

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Healthcare Facilities Management

4 (Amendment)

5 907 KAR 1:825. Diagnosis-related group (DRG) inpatient hospital reimbursement.

6 RELATES TO: KRS 13B.140, 205.510(16), 205.565, 205.637, 205.638, 205.639,

7 205.640, 205.641, 216.380, 42 C.F.R. Parts 412, 413, 440.10, 440.140, 447.250-

8 447.280, 42 U.S.C. 1395f(l), 1395ww(d)(5)(F), x(mm), 1396a, 1396b, 1396d, 1396r-4,

9 Pub. L. 111-148

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

11 205.637(3), 205.640(1), 205.641(2), 216.380(12), 42 C.F.R. 447.200, 447.250,

12 447.252, 447.253, 447.271, 447.272, 42 U.S.C. 1396a, 1396r-4

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

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

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

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

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

18 istrative regulation establishes the method for determining the amount payable via a di-

19 agnosis-related group methodology by the Medicaid program for a hospital inpatient

20 service including provisions necessary to enhance reimbursement pursuant to KRS

21 142.303 and 205.638.

1 Section 1. Definitions. (1) "Acute care hospital" is defined by KRS 205.639(1).

2 (2) "Adjustment factor" means the factor by which non-neonatal care relative weights
3 shall be reduced to offset the expenditure pool adjustment necessary to enhance neo-
4 natal care relative weights.

5 (3) "Appalachian Regional Hospital System" means a private, not-for-profit hospital
6 chain operating in a Kentucky county that receives coal severance tax proceeds.

7 (4) "Base rate" means the per discharge hospital-specific DRG rate for an acute care
8 hospital that is multiplied by the relative weight to calculate the DRG base payment.

9 (5) "Base year" means the state fiscal year period used to establish DRG rates.

10 (6) "Base year Medicare rate components" means Medicare inpatient prospective
11 payment system rate components in effect on October 1 during the base year as listed
12 in the CMS IPPS Pricer Program.

13 (7) "Budget neutrality" means that reimbursements resulting from rates paid to pro-
14 viders under a per discharge methodology do not exceed payments in the base year
15 adjusted for inflation based on the CMS Input Price Index, which is the wage index pub-
16 lished by CMS in the Federal Register[.].

17 (8) "Budget neutrality factor" means a factor that is applied to a DRG base rate or the
18 direct graduate medical educational payment so that budget neutrality is achieved.

19 (9) "Capital cost" means capital related expenses including insurance, taxes, interest
20 and depreciation related to plant and equipment.

21 (10) "CMS" means the Centers for Medicare and Medicaid Services.

22 (11) "CMS IPPS Pricer Program" means the software program published on the CMS
23 website of <http://www.cms.hhs.gov> which shows the Medicare rate components and

1 payment rates under the Medicare inpatient prospective payment system for a dis-
2 charge within a given federal fiscal year.

3 (12) "Cost center specific cost-to-charge ratio" means a ratio of a hospital's cost cen-
4 ter specific total hospital costs to its cost center specific total charges extracted from the
5 Medicare cost report corresponding to the hospital full fiscal year falling within the base
6 year claims date period.

7 (13) "Cost outlier" means a claim for which estimated cost exceeds the outlier thre-
8 shold.

9 (14) "Critical access hospital" or "CAH" means a hospital meeting the licensure re-
10 quirements established in 906 KAR 1:110 and designated as a critical access hospital
11 by the department.

12 (15) "Department" means the Department for Medicaid Services or its designated
13 agent.

14 (16) "Diagnosis code" means a code:

15 (a) Maintained by the Centers for Medicare and Medicaid Services (CMS) to group
16 and identify a disease, disorder, symptom, or medical sign; and

17 (b) Used to measure morbidity and mortality.

18 (17) "Diagnostic categories" means the diagnostic classifications containing one or
19 more DRGs used by Medicare programs, assigned in the base year with modifications
20 established in Section 2(15) of this administrative regulation.

21 (18)~~(17)~~ "Diagnostic related group" or "DRG" means a clinically-similar grouping of
22 services that can be expected to consume similar amounts of hospital resources.

23 (19)~~(18)~~ "Distinct part unit" means a separate unit within an acute care hospital that

1 meets the qualifications established in 42 C.F.R. 412.25 and is designated as a distinct
2 part unit by the department.

3 ~~(20)~~~~(19)~~ "DRG average length of stay" means the Kentucky arithmetic mean length
4 of stay for each DRG, calculated by dividing the sum of patient days in the base year
5 claims data for each DRG by the number of discharges for each DRG.

6 ~~(21)~~~~(20)~~ "DRG base payment" means the base payment for claims paid under the
7 DRG methodology. Excluding

8 ~~(22)~~~~(21)~~ "Enhanced neonatal care relative weight" means a neonatal care relative
9 weight increased, with a corresponding reduction to non-neonatal care relative weights,
10 to facilitate reimbursing neonatal care at 100% of Medicaid allowable costs in aggregate
11 by category.

12 ~~(23)~~~~(22)~~ "Federal financial participation" is defined ~~by~~~~in~~ 42 C.F.R. 400.203.

13 ~~(24)~~~~(23)~~ "Fixed loss cost threshold" means the amount, equal to \$29,000, which is
14 combined with the full DRG payment or transfer payment for each DRG to determine
15 the outlier threshold.

16 ~~(25)~~~~(24)~~ "Geometric mean" means the measure of central tendency for a set of val-
17 ues expressed as the nth (number of values in the set) root of their product.

18 ~~(26)~~~~(25)~~ "GII" means ~~Global Insight, Incorporated.~~

19 ~~(26)~~ "Government entity" means an entity that qualifies as a unit of government for
20 the purposes of 42 U.S.C. 1396b(w)(6)(A).

21 (27) "High intensity level II neonatal center" means an in-state hospital with a level II
22 neonatal center which:

23 (a) Is licensed for a minimum of twenty-four (24) neonatal level II beds;

1 (b) Has a minimum of 1,500 Medicaid neonatal level II patient days per year;

2 (c) Has a gestational age lower limit of twenty-seven (27) weeks; and

3 (d) Has a full-time perinatologist on staff.

4 (28) "High volume per diem payment" means a per diem add-on payment made to
5 hospitals meeting selected Medicaid utilization criteria established in Section 2(12) of
6 this administrative regulation.

7 (29) "Hospital-acquired condition" means a condition:

8 (a)1. Associated with a diagnosis code selected by the Secretary of the U.S.

9 Department of Health and Human Services pursuant to 42 USC 1395ww(d)(4)(D); and

10 2. Not present upon the recipient's admission to the hospital; or

11 (b)1. Which is recognized by the Centers for Medicare and Medicaid Services as a
12 hospital-acquired condition.

13 (30)[(29)] "Indexing factor" means the percentage that the cost of providing a service
14 is expected to increase during the universal rate year.

15 (31)[(30)] "Inflation factor" means the percentage that the cost of providing a service
16 has increased, or is expected to increase, for a specific period of time based on
17 changes in the CMS input price index.

18 (32)[(31)] "Intrahospital transfer" means a transfer within the same acute care hos-
19 pital resulting in a discharge from and a new admission to a licensed and certified acute
20 care bed, psychiatric distinct part unit, or rehabilitation distinct part unit.

21 (33)[(32)] "Level I neonatal care" or Level 1 DRG" means care provided to newborn
22 infants of a more intensive nature than the usual nursing care provided in newborn care
23 units, on the basis of physicians' orders and approved nursing care plans, which are

1 assigned to DRGs 385-390.

2 (34)~~(33)~~ "Level II neonatal center" means a facility with a licensed level II bed which
3 provides specialty care (DRGs 675-680) for infants which includes monitoring for apnea
4 spells, incubator or other assistance to maintain the infant's body temperature, and
5 feeding assistance.

6 (35)~~(34)~~ "Level III neonatal center" means a facility with a licensed level III bed
7 which provides specialty care (DRGs 685-690) of infants which includes ventilator or
8 other respiratory assistance for infants who cannot breathe adequately on their own,
9 special intravenous catheter to monitor and assist blood pressure and heart function,
10 observation and monitoring of conditions that are unstable or may change suddenly,
11 and postoperative care.

12 (36)~~(35)~~ "Long-term acute care hospital" means a hospital that meets the require-
13 ments established in 42 C.F.R. 412.23(e).

14 (37)~~(36)~~ "Low intensity level III neonatal center" means a facility with fewer than four
15 (4) licensed level III neonatal beds.

16 (38)~~(37)~~ "Medicaid shortfall" means the difference between a provider's allowable
17 cost of providing services to Medicaid recipients and the amount received in accor-
18 dance with the payment provisions established in Section 2 of this administrative regu-
19 lation.

20 (39)~~(38)~~ "Medical education costs" means direct and allowable costs that are:

- 21 (a) Associated with an approved intern and resident program; and
- 22 (b) Subject to limits established by Medicare.

23 (40)~~(39)~~ "Medically necessary" or "medical necessity" means that a covered benefit

1 shall be provided in accordance with 907 KAR 3:130.

2 (41) "Never event" means:

3 (a) A procedure, service, or hospitalization not reimbursable by Medicare pursuant to
4 CMS Manual System Pub 100-03 Medicare National Coverage Determinations
5 Transmittal 101; or

6 (b) A hospital-acquired condition.

7 (42)[(40)] "Outlier threshold" means the sum of the DRG base payment or transfer
8 payment and the fixed loss cost threshold.

9 (43)[(41)] "Pediatric teaching hospital" is defined in KRS 205.565(1).

10 (44)[(42)] "Per diem rate" means the per diem rate paid by the department for inpa-
11 tient care in an in-state psychiatric or rehabilitation hospital, inpatient care in a long-
12 term acute care hospital, inpatient care in a critical access hospital or psychiatric or re-
13 habilitation services in an in-state acute care hospital which has a distinct part unit.

14 (45)[(43)] "Psychiatric hospital" means a hospital which meets the licensure require-
15 ments as established in 902 KAR 20:180.

16 (46)[(44)] "Quality improvement organization" or "QIO" means an organization that
17 complies with 42 C.F.R. 475.101.

18 (47)[(45)] "Rebase" means to redetermine base rates, DRG relative weights, per di-
19 em rates, and other applicable components of the payment methodology using more
20 recent data.

21 (48)[(46)] "Rehabilitation hospital" means a hospital meeting the licensure require-
22 ments as established in 902 KAR 20:240.

23 (49)[(47)] "Relative weight" means the factor assigned to each Medicare DRG classi-

1 fication that represents the average resources required for a Medicare DRG classifica-
2 tion paid under the DRG methodology relative to the average resources required for all
3 DRG discharges in the state paid under the DRG methodology for the same time pe-
4 riod.

5 (50)~~(48)~~ "Resident" means an individual living in Kentucky who is not receiving pub-
6 lic assistance in another state.

7 (51)~~(49)~~ "Rural hospital" means a hospital located in a rural area pursuant to 42
8 C.F.R. 412.64(b)(1)(C).

9 (52)~~(50)~~ "State university teaching hospital" means:

10 (a) A hospital that is owned or operated by a Kentucky state-supported university
11 with a medical school; or

12 (b) A hospital:

13 1. In which three (3) or more departments or major divisions of the University of Ken-
14 tucky or University of Louisville medical school are physically located and which are
15 used as the primary (greater than fifty (50) percent) medical teaching facility for the
16 medical students at the University of Kentucky or the University of Louisville; and

17 2. That does not possess only a residency program or rotation agreement.

18 (53)~~(51)~~ "Transfer payment" means a payment made for a recipient who is trans-
19 ferred to or from another hospital for a service reimbursed on a prospective discharge
20 basis.

21 (54)~~(52)~~ "Trending factor" means the inflation factor as applied to that period of time
22 between the midpoint of the base year and the midpoint of the universal rate year.

23 (55)~~(53)~~ "Type III hospital" means an in-state disproportionate share state university

1 teaching hospital, owned or operated by either the University of Kentucky or the Univer-
2 sity of Louisville Medical School.

3 ~~(56)~~~~(54)~~ "Universal rate year" means the twelve (12) month period under the pros-
4 pective payment system, beginning July of each year, for which a payment rate is es-
5 tablished for a hospital regardless of the hospital's fiscal year end.

6 ~~(57)~~~~(55)~~ "Urban hospital" means a hospital located in an urban area pursuant to 42
7 C.F.R. 412.64(b)(1)(ii).

8 ~~(58)~~~~(56)~~ "Urban trauma center hospital" means an acute care hospital that:

9 (a) Is designated as a Level I Trauma Center by the American College of Surgeons;

10 (b) Has a Medicaid utilization rate greater than twenty-five (25) percent; and

11 (c) At least fifty (50) percent of its Medicaid population are residents of the county in
12 which the hospital is located.

13 Section 2. Payment for an Inpatient Acute Care Service in an In-state Acute Care
14 Hospital. (1) An in-state acute care hospital shall be paid for an inpatient acute care
15 service, except for a service not covered pursuant to 907 KAR 1:012, on a fully-
16 prospective per discharge basis.

17 (2) For an inpatient acute care service, except for a service not covered pursuant to
18 907 KAR 1:012, in an in-state acute care hospital, the total hospital-specific per dis-
19 charge payment shall be the sum of:

20 (a) A DRG base payment;

21 (b) If applicable, a high volume per diem payment; and

22 (c) If applicable, a cost outlier payment amount.

23 (3)(a) In assigning a DRG for a claim, the department shall exclude from the DRG

1 consideration any secondary diagnosis code associated with:

2 1. A hospital-acquired condition; or

3 2. A service associated with a never event.

4 (b) A DRG assignment for payment purposes shall be based on the Medicare grou-
5 per version twenty-four (24) effective in the Medicare inpatient prospective payment
6 system as of October 1, 2006.

7 ~~(c)[in effect in the Medicare inpatient prospective payment system at the time of re-~~
8 ~~basing.~~

9 ~~(b) For a rate effective June 16, 2008,]~~ The department shall assign to the base year
10 claims data, DRG classifications from Medicare grouper version twenty-four (24) effec-
11 tive in the Medicare inpatient prospective payment system as of October 1, 2006.

12 (4) A DRG base payment shall be calculated for a discharge by multiplying the hos-
13 pital specific base rate by the DRG relative weight.

14 (5)(a) The department shall determine a base rate by calculating a case mix, outlier
15 payment and budget neutrality adjusted cost per discharge for each in-state acute care
16 hospital as described in subsections (5) through (10) of this section of this administra-
17 tive regulation.

18 (b) A hospital specific cost per discharge used to calculate a base rate shall be
19 based on base year inpatient paid claims data.

20 (c) ~~[For a rate effective June 16, 2008,]~~ A hospital specific cost per discharge shall
21 be calculated using state fiscal year 2006 inpatient Medicaid paid claims data.

22 (6)(a) The department shall calculate a cost to charge ratio for the fifteen (15) Medi-
23 caid and Medicare cost centers displayed in paragraph (b) of this subsection.

1 (b) If a hospital lacks cost-to-charge information for a given cost center or if the hos-
 2 pital's cost-to-charge ratio is above or below three (3) standard deviations from the
 3 mean of a log distribution of cost-to-charge ratios, the department shall use the state-
 4 wide geometric mean cost-to-charge ratio for the given cost center.
 5

Table 1. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk		
Kentucky Medicaid Cost Center	Kentucky Medicaid Cost Center Description	Medicare Cost Report Standard Cost Center
1	Routine Days	25
2	Intensive Days	26, 27, 28, 29, 30
3	Drugs	48, 56
4	Supplies or equipment	55, 66, 67
5	Therapy services excluding inhalation therapy	50, 51, 52
6	Inhalation therapy	49
7	Operating room	37, 38
8	Labor and delivery	39
9	Anesthesia	40
10	Cardiology	53, 54
11	Laboratory	44, 45

12	Radiology	41, 42
13	Other services	43, 46, 47, 57, 58, 59, 60, 61, 62, 63, 63.5, 64, 65, 68
14	Nursery	33
15	Neonatal intensive days	30

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2 (7)(a) For a hospital with an intern or resident reported on its Medicare cost report,
3 the department shall calculate allocated overhead by computing the difference between
4 the costs of interns and residents before and after the allocation of overhead costs.

5 (b) The ratio of overhead costs for interns and residents to total facility costs shall be
6 multiplied by the costs in each cost center prior to computing the cost center cost-to-
7 charge ratio.

8 (8) For an in-state acute care hospital, the department shall compile the number of
9 patient discharges, patient days and total charges from the base year claims data. The
10 department shall exclude from the rate calculation:

11 (a) Claims paid under a managed care program;

12 (b) Claims for rehabilitation and psychiatric discharges reimbursed on a per diem ba-
13 sis;

14 (c) Transplant claims; and

15 (d) Revenue codes not covered by the Medicaid Program.

16 (9)(a) The department shall calculate the cost of a base year claim by multiplying the
17 charges from each accepted revenue code by the corresponding cost center specific
18 cost-to-charge ratio.

1 (b) The department shall base cost center specific cost-to-charge ratios on data ex-
2 tracted from the most recently, as of June 1, finalized cost report.

3 (c) Only an inpatient revenue code recognized by the department shall be included in
4 the calculation of estimated costs.

5 (10) Using the base year Medicaid claims referenced in subsection (8) of this section
6 of this administrative regulation, the department shall compute a hospital specific cost
7 per discharge by dividing a hospital's Medicaid costs by its number of Medicaid dis-
8 charges.

9 (11) The department shall determine an in-state acute care hospital's DRG base
10 payment rate by adjusting the hospital's specific Medicaid allowable cost per discharge
11 by the hospital's case mix, expected outlier payments and budget neutrality.

12 (a)1. A hospital's case mix adjusted cost per discharge shall be calculated by dividing
13 the hospital's cost per discharge by its case mix index; and

14 2. The hospital's case mix index shall be equal to the average of its DRG relative
15 weights for acute care services for base year Medicaid discharges referenced in sub-
16 section (8) of this section of this administrative regulation.

17 (b)1. A hospital's case mix adjusted cost per discharge shall be multiplied by an initial
18 budget neutrality factor.

19 2. The initial budget neutrality factor for a rate shall be 0.7065 for all hospitals.

20 3. When rates are rebased, the initial budget neutrality factor shall be calculated so
21 that total payments in the rate year shall be equal to total payments in the prior year
22 plus inflation for the upcoming rate year and adjusted to eliminate changes in patient
23 volume and case mix.

1 (c)1. Each hospital's case mix and initial budget neutrality adjusted cost per dis-
2 charge shall be multiplied by a hospital-specific outlier payment factor.

3 2. A hospital-specific outlier payment factor shall be the result of the following formu-
4 la: ((expected DRG non-outlier payments) -
5 (expected proposed DRG outlier payments))/(expected DRG non-outlier payments).

6 (d)1. A hospital's case mix, initial budget neutrality and outlier payment adjusted cost
7 per discharge shall be multiplied by a secondary budget neutrality factor.

8 2. The secondary budget neutrality factor for a hospital shall be 1.0562.

9 3. When rates are rebased, the secondary budget neutrality factor shall be calcu-
10 lated so that total payments in the rate year shall be equal to total payments in the prior
11 year plus inflation for the upcoming rate year and adjusted to eliminate changes in pa-
12 tient volume and case mix.

13 (12)(a) The department shall make a high volume per diem payment, except as ex-
14 cluded in paragraph (h) of this subsection, to an in-state acute care hospital with high
15 Medicaid volume for base year covered Medicaid days referenced in subsection (8) of
16 this section of this administrative regulation.

17 (b) High volume per diem criteria shall be based on the number of Kentucky Medica-
18 id days or the hospital's Kentucky Medicaid utilization percentage.

19 (c)1. A high volume per diem payment shall be made in the form of a per diem add-
20 on amount in addition to the DRG base payment rate encompassing the DRG average
21 length-of-stay days per discharge.

22 2. The payment shall be equal to the applicable high volume per diem add-on
23 amount multiplied by the DRG average length-of-stay associated with the claim's DRG

1 classification.

2 (d)1. The department shall determine a per diem payment associated with Medicaid
3 days-based criteria separately from a per diem payment associated with Medicaid utili-
4 zation-based criteria.

5 2. If a hospital qualifies for a high volume per diem payment under both the Medicaid
6 days-based criteria and the Medicaid utilization-based criteria, the department shall pay
7 the higher of the two add-on per diem amounts.

8 (e) The department shall pay the indicated high volume per diem payment if either
9 the base year covered Kentucky Medicaid inpatient days or Kentucky Medicaid inpa-
10 tient day's utilization percent meet the criteria established in Table 2 below:

11

Table 2. High Volume Adjustment Eligibility Criteria			
Kentucky Medicaid Inpatient Days		Kentucky Medicaid Inpatient Days Utilization	
Days Range	Per Diem Payment	Medicaid Utilization Range	Per Diem Payment
0 - 3,499 days	\$0 per day	0.0% - 13.2%	\$0.00 per day
3,500 - 4,499 days	\$22.50 per day	13.3% - 16.1%	\$22.50 per day
4,500 - 5,999 days	\$45.00 per day	16.2% - 21.6%	\$45.00 per day
6,000 - 7,399 days	\$80.00 per day	21.7% - 27.2%	\$81.00 per day

7,400 - 10,999 days	\$118.15 per day	27.3% - 100.00%	\$92.75 per day
11,000 - 19,999 days	\$163.49 per day		
20,000 and above days	\$325.00 per day		

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(f) The department shall use base year claims data referenced in subsection (8) of this section of this administrative regulation to determine if a hospital qualifies for a high volume per diem add-on payment.

(g) The department shall only change a hospital's classification regarding a high volume add-on payment or per diem amount during a rebasing year.

(h)1. The department shall not make a high volume per diem payment for a level I neonatal care, level II neonatal center, or level III neonatal center claim.

2. A level I neonatal care, level II neonatal center, or level III neonatal center claim shall be included in a hospital's high volume adjustment eligibility criteria calculation established in paragraph (e) - Table 2 - of this section.

(13)(a) The department shall make an additional cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each diagnostic category.

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

(c) A discharge shall qualify for an additional cost outlier payment if its estimated cost exceeds the DRG's outlier threshold.

1 (d)1. The department shall calculate the estimated cost of a discharge, for purposes
2 of comparing the discharge cost to the outlier threshold, by multiplying the sum of the
3 hospital specific Medicare operating and capital-related cost-to-charge ratios by the
4 Medicaid allowed charges.

5 2. A Medicare operating or capital-related cost-to-charge ratio shall be extracted from
6 the CMS IPPS Pricer Program.

7 (e)1. The department shall calculate an outlier threshold as the sum of a hospital's
8 DRG base payment or transfer payment and the fixed loss cost threshold.

9 2. The fixed loss cost threshold shall equal \$29,000.

10 (f) A cost outlier payment shall equal eighty (80) percent of the amount by which es-
11 timated costs exceed a discharge's outlier threshold.

12 (14) The department shall calculate a Kentucky Medicaid-specific DRG relative
13 weight by:

14 (a)1. Selecting Kentucky base year Medicaid inpatient paid claims, excluding those
15 described in subsection (8) of this section of this administrative regulation; and

16 2. [~~For a rate effective June 16, 2008,~~] A hospital-specific cost per discharge shall be
17 calculated using state fiscal year 2006 inpatient Medicaid paid claims data;

18 (b)1. Reassigning the DRG classification for the base year claims based on the Med-
19 icare DRG in effect in the Medicare inpatient prospective payment system at the time of
20 rebasing; and

21 2. [~~For a rate effective June 16, 2008,~~] The department shall assign to the base year
22 claims data the Medicare grouper version 24 DRG classifications which were effective
23 in the Medicare inpatient prospective payment system as of October 1, 2006;

- 1 (c) Removing the following claims from the calculation:
- 2 1. Claims data for a discharge reimbursed on a per diem basis including:
- 3 a. A psychiatric claim, defined as follows:
- 4 (i) An acute care hospital claim with a psychiatric DRG;
- 5 (ii) A psychiatric distinct part unit claim; and
- 6 (iii) A psychiatric hospital claim;
- 7 b. A rehabilitation claim, defined as follows:
- 8 (i) An acute care hospital claim with rehabilitation DRG;
- 9 (ii) A rehabilitation distinct part unit claim; and
- 10 (iii) A rehabilitation hospital claim;
- 11 c. A critical access hospital claim; and
- 12 d. A long term acute care hospital claim;
- 13 2. A transplant service claim as specified in subsection (21) of this section of this
- 14 administrative regulation;
- 15 3. A claim for a patient discharged from an out-of-state hospital; and
- 16 4. A claim with total charges equal to zero (0);
- 17 (d) Calculating a relative weight value for a low volume DRG by:
- 18 1.a. Arraying a DRG with less than twenty-five (25) cases in order by the Medicare
- 19 DRG relative weight in effect in the Medicare inpatient prospective payment system at
- 20 the same time as the Medicare DRG grouper version, published in the Federal Regis-
- 21 ter, relied upon for Kentucky DRG classifications; and
- 22 b.~~[For a rate effective June 16, 2008,]~~ The department shall use the Medicare DRG
- 23 relative weight which was effective in the Medicare inpatient prospective payment sys-

1 tem as of October 1, 2006;

2 2. Grouping a low volume DRG, based on the Medicare DRG relative weight sort, in-
3 to one (1) of five (5) categories resulting in each category having approximately the
4 same number of Medicaid cases;

5 3. Calculating a DRG relative weight for each category; and

6 4. Assigning the relative weight calculated for a category to each DRG included in
7 the category;

8 (e)1. Standardizing the labor portion of the cost of a claim for differences in wage
9 and the full cost of a claim for differences in indirect medical education costs across
10 hospitals based on base year Medicare rate components;

11 a. [~~For a rate effective June 16, 2008,~~] Base year Medicare rate components shall
12 equal Medicare rate components effective in the Medicare inpatient prospective pay-
13 ment system as of October 1, 2005; and

14 b. Base year Medicare rate components used in the Kentucky inpatient prospective
15 payment system shall include:

16 (i) Labor-related percentage and non-labor-related percentage;

17 (ii) Operating and capital cost-to-charge ratios;

18 (iii) Operating indirect medical education costs; or

19 (iv) Wage indices;

20 2.a. The department shall standardize costs using the following formula: standard
21 cost = $\{((\text{labor related percentage} \times \text{costs}) / \text{Medicare wage index}) + (\text{nonlabor related}$
22 $\text{percentage} \times \text{costs})\} / (1 + \text{Medicare operating indirect medical education factor});$ and

23 b. [~~For a rate effective June 16, 2008,~~] The labor related percentage shall equal six-

1 ty-two (62) percent and the nonlabor related percentage shall equal thirty-eight (38)
2 percent;

3 (f) Removing statistical outliers by deleting any case that is:

4 1. Above or below three (3) standard deviations from the mean cost per discharge;

5 and

6 2. Above or below three (3) standard deviations from the mean cost per day;

7 (g) Computing an average standardized cost for all DRGs in aggregate and for each
8 DRG, excluding statistical outliers;

9 (h) Computing DRG relative weights:

10 1. For a DRG with twenty-five (25) claims or more by dividing the average cost per
11 discharge for each DRG by the statewide average cost per discharge; and

12 2. For a DRG with less than twenty-five (25) claims by dividing the average cost per
13 discharge for each of the five (5) low volume DRG categories by the statewide average
14 cost per discharge;

15 (i) Calculating, for the purpose of a transfer payment, Kentucky Medicaid geometric
16 mean length of stay for each DRG based on the base year claims data used to calcu-
17 late DRG relative weights;

18 (j) Employing enhanced neonatal care relative weights;

19 (k) Applying an adjustment factor to relative weights not referenced in paragraph (j)
20 of this subsection to offset the level I, II, and III neonatal care relative weight increase
21 resulting from the use of enhanced neonatal care relative weights; and

22 (l) Excluding high intensity level II neonatal center claims and low intensity level III
23 neonatal center claims from the neonatal care relative weight calculations.

1 (15) The department shall:

2 (a) Separately reimburse for a mother's stay and a newborn's stay based on the di-
3 agnostic category assigned to the mother's stay and to the newborn's stay;

4 (b) Establish a unique set of diagnostic categories and relative weights for an in-state
5 acute care hospital identified by the department as providing level I neonatal care, level
6 II neonatal center care, or level III neonatal center care as follows:

7 1. The department shall exclude high intensity level II neonatal center claims and low
8 intensity level III neonatal center claims from the neonatal center relative weight calcu-
9 lations;

10 2. The department shall reassign a claim that would have been assigned to a Medi-
11 care DRG 385-390 to a Kentucky-specific:

12 a. DRG 675-680 for an in-state acute care hospital with a level II neonatal center;
13 and

14 b. DRG 685-690 for an in-state acute care hospital with a level III neonatal center;

15 3. The department shall assign a DRG 385-390 for a neonatal claim from a hospital
16 which does not operate a level II or III neonatal center; and

17 4.a. The department shall compute a separate relative weight for a level II, or III neo-
18 natal intensity care unit (NICU) neonatal DRG;

19 b. The department shall use base year claims from level II neonatal centers, exclud-
20 ing claims from any high intensity level II neonatal center, to calculate relative weights
21 for DRGs 675-680; and

22 c. The department shall use base year claims from level III neonatal centers to calcu-
23 late relative weights for DRGs 685-690.

1 (16) The department shall:

2 (a) Expend in aggregate by category (level I neonatal care, level II or III neonatal
3 center care) and not by individual facilities:

4 1. A total expenditure for level I neonatal care projected to equal 100% of Medicaid
5 allowable cost for the universal rate year;

6 2. A total expenditure for level II neonatal center care projected to equal 100% of
7 Medicaid allowable cost for the universal rate year; or

8 3. A total expenditure for Level III neonatal center care projected to equal 100% of
9 Medicaid allowable cost for the universal rate year;

10 (b) Adjust neonatal care DRG relative weights to result in:

11 1. Total expenditures for level I neonatal care projected to equal 100% of Medicaid
12 allowable cost for the universal rate year;

13 2. Total expenditures for level II neonatal center care projected to equal 100% of
14 Medicaid allowable cost for the universal rate year; or

15 3. Total expenditures for level III neonatal center care projected to equal 100% of
16 Medicaid allowable cost for the universal rate year; and

17 (c) Not cost settle reimbursement referenced in this subsection.

18 (17) The department shall reimburse an individual:

19 (a) Hospital which does not operate a level II or III neonatal center, for level I neo-
20 natal care at the statewide average Medicaid allowable cost per each level I DRG;

21 (b) Level II neonatal center for level II neonatal care at the average Medicaid allowa-
22 ble cost per DRG of all level II neonatal centers; or

23 (c) Level III neonatal center for level III neonatal care at the average Medicaid allow-

1 able cost per DRG of all level III neonatal centers.

2 (18) If a patient is transferred to or from another hospital, the department shall make
3 a transfer payment to the transferring hospital if the initial admission and the transfer
4 are determined to be medically necessary.

5 (a) For a service reimbursed on a prospective discharge basis, the department shall
6 calculate the transfer payment amount based on the average daily rate of the transfer-
7 ring hospital's payment for each covered day the patient remains in that hospital, plus
8 one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

9 1. The department shall calculate an average daily rate by dividing the DRG base
10 payment by the statewide Medicaid geometric mean length-of-stay for a patient's DRG
11 classification.

12 2. If a hospital qualifies for a high volume per diem add-on payment in accordance
13 with subsection (2) of this section, the department shall pay the hospital the applicable
14 per diem add-on for the DRG average length-of-stay.

15 3. Total reimbursement to the transferring hospital shall be the transfer payment
16 amount and, if applicable, a high volume per diem add-on amount and a cost outlier
17 payment amount.

18 (b) For a hospital receiving a transferred patient, the department shall reimburse the
19 DRG base payment, and, if applicable, a high volume per diem add-on amount and a
20 cost outlier payment amount.

21 (19) The department shall treat a transfer from an acute care hospital to a qualifying
22 postacute care facility for selected DRGs in accordance with paragraph (b) of this sub-
23 section as a postacute care transfer.

1 (a) The following shall qualify as a postacute care setting:

2 1. A psychiatric, rehabilitation, children's, long-term, or cancer hospital;

3 2. A skilled nursing facility; or

4 3. A home health agency.

5 (b) A DRG eligible for a postacute care transfer payment shall be in accordance with
6 42 U.S.C. 1395ww(d)(4)(C)(i).

7 (c) The department shall pay each transferring hospital an average daily rate for
8 each day of stay.

9 1. A payment shall not exceed the full DRG payment that would have been made if
10 the patient had been discharged without being transferred.

11 2. A DRG identified by CMS as being eligible for special payment shall receive fifty
12 (50) percent of the full DRG payment plus the average daily rate for the first day of the
13 stay and fifty (50) percent of the average daily rate for the remaining days of the stay,
14 up to the full DRG base payment.

15 3. A DRG that is referenced in paragraph (b) of this subsection and not referenced in
16 subparagraph 2 of this paragraph of this subsection shall receive twice the per diem
17 rate the first day and the per diem rate for each following day of the stay prior to the
18 transfer.

19 (d) The per diem amount shall be the base DRG payment allowed divided by the
20 statewide Medicaid geometric mean length of stay for a patient's DRG classification.

21 (20) The department shall reimburse for an intrahospital transfer to or from an acute
22 care bed to or from a rehabilitation or psychiatric distinct part unit:

23 (a) The full DRG base payment allowed; and

1 (b) The facility-specific distinct part unit per diem rate, in accordance with 907 KAR
2 1:815, for each day the patient remains in the distinct part unit.

3 (21)(a) The department shall reimburse for a kidney, cornea, pancreas, or kidney
4 and pancreas transplant on a prospective per discharge method according to the pa-
5 tient's DRG classification.

6 (b) A transplant not referenced in paragraph (a) of this subsection shall be reim-
7 bursed in accordance with 907 KAR 1:350.

8 (22) The department shall adjust the non-neonatal care DRGs to result in the aggre-
9 gate universal rate year reimbursement for all services (non-neonatal and neonatal) to
10 equal the aggregate base year reimbursement for all services (non-neonatal and neo-
11 natal inflated by the trending factor).

12 Section 3. Never Events. (1) For each diagnosis on a claim, a hospital shall specify
13 on the claim whether the diagnosis was present upon the individual's admission to the
14 hospital.

15 (2) In assigning a DRG for a claim, the department shall exclude from the DRG con-
16 sideration any secondary diagnosis code associated with a hospital-acquired condition.

17 (3) A hospital shall not bill:

18 (a) A recipient for:

19 1. Treatment for or related to a hospital-acquired condition;

20 2. A never event; or

21 3. Treatment related to a never event;

22 (b) The Cabinet for Health and Family Services for:

23 1. Treatment for or related to a hospital-acquired condition associated with a child in

1 the custody of the Cabinet for Health and Family Services;
2 2. A never event associated with a child in the custody of the Cabinet for Health and
3 Family Services; or
4 3. Treatment related to a never event associated with a child in the custody of the
5 Cabinet for Health and Family Services;
6 (c) The Department for Juvenile Justice for:
7 1. Treatment for or related to a hospital-acquired condition associated with a child in
8 the custody of the Department for Juvenile Justice;
9 2. A never event associated with a child in the custody of the Department for
10 Juvenile Justice; or
11 3. Treatment related to a never event associated with a child in the custody of the
12 Department for Juvenile Justice.
13 (4) A recipient, the Cabinet for Health and Family Services, or the Department for
14 Juvenile Justice shall not be liable for:
15 (a) Treatment for or related to a hospital-acquired condition;
16 (b) A never event; or
17 (c) Treatment related to a never event.
18 (5)The department's treatment of never events, including hospital-acquired
19 conditions, shall not affect the calculation of base rates or relative weights:
20 (a) Previously implemented by the department; or
21 (b) As described in Section 2 of this administrative regulation.
22 Section 4. Preadmission Services for an Inpatient Acute Care Service. A preadmis-
23 sion service provided within three (3) calendar days immediately preceding an inpatient

1 admission reimbursable under the prospective per discharge reimbursement methodol-
2 ogy shall:

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

5 (2) Exclude a service furnished by a home health agency, a skilled nursing facility or
6 hospice, unless it is a diagnostic service related to an inpatient admission or an outpa-
7 tient maintenance dialysis service.

8 Section 5.~~[4.]~~ Direct Graduate Medical Education Costs at In-state Hospitals with
9 Medicare-approved Graduate Medical Education Programs. (1) If federal financial par-
10 ticipation for direct graduate medical education costs is not provided to the department,
11 pursuant to federal regulation or law, the department shall not reimburse for direct
12 graduate medical education costs.

13 (2) If federal financial participation for direct graduate medical education costs is pro-
14 vided to the department, the department shall reimburse for the direct costs of a gradu-
15 ate medical education program approved by Medicare as follows:

16 (a) A payment shall be made:

- 17 1. Separately from the per discharge and per diem payment methodologies; and
18 2. On an annual basis; and

19 (b) The department shall determine an annual payment amount for a hospital as fol-
20 lows:

- 21 1. The hospital-specific and national average Medicare per intern and resident
22 amount effective for Medicare payments on October 1 immediately preceding the uni-
23 versal rate year shall be provided by each approved hospital's Medicare fiscal interme-

1 diary;

2 2. The higher of the average of the Medicare hospital-specific per intern and resident
3 amount or the Medicare national average amount shall be selected;

4 3. The selected per intern and resident amount shall be multiplied by the hospital's
5 number of interns and residents used in the calculation of the indirect medical educa-
6 tion operating adjustment factor. The resulting amount shall be the estimated total ap-
7 proved direct graduate medical education costs;

8 4. The estimated total approved direct graduate medical education costs shall be di-
9 vided by the number of total inpatient days as reported in the hospital's most recently
10 finalized cost report on Worksheet D, Part 1, to determine an average approved gradu-
11 ate medical education cost per day amount;

12 5. The average graduate medical education cost per day amount shall be multiplied
13 by the number of total covered days for the hospital reported in the base year claims
14 data to determine the total graduate medical education costs related to the Medicaid
15 Program; and

16 6. Medicaid Program graduate medical education costs shall then be multiplied by
17 the budget neutrality factor.

18 Section 6.[5.] Budget Neutrality Factors. (1) When rates are rebased, estimated pro-
19 jected reimbursement in the universal rate year shall not exceed payments for the same
20 services in the prior year adjusted for inflation based on changes in the Price Index Le-
21 vels in the CMS IPPS Hospital Input Price Index~~[using the inflation factor prepared by~~
22 ~~GII for the universal rate year and adjusted for changes in patient utilization].~~

23 (2) The estimated total payments for each facility under the reimbursement metho-

1 dology in effect in the year prior to the universal rate year shall be estimated from base
2 year claims.

3 (3) The estimated total payments for each facility under the reimbursement metho-
4 dology in effect in the universal rate year shall be estimated from base year claims.

5 (4) If the sum of all the acute care hospitals' estimated payments under the metho-
6 dology used in the universal rate year exceeds the sum of all the acute care hospitals'
7 adjusted estimated payments under the prior year's reimbursement methodology, each
8 hospital's DRG base rate and per diem rate shall be multiplied by a uniform percentage
9 to result in estimated total payments for the universal rate year being equal to total ad-
10 justed payments in the year prior to the universal rate year.

11 Section 7.[6.] Reimbursement Updating Procedures. (1) For rate years between re-
12 basing periods, the department shall annually, on July 1, update the hospital-specific
13 base rates for inflation based on changes in the Price Index Levels in the CMS IPPS
14 Hospital Input Price Index from the midpoint of the previous rate year to the midpoint of
15 the universal rate year~~use the inflation factor prepared by GII for the universal rate year~~
16 ~~to inflate a hospital-specific base rate for rate years between rebasing periods].~~

17 (2) Except for an appeal in accordance with Section 21~~[Section 20]~~ of this adminis-
18 trative regulation, the department shall make no other adjustment.

19 (3) The department shall rebase DRG reimbursement rates on July 1, 2012 and
20 every fourth (4th) year after that~~[every four (4) years].~~

21 Section 8.[7.] Use of a Universal Rate Year. (1) A universal rate year shall be estab-
22 lished as July 1 through June 30 of the following year to coincide with the state fiscal
23 year.

1 (2) A hospital shall not be required to change its fiscal year to conform with a univer-
2 sal rate year.

3 Section 9[~~8~~.] Cost Reporting Requirements. (1) An in-state hospital participating in
4 the Medicaid Program shall submit to the department a copy of each Medicare cost re-
5 port it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid
6 Schedule KMAP-1 and the Supplemental Medicaid Schedule KMAP-4 as required by
7 this subsection.

8 (a) A cost report shall be submitted:

- 9 1. For the fiscal year used by the hospital; and
- 10 2. Within five (5) months after the close of the hospital's fiscal year.

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

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

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

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

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

22 (4) An in-state hospital shall submit to the department a final Medicare-audited cost
23 report upon completion by the Medicare intermediary along with an electronic cost re-

1 port file (ECR).

2 Section 10.[9-] Unallowable Costs. (1) The following shall not be allowable cost for
3 Medicaid reimbursement:

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

5 (b) A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet
6 for Health and Family Services. A legal fee relating to a lawsuit against the Cabinet for
7 Health and Family Services shall only be included as a reimbursable cost in the period
8 in which the suit is settled after a final decision has been made that the lawsuit is suc-
9 cessful or if otherwise agreed to by the parties involved or ordered by the court; and

10 (c) A cost for travel and associated expenses outside the Commonwealth of Ken-
11 tucky for the purpose of a convention, meeting, assembly, conference, or a related ac-
12 tivity, subject to the limitations of subparagraphs 1 and 2 of this paragraph..

13 1. A cost for a training or educational purpose outside the Commonwealth of Ken-
14 tucky shall be allowable.

15 2. If a meeting is not solely educational, the cost, excluding transportation, shall be
16 allowable if an educational or training component is included.

17 (2) A hospital shall identify an unallowable cost on a Supplemental Medicaid Sche-
18 dule KMAP-1.

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

21 Section 11.[10-] Trending of a Cost Report for DRG Re-basing Purposes. (1) An al-
22 lowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the
23 department, either audited or unaudited, shall be trended to the beginning of the uni-

1 universal rate year to update a hospital's Medicaid cost.

2 (2) The department shall trend for inflation based on changes in the Price Index Le-
3 vels in the CMS IPPS Hospital Input Price Index~~[use the inflation factor prepared by GH~~
4 ~~as the trending factor for the period being trended]~~.

5 Section 12~~[11-]~~ Indexing for Inflation. (1) After an allowable Medicaid cost has been
6 trended to the beginning of a universal rate year, an indexing factor shall be applied to
7 project inflationary cost in the universal rate year.

8 (2) The department shall trend for inflation based on changes in the Price Index Le-
9 vels in the CMS IPPS Hospital Input Price Index~~[use the inflation factor prepared by GH~~
10 ~~as the indexing factor for the universal rate year]~~.

11 Section 13~~[12-]~~ Readmission. (1) An inpatient admission within fourteen (14) calen-
12 dar days of discharge for the same diagnosis shall be considered a readmission and
13 reviewed by the QIO.

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

16 Section 14~~[13-]~~ Reimbursement for Out-of-state Hospitals. (1) The department shall
17 reimburse an acute care out-of-state hospital, except for a children's hospital located in
18 a Metropolitan Statistical Area as defined by the United States Office of Management
19 and Budget whose boundaries overlap Kentucky and a bordering state, and except for
20 Vanderbilt Medical Center, for inpatient care:

21 (a) On a fully-prospective per discharge basis based on the patient's diagnostic cate-
22 gory; and

23 (b) An all-inclusive rate.

1 (2) The all-inclusive rate referenced in subsection (1)(b) of this section of this admin-
2 istrative regulation shall:

3 (a) Equal the facility-specific Medicare base rate multiplied by:

4 1. 0.7065; and

5 2. The Kentucky-specific DRG relative weights after the relative weights have been
6 reduced by twenty (20) percent;

7 (b) Exclude:

8 1. Medicare indirect medical education cost or reimbursement;

9 2. High volume per diem add-on reimbursement;

10 3. Disproportionate share hospital distributions; and

11 4. Any adjustment mandated for in-state hospitals pursuant to KRS 205.638; and

12 (c) Include a cost outlier payment if the associated discharge meets the cost outlier
13 criteria established in Section 2(13) of this administrative regulation.

14 1. The department shall determine the cost outlier threshold for an out-of-state claim
15 using the same method used to determine the cost outlier threshold for an in-state
16 claim.

17 2. The department shall calculate the estimated cost of each discharge, for purposes
18 of comparing the estimated cost of each discharge to the outlier threshold, by multiply-
19 ing the sum of the hospital-specific operating and capital-related mean cost-to-charge
20 ratios by the discharge-allowed charges.

21 3. The department shall use the Medicare operating and capital-related cost-to-
22 charge ratios published in the Federal Register for outlier payment calculations as of
23 October 1 of the year immediately preceding the start of the universal rate year; and

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

3 (3) The department shall reimburse for inpatient acute care provided by an out-of-
4 state children's hospital located in a Metropolitan Statistical Area as defined by the
5 United States Office of Management and Budget and whose boundaries overlap Ken-
6 tucky and a bordering state, and except for Vanderbilt Medical Center, an all-inclusive
7 rate equal to the average all-inclusive base rate paid to in-state children's hospitals.

8 (4) The department shall reimburse for inpatient care provided by Vanderbilt Medical
9 Center at the Medicare operating and capital-related cost-to-charge ratio, extracted
10 from the CMS IPPS Pricer Program in effect at the time the care was provided, multip-
11 lied by eighty-five (85) percent. For example, if care was provided on September 13,
12 2008, the cost-to-charge ratio used shall be the cost-to-charge ratio extracted from the
13 CMS IPPS Pricer Program in effect on September 13, 2008.

14 (5) An out-of-state provider shall not be eligible to receive high volume per diem add-
15 on payments, indirect medical education reimbursement or disproportionate share hos-
16 pital payments.

17 (5) The department shall make a cost outlier payment for an approved discharge
18 meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall
19 be subject to Quality Improvement Organization review and approval.

20 (a) The department shall determine the cost outlier threshold for an out-of-state claim
21 using the same method used to determine the cost outlier threshold for an in-state
22 claim.

23 (b) The department shall calculate the estimated cost of each discharge, for purpos-

1 es of comparing the estimated cost of each discharge to the outlier threshold, by multip-
2 lying the sum of the hospital-specific operating and capital-related mean cost-to-charge
3 ratios by the discharge-allowed charges.

4 (c) The department shall use the Medicare operating and capital-related cost-to-
5 charge ratios published in the Federal Register for outlier payment calculations as of
6 October 1 of the year immediately preceding the start of the universal rate year.

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

9 Section 15.~~[14.]~~ Supplemental Payments. (1) Payment of a supplemental payment
10 established in this section shall be contingent upon the department's receipt of corres-
11 ponding federal financial participation.

12 (2) If federal financial participation is not provided to the department for a supple-
13 mental payment, the department shall not make the supplemental payment.

14 (3) In accordance with subsections (1) and (2) of this section, the department shall:

15 (a) In addition to a payment based on a rate developed under Section 2 of this ad-
16 ministrative regulation, make quarterly supplemental payments to:

17 1. A hospital that qualifies as a nonstate pediatric teaching hospital in an amount:

18 a. Equal to the sum of the hospital's Medicaid shortfall for Medicaid recipients under
19 the age of eighteen (18) plus an additional \$250,000 (\$1,000,000 annually); and

20 b. Prospectively determined by the department with an end of the year settlement
21 based on actual patient days of Medicaid recipients under the age of eighteen (18);

22 2. A hospital that qualifies as a pediatric teaching hospital and additionally meets the
23 criteria of a Type III hospital in an amount:

- 1 a. Equal to the difference between payments made in accordance with Sections 2,4
2 and 5[2, 3, and 4] of this administrative regulation and the amount allowable under 42
3 C.F.R. 447.272, not to exceed the payment limit as specified in 42 C.F.R. 447.271;
- 4 b. That is prospectively determined with no end of the year settlement; and
- 5 c. Based on the state matching contribution made available for this purpose by a fa-
6 cility that qualifies under this paragraph; and
- 7 3. A hospital that qualifies as an urban trauma center hospital in an amount:
 - 8 a. Based on the state matching contribution made available for this purpose by a
9 government entity on behalf of a facility that qualifies under this paragraph;
 - 10 b. Based upon a hospital's proportion of Medicaid patient days to total Medicaid pa-
11 tient days for all hospitals that qualify under this paragraph;
 - 12 c. That is prospectively determined with an end of the year settlement; and
 - 13 d. That is consistent with the requirements of 42 C.F.R. 447.271.
- 14 (b) Make quarterly supplemental payments to the Appalachian Regional Hospital
15 system:
 - 16 1. In an amount that is equal to the lesser of:
 - 17 a. The difference between what the department pays for inpatient services pursuant
18 to Section 2, 4, and 5[2, 3, and 4] of this administrative regulation and what Medicare
19 would pay for inpatient services to Medicaid eligible individuals; or
 - 20 b. \$7.5 million per year in aggregate;
 - 21 2. For a service provided on or after July 1, 2005; and
 - 22 3. Subject to the availability of coal severance funds, in addition to being subject to
23 the availability of federal financial participation, which supply the state's share to be

1 matched with federal funds;

2 (c) Base a quarterly payment to a hospital in the Appalachian Regional Hospital Sys-
3 tem on its Medicaid claim volume in comparison to the Medicaid claim volume of each
4 hospital within the Appalachian Regional Hospital System; and

5 (d) Make a supplemental payment to an in-state high intensity level II neonatal center
6 of \$2,870 per paid discharge for a DRG 675 - 680.

7 (4) An overpayment made to a facility under this section shall be recovered by sub-
8 tracting the overpayment amount from a succeeding year's payment to be made to the
9 facility.

10 (5) For the purpose of this section, Medicaid patient days shall not include days for a
11 Medicaid recipient eligible to participate in the state's Section 1115 waiver as described
12 in 907 KAR 1:705.

13 (6) A payment made under this section shall not duplicate a payment made via 907
14 KAR 1:820.

15 (7) A payment made in accordance with this section shall be in compliance with the
16 limitations established in 42 C.F.R. 447.272.

17 Section 16,~~[15]~~ Certified Public Expenditures. (1) The department shall reimburse an
18 in-state public government-owned or operated hospital the full cost of an inpatient ser-
19 vice via a certified public expenditure (CPE) contingent upon approval by the Centers
20 for Medicare and Medicaid Services (CMS).

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

23 (3) The department shall verify whether or not a given CPE is allowable as a Medica-

1 id cost.

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

5 (b) If any difference between actual cost and submitted costs remains, the depart-
6 ment shall reconcile any difference with the provider.

7 Section 17.~~[16.]~~ Access to Subcontractor's Records. If a hospital has a contract with
8 a subcontractor for services costing or valued at \$10,000 or more over a twelve (12)
9 month period:

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

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

12 (b) In accordance with 907 KAR 1:672; and

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

15 Section 18.~~[17.]~~ New Provider, Change of Ownership, or Merged Facility. (1) If a
16 hospital undergoes a change of ownership, the new owner shall continue to be reim-
17 bursed at the rate in effect at the time of the change of ownership.

18 (2)(a) 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 (b) During the projected rate year, the budget shall be adjusted if indicated and justi-
22 fied by the submittal of additional information.

23 (3) If two (2) or more separate entities merge into one (1) organization, the depart-

1 ment shall:

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

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

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

6 (d) Compute on a weighted average the rate of increase control applicable to each
7 entity, based on the reported paid Medicaid days for each entity taken from the cost re-
8 port previously used for rate setting; and

9 (e) Require each provider to submit a cost report for the period:

10 1. Ended as of the day before the merger within five (5) months of the end of the
11 hospital's fiscal year end; and

12 2. Starting with the day of the merger and ending on the fiscal year end of the
13 merged entity in accordance with Section 8 of this administrative regulation.

14 Section 19.~~[18.]~~ Federal Financial Participation. A provision established in this
15 administrative regulation shall be null and void if the Centers for Medicare and Medicaid
16 Services:

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

18 (2) Disapproves the provision.~~[A provision established in this administrative~~
19 ~~regulation shall be effective contingent upon the department's receipt of federal~~
20 ~~financial participation for the respective provision.]~~

21 Section 20.~~[19.]~~ Department reimbursement for inpatient hospital care shall not ex-
22 ceed the upper payment limit established in 42 C.F.R. 447.271 or 447.272.

23 Section 21.~~[20.]~~ Appeals. (1) An administrative review shall not be available for the

1 following:

2 (a) A determination of the requirement, or the proportional amount, of a budget neu-
3 trality adjustment in the prospective payment rate; or

4 (b) The establishment of:

5 1. Diagnostic related groups;

6 2. The methodology for the classification of an inpatient discharge within a DRG; or

7 3. An appropriate weighting factor which reflects the relative hospital resources used
8 with respect to a discharge within a DRG.

9 (2) An appeal shall comply with the review and appeal provisions established in 907
10 KAR 1:671.

11 Section 22.~~[24.]~~ Incorporation by Reference. (1) The following material is incorpo-
12 rated by reference:

13 (a) "Supplemental Medicaid Schedule KMAP-1"; January 2007 edition; [~~and~~]

14 (b) "Supplemental Medicaid Schedule KMAP-4", January 2007 edition; and

15 (c) "CMS Manual System Pub 100-03 Medicare National Coverage Determinations
16 Transmittal 101," June 12, 2009 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. (35 Ky.R. 484; Am. 1255;
20 1475; eff. 1-5-2009.)

907 KAR 1:825

REVIEWED:

Date

Elizabeth A. Johnson, Commissioner
Department for Medicaid Services

APPROVED:

Date

Janie Miller, Secretary
Cabinet for Health and Family Services

907 KAR 1:825

A public hearing on this administrative regulation shall, if requested, be held on August 23, 2010, at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by August 16, 2010, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business August 31, 2010. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 1:825

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact: Jill Hunter (502) 564-5707, Darlene Burgess (502) 564-5707 or Stuart Owen (502) 564-2015

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes the method for determining the amount payable by the Medicaid program for inpatient hospital acute care.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Medicaid program's reimbursement for inpatient hospital acute care as required by 42 USC 1396d(a)(1) and KRS 205.560.
 - (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 the Medicaid program's reimbursement for inpatient hospital acute care as required by 42 USC 1396d(a)(1) and KRS 205.560.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing the Medicaid program's reimbursement for inpatient hospital acute care as required by 42 USC 1396d(a)(1) and KRS 205.560.

- (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: The amendment eliminates Medicaid reimbursement of care related to conditions acquired by patients in a hospital unrelated to the condition for which the patient was admitted to the hospital and care associated with events which never should have happened. The policy only applies to acute care hospitals as the Centers for Medicare and Medicaid Services (CMS) exempts miscellaneous other hospital types from the policy. The amendment also entails language and formatting revisions to comply with KRS Chapter 13A requirements.
 - (b) The necessity of the amendment to this administrative regulation: The amendment is necessary to comply with guidance from the Centers for Medicare and Medicaid Services (CMS). The amendment is also necessary to provide a substantial incentive to hospitals to ensure that they avoid putting patients at risk of acquiring a medical problem – while in the hospital – unrelated to the patient's admitting problem.
 - (c) How the amendment conforms to the content of the authorizing statutes: The amendment – which addresses Medicaid inpatient hospital reimbursement - conforms with KRS 194A030(2) which establishes the Department for Medicaid Services as the single state agency authorized to administer Title XIX of the

Social Security Act. The amendment also confirms with KRS 194A.050(1) which charges the Cabinet for Health and Family Services secretary to “. . . . adopt administrative regulations necessary under applicable laws to protect, develop, and maintain the healthof the individual citizens of the Commonwealth”

- (d) How the amendment will assist in the effective administration of the statutes: The amendment is expected to assist in the effective administration of KRS 194A.050(1) by providing a substantial incentive to hospitals to ensure that they avoid putting patients at risk of acquiring a medical problem – while in the hospital – unrelated to the patient’s admitting problem.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There are approximately sixty-five (65) acute care hospitals in Kentucky.
- (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. No compliance action is mandated; however, acute care hospitals will not be reimbursed for treatment of a condition a patient acquires – unrelated to their admitting condition – while in the hospital or for care associated with a never event.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). This amendment imposes no cost on the regulated entities.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3)? The Department for Medicaid Services (DMS) hopes that the incidence rate of hospital-acquired conditions and never events will drop as a result of the amendment; thus, benefiting inpatient hospital patients.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: The Department for Medicaid Services (DMS) projects that the amendment will reduce expenditures by approximately \$300,000 (state and federal shares combined) annually.
 - (b) On a continuing basis: DMS projects that the amendment will reduce expenditures by approximately \$300,000 (state and federal shares combined) annually.
- (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 and matching funds of general fund appropriations.

- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding will be necessary to implement the amendment to this administrative regulation.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation neither establishes nor increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used.) Tiering was not applied in this administrative regulation because it applies equally to all individuals or entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:825

Agency Contact: Jill Hunter (502) 564-5707, Darlene Burgess (502) 564-5707 or Stuart Owen (502) 564-2015

1. Federal statute or regulation constituting the federal mandate. Public Law 111-148 (Section 2702), 42 USC 1395ww(d)(4)(D), 42 CFR 447.253, 42 CFR 447.272 and 42 CFR 447.250.
2. State compliance standards. KRS 205.560(2) states, "(2) Payments for hospital care, nursing-home care, and drugs or other medical, ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount of the payment to the cost of providing the services or supplies. KRS 205.520(3) states, "to qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."
3. Minimum or uniform standards contained in the federal mandate. Pursuant to 42 CFR 447.253(b)(1), State Medicaid programs must reimburse for inpatient hospital services "through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards."

Pursuant to 42 CFR 447.253(b)(2), State Medicaid programs reimbursement for inpatient hospitals must "not exceed the upper payment limits as specified in 42 CFR 447.272."

Pursuant to 42 CFR 447.253(c), "In determining payment when there has been a sale or transfer of the assets of a hospital, the state's methods and standards must provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than the payments would increase under Medicare under §§413.130, 413.134, 413.153, and 413.157 of this chapter, insofar as these sections affect payments for depreciation, interest on capital indebtedness, return on equity capital (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

Public Law 111-148, Section 2702 states, "(a) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall identify current State practices that prohibit payment for health care acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall pro-

hibit payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment regarding hospital-acquired conditions has been mandated to become effective July 1, 2011 and is currently “encouraged” by the Centers for Medicare and Medicaid Services (CMS) via a letter to state Medicaid directors numbered “SMDL 08-004.”
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The policy is not stricter than the federal guidance.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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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? The Department for Medicaid Services (DMS) will be affected by the amendment and any hospital owned by local government could be affected if patients in the hospital acquire conditions – while in the hospital - unrelated to the medical condition for which they sought treatment in the hospital.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), KRS 205.560(2), 42 USC 1396a(a)(10), 42 USC 1396d(a)(1), Public Law 111-148 (Section 2702), 42 USC 1395ww(d)(4)(D), 42 CFR 447.253, 42 CFR 447.272 and 42 CFR 447.250.

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? DMS anticipates no revenue being generated for the first year for state or local government due to the amendment to this administrative regulation.

(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? DMS anticipates no revenue being generated in subsequent years for state or local government due to the amendment to this administrative regulation.

(c) How much will it cost to administer this program for the first year? As a result of the amendment, DMS will experience minimal administrative cost in the form of Medicaid Management Information System (MMIS) programming changes. Conversely, the Department for Medicaid Services (DMS) projects that the

amendment will reduce expenditures by approximately \$300,000 (state and federal shares combined) annually.

- (d) How much will it cost to administer this program for subsequent years? No cost is anticipated for subsequent years. DMS projects that the amendment will reduce expenditures by approximately \$300,000 (state and federal shares combined) annually.

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

907 KAR 1:825, Diagnosis-related group (DRG) inpatient hospital reimbursement

Summary of Material Incorporated by Reference

(1) The forms “Supplemental Medicaid Schedule KMAP-1 and KMAP4”, January 2007 editions are incorporated by reference and are used by participating providers for cost reporting purposes. Each form contains one (1) page.

(2) The “CMS Manual System Pub 100-03 Medicare National Coverage Determinations Transmittal 101”; June 12, 2009 edition is an eleven (11)-page document establishing procedures, services, or hospitalizations known as never events which are not reimbursable by the Centers for Medicare and Medicaid Services (CMS). The Department for Medicaid Services (DMS) is mirroring the CMS policy regarding these procedures, services, or hospitalizations.

A total of thirteen (13) pages are incorporated by reference.