

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Hospital and Provider Operations

4 (Amended after Comments)

5 907 KAR 1:815. Non-Diagnostic Related Group Inpatient Hospital Reimbursement.

6 RELATES TO: KRS 13B.140, 205.510(16), 205.637, 205.639, 205.640, 205.641,

7 216.380, 42 C.F.R. Parts 412, 413, 440.10, 440.140, 447.250-447.280, 42 U.S.C.

8 1395f(l), tt, ww(d)(5)(F), x(mm), 1396a, 1396b, 1396d, 1396r-4

9 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(2),

10 205.637(3), 205.640(1), 205.641(2), 216.380(13), 42 C.F.R. 447.252, 447.253, 42

11 U.S.C. 1396a, 1396r-4

12 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family

13 Services, Department for Medicaid Services has responsibility to administer the Medi-

14 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to

15 comply with a requirement that may be imposed, or opportunity presented by federal

16 law for the provision of medical assistance to Kentucky's indigent citizenry. This admin-

17 istrative regulation establishes provisions related to non-DRG-reimbursed inpatient hos-

18 pital reimbursement including provisions necessary to enhance reimbursement pursuant

19 to KRS 142.303, 205.638 and 2006 Ky Acts ch. 252.

20 Section 1. Definitions. (1) "Base year" means the state fiscal year cost reporting pe

1 riod used to establish a per diem rate.

2 (2) "Capital costs" means capital related expenses including insurance, taxes, inter-
3 est, and depreciation related to plant and equipment.

4 (3) "CMS" means Centers for Medicare and Medicaid Services.

5 (4) "Critical access hospital" or "CAH" means a hospital meeting the licensure re-
6 quirements established in 906 KAR 1:110, Critical access hospital services.

7 (5) "Department" means the Department for Medicaid Services or its designee.

8 (6) "Diagnostic related group" or "DRG" means a clinically-similar grouping of ser-
9 vices that can be expected to consume similar amounts of hospital resources.

10 (7) "Distinct part unit" means a separate unit within an acute care hospital that meets
11 the qualifications established in 42 C.F.R. 412.25.

12 (8) "DRG service" means a discharge, excluding crossover claims or no pay claims,
13 assigned a discharge classification by the diagnostic related group grouper used by the
14 department, pursuant to 907 KAR 1:013, Diagnostic and related group (DRG) inpatient
15 hospital reimbursement, whether the discharge is reimbursed by discharge or via a per
16 diem basis.

17 (9) "GII" means Global Insight, Incorporated.

18 (10) "Indexing factor" means the percentage that the cost of providing a service is
19 expected to increase during the universal rate year.

20 (11) "Inflation factor" means the percentage that the cost of providing a service has
21 increased, or is expected to increase, for a specific period of time.

22 (12) "Long-term acute care hospital" or "LTAC" means a hospital that meets the re-
23 quirements established in 42 C.F.R. 412.23(e).

1 (13) "Medical education cost" means a direct cost that is:

2 (a) Associated with an approved intern and resident program; and

3 (b) Subject to limits established by Medicare.

4 (14) "Operating cost" means allowable routine, ancillary service or special care unit
5 cost related to inpatient hospital care.

6 (15) "Parity factor" means a factor applied to a per diem rate to establish cost cover-
7 age parity with diagnostic related group hospital reimbursement.

8 (16) "Per diem rate" means a hospital's all-inclusive daily rate as calculated by the
9 department.

10 (17) "Psychiatric hospital" means a hospital meeting the licensure requirements es-
11 tablished in 902 KAR 20:180, Psychiatric hospitals; operation and services.

12 (18) "Rehabilitation hospital" means a hospital meeting the licensure requirements
13 established in 902 KAR 20:240, Comprehensive physical rehabilitation hospital ser-
14 vices.

15 (19) "State-designated free-standing rehabilitation teaching hospital that is not state-
16 owned or operated" means a hospital not state-owned or operated which:

17 (a) Provides at least 3,000 days of rehabilitation care to Medicaid eligible recipients in
18 a fiscal year;

19 (b) Provides at least fifty-one (51) percent of the statewide total of inpatient acute
20 rehabilitation care to Medicaid eligible recipients;

21 (c) Provides physical and occupational therapy services to Medicaid recipients
22 needing inpatient rehabilitation services in order to function independently outside of an
23 institution post-discharge;

1 (d) Is licensed as an acute hospital limited to rehabilitation; and

2 (e) Is a teaching hospital.

3 (20) "Swing bed" means a bed approved pursuant to 42 USC 1395tt to be used to
4 provide either acute care or extended skilled nursing care to a recipient.

5 (21) "Third party payor" means a payor of a third party pursuant to KRS 205.510(16).

6 (22) "Trending factor" means the inflation factor as applied to that period of time be-
7 tween a facility's base fiscal year end and the beginning of the universal rate year.

8 (23) "Universal rate year" means the twelve (12) month period under the prospective
9 payment system, beginning July of each year, for which a payment rate is established
10 for a hospital regardless of the hospital's fiscal year end.

11 (24) "Weighted average" means an average that reflects an individual element's pro-
12 portionality to all elements.

13 Section 2. Payment for Rehabilitation or Psychiatric Care in an In-State Acute Care
14 Hospital.

15 (1) For rehabilitation care in an in-state acute care hospital that has a Medicare-
16 designated rehabilitation distinct part unit, the department shall reimburse:

17 (a) A facility specific per diem based on the most recently received Medicare cost re-
18 port received prior to the rate year, trended and indexed to the current state fiscal year;
19 and

20 (b) In accordance with Sections 6 and 9 of this administrative regulation.

21 (2) The department shall reimburse for psychiatric care in an in-state acute care hos-
22 pital that has a Medicare-designated psychiatric distinct part unit on a per diem basis as
23 follows:

1 (a) Reimbursement for an inpatient psychiatric service shall be determined by multi-
2 plying a hospital's psychiatric per diem rate by the number of allowed patient days.

3 (b) A psychiatric per diem rate shall be the sum of a psychiatric operating per diem
4 rate and a psychiatric capital per diem rate.

5 1. The psychiatric operating cost-per-day amounts used to determine the psychiatric
6 operating per diem rate shall be calculated for each hospital by dividing its Medicaid
7 psychiatric cost basis, excluding capital costs and medical education costs, by the num-
8 ber of Medicaid psychiatric patient days in the base year.

9 2. The Medicaid psychiatric cost basis and patient days shall be based on Medicaid
10 claims for patients with a psychiatric diagnosis with dates of service in the base year.

11 The psychiatric operating per diem rate shall be adjusted for:

12 a. The price level increase from the midpoint of the base year to the midpoint of the
13 universal rate year using the CMS Input Price Index; and

14 b. The change in the Medicare published wage index from the base year to the uni-
15 versal rate year.

16 (c)1. A psychiatric capital per diem rate shall be facility-specific and shall be calcu-
17 lated for each hospital by dividing its Medicaid psychiatric capital cost basis by the
18 number of Medicaid psychiatric patient days in the base year.

19 2. The Medicaid psychiatric capital cost basis and patient days shall be based on
20 Medicaid claims for patients with psychiatric diagnoses with dates of service in the base
21 year.

22 3. The psychiatric capital per diem rate shall not be adjusted for inflation.

23 (3) The department shall reimburse for rehabilitation or psychiatric care provided in

1 an in-state hospital that does not have a Medicare-designated distinct part unit:

2 (a)1. On a facility specific per diem basis equivalent to its aggregate projected pay-
3 ments for DRG services divided by its aggregate projected Medicaid paid days.

4 2. Aggregate projected payments and projected Medicaid paid days shall be the sum
5 of:

6 a. Aggregate projected payments and aggregate projected Medicaid paid days for
7 non-per diem DRG services as calculated by the model established in 907 KAR 1:013,
8 Diagnostic related group (DRG) inpatient hospital reimbursement;

9 b. Actual prior year payments inflated by the GII; and

10 c. Per diem DRG service Medicaid days; and

11 (b) In accordance with Sections 6 and 9 of this administrative regulation.

12 Section 3. Payment for Long-term Acute Care Hospital Care, In-State Freestanding
13 Psychiatric Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.

14 (1) The department shall reimburse for inpatient care provided to eligible Medicaid
15 recipients in an in-state freestanding psychiatric hospital, in-state freestanding rehabili-
16 tation hospital, or LTAC hospital on a per diem basis.

17 (2) The department shall calculate a per diem rate by:

18 (a) Using a hospital's state fiscal year 2005 cost report, allowable cost and paid days
19 to calculate a base cost per day for the hospital;

20 (b) Trending and indexing a hospital's specific cost, excluding capital cost, per day to
21 the current state fiscal year;

22 (c) Calculating an average base cost per day for hospitals within similar categories,
23 for example rehabilitation hospitals, using the indexed and trended base cost per day;

1 (d) Assigning no hospital a base cost per day equaling less than ninety-five (95) per-
2 cent of the weighted average trended and indexed base cost per day of hospitals within
3 the corresponding category;

4 (e) Applying a parity factor equivalent to aggregate cost coverage established by the
5 DRG reimbursement methodology described in 907 KAR 1:013, Diagnostic related
6 group hospital reimbursement; and

7 (f) Applying available provider tax funds on a pro-rata basis to the pre-provider tax
8 per diem calculated in paragraphs (a) through (e) of this subsection.

9 Section 4. Payment to a Newly-participating In-State Freestanding Psychiatric Hospi-
10 tal, Freestanding Rehabilitation Hospital or a Long Term Acute Care Hospital. (1) The
11 department shall reimburse a newly-participating in-state freestanding psychiatric hospi-
12 tal, freestanding rehabilitation hospital or long term acute care hospital the minimum per
13 diem rate paid to hospitals in their category until the first fiscal year cost report submit-
14 ted by the hospital has been finalized.

15 (2) Upon finalization of the first fiscal year cost report for a facility, the department
16 shall reimburse the facility a per diem rate in accordance with Section 3 of this adminis-
17 trative regulation.

18 Section 5. Payment for Critical Access Hospital Care. (1) The department shall pay a
19 per diem rate to a critical access hospital equal to the hospital's Medicare rate.

20 (2) A critical access hospital's final reimbursement for a fiscal year shall reflect any
21 adjustment made by CMS.

22 (3)(a) A critical access hospital shall comply with the cost reporting requirements es-
23 tablished in Section 10 of this administrative regulation.

1 (b) A cost report submitted by a critical access hospital to the department shall be
2 subject to audit and review.

3 (4) An out-of-state critical access hospital shall be reimbursed under the same meth-
4 odology as an in-state critical access hospital.

5 (5) The department shall reimburse for care in a federally defined swing bed in a criti-
6 cal access hospital pursuant to 907 KAR 1:065, Payments for price-based nursing facil-
7 ity services.

8 Section 6. Reimbursement Limit. Total reimbursement to a hospital, other than to a
9 critical access hospital, shall be subject to the limitation established in 42 C.F.R.
10 447.271.

11 Section 7. In-State Hospital Reimbursement Updating Procedures. (1) The depart-
12 ment shall adjust an in-state hospital's per diem rate annually according to the following:

13 (a) An operating and professional component per diem rate shall be inflated from the
14 midpoint of the previous universal rate year to the midpoint of the current universal rate
15 year using the GII; and

16 (b) A capital per diem rate shall not be adjusted for inflation.

17 (2) The department shall, except for a critical access hospital, rebase an in-state
18 hospital's per diem rate every four (4) years.

19 (3) Except for an adjustment resulting from an appeal in accordance with Section 21,
20 the department shall make no other adjustment.

21 Section 8. Use of a Universal Rate Year. (1) A universal rate year shall be estab-
22 lished as July 1 through June 30 to coincide with the state fiscal year.

23 (2) A hospital shall not be required to change its fiscal year to conform to a universal

1 rate year.

2 Section 9. Cost Basis. (1) An allowable Medicaid cost shall:

3 (a) Be a cost allowed after a Medicaid or Medicare audit;

4 (b) Be in accordance with 42 C.F.R. Parts 412 and 413;

5 (c) Include an in-state hospital's provider tax; and

6 (d) Not include a cost listed in Section 11 of this administrative regulation.

7 (2) A prospective rate shall include both routine and ancillary costs.

8 (3) A prospective rate shall not be subject to retroactive adjustment, except for:

9 (a) A critical access hospital; or

10 (b) A facility with a rate based on un-audited data.

11 (4) An overpayment shall be recouped by the department as follows:

12 (a) A provider owing an overpayment shall submit the amount of the overpayment to
13 the department; or

14 (b) The department shall withhold the overpayment amount from a future Medicaid
15 payment due the provider.

16 Section 10. In-State Hospital Cost Reporting Requirements.

17 (1) An in-state hospital participating in the Medicaid program shall submit to the
18 department a copy of a Medicare cost report it submits to CMS, an electronic cost report
19 file (ECR), the Supplemental Medicaid Schedule KMAP-1 and the Supplemental
20 Medicaid Schedule KMAP-4 as follows:

21 (a) A cost report shall be submitted:

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

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

1 (b) Except as follows, the department shall not grant a cost report submittal
2 extension:

3 1. If an extension has been granted by Medicare, the cost report shall be submitted
4 simultaneously with the submittal of the Medicare cost report; or

5 2. If a catastrophic circumstance exists, for example flood, fire, or other equivalent
6 occurrence, the department shall grant a thirty (30) day extension.

7 (2) If a cost report submittal date lapses and no extension has been granted, the
8 department shall immediately suspend all payment to the hospital until a complete cost
9 report is received.

10 (3) A cost report submitted by a hospital to the department shall be subject to audit
11 and review.

12 (4) An in-state hospital shall submit a final Medicare-audited cost report upon
13 completion by the Medicare intermediary to the department.

14 Section 11. Unallowable Costs.

15 (1) The following shall not be allowable cost for Medicaid reimbursement:

16 (a) A cost associated with a political contribution;

17 (b)1. A cost associated with a legal fee for an unsuccessful lawsuit against the
18 Cabinet for Health and Family Services.

19 2. A legal fee relating to a lawsuit against the Cabinet for Health and Family Services
20 shall only be included as a reimbursable cost in the period in which the suit is settled
21 after a final decision has been made that the lawsuit is successful or if otherwise agreed
22 to by the parties involved or ordered by the court; and

23 (c)1. A cost for travel and associated expenses outside the Commonwealth of

1 Kentucky for the purpose of a convention, meeting, assembly, conference, or a related
2 activity.

3 2. A cost for a training or educational purpose outside the Commonwealth of
4 Kentucky shall be allowable.

5 3. If a meeting is not solely educational, the cost, excluding transportation, shall be
6 allowable if an educational or training component is included.

7 (2) A hospital shall identify an unallowable cost on a Supplemental Medicaid
8 Schedule KMAP-1.

9 (3) A Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted to
10 the department with an annual cost report.

11 Section 12. Trending of an In-state Hospital's Cost Report Used for Rate Setting Pur-
12 poses.

13 (1) An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on
14 file in the department, either audited or un-audited, shall be trended to the beginning of
15 the universal rate year to update an in-state hospital's Medicaid cost.

16 (2) The trending factor, referenced in subsection (1) of this Section, to be used shall
17 be the inflation factor prepared by GII for the period being trended.

18 Section 13. In-State Hospital Indexing for Inflation. (1) After an allowable Medicaid
19 cost has been trended to the beginning of a universal rate year, an indexing factor shall
20 be applied to project inflationary cost in the universal rate year.

21 (2) The department shall apply the inflation factor prepared by GII for the universal
22 rate year as the indexing factor.

23 Section 14. In-State Hospital Minimum Occupancy Factor. (1) If an in-state hospital's

1 minimum occupancy is not met, allowable Medicaid capital costs shall be reduced by:

2 (a) Artificially increasing the occupancy factor to the minimum factor; and

3 (b) Calculating the capital costs using the calculated minimum occupancy factor.

4 (2) The following minimum occupancy factors shall apply:

5 (a) A sixty (60) percent minimum occupancy factor shall apply to a hospital with 100
6 or fewer total licensed beds;

7 (b) A seventy-five (75) percent minimum occupancy factor shall apply to a hospital
8 with 101 or more total licensed beds; and

9 (c) A newly-constructed in-state hospital shall be allowed one (1) full universal rate
10 year before a minimum occupancy factor shall be applied.

11 Section 15. Reduced Depreciation Allowance. The allowable amount for depreciation
12 on a hospital building and fixtures, excluding major movable equipment, shall be sixty-
13 five (65) percent of the reported depreciation amount as shown in the hospital's cost re-
14 ports.

15 Section 16. Reimbursement for Out-of-state Hospitals. (1) For inpatient psychiatric or
16 rehabilitation care provided by an acute out-of-state hospital, the department shall reim-
17 burse a per diem rate comprised of an operating per diem rate and a capital per diem
18 rate.

19 (a) The psychiatric operating per diem rate shall be the median operating cost, ex-
20 cluding graduate medical education cost or any provider tax cost , per day for all in-state
21 acute care hospitals that have licensed psychiatric beds pursuant to 902 KAR 20:180,
22 Psychiatric hospitals; operation and services.

23 (b) The psychiatric capital per diem rate shall be the median psychiatric capital per

1 diem rate paid for all in-state acute care hospitals that have licensed psychiatric beds
2 pursuant to 902 KAR 20:180, Psychiatric hospitals; operation and services.

3 (c) The per diem rate shall not include any adjustment mandated for in-state hospi-
4 tals pursuant to 2006 Ky Acts. ch. 252.

5 (2) For care provided by an out-of-state freestanding psychiatric hospital, the de-
6 partment shall reimburse a per diem rate comprised of a psychiatric operating per diem
7 rate and a capital per diem rate.

8 (a) The psychiatric operating per diem rate shall equal the median operating cost,
9 excluding graduate medical education cost or any provider tax cost, per day for all in-
10 state freestanding psychiatric hospitals.

11 (b) The psychiatric capital per diem rate shall be the median psychiatric capital per
12 diem rate for all in-state freestanding psychiatric hospitals.

13 (c) The per diem rate shall not include any adjustment mandated for in-state hospi-
14 tals pursuant to 2006 Ky Acts. ch. 252.

15 (3) For care in an out-of-state rehabilitation hospital, the department shall reimburse
16 a per diem rate equal to the median rehabilitation per diem rate for all in-state rehabilita-
17 tion hospitals minus any adjustment mandated for in-state hospitals pursuant to 2006
18 Ky Acts. ch. 252.

19 (4) The department shall apply the requirements of 42 C.F.R. 447.271 on a claim-
20 specific basis to payments made via this Section of this administrative regulation.

21 Section 17. Supplemental Payments. In addition to a payment based on a rate
22 developed under Section 2, 3 or 4 of this administrative regulation, the department shall:

23 (1) Make quarterly supplemental payments to an in-state hospital which qualifies as a

1 psychiatric access hospital in an amount:

2 (a) Equal to the hospital's uncompensated costs of providing care to Medicaid
3 recipients and individuals not covered by a third party payor, not to exceed \$6 million
4 annually; and

5 (b) Consistent with the requirements of 42 C.F.R. 447.271; and

6 (2) Make an annual payment to an in-state state-designated free-standing rehabilita-
7 tion teaching hospital that is not state-owned or operated in an amount:

8 (a) Determined on a per diem or per discharge basis equal to the non-reimbursed
9 costs of providing care to Medicaid recipients;

10 (b) Costs shall be the amount of cost identified on a hospital's most recent cost report
11 received by the department [~~finalized cost report~~] for a fiscal year reduced by the cost of
12 care covered by third parties.

13 (c) Equal to the amount of per diem payments pursuant to this administrative regula-
14 tion or per discharge diagnostic related group payments pursuant to 907 KAR 1:013,
15 Diagnostic related group hospital reimbursement, received by the hospital for Medicaid
16 recipients not covered by third parties.

17 Section 18. Certified Public Expenditures. (1) The department shall reimburse an in-
18 state public government-owned hospital the full cost of inpatient care via a certified pub-
19 lic expenditure (CPE) contingent upon approval by CMS.

20 (2) To determine the amount of costs eligible for a CPE, an in-state hospital's allowed
21 charges shall be multiplied by the hospital's operating cost-to-total charges ratio.

22 (3) The department shall verify whether or not a given CPE is allowable as a Medi-
23 caid cost.

1 (4)(a) Subsequent to a cost report being submitted to the department and finalized, a
2 CPE shall be reconciled with the actual costs reported to determine the actual CPE for
3 the period.

4 (b) If any difference between actual cost and submitted cost remains, the department
5 shall reconcile any difference with the provider.

6 Section 19. Access to Subcontractor's Records. If a hospital has a contract with a
7 subcontractor for services costing or valued at \$10,000 or more over a twelve (12)
8 month period:

9 (1) The contract shall contain a provision granting the department access:

10 (a) To the subcontractor's financial information; and

11 (b) In accordance with 907 KAR 1:672, Provider enrollment, disclosure, and
12 documentation for Medicaid participation; and

13 (2) Access shall be granted to the department for a subcontract between the
14 subcontractor and an organization related to the subcontractor.

15 Section 20. New Provider, Change of Ownership, or Merged Facility.

16 (1) If a hospital undergoes a change of ownership, the new owner shall continue to
17 be reimbursed at the rate in effect at the time of the change of ownership.

18 (2) Until a fiscal year end cost report is available, a newly constructed or newly
19 participating hospital shall submit an operating budget and projected number of patient
20 days within thirty (30) days of receiving Medicaid certification.

21 (a) A prospective per diem shall be set based on the operating budget and projected
22 number of patient days for care not subject to a diagnostic related group method of
23 reimbursement.

1 (b) A prospective per diem rate set in accordance with paragraph (a) of this
2 subsection shall be tentative and subject to settlement at the time the first audited fiscal
3 year end report is available to the department.

4 (c) During the projected rate year, the budget shall be adjusted if indicated and
5 justified by the submittal of additional information.

6 (3) If two (2) or more separate entities merge into one (1) organization, the
7 department shall:

8 (a) Merge the latest available data used for rate setting;

9 (b) Combine bed utilization statistics, creating a new occupancy ratio;

10 (c) Combine costs using the trending and indexing figures applicable to each entity in
11 order to arrive at correctly trended and indexed costs;

12 (d) Compute on a weighted average the rate of increase control applicable to each
13 entity, based on the reported paid Medicaid days for each entity taken from the cost
14 report previously used for rate setting;

15 (e) If one (1) of the entities merging has disproportionate status and the other does
16 not, retain for the merged entity the status of the entity which reported the highest
17 number of Medicaid days paid;

18 (f) Recognize an appeal of the merged per diem rate in accordance with 907 KAR
19 1:671, Conditions of Medicaid provider participation, withholding overpayments,
20 administrative appeal process, and sanctions; and

21 (g)1. Require each provider to submit a Medicaid cost report for the period ended as
22 of the day before the merger within five (5) months of the end of the hospital's fiscal
23 year end.

1 2. A Medicaid cost report for the period starting with the day of the merger and
2 ending on the fiscal year end of the merged entity shall also be filed with the department
3 in accordance with Section 10 of this administrative regulation.

4 Section 21. Appeals. (1) An administrative review shall not be available for a facility
5 or service reimbursed via the per diem methodology for the determination of the
6 requirement, or the proportional amount, of any budget neutrality adjustment used in the
7 calculation of the per diem rate.

8 (2) An administrative review shall be available for a calculation error in the establish-
9 ment of a per diem rate.

10 (3) An appeal shall comply with the review and appeal provisions established in 907
11 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, ad-
12 ministrative appeal process, and sanctions.

13 Section 22. Incorporation by Reference. (1) The following material is incorporated by
14 reference:

15 (a) "Supplemental Medicaid Schedule KMAP-1"; January 2007 edition; and

16 (b) "Supplemental Medicaid Schedule KMAP-4", January 2007 edition.

17 (2) This material may be inspected, copied, or obtained, subject to applicable copy-
18 right law, at the Department for Medicaid Services, 275 East Main Street, Frankfort,
19 Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m..

907 KAR 1:815
Amended after Comments

REVIEWED:

Date

Elizabeth A. Johnson, Commissioner
Department for Medicaid Services

APPROVED:

Date

Janie Miller, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:815

Cabinet for Health Services

Department for Medicaid Services

Agency Contact Person: Barry Ingram (502) 564-5969 or Stuart Owen (502) 564-6204

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes reimbursement for non-diagnostic related group (DRG)-reimbursed inpatient hospital care. Previously the provisions were contained in a broader inpatient hospital reimbursement regulation, 907 KAR 1:013, Payments for inpatient hospital services. Policy revision includes basing per diem reimbursement on more recent cost reports and introducing a parity factor to ensure that non-DRG hospital reimbursement keeps pace with DRG hospital reimbursement.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal and state laws (including KRS 142.303, 205.638 and 2006 Ky Acts ch. 252) governing reimbursement of inpatient hospital care to Medicaid recipients.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing non-DRG inpatient hospital reimbursement at a level necessary to ensure recipient access to care and by increasing reimbursement in accordance with KRS 142.303, 205.638 and 2006 Ky Acts ch. 252.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing non-DRG inpatient hospital reimbursement at a level necessary to ensure recipient access to care and by increasing reimbursement in accordance with KRS 142.303, 205.638 and 2006 Ky Acts ch. 252.

- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: This administrative regulation establishes reimbursement for non-diagnostic related group (DRG)-reimbursed inpatient hospital care. Previously the provisions were contained in a broader inpatient hospital reimbursement regulation, 907 KAR 1:013, Payments for inpatient hospital services. Policy revision includes per diem reimbursement updating by basing per diem reimbursement on more recent cost reports and introducing a parity factor to ensure that non-DRG hospital reimbursement keeps pace with DRG hospital reimbursement. An initial amended version of this administrative regulation was submitted to the Legislative Research Commission (LRC) on October 15 but was withdrawn

and replaced by this administrative regulation in order to establish a more appropriate reimbursement for out-of-state freestanding psychiatric hospitals to ensure that in-state freestanding psychiatric hospitals are adequately enabled to care for Kentucky Medicaid recipients. The amendment after comments clarifies that the department will use costs from a hospital's most recently submitted cost report to determine supplemental payments.

- (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation which was previously contained in a larger broad reaching inpatient hospital reimbursement administrative regulation. The Department for Medicaid Services (DMS) is dividing the larger administrative regulation into three narrower in scope administrative regulations. This administrative regulation is necessary to comply with federal and state laws (including KRS 142.303, 205.638 and 2006 Ky Acts ch. 252) governing reimbursement of inpatient hospital care to Medicaid recipients. An initial amended version of this administrative regulation was submitted to the Legislative Research Commission (LRC) on October 15 but was withdrawn and replaced by this administrative regulation in order to establish a more appropriate reimbursement for out-of-state freestanding psychiatric hospitals to ensure that in-state freestanding psychiatric hospitals are adequately enabled to care for Kentucky Medicaid recipients. The amendment after comments is necessary to clarify, rather than amend, policy.
 - (c) How the amendment conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing non-DRG inpatient hospital reimbursement at a level necessary to ensure recipient access to care and by increasing reimbursement in accordance with KRS 142.303, 205.638 and 2006 Ky Acts ch. 252. The amendment after comments complies with statutes by clarifying policy related to the use of cost reports and supplemental payments.
 - (d) How the amendment will assist in the effective administration of the statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing non-DRG inpatient hospital reimbursement at a level necessary to ensure recipient access to care and by increasing reimbursement in accordance with KRS 142.303, 205.638 and 2006 Ky Acts ch. 252. The amendment after comments complies with statutes by clarifying policy related to the use of cost reports and supplemental payments.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect all inpatient hospitals not reimbursed via a DRG methodology. The current number of such hospitals is fifty-five (55).
- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: The

administrative regulation establishes reimbursement, including a reimbursement increase for all except critical access hospitals, for the regulated entities rather than imposes mandates with associated costs. Hospitals will not need to take any action to comply with the amendment after comments as it clarified policy. The amendment after comments clarifies that most recently submitted costs report will be used to determine a hospital's supplemental payments; thus, ensuring the use of more accurate data for such calculations.

- (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The administrative regulation establishes reimbursement, including a reimbursement increase for all except critical access hospitals, for the regulated entities rather than imposes mandates with associated costs. No cost is imposed on hospitals as a result of the amendment after comments.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The administrative regulation establishes reimbursement, including a reimbursement increase for all except critical access hospitals, for the regulated entities rather than imposes mandates with associated costs. An initial amended version of this administrative regulation was submitted to the Legislative Research Commission (LRC) on October 15 but was withdrawn and replaced by this administrative regulation in order to establish a more appropriate reimbursement for out-of-state freestanding psychiatric hospitals to ensure that in-state freestanding psychiatric hospitals are adequately enabled to care for Kentucky Medicaid recipients. The amendment after comments clarifies that a hospital's most recently submitted cost report will be used to determine any supplemental payments to it. Using more current cost report data should benefit hospitals.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: DMS projects that the amendment will cost approximately \$1.5 million (\$1.04 million federal funds; \$0.46 million state funds) annually. The amendment after comments is not expected to impact departmental cost.
 - (b) On a continuing basis: DMS projects that the amendment will cost approximately \$1.5 million (\$1.04 million federal funds; \$0.46 million state funds) annually. The amendment after comments is not expected to impact departmental cost.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX, matching funds of general fund appropriations and hospital provider tax funds pursuant to KRS 142.303, 205.638 and 2006 Ky Acts ch. 252.
- (7) Provide an assessment of whether an increase in fees or funding will be

necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The current fiscal year budget will not need to be adjusted to provide funds for implementing this administrative regulation. The current fiscal year budget will not need to be adjusted as a result of the amendment after comments.

- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish or increase any fees. The amendment after comments does not add or increase any fee.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering is applied in that critical access hospitals are reimbursed a Medicare rate as mandated by KRS 216.380 and in accordance with 42 USC 1395f(l). The amendment after comments does not alter the tiering.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:815 Contact Person: Barry Ingram (502) 564-5969 or Stuart Owen (502) 564-6204

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

Yes X No
If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Eight (8) Medicaid-participating per diem hospitals are owned by local government in Kentucky.
3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. The initial amendment and amendment after comments are authorized by 42 CFR 412, 413, 42 USC 1395f(l), KRS 142.303, 205.520(3), 205.638, 216.380 and 2006 Ky Acts ch. 252.
4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
 - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulation is expected to generate additional revenue for local government-owned but not state government-owned hospitals. DMS does not anticipate a fiscal impact as a result of the amendment after comments.
 - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This administrative regulation is expected to generate additional revenue for county-owned government but not state government. DMS does not anticipate a fiscal impact as a result of the amendment after comments.
 - (c) How much will it cost to administer this program for the first year? DMS projects that the amendment will cost approximately \$1.5 million (\$1.04 million federal funds; \$0.46 million state funds) annually. DMS does not anticipate a fiscal impact as a result of the amendment after comments.

(d) How much will it cost to administer this program for subsequent years? DMS projects that the amendment will cost approximately \$1.5 million (\$1.04 million federal funds; \$0.46 million state funds) annually. DMS does not anticipate a fiscal impact as a result of the amendment after comments.

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

Revenues (+/-): _____

Expenditures (+/-): _____

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

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:815 Contact Person: Stuart Owen (502)-564-6204 or
Barry Ingram (502) 564-5969

1. Federal statute or regulation constituting the federal mandate.
42 CFR Chapter 412, Chapter 413 and 447.200, 447.250, 447.271, and 447.272
address inpatient hospital reimbursement provisions.

2. State compliance standards.

KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.560 addresses Medicaid reimbursement. 2006 Ky Acts ch. 252, KRS 142.303 and 205.638 address the utilization of hospital provider tax revenues to enhance inpatient hospital reimbursement.

3. Minimum or uniform standards contained in the federal mandate.

Medicaid agency payments to providers must be sufficient to enlist enough providers so that Medicaid services are available to recipients at least to the same extent that comparable services are available to the general population. Payments for hospital services should be rates that the State finds, and makes assurances satisfactory to the United States Health and Human Services Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

This administrative regulation, including the amendment after comments, does not impose stricter, than federal, requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

This administrative regulation, including the amendment after comments, does not impose stricter, than federal, requirements.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:815, Non-Diagnostic Related Group Inpatient Hospital Reimbursement

Summary of Material Incorporated by Reference

(1) The “Supplemental Medicaid Schedule KMAP-1”; January 2007 edition is incorporated by reference and used to document hospital costs, legal fees, political contributions and out-of-state travel and is a one (1) page form.

(2) The “Supplemental Medicaid Schedule KMAP-4”, January 2007 edition and is used to document miscellaneous care or related including whether non-emergency obstetric services are offered, age threshold (under or over eighteen (18)) of predominant number of individuals served, Medicaid revenues, total revenues, state and local government revenues, charges attributable to charity care, and total inpatient charges. The form consists of one (1) page.