factor determined in accordance with subparagraph "g." below.

c. Beginning October 1, 2015, the hospital-specific capital rate referenced in subparagraph "a." above shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS as described in subparagraphs "d" through "g" below. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

d. The Medicare IPPS standard amount established for capital costs shall be multiplied by the geographic adjustment factor (GAF) associated with the final CBSA assigned to the hospital by Medicare.

e. The capital rate shall be updated in accordance with Item "R" below.

2. Acute Care Hospital Services

f. Effective October 1, 2015, the hospital-specific capital IME factor shall be taken from the Medicare Inpatient Prospective Payment System (IPPS) Final Rule Data Files and Tables published by CMS.

g. The capital IME factor shall be updated in accordance with Item "R." below.

F. 1) The department shall make a cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each DRG as established as follows.

2) A cost outlier shall be subject to QIO review and approval.

3) A discharge shall qualify for a cost outlier payment if its estimated cost, as calculated in Item "F" (4) below, exceeds the DRG's outlier threshold, as calculated in Item "F" (5) below.

4) a. The department shall calculate the estimated cost of a discharge:

(1) For purposes of comparing the discharge cost to the outlier threshold; and

(2) By multiplying the sum of the hospital-specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.

b. (1) A Medicare operating and capital-related cost-to-charge ratio shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

(2) The Medicare operating and capital cost-to-charge ratios shall be updated in accordance with Item "R." below.

5) a. The department shall calculate an outlier threshold as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold.

b. (1) Beginning October 1, 2015, the fixed loss cost threshold shall equal the Medicare fixed loss cost threshold established for Federal Fiscal Year 2016.

(2) The fixed loss cost threshold shall be updated in accordance with Item "R." below.

6) a. For specialized burn DRGs as established by Medicare, a cost outlier payment shall equal ninety (90) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

b. For all other DRGs, a cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

G. 1) The department shall establish DRG relative weights obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect under Item "D." above. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

2) Relative weights shall be revised to match the grouping software version for updates in accordance with Item "R." below.

H. The department shall separately reimburse for a mother's stay and a newborn's stay based on the DRGs assigned to the mother's stay and the newborn's stay.

I. 1) 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.

2) 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.

2. Acute Care Hospital Services

3) a. The department shall calculate an average daily discharge rate by dividing the DRG base payment by the Medicare geometric mean length-of-stay for a patient's DRG classification.
b. The Medicare geometric length-of-stay shall be obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect under subparagraph "c." below.
c. The geometric length-of-stay values shall be revised to match the grouping software version for updates in accordance with Item "R." below.

4) Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five (95) percent of the amount calculated for each.

5) For a hospital receiving a transferred patient, the department shall reimburse the standard DRG payment established in Item "D." above.

J. 1) The department shall reimburse a transferring hospital for a transfer from an acute care hospital to a qualifying post-acute care facility for selected DRGs as a post-acute care transfer.

2) The following shall qualify as a post-acute care setting:
a. A skilled nursing facility;
b. A cancer or children's hospital;
c. A home health agency;
d. A rehabilitation hospital or rehabilitation distinct part unit located within an acute care hospital;
e. A long-term acute care hospital; or
f. A psychiatric hospital or psychiatric distinct part unit located within an acute care hospital.

3) A DRG eligible for a post-acute care transfer payment shall be in accordance with 42 U.S.C. 1395ww(d)(4)(J).

4) a. The department shall pay each transferring hospital an average daily rate for each day of a stay.
b. A transfer-related payment shall not exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.
c. A DRG identified by CMS as being eligible for special transfer payment in the Medicare IPPS Final Rule Data Files and Tables, 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. The Medicare IPPS release is found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. DRG special transfer payment indicators will be updated in accordance with Item "R" below.
d. A DRG that is referenced in paragraph 3) of this subsection and not referenced in subparagraph "c." above shall receive twice the average daily rate for the first day of the stay and the average daily rate for each following day of the stay prior to the transfer.
e. Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five (95) percent of the amount calculated for each.

5) a. The average daily rate shall be the base DRG payment allowed divided by the Medicare geometric mean length-of-stay for a patient's DRG classification.
b. The Medicare geometric mean length-of-stay shall be determined and updated in accordance with Item "I(3)" above.

2. Acute Care Hospital Services

K. The department shall reimburse a receiving hospital for a transfer to a rehabilitation or psychiatric distinct part unit the facility-specific distinct part unit per diem rate, in accordance with 907 KAR 10:815 (published 5/3/11), for each day the patient remains in the distinct part unit.

L. 1) The department shall reimburse for an organ transplant on a prospective per discharge method according to the recipient's DRG classification.

2) a. The department's organ transplant reimbursement shall include an interim reimbursement followed by a final reimbursement.

b. The final reimbursement shall:

(1) Include a cost settlement process based on the Medicare 2552 cost report form; and

(2) Be designed to reimburse hospitals for ninety-five (95) percent of organ acquisition costs.

c. (1) An interim organ acquisition payment shall be made using a fixed-rate add-on to the standard DRG payment using the rates below:

(a) Kidney Acquisition - $65,000;
(b) Liver Acquisition - $55,000;
(c) Heart Acquisition - $70,000;
(d) Lung Acquisition - $65,000; or
(e) Pancreas Acquisition - $40,000.

(2) Upon receipt of a hospital's as-filed Medicare cost report, the department shall calculate a tentative settlement at ninety-five (95) percent of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified above.

(3) Upon receipt of a hospital's finalized Medicare cost report, the department shall calculate a final reimbursement which shall be a cost settlement at ninety-five (95) percent of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified above.

(4) The final cost settlement shall reflect any cost report adjustments made by CMS.

M. Payment Adjustment for Provider Preventable Conditions

Effective June 1, 2012, and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFR2 434, 438 and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Never Events (NE), Other Provider Preventable Conditions (OPPCs) and Additional Other Provider Preventable Conditions (AOPPC).

Payments for Health Care Acquired Conditions (HCACs) shall be adjusted in the following manner:

For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC.

For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number of days associated with the diagnoses not present on admission for any HCAC. The number of reduced days shall be based on the average length of stay (ALOS) on the diagnosis tables published by the ICD vendor used by the Medicaid agency. For example, an inpatient claims with 45 covered days identified with an HCAC diagnosis having an ALOS of 3.4, shall be reduced to 42 covered days.

2. Acute Care Hospital Services

Also, consistent with the requirement of 42 CFR 447.26(c):

(c)(2) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(c)(3) Reductions in provider payment may be limited to the extent that the following apply:

i. The identified provider preventable conditions would otherwise result in an increase in payment.

ii. The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.

(c)(5) Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

Health Care-Acquired Conditions

The state identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A:

☒ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-A

☒ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

N. Preadmission Services for an Inpatient Acute Care Service.

A preadmission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:

1) Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and
2) 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.

2. Acute Care Hospital Services

O. Reimbursement for Sole Community Hospitals.

An operating rate for sole community hospitals shall be calculated as described below:

1) a. For each sole community hospital, the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
   b. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables, located at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.
   c. Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with Item "R." below.
2) a. The department shall compare the rate referenced in paragraph 1) above with the operating rate calculated in Item "E(3)" above.
   b. The higher of the two rates compared in "2) a." above shall be utilized as the operating rate for sole community hospitals.

P. Reimbursement for Medicare Dependent Hospitals.

1) a. For a Medicare-dependent hospital, the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
   b. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
   c. Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with the reimbursement updating procedures in Item "R." below.
2) a. The department shall compare the Medicare-dependent hospital rate referenced in paragraph 1) above with the operating rate calculated in Item "E(3)" above.
   b. If the Item "E(3)" operating rate is higher, it shall be utilized as the hospital's operating rate for the period.
3) a. If the rate referenced in paragraph (1) is higher, the department shall calculate the arithmetic difference between the two (2) rates.
   b. The difference shall be multiplied by seventy-five (75) percent.
   c. The resulting product shall be added to the Item "E(3)" operating rate to determine the hospital's operating rate for the period.
4) If CMS terminates the Medicare-dependent hospital program, a hospital that is a Medicare-dependent hospital at the time that CMS terminates the program shall receive operating rates as calculated in Item "E(3)" above.

Q. Direct Graduate Medical Education Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs.

1) The department shall reimburse for the direct costs of a graduate medical education program approved by Medicare as established below.
   a. A payment shall be made:
      (1) Separately from the per discharge and per diem payment methodologies; and
      (2) On an annual basis corresponding to the hospital's fiscal year.

2. Acute Care Hospital Services

b. The department shall determine an annual payment amount for a hospital:
(1) Total direct graduate medical education costs shall be obtained from a facility's as-filed CMS 2552 cost report, worksheet E-4, line 25.
(2) (a) The facility's Medicaid utilization shall be calculated by dividing Medicaid fee-for-service covered days during the cost report period, as reported by the Medicaid Management Information System, by total inpatient hospital days, as reported on worksheet E-4, line 27 of the CMS 2552 cost report.
(b) The resulting Medicaid utilization factor shall be rounded to six (6) decimals.
(3) The total graduate medical education costs shall by multiplied by the Medicaid utilization factor to determine the total graduate medical education costs related to the fee-for-service Medicaid program.
(4) Medicaid program graduate medical education costs shall then be multiplied by ninety-five (95) percent to determine the annual payment amount.

R. Reimbursement Updating Procedures.

1) a. The department shall annually update the Medicare grouper software to the most current version used by the Medicare program. The annual update shall be effective October 1 of each year, except as provided below.
b. If Medicare does not release a new grouper version effective October 1 of a given year
(1) The current grouper effective prior to October 1 shall remain in effect until a new grouper is released; and
(2) When the new grouper is released by Medicare, the department shall update the Medicare grouper software to the most current version used by the Medicare program.
c. The department shall not update the Medicare grouper software more than once per federal fiscal year which shall be October 1 through September 30 of the following year.

2) At the time of the grouper update, all DRG relative weights and geometric length-of-stay values shall be updated to match the most recent relative weights and geometric length-of-stay values effective for the Medicare program.

3) a. Annually, on October 1, all values obtained from the Medicare IPPS Final Rule Data Files and Tables shall be updated to reflect the most current Medicare IPPS final rule in effect. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
b. (1) Within thirty (30) days after the Centers for Medicare and Medicaid Services publishes the Medicare IPPS Final Rule Data Files and Tables for a given year, the department shall send a notice to each hospital containing the hospital's data from the Medicare IPPS Final Rule Data Files and Tables to be used by the department to establish diagnosis related group rates on October 1.

2. Acute Care Hospital Services

(2) The notice referenced above shall request that the hospital:
(a) Review the information; and
(b) If the hospital discovers that the data in the notice sent by the department does not match the data published by the Centers for Medicare and Medicaid Services, notify the department of the discrepancy prior to October 1.

4) All Medicare IPPS final rule values utilized shall be updated to reflect any correction notices issued by CMS, if applicable.

5) Other than an adjustment resulting from an appeals decision requiring an amendment, the department shall make no other adjustment.

S. Readmissions.

1) An unplanned inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.

2) Reimbursement for an unplanned readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.

T. Reimbursement for Out-of-State Hospitals.

1) The department shall reimburse an acute care out-of-state hospital for inpatient care on a fully prospective per discharge basis except for the following hospitals:
a. 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; and
b. Vanderbilt Medical Center.

2) For eligible inpatient acute care service in an out-of-state acute care hospital the total hospital-specific per discharge payment shall be calculated in the same manner as an in-state hospital with modifications to rates used as described below.

3) The DRG payment parameters listed below shall be modified for out-of-state hospitals not specifically excluded in paragraph 1).
a. The operating rate used in the calculation of the operating base payment described in Item "E(3)(a)" shall equal the average of all in-state acute care hospital operating rates calculated in accordance with Item "E(3)" multiplied by eighty (80) percent, excluding any adjustments made for:
(1) Sole community hospitals; or
(2) Medicare-dependent hospitals.
b. The capital rate used in the calculation of the capital base payment described in Item "E(4)(a)" shall equal the average of all in-state acute care hospital capital rates calculated in accordance with Item "E(4)" multiplied by eighty (80) percent.
c. The DRG relative weights used in the calculation of the operating base payment described in Item "E(3)(a)" and the calculation of the capital base payment described in Item "E(4)(a)" shall be reduced by twenty (20) percent.

2. Acute Care Hospital Services

d. The following provisions shall not be applied:
(1) Medicare indirect medical education cost or reimbursement;
(2) Organ acquisition cost settlements;
(3) Disproportionate share hospital distributions; and
(4) Any adjustment mandated for in-state hospitals pursuant to KRS 205.638.

e. The Medicare operating and capital cost-to-charge ratios used to estimate the cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, shall be determined by calculating the arithmetic mean of all in-state cost-to-charge ratios established in accordance with Item "F(4)" above.

4) 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, and except for Vanderbilt Medical Center, the average operating rate and average capital rate paid to in-state children's hospitals.

5) The department shall reimburse for inpatient care provided by Vanderbilt Medical Center using the hospital-specific Medicare base rate extracted from the CMS IPPS Pricer Program in effect at the time that the care was provided multiplied by eighty-five (85) percent.

6) The out-of-state hospitals referenced in paragraphs 4) and 5) shall not be eligible to receive indirect medical education reimbursement, organ acquisition cost settlements, or disproportionate share hospital payments.

7) a. The department shall reimburse a hospital referenced in subsection 4) or 5) of this section a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG.
b. A cost outlier shall be subject to quality improvement organization review and approval.
c. The department shall determine the cost outlier threshold for an out-of-state claim regarding a hospital using the same method used to determine the cost outlier threshold for an in-state claim as described in Item F above.

U. Certified Public Expenditures.
1) a. The department shall reimburse an in-state public government-owned or operated hospital the full cost of a Medicaid fee-for-service inpatient service provided during a given state fiscal year via a certified public expenditure (CPE).
b. A payment shall be limited to the federal match portion of the hospital's uncompensated care cost for inpatient Medicaid fee-for-service recipients.
2) To determine the amount of costs eligible for a CPE, a hospital's allowed days shall be multiplied by routine cost per diems found on worksheet D-1 Part II, lines 38 and 42-47 of the CMS 2552-10 cost report. Allowed ancillary charges shall be multiplied by cost-center specific cost-to-charge ratios from the hospital's 2552-10 cost report found on worksheet C part I, column 9.
3) The department shall verify whether or not a given CPE is allowable as a Medicaid cost.

2. Acute Care Hospital Services

4) a. An interim CPE reconciliation settlement shall be processed upon receipt of a facility's as-filed 2552-10 cost report.
b. Subsequent to a final cost report being submitted to the department, a final CPE settlement shall be reconciled with the actual costs reported to determine the final CPE for the period.
c. If any difference between actual cost and submitted costs remains, the department shall reconcile any difference with the provider.

V. Intensity Operating Allowance Inpatient Supplement Payments.

1) 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.
2) The detailed formula to determine the supplemental payments is described in Exhibit B incorporated as part of this attachment.
3) The prospective supplemental payments will be reconciled annually to the final cost report filed for the rate year or prospective payment period.
4) Any payments made under 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.
5) Payments made under this section shall be prospectively determined quarterly amounts, subject to a year-end reconciliation.
6) In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by CMS, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.

7) 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:
a. Calculated by determining the difference between Medicaid costs as stated on the audited Medicare 2552-10 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,
b. 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.)

W. Supplemental Payments for DRG Psychiatric Access Hospitals

1) 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:

2. Acute Care Hospital Services

a. The hospital is not located in a Metropolitan Statistical Area (MSA);
b. 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;
c. 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
d. The hospital provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.

2) 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 according with the following:

$$\frac{\text{Medicaid patient days}}{\text{Total Medicaid patient days}} \times \text{Fund} = \text{Payment}$$

3) 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.

X. 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.

Y. Supplemental DRG Payments

1) 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.

2) 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.

a. For the purpose of this attachment, Medicaid patient days shall not include enrollee days which means a day of an inpatient hospital stay of a Medicaid recipient who is enrolled with a managed care organization.
b. A payment made under the Supplemental DRG payments shall not duplicate a payment made via Disproportionate share hospital distributions.

2. Acute Care Hospital Services

Z. Per Diem Methodology: Payment for Rehabilitation or Psychiatric or Substance Abuse Care in an In-State Acute Care Hospital.

1) Distinct Part Unit (DPU)

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. Routine costs for the distinct part unit will be determined by multiplying allowed days by worksheet D-1 Part I, Title XIX - Subprovider, line 38. Ancillary costs will be determined by multiplying allowed charges by the cost center specific cost-to-charge ratio found on worksheet C part I, column 9 of the 2552-10 cost report.

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 inflation in accordance with Section (5)(A)(1) of this attachment.

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.

2) Non Distinct Part Unit (Non-DPU)

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

b. 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 or Substance Abuse 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 including both psychiatric or substance abuse care where applicable.

B. The department shall calculate a per diem rate by:

1) For rates effective July 1, 2015 through June 30, 2019, using a hospital's fiscal year 2014 Medicare cost report, allowable cost and paid days to calculate a base cost per day for the hospital. Routine costs will be determined by multiplying allowed days by worksheet D-1 Part I, Title XIX, line 38. Ancillary costs will be determined by multiplying allowed charges by the cost center specific cost-to-charge ratio found on worksheet C part I, column 9 of the 2552-10 cost report. Rates will be re-based every four years with adjustments for inflation in non-rebase years, in accordance with section 5 of this attachment. For future rebasing periods beginning July 1, 2019, using the most recently received hospital fiscal year Medicare cost report at the time of rate-setting;

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;

3. Payment for Long-term Acute Care Hospital Care, In-State Freestanding Psychiatric or Substance Abuse Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.

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) Applying available provider tax funds on a pro-rata basis to the pre-provider tax per diem calculated in paragraphs 1 through 5 of this subsection.

C. 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.

D. 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.

E. 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 is submitted by the hospital.

2) Upon submission 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.

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.

1) A critical access hospital shall comply with the cost reporting requirements established in the In-State Hospital Cost Reporting Requirements section.
2) 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 including psychiatric or substance abuse care, where applicable.

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 IHS 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 psychiatric, rehabilitation, and long-term acute care 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 including psychiatric or substance abuse care, where applicable.

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) 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.

2) 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.

3) 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 or critical access operating per diem rate shall equal the median operating rate, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding hospitals of the same type. The psychiatric operating per diem rate shall equal seventy (70) percent of the median operating rate, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding psychiatric hospitals.

2) The long term acute care or critical access capital per diem rate shall be the median capital per diem rate for all in-state freestanding hospitals of the same type. The psychiatric capital per diem rate shall equal seventy (70) percent of the median capital rate, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding psychiatric hospitals.

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 most recently received 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, excluding university teaching hospitals;
3) Be a prospective amount. For example, a DSH distribution made to a hospital in October 2007 shall be applied to the reimbursement for 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, up to 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 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
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) For the Federal Fiscal Year ending September 30, 2015 and September 30, 2016 by multiplying the final SFY 2013-2014 indigent share factor by the total fund allocated to the acute care pool.
2) For the period beginning October 1, 2016 and subsequent state fiscal years, by:
   a. Determining a hospital's average reimbursement per discharge;
   b. Dividing the hospital's average reimbursement per discharge by Medicaid days per discharge;

8. Disproportionate Share Hospital Provisions

c. Payment for Long-term Acute Care Hospital Care, In-State Freestanding Psychiatric or Substance Abuse Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.

d. 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 for purposes of this section;

e. Determining an in-state hospital's outpatient indigent care cost for purposes of this section by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with 803 KAR 25:091 (Published 10/25/2011);

f. 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

g. 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 to establish a DSH distribution on a pro rata basis:

(1) Annual distribution to acute care hospitals shall be calculated for the period ending September 30, 2015 and ending September 30, 2016, by multiplying the final SFY 2013-2014 indigent care factor by the total fund allocated to the acute care pool.

(2) Annual distribution to acute care hospitals shall be calculated for the period beginning October 1, 2016 and subsequent state fiscal years, by multiplying the annual indigent care factor for each hospital by the total fund allocated to the acute care 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:

For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:

1) 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

2) 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 by the Department of Labor in accordance with 803 KAR 25:091;

3) 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

4) 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.

8. Disproportionate Share Hospital Provisions

E. Disproportionate Share Hospital Distribution to a Private Psychiatric Hospital. The department shall determine a DSH distribution to a private psychiatric hospital:

For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:

1) 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
2) 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 by the Department of Labor in accordance with 803 KAR 25:091 (published 10/25/11) or by establishing an inpatient equivalency;
3) 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
4) 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 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.

8. Disproportionate Share Hospital Provisions

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 lessor 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.

8. Disproportionate Share Hospital Provisions

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.

8. Disproportionate Share Hospital Provisions

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) The final hospital-specific DSH limit will be determined retrospectively through the annual DSH examination. For a given state fiscal year DSH examination, in the event DSH payments are found to exceed the limits described in subsection 1 above, funds may be redistributed in accordance with state plan, Attachment 4.19.A, Section (1)(O).

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:

Level I PRTF

To be reimbursable under the Medicaid Program, Level I PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level I PRTF services in accordance with Attachment 3.1-A, Section 16 – Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

1 The department shall reimburse for Level I PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of $280.09; or the usual and customary charge

2 The per diem rate shall be increased each biennium by 2.22 percent.

3 The per diem or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:

(a) Including all care and treatment costs;

(b) Including costs for all ancillary services;

(c) Including capital costs;

(d) Including room and board costs; and

(e) Excluding the costs of drugs as drugs shall be covered and reimbursed under Kentucky's pharmacy program in accordance 907 KAR 1:018 (published 3/2/2012).

Level II PRTF

To be reimbursable under the Medicaid program, Level II PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level II PRTF services in accordance with Attachment 3.1-A, Section 16 – Inpatient Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

1 The department shall reimburse a per diem rate as follows for Level II PRTF services and costs for a recipient not enrolled in a managed care organization:

(a) $345 for Level II PRTF services to a recipient who meets the rate group one (1) criteria described below;

(b) $365 for Level II PRTF services to a recipient who meets the rate group two (2) criteria described below;

(c) $385 for Level II PRTF services to a recipient who meets the rate group three (3) criteria described below; or

(d) $405 for Level II PRTF services to a recipient who meets the rate group four (4) criteria described below.

2 Rate Groups

(a) Rate group one (1) criteria shall be for a recipient who:
1. Is twelve (12) years of age or younger;
2. Is male or female; and
3. Is sexually reactive; or
(i) Has a severe and persistent aggressive behavior;
(ii) Does not have an intellectual or a developmental disability; and
(iii) Has an intelligence quotient higher than seventy (70).

(b) Rate group two (2) criteria shall be for a recipient who:
1. Is twelve (12) years of age or younger;
2. Is male or female; and
3. Is sexually reactive; and
(i) Has a severe and persistent aggressive behavior;
(ii) Does not have an intellectual or a developmental disability; and
(iii) Has an intelligence quotient higher than seventy (70).

(c) Rate group three (3) criteria shall be for a recipient who:
1. Is thirteen (13) years of age or older;
2. Is male or female; and
3. Is sexually reactive; or
(i) Has a severe and persistent aggressive behavior;
(ii) Does not have an intellectual or a developmental disability; and
(iii) Has an intelligence quotient higher than seventy (70).

(d) Rate group four (4) criteria shall be for a recipient who:
1. Is thirteen (13) years of age or older;
2. Is male or female; and
3. Is sexually reactive; and
(i) Has a severe and persistent aggressive behavior;
(ii) Does not have an intellectual or a developmental disability; and
(iii) Has an intelligence quotient higher than seventy (70).

(e) Rate group four (4) criteria also includes the following for a recipient who:
1. Is under twenty-two (22) years of age;
2. Is male or female; and
3. Is sexually reactive; or
(i) Has a severe and persistent aggressive behavior;
(ii) Has an intellectual or a developmental disability; and
(iii) Has an intelligence quotient lower than seventy (70).

C. The per diem rates referenced above, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:
(a) Including all care and treatment costs;
(b) Including costs for all ancillary services;
(c) Including capital costs;
(d) Including room and board costs; and
(e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program

D. The department shall annually evaluate each per diem rate for Level II PRTF services and costs by reviewing the most recent, reliable claims data and cost report data to analyze treatment patterns, technology, and other factors that may alter the cost of efficiently providing Level II PRTF services.

E The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.

F. (1) The department's reimbursement for a bed reserve day which qualifies as a bed reserve day for a recipient not enrolled in a managed care organization shall be:

(a) Seventy-five (75) percent of the rate established if the Level I or II PRTF's occupancy percent is at least eighty-five (85) percent; or

(b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is less than eighty-five (85) percent.

(c) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:

i. Is in Medicaid payment status in a Level I or II PRTF;

ii. Has been in the Level I or II PRTF overnight for at least one (1) night;

iii. Is reasonably expected to return requiring Level I or II PRTF care; and

iv. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital

(2) The department's reimbursement for a therapeutic pass day which qualifies as a therapeutic pass day for a recipient not enrolled in a managed care organization shall be:

(a) 100 percent of the rate established if the Level I or II PRTF's occupancy percent is at least fifty (50) percent; or

(b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is below fifty (50) percent.

(c) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:

i. Is in Medicaid payment status in a Level I or II PRTF;

ii. Has been in the Level I or II PRTF overnight for at least one (1) night;

iii. Is reasonably expected to return requiring Level I or II PRTF care; and

iv. Has not exceeded the therapeutic pass day limit established; or

v. Received an exception to the limit.

vi. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.

vii. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

(3) (a) A Level I or II PRTF's occupancy percent shall be based on a midnight census.

(b) An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.

(c) An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.

(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:

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"), and freestanding psychiatric, rehabilitation, and long-term acute care hospitals*: Estimated costs using the Medicare TEFRA approach (same approach as the outpatient analysis)

- *State-owned or operated university teaching 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.

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
• 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	"Final Rule" Federal Register
• Wage indices • Geographic Adjustment Factors ("GAF") • Operating IME Adjustment Factors • Capital IME Adjustment Factors • Other Hospital ("HSP") Factors • Medicare Hospital Aggregate Operating and Capital CCRs	CMS IPPS Final Rule Data Files and Tables
• Quarterly Price Index Levels	CMS PPS Hospital Input Price Index Levels, published by GLOBAL INSIGHT

Kentucky Department for Medicaid Services
Upper Payment Limit Methodology

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.

b) Indirect Medical Education ("IME") Factors: operating and capital IME factors were obtained from the Medicare IPPS Final Rule public use file. .

c) Disproportionate Share Hospital ("DSH") Payment per Discharge Factors: DSH factors were determined for each hospital using Medicare DSH payments amounts and discharge information reported on the Medicare cost report.

d) Hospital-Specific ("HSP") Factor: Operating HSP factors were extracted from the IPPS Final Rule public use file for qualifying Sole Community Hospitals and Medicare Dependent Hospitals.

3) Development of Inpatient Paid Claims Database: Payments under the annual FFY 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:

(Length of stay +1)/(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 +[((Length of stay +1)*0.5)/(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: 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 Medicare IPPS fixed loss amount and the full DRG payment, including IME and DSH payments. For transfer claims, the outlier threshold was multiplied by the transfer adjustment.

If a claim qualified for an outlier payment, outlier payments were calculated as follows:

i. Outlier payment:

[(Claim Cost) - (Outlier Threshold)]*(Marginal Cost Factor)

ii. 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

Kentucky Department for Medicaid Services
Upper Payment Limit Methodology

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 using Medicare GME payments and discharge information reported on the Medicare cost report. Medicare GME payments were divided by reported discharges to determine a per discharge GME cost. b) The Medicaid portion of the direct GME costs was estimated by multiplying Medicaid days times the GME payment per discharge determined in paragraph a.

5) Other Medicare IPPS Payments: Additional Medicare payments were added to the UPL demonstration for various payment programs from E part A of the cost report, including:

- High Percentage ESRD Beneficiary Discharges (Acuity Adjusted)
- New Technology Add-ons (Acuity Adjusted)
- Credits Received from Manufacturers for Replacement Devices (Acuity Adjusted)
- Organ Acquisition Costs
- Cost of Teaching Physicians
- Routine Service Pass-Throughs
- Ancillary Services Pass-Throughs

Acuity adjusted payments were divided by the ratio of Medicaid case mix index (CMI) to Medicare CMI to account for differences in patient acuity between the two demographics. Payments were then divided by total discharges reported on the Medicare cost report and multiplied by Medicaid discharges to estimate the Medicaid portion of the costs.

B. Psychiatric and Rehabilitation DPUs, Freestanding Psychiatric, Rehabilitation, and Long-term Acute Care Hospitals

Kentucky Medicaid reimburses all claims from psychiatric and rehabilitation DPUs and freestanding psychiatric, rehabilitation, and long-term acute care hospitals 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 and freestanding hospital claims.

Inpatient services include both routine and ancillary costs. Routine costs were estimated by applying cost per diems from the appropriate subprovider line on D-1 part II of the Medicare cost report to Medicaid patient days reported by the MMIS, while ancillary costs were estimated by applying cost-to-charge ratios from C part I, column 9 of the Medicare cost report to Medicaid claim ancillary charges reported by the MMIS. MMIS charges were allocated to Medicare cost centers utilizing hospital-specific groupings on subprovider worksheet D-3, Title XIX of the Medicare cost report.

Kentucky Department for Medicaid Services
Upper Payment Limit Methodology

1) Inflation Factors: After routine and ancillary costs were calculated for each hospital DPU, inflation factors were developed to inflate costs 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

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 all applicable Medicaid payment fields for each hospital.

B. Other Supplemental Inpatient Medicaid Payments:

   1) Direct GME Payments: Based on Medicaid direct graduate medical education payments.

   2) Intensity Operating Allowance ("IOA") Payments: Based on Medicaid IOA payments to teaching hospitals.

   3) Level II Neonatal Payment: Based on Medicaid Level II Neonatal payments to Central Baptist (if applicable)

   4) All other payments that may be made determined on a year by year basis.

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.

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 (MCR Wksht E part A Line 1)		
b.	IME Adjustment (MCR Wksht E Part A Line 29)		
c.	DSH Adjustment (MCR Wksht E Part A Line 34)		
d.	Capital Adjustment (MCR Wksht. E Part A Lines 50 and 51)		
e.	Credits received from manufacturers for replaced devices (Wksht E Part A Line 68)	$	
f.	Total Medicare Payments Subject to Case Mix Index (total lines 1a through 1d, less line 1e)		
2.	Adjustment for Case Mix Index		
a.	Medicare Case Mix Index-From Medicare annual PS&R Reports		
b.	Case Mix Adjusted Total Payments (ln 1f/ln 2a)		#DIV/o!
3.	Medicare Payments for (Fiscal Year End) not subject to case mix index		
a.	Outlier Adjustment (MCR Wksht E Part A Line 2.)		
b.	GME adjustment (MCR Wksht E Part A Line 52) – 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 Lines 54 and 55)	$	
e.	Routine service pass-thru (Wksht E Part A Line 57)		
f.	Other ancillary other pass-thru (Wksht E Part A Lines 53 and 58 and E Part B Ln 9)Total Medicare		
g.	Payments Not Subject to Case Mix Index (total lines 3a through 3f)	$	
4.	Total Medicare Payment		#DIV/0!
5.	Medicare Discharges (MCR Wksht. S-3 Part 1 Line 12)-Reconciled to Medicare annual PS&R Reports		

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 (In 6a/In7a)	*DIV/0!
8.	Medicaid Payments not subject to case mix index-Reconciled to the annual Medicaid paid claims listing.	

	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 (IN 7b + In 8e)		#DIV/0!
10.	Calculate Per Case Payment		
	a. Medicaid Discharges-Reconciled to the Medicaid MMIS.		
	b. Per case Medicaid rate with case mix removed (In 9/In 10a)		#DIV/0!
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/Ln10a)		#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 U PL 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.	Less of Charge Gap (Ln 16) or UPL Gap (Ln 13.3)		#DIV/0!
Step 6: Calculate Federal Payment Available			
18.	Federal Matching Percentage	$	
19.	Federal Incremental Payment (Ln 17 x Ln 18)		#DIV/0!
20.	State Match (Line 17 – Ln 19)		#DIV/0!
NOTE:			

1. This worksheet shall include all Medicare & Medicaid payments EXCEPT Medicaid DSH
2. All MCR reference are to the CMS 2552-10 cost report forms. In the event the cost report 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

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 Grouper (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 0-4 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 0-4 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 111 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.