(1) General Overview

A. Beginning October 15, 2007, the Department will pay for inpatient hospital services in general acute care hospitals under a revised DRG-based methodology. The methodology is similar to the Medicare Prospective Payment System. The revised system will have hospital specific operating and capital base rates, and Kentucky specific relative weights. Hospital services not paid for using the DRG-based methodology will be paid for using per diem rates unless otherwise stated in this plan.

The following will be excluded from the DRG methodology:

1. Services provided in Critical access hospitals;

2. Services provided in Free-standing rehabilitation hospitals;

3. Services provided in Long-term acute care hospitals;

4. Psychiatric services in Acute care hospitals;

5. Services provided in Free-standing psychiatric hospitals;

6. Rehabilitation services in Acute care hospitals; and

7. Transplant services, other than kidney, pancreas, and cornea.

B. Appeals and Review Process. Hospitals will be able to utilize the dispute resolution and appeals process described in 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative process, and sanctions. (Revised effective 12-19-2001).

1. An appeal shall comply with the review and appeal provisions established in 907 KAR 1:671, as previously cited.

2. An appeal shall not be allowable unless compliant with the terms and conditions shown in 907 KAR 1:671, as previously cited.

3. An administrative review shall specifically not be available for the following; this listing of exclusions is not to be considered exhaustive or complete:

a. A determination of the requirement, or the proportional amount, of a budget neutrality adjustment in the prospective payment rate; or

b. The establishment of:

1) Diagnostic related groups;

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

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

C. Adjustment of rates

1. Final rates are not adjusted except for correction of errors, to make changes resulting from the dispute resolution or appeals process if the decision determines that rates were not established in accordance with the approved State Plan, Attachment 4.19-A (attachment), or to make changes resulting from Federal Court orders including to the extent necessary action to expand the effect of a Federal Court order to similarly situated facilities.

2. New rates may be set for each universal rate year, and at any point in the rate year when necessitated by a change in the applicable statute or regulation subject to a state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS).

D. Use of a Universal Rate Year

1. A universal rate year shall be established as July 1 through June 30 of the following year to coincide with the state fiscal year.

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

E. Cost Reporting Requirements. The department follows the Medicare Principles of reimbursement found in 42 CFR 413 and the CMS Publication 15 to determine allowable cost. Additional cost report requirements are as follows:

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

   a. A cost report shall be submitted:

      1) For the fiscal year used by the hospital; and

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

   b. Except as follows, the department shall not grant a cost report submittal extension:

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

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

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

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

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

F. Unallowable Costs

1. The following shall not be allowable cost for Medicaid reimbursement unless otherwise noted:

   a. A cost associated with a political contribution;

   b. The allowability of legal fees is determined in accordance with the following:

      1) A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet for Health and Family Services is not allowable;

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

   c. Cost associated with travel and related expenses must take into consideration the following:

      1) A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity is not allowable.

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

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

2. A hospital shall identify an unallowable cost on the Supplemental Medicaid Schedule KMAP-1.

3. The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report.

G. Trending of an In-state Hospital's Cost Report Used for Non-DRG Rate Setting Purposes.

1. An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the department, either audited or un-audited, shall be trended from the midpoint of the cost report year to the beginning of the universal rate year to update an in-state hospital's Medicaid cost. This methodology applies for all rate setting throughout this attachment.

2. The trending factor to be used shall be the inflation factor prepared by GII (Global Insight, Incorporated, a market basket data indexing and forecasting firm referred to as GII) for the period being trended.

H. Indexing for Inflation of an In-state Hospital's Cost Report Used for Rate Setting Purposes.

1. After an allowable Medicaid cost has been trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost to the midpoint in the universal rate year. This methodology applies for all rate setting throughout this attachment.

2. The department shall use the inflation factor prepared by GII (Global Insight, Incorporated) as the indexing factor for the universal rate year.

I. Cost Basis.

1. An allowable Medicaid cost shall:

   a. Be a cost allowed after a Medicaid or Medicare audit;

   b. Be in accordance with 42 C.F.R. Part 413;

   c. Include an in-state hospital's provider tax; and

   d. Not include a cost in the Unallowable Costs listed in Section (I)F of this attachment.

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

3. A prospective rate shall not be subject to retroactive adjustment, except for:

   a. A critical access hospital; or
   b. A facility with a rate based on un-audited data.

4. An overpayment shall be recouped by the department as follows:

   a. A provider owing an overpayment shall submit the amount of the overpayment to the department; or

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

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

1. The contract shall contain a provision granting the department access:

   a. To the subcontractor's financial information; and

   b. In accordance with 907 KAR 1:672, published on January 4, 2008, Provider enrollment, disclosure, and documentation for Medicaid participation; and

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

K. New Provider, Change of Owner or Merged Facility

1. A new provider.

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

   b. During the projected rate year, the budget shall be adjusted if indicated and justified by the submittal of additional information.

2. If a hospital undergoes a change of ownership, the new owner shall be reimbursed at the rate in place at the time of the ownership change.

3. A merged facility of two or more entities.

4. a. The merger of two per diem facilities shall:

   1.) Merge the latest available data used for rate setting.

   2.) Combine bed utilization statistics, creating a new occupancy ratio.

   3.) Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs.

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

   5.) Recognize an appeal of the merged per diem rate in accordance with the state regulation on Conditions of Medicaid provider participation, withholding overpayments, administrative appeal process, and sanctions.

   b. In the merger of two DRG facilities, the rate of the purchasing facility shall be applicable to the merged entity.

   c. In the merger of a per diem facility and a DRG facility, the facility shall elect either a per diem style of reimbursement or a DRG style of reimbursement. Upon determination of the style, the rate shall be set in accordance with either item a. or item b. of this subsection.

5. Cost report submission.

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

   b. A Medicaid cost report for the period starting with the day of the merger and ending on the fiscal year end for the merged entity shall also be filed with the department in accordance with this attachment.

L. Payment Not to Exceed Charges or the Upper Payment Limits.

1. The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges plus disproportionate share payments, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges, the state will recoup payments in excess of allowable charges plus disproportionate share payments.

2. The state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement. Medicare upper payment limits as required by 42 CFR 447.272 will be determined in advance of the fiscal year from cost report and other applicable data from the most recent rate setting as compared to reimbursement for the same period. Cost data and reimbursement shall be trended forward to reflect current year upper payment limits. See Exhibit A for detail description and formula for UPL demonstration.

M. Public Process for Determining Rates for Inpatient Hospitals. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

N. The Hospital Provider Tax is described in Kentucky Revised Statute 142.303, revised June 26, 2007.

(2) Acute Care Hospital Services

A. DRG-Based Methodology

1. An in-state acute care hospital shall be paid for an inpatient acute care service on a fully-prospective per discharge basis.

2. For an inpatient acute care service in an in-state acute care hospital, the total hospital-specific per discharge payment shall be the sum of:

   a. A DRG base payment;
   b. If applicable, a high volume per diem payment; and
   c. If applicable, a cost outlier payment amount.

3. For a rate effective on or after January 5, 2009, the department shall assign to the base year claims data as described in item 5(c), DRG classifications from Medicare grouper version twenty-four (24) effective in the Medicare inpatient prospective payment system as of October 1, 2006.

4. A DRG base payment shall be calculated for a discharge by multiplying the hospital specific base rate by the DRG relative weight.

5. Calculating base rates.

   a. The department shall determine a base rate by calculating hospital cost per discharge, adjusted for hospital case mix, outlier payments medical education costs and budget neutrality as described in subsections (5) through (11) of this section.

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

   c. For rates effective on or after January 5, 2009, the base year claims data for calculating a hospital specific cost per discharge shall be calculated using state fiscal year 2006 inpatient Medicaid paid claims data.

6. Calculating cost to charge ratios.

   a. The department shall calculate hospital-specific cost to charge ratios for the fifteen (15) cost centers displayed in Table 1 below.
   b. If a hospital lacks cost-to-charge information for a given cost center or if the hospital's cost-to-charge ratio is above or below three (3) standard deviations from the mean of a log distribution of cost-to-charge ratios, the department shall use the statewide geometric mean cost-to-charge ratio for the given cost center.

   c. The department shall base cost center specific cost-to-charge ratios on cost and charge data extracted from the most recently submitted CMS Form 2552 Medicare cost report.

The costs used in the cost-to-charge ratios, which include operating and capital costs and exclude direct medical education costs, are extracted from Worksheet C, Part I, Column 5. The charges used in the cost-to-charge ratios are extracted from Worksheet C, Part I, Column 8.

Table 1. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk

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

7. For hospitals with interns and residents cost-reported on Medicare cost report Worksheet B, Part I, Columns 22 and 23, the department shall multiply each of the hospital's cost-to-charge ratios by its indirect medical education adjustment factor. A hospital's indirect medical education adjustment factor shall be calculated as follows:

a. Compute the costs of interns and residents before the allocation of overhead costs to the patient service cost centers in Medicare cost report Worksheet B, Part I by summing the costs found in Column 0, Lines 22 and 23; and

b. Compute the costs of interns and residents after the allocation of overhead costs to the patient service cost centers in Medicare cost report Worksheet B, Part I by summing the costs found in Columns 22 and 23, Line 103; and

c. Compute the difference in costs of interns and residents after the allocation of overhead costs to the patient service cost centers in the Medicare cost report Worksheet B, Part I (as determined in (b) of this subsection) and before the allocation (as determined in (a) of this subsection); and

d. Divide the difference calculated in (c) of this subsection by total costs after allocation, found in Medicare cost report Worksheet B, Part I, Column 27, Line 103.

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

a. Claims paid under a managed care program;

b. Claims for rehabilitation and psychiatric discharges reimbursed on a per diem basis;

c. Claims in hospital-based skilled nursing facilities or long-term care units;

d. Transplant claims other than kidney, pancreas, and cornea; and

e. Revenue codes not covered by the Medicaid Program; and

f. Claims with charges equal to zero (0).

9 Calculating the Cost of a base year claim.

a. The department shall calculate the Medicaid cost of a base year claim by multiplying the charges from each Medicaid covered revenue code by the corresponding cost center specific cost-to-charge ratio.

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

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

10. Using the base year Medicaid claims referenced in subsection (8) of this Section, the department shall compute an average hospital specific cost per discharge by dividing a hospital's Medicaid costs as determined in subsection 9 by its number of Medicaid discharges.

11. The department shall determine an in-state acute care hospital's DRG base payment rate by adjusting the hospital's average cost per discharge by the hospital's case mix index, expected outlier payments and budget neutrality factors.

a. Case mix calculations.

1) A hospital's case mix adjusted cost per discharge shall be calculated by dividing the

hospital's average cost per discharge by its case mix index; and

2) The hospital's case mix index shall be equal to the average of its DRG relative weights for acute care services for base year Medicaid discharges referenced in subsection 8 above.

b. Case mix adjustments.

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

2) The initial budget neutrality factor for rates effective January 5, 2009 shall be 0.7065 for all hospitals.

3) When rates are rebased, the initial budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted to eliminate changes in patient volume and wage index as published by CMS in the Federal Register.

c. Consideration of outliers.

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

2) A hospital-specific outlier payment factor shall be calculated using the following formula: ((expected DRG non-outlier payments) - (expected proposed DRG outlier payments))/(expected DRG non-outlier payments).

d. Consideration of budget neutrality.

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

2) The secondary budget neutrality factor for rates effective January 5, 2009, shall be 1.0562.

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

12. High volume adjustments as of October 15, 2007.

a. The department shall make a high volume per diem payment to an in-state acute care hospital for the rate year beginning October 15, 2007 in addition to the DRG base payment rate.

b. To qualify for high volume per diem payments, a hospital must meet either the Kentucky Medicaid patient days criteria or the Kentucky Medicaid utilization percentage as shown in Table 2.

c. A high volume per diem payment shall be equal to the applicable high volume per diem amount multiplied by the DRG's statewide arithmetic mean length-of-stay.

d. The DRG statewide arithmetic mean length of stay shall be calculated using the base year claims described in section (2)A.5.c.

e. The department shall pay the greater of the high volume per diem payment for estimated Kentucky Medicaid inpatient days or Kentucky Medicaid inpatient days utilization criteria established in Table 2 below:

Table 2 - High Volume Adjustment Eligibility Criteria as of October 15, 2007			
Kentucky Medicaid Inpatient Days		Kentucky Medicaid Inpatient Days Utilization	
Days Range	Per Diem Payment	Medicaid Utilization Range	Per Diem Payment
3,000 – 4,200 days	$40 per day	19.5% - 20%	$50 per day
4,200 -- 5,600 days	$60 per day	20.1% - 27.2%	$115 per day
5,600 - 9,000 days	$100 per day	27.3% - above	$125 per day
9,000 - 20,000 days	$125 per day		
20,000 and above days	$205 per day		

f. Base year classification.

1) The department shall use base year claims data referenced in section (2)A.5.c to determine if a hospital qualifies for a high volume per diem add-on payment.

2) As of October 15, 2007, the department shall determine Kentucky Medicaid inpatient days for a hospital by multiplying the DRG classification for each base year claim by the corresponding Kentucky DRG average length of stay.

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.

13. High volume adjustments as of November 15, 2007.

a. The department shall make a high volume per diem payment to an in-state acute care hospital beginning November 15, 2007 in addition to the DRG base payment rate.

b. To qualify for high volume per diem payments, a hospital must meet either the Kentucky Medicaid patient days criteria or the Kentucky Medicaid utilization percentage as shown in Table 3.

c. A high volume per diem payment shall be equal to the applicable high volume per diem amount multiplied by the DRG's statewide arithmetic mean length-of-stay.

d. The DRG statewide arithmetic mean length of stay shall be calculated using the base year claims referenced in section (2)A.5.c.

e. The department shall pay the greater of the high volume per diem payment for covered Kentucky Medicaid inpatient days criteria or Kentucky Medicaid inpatient days utilization percent criteria established in Table 3 below:

Table 3 – High Volume Adjustment Eligibility Criteria as of November 15, 2007			
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 - 7,399 days	$45.00 per day	16.2% - 21.6%	$45.00 per day
7,400 - 10,999 days	$129.00 per day	21.7% - 27.2%	$81.00 per day
11,000 – 19,999 days	$172.00 per day	27.3% - 100.00%	$92.75 per day
20,000 and above days	$306.00 per day		

f. The department shall use base year claims data referenced in item (2)A.5.c 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.

14. High volume adjustments as of January 5, 2009.

a. The department shall make a high volume per diem payment, except as excluded in item b. of this list, to an in-state acute care hospital beginning January 5, 2009 in addition to the DRG base payment rate, for each diagnostic category.

b. To qualify for high volume per diem payments, a hospital must meet either the Kentucky Medicaid patient days criteria or the Kentucky Medicaid utilization percentage as shown in Table 4.

c. A high volume per diem payment shall be made in the form of a per diem ad on amount in addition to the DRG base payment rate encompassing the DRG average length-of-stay days per discharge.

d. A high volume per diem payment shall be equal to the applicable high volume per diem amount multiplied by the DRG's statewide arithmetic mean length-of-stay.

e. The DRG statewide arithmetic mean length of stay shall be calculated using the base year claims referenced in section (2)A.5.c.

f. The department shall pay the greater of the high volume per diem payment for covered Kentucky Medicaid inpatient days criteria or Kentucky Medicaid inpatient days utilization percent criteria established in Table 4 below:

Table 4 High Volume Adjustment Eligibility Criteria as of January 5, 2009

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%	$92.75 per day
11,000 – 19,999 days	$163.49 per day		
20,000 and above days	$325.00 per day		

f. The department shall use base year claims data referenced in Item (2)A.5.a 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. The department shall not make a high volume per diem payment for a level I neonatal center, level II neonatal center, or level III neonatal center.

i. A level I neonatal center, level II neonatal center, or level III neonatal center claim shall be included in a hospital's high volume adjustment eligibility criteria calculation.

15. Cost outlier adjustments.

a. The department shall make an additional cost outlier payment for an approved discharge paid under the DRG-based methodology, and meeting the Medicaid criteria for a cost outlier payment.

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

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

d. Outlier calculations.

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

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

e. Outlier thresholds.

1) The department shall calculate an outlier threshold as the sum of a hospital's DRG [illegible]

base payment or transfer payment, before outlier payments and excluding Medicaid high volume per diem payments, and the fixed loss cost threshold.

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

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

16. The department shall calculate Kentucky Medicaid-specific DRG relative weights by:

a. Relative weight factors.

1) Selecting Kentucky base year Medicaid inpatient paid claims, excluding those described in subsection (8) of this section;

2) For rates effective January 5, 2009, a hospital-specific cost per discharge shall be calculated using state fiscal year 2006 inpatient Medicaid paid claims data;

b. DRG Classification.

1) Reassigning the DRG classification for the base year claims based on the Medicare DRG in effect in the Medicare inpatient prospective payment system at the time of rebasing; and

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

3) Consideration of DRG usage:

a) Arraying DRGs with less than twenty-five (25) cases in the base year in order by the Medicare DRG relative weight in effect in the Medicare inpatient prospective payment system for the Medicare DRG grouper version twenty-four (24), published in the Federal Register, relied upon for Kentucky DRG classifications; and

b) For rates effective June 16, 2008, the department shall use the Medicare DRG relative weights which were effective for the Medicare inpatient prospective payment system as of October 1, 2006;

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

5) Calculating DRG relative weights for each category; and

6) Assigning the relative weight calculated for a category to each DRG included in the category;

c. Removing the following claims from the calculation:

1) Claims data for a discharge reimbursed on a per diem basis including:

a) A psychiatric claim, defined as follows:

(i) An acute care hospital claim with a psychiatric DRG;
(ii) A psychiatric distinct part unit claim; and
(iii) a psychiatric hospital claim;

b) A rehabilitation claim, defined as follows:

(i) An acute care hospital claim with rehabilitation DRG;
(ii) a rehabilitation distinct part unit claim; and
(iii) A rehabilitation hospital claim;

c) A critical access hospital claim; and

d) A long term acute care hospital claim;

2) A transplant service claim as specified in item 21 of this section;

3) A claim for a patient discharged from an out-of-state hospital; and

4) A claim with total charges equal to zero (0);

d. Calculating relative weight values for DRGs with twenty-five (25) or more cases in the base year, by:

1) General considerations.

a) Standardizing the labor portion of the cost of a claim for differences in Medicare wage indices and the full cost of a claim for differences in Medicare indirect medical education factors using Medicare rate components;

b) For rates effective January 5, 2009, base year Medicare rate components shall equal Medicare rate components effective in the Medicare inpatient prospective payment system as of October 1, 2005; and

c) Base year Medicare rate components used in the Kentucky inpatient prospective payment system include:

(i) Labor-related percentage and non-labor-related percentage;
(ii) Operating and capital cost-to-charge ratios;
(iii) Operating indirect medical education factors; and
(iv) Wage indices;

2) Cost factors.

a) The department shall standardize costs using the following formula: standard cost = [((labor related percentage X costs)/Medicare wage index) + (nonlabor related percentage X costs)]/(1 + Medicare operating indirect medical education factor); and

b) For rates effective January 5, 2009, the labor related percentage shall equal sixty-two (62) percent and the nonlabor related percentage shall equal thirty-eight (38) percent;

3) Removing statistical outliers by deleting any claim that is:

a) Above or below three (3) standard deviations from the mean cost per discharge for each DRG; and

b) Above or below three (3) standard deviations from the mean cost per day for each DRG;

e. Computing an average standardized cost for all DRGs in aggregate and for each DRG or low volume DRG category, excluding statistical outliers;

f. Computing DRG relative weights:

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

2) For a DRG with less than twenty-five (25) claims in the base year by dividing the average cost per discharge for each of the five (5) low volume DRG categories by the statewide average cost per discharge; and

g. Calculating, for the purpose of a transfer payment, Kentucky Medicaid geometric mean length of stay for each DRG and low volume DRG category based on the base year claims data used to calculate DRG relative weights.

h. Employing enhanced neonatal care relative weights as follows:

1) Excluding high intensity level II neonatal center claims and low intensity level III neonatal center claims from the neonatal care relative weight calculations; and

2) Applying an adjustment factor to relative weights not referenced in paragraph 1) of this subsection to offset the level I, II, and III neonatal care relative weight increase resulting from the use of enhanced neonatal care relative weights.

3) See Exhibit C of this attachment for the detailed calculations.

17. The department shall:

a. Separately reimburse for a mother's stay and a newborn's stay based on the DRG assigned to the mother's stay and to the newborn's stay;

b. Establish a unique set of diagnostic categories and relative weights for in-state acute care hospitals identified by the department providing level I neonatal care, qualifying as a level II neonatal care center and level III neonatal care center, as follows:

1) The department shall exclude high intensity level II neonatal center claims and low intensity level III neonatal center claims from the neonatal center relative weight calculations;

2) The department shall reassign a claim that would have been assigned to a Medicare DRG 385-390 to a Kentucky-specific:

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

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

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

4) Computations and calculations.

a) The department shall compute a separate relative weight for a level II or III neonatal intensive care unit (NICU) neonatal DRG;

b) As of October 15, 2007, the department shall use base year claims from level II neonatal centers to calculate relative weights for DRGs 675-680.

c) As of November 15, 2007, the department shall use base year claims from level II neonatal centers, excluding claims from any high intensity level II neonatal center, to calculate relative weights for DRGs 675-680; and

d) The department shall use base year claims from level III neonatal centers to calculate relative weights for DRGs 685-690.

18. The department shall:

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

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

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

3) A total expenditure for level III neonatal center care projected to equal 100% of Medicaid allowable cost for the universal rate year.

4) Medicaid allowable cost shall be determined based on the providers CMS 2552-96 Medicare cost report.

b. Adjust neonatal care DRG relative weights to result in:

1) Total expenditures for level I Neonatal care projected to equal 100% of Medicaid allowable cost for the universal rate year;

2) Total expenditures for level II Neonatal care projected to equal 100% of Medicaid allowable cost for the universal rate year; or

3) Total expenditures for level III Neonatal care projected to equal 100% of Medicaid allowable cost for the universal rate year; and

c. Not cost settle reimbursement referenced in this subsection.

19. The department shall reimburse an individual:

a. Level I neonatal center for level I neonatal care at the average Medicaid allowable cost per DRG of all level I neonatal centers;

b. Level II neonatal center for level II neonatal care at the average Medicaid allowable cost per DRG of all level II neonatal centers; or

c. Level III neonatal center for level III neonatal care at the average Medicaid allowable cost per DRG of all level III neonatal centers.

20. The department shall adjust the non-neonatal care DRGs to result in the aggregate universal rate year reimbursement for all services (non-neonatal and neonatal) to equal the aggregate base year reimbursement for all services (non-neonatal and neonatal) inflated by the trending factor.

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

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

1) The department shall calculate an average daily rate by dividing the DRG base payment, excluding outlier payments and Medicaid high volume per diem payments, by the statewide Medicaid geometric mean length-of-stay for a patient's DRG classification.

2) If a hospital qualifies for a high volume per diem add-on payment in accordance with

Section (2)A 12 of this attachment under the DRG-based methodology, the department shall pay the hospital the applicable per diem add-on for the DRG average length-of-stay.

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

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

22. The department shall treat a transfer from an acute care hospital to a qualifying post-acute care facility for selected DRGs in accordance with paragraph (b) of this subsection as a post-acute care transfer.

a. The following shall qualify as a post-acute care setting:

1) A psychiatric, rehabilitation, children's hospital, long-term acute care hospital, or cancer hospital;
2) A skilled nursing facility; or
3) A home health agency.

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

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

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

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

3) A DRG that is referenced in item 22.b. and not referenced in item 22.c.2. shall receive twice the per diem rate the first day and the per diem rate for each following day of the stay prior to the transfer.

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

23. The department shall reimburse for an intrahospital transfer to or from an acute care bed to or from a rehabilitation or psychiatric distinct part unit;

a. The full DRG base payment allowed; and

b. The facility-specific distinct part unit per diem rate for each day the patient remains in the distinct part unit.

24. Transplant services.

a. The department shall reimburse for a kidney, cornea, pancreas, or kidney and pancreas transplant on a prospective per discharge method according to the patient's DRG classification.

b. A transplant not referenced in paragraph (a) of this subsection, shall be reimbursed in accordance with 907 KAR 1:350 published on January 5, 2007, Coverage and payments for organ transplants.

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

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

b. Exclude a service furnished by a home health agency, a skilled nursing facility or hospice unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.

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

a. If federal financial participation for direct graduate medical education costs is not provided to the department, pursuant to 42 C.F.R. 447.201(c) or other federal regulation or law, the department shall not reimburse for direct graduate medical education costs.

b. If federal financial participation for direct graduate medical education costs is provided to the department, the department shall reimburse for the direct costs of a graduate medical education program approved by Medicare as follows

1) A payment shall be made:

a) Separately from the per discharge and per diem payment methodologies; and

b) On an annual basis; and

2) The department shall determine an annual payment amount for a hospital as follows:

a) The hospital-specific and national average Medicare per intern and resident amount effective for Medicare payments on October 1 immediately preceding the universal rate year shall be provided by each approved hospital's Medicare fiscal intermediary;

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

c) The selected per intern and resident amount shall be multiplied by the hospital's number of interns and residents used in the calculation of the indirect medical education operating adjustment factor. The resulting amount is an estimate of total approved direct graduate medical education costs;

d) The estimated total approved direct graduate medical education costs shall be divided by the number of total inpatient days as reported in the hospital's most recently finalized cost report on Worksheet D, Part 1, to determine an average approved graduate medical education cost per day amount;

e) The average graduate medical education cost per day amount shall be multiplied by the number of total covered days for the hospital reported in the base year claims data, excluding services described in subsection (8), to determine the total graduate medical education costs related to the Medicaid Program; and

f) Medicaid Program graduate medical education costs shall then be multiplied by the budget neutrality factor.

27. Budget Neutrality Factors.

a. When rates are rebased, estimated projected reimbursement in the universal rate year shall not exceed payments for the same services in the prior year adjusted for inflation using the inflation factor prepared by GII for the universal rate year and adjusted for changes in patient utilization and case mix.

b. The estimated total payments for each facility under the reimbursement methodology in effect in the year prior to the universal rate year shall be estimated from base year claims.

c. The estimated total payments for each facility under the reimbursement methodology in effect in the universal rate year shall be estimated from base year claims.

d. If the sum of all the acute care hospitals' estimated payments under the methodology used in the universal rate year exceeds the sum of all the acute care hospitals' adjusted estimated payments under the prior year's reimbursement methodology, each hospital's DRG base rate and per diem rates shall be multiplied by a uniform percentage to result in estimated total payments for the universal rate year being equal to total adjusted payments in the year prior to the universal rate year.

e. When rates are rebased, the budget neutrality factors shall take into consideration the high volume adjustment payments.

28. Reimbursement Updating Procedures.

a. The department shall annually, on July 1, use the inflation factor prepared by GII for the universal rate year to inflate a hospital-specific base rate for rate years between rebasing periods.

b. The department shall rebase payment rates using the DRG reimbursement methodology every four (4) years. The first rebasing year under this provision shall be for the universal rate year beginning on July 1, 2012.

c. Except for an appeal in accordance with section (1)B. of this attachment, the department shall make no other adjustment.

29. Trending Medicaid Costs for DRG Re-basing Purposes.

a. Estimated Medicaid costs used to calculate DRG relative weights and DRG base rates shall be trended to the midpoint of the universal rate year.

b. The department shall use the inflation factor prepared by GII as the trending factor for the period being trended.

c. On an annual basis, the DRG rates will be changed as stated in item a. of this trending section unless it is higher than GII inflation factor found in item b. of this section. If the

GII trending factor is lower than the trending factor calculated in Item a. of this section, the GII trending factor will be used.

30. Readmissions.

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

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

31. Intensity Operating Allowance Inpatient Supplement Payments.

a. Beginning October 15, 2007, a State owned or operated University Teaching Hospital, including a hospital operated by a related party organization as defined at 42 CFR 413.17, which is operated as part of an approved School of Medicine, shall be based on the upper payment limits as required by 42 CFR 447.272 and will be determined prospectively each year based on the difference between the total payments made by Medicaid, excluding DSH, and the estimated Medicare payments for the same services. The Medicare payments will be determined based on the Medicare Principles of Reimbursement in accordance with 42 CFR 412 and 413.

b. The detailed formula to determine the supplemental payments is described in Exhibit B incorporated as part of this attachment.

c. The prospective supplemental payments will be reconciled annually to the final cost report filed for the rate year or prospective payment period.

d. Any payments made under subsection a of this section are subject to the payment limitations as specified in 42 CFR 447.271, whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

e. Payments made under this section shall be prospectively determined quarterly amounts, subject to a year-end reconciliation described in 2.a.

f. In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Health Care Financing Administration, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.

g. Pediatric Teaching Hospital

A state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

1) Calculated by determining the difference between Medicaid costs as stated on the audited cost report filed as of June 1 each year and payments received for the Medicaid recipients (i.e., Medicare, KMAP, TPL, and Medical Education); and including,

2) An additional quarterly payment of $250,000 ($1 million annually).

(Medicaid recipients shall not include recipients receiving services reimbursed through a Medicaid managed care contract.)

32. Supplemental Payments for DRG Psychiatric Access Hospitals

   a. For services provided on and after April 2, 2001 the Department shall provide supplemental payments to certain hospitals to assure access to psychiatric services for patients in rural areas of the Commonwealth. To qualify for psychiatric access payments a hospital must meet the following criteria:

      1) The hospital is not located in a Metropolitan Statistical Area (MSA);

      2) The hospital provides at least 65,000 days of inpatient care as reflected in the Department's Hospital Rate data for Fiscal Year 1998-99;

      3) The hospital provides at least 20% of inpatient care to Medicaid eligible recipients as reflected in the Department's Hospital Rate data for State Fiscal Year 1998-99; and

      4) The hospital provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.

   b. Each qualifying hospital will receive a psychiatric access payment amount based on its proportion of the hospital's Medicaid psychiatric days to the total Medicaid psychiatric days for all qualifying hospitals applied to the total funds for these payments. Payments will be made on a quarterly basis in according with the following:

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

   c. Total Medicaid payments to a hospital from all sources shall not exceed Medicaid charges plus disproportionate share payments. A hospital's disproportionate share payment shall not exceed the sum of the payment shortfall for Medicaid services and the costs of the uninsured. The fund shall be an amount not to exceed $6 million annually.

33. Appalachian Regional Hospital System supplemental payments.

   All DRG hospitals operating in the Commonwealth of Kentucky that belong to the Appalachian Regional Hospital System will receive an adjusted payment equal to the difference between what Medicaid pays for inpatient services and what Medicare would pay for those same services to Medicaid eligible individuals or its proportionate share of $7.5 million, whichever is lower. The Upper Payment Limit as defined in 42 CFR 447.272 will be applied on a facility-specific basis as described in Exhibit A. These payments will be made on a quarterly basis within 30 days of the end of the quarter.

34. Supplemental DRG Payments

   a. In-state high intensity level II neonatal center.

      1) The Department will make prospective supplemental payments to in-state hospitals for all DRGs 675 through 680 as referenced in Section (2)A.15.b.1 of this attachment to a hospital with a Level II neonatal intensive care unit that meets the following qualifications:

         a) Is licensed for a minimum of 24 neonatal level II beds;

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

         c) Has a gestational age lower limit of twenty-seven (27) weeks; and to a hospital with a Level II neonatal intensive care unit that meets the following qualifications:

a) Is licensed for a minimum of 24 neonatal level II beds;

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

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

d) Has a full-time perinatologist on staff.

e) The payment will be an additional add-on per discharge for each of the above DRGs.

2) Before July 1, 2007, the add-on will be $3,775;

3) From July 1, 2007 through October 14, 2007, the add-on will be $9,853; and

4) On or after October 15, 2007, the add-on will be $2,870.

b. The Department will pay no more in the aggregate for inpatient hospital services than the inpatient Upper Payment Limit, as set forth in 42 CFR 447.253(b)(2) and 42 CFR 447.272. The Department will determine the inpatient Upper Payment Limit by estimating what would be paid for inpatient hospital services under the Medicare principles of reimbursement. The methodology used by the Department to calculate the inpatient Upper Payment Limits can be found in Attachment 4.19-A Exhibit A.

c. An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility in accordance with applicable federal regulations.

d. For the purpose of this attachment, Medicaid patient days shall not include days for a Medicaid recipient eligible to participate in the state's Section 1115 waiver as described as the Demonstration project: Services provided through regional managed care partnerships 1115 Wavier.

e. A payment made under the Supplemental DRG payments shall not duplicate a payment made via Item (8) Disproportionate share hospital distributions.

f. Supplemental Payment for Hospitals Paid Using the DRG-Based Methodology

1) Hospitals paid using the DRG payment system shall receive, subject to conditions specified in this section,, supplemental payments for the calendar quarters beginning with the calendar quarter ending March 31, 2009 and ending with the calendar quarter ending on December 31, 2010.

2) The aggregate supplemental payments described herein shall not exceed $195,000,000 less any amount set aside that would have gone to those hospitals that decline the supplemental payment and retain their appeal rights.

3) Each hospital's share of the aggregate pool shall be equal to its proportionate

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

4) Hospitals receiving the Intensity Operating Allowance Supplement as established in this attachment shall not be eligible for the supplement payments described in this section since they are already receiving a supplement payment.

5) Any payments made under this supplement provision are subject to the upper payment limits specified in 42 CFR Part 447. See attached Exhibit A for the detailed methodology used to calculate the upper payment limits.

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

1. As of October 15, 2007, the department shall reimburse for rehabilitation or psychiatric care in an in-state acute care hospital that has a Medicare-designated rehabilitation or psychiatric distinct part unit:

   a. On a facility specific per diem basis equivalent to the per diem cost reported for Medicare distinct part unit patients on the most recently Medicare cost report received prior to the rate year; and

   b. In accordance with Reimbursement Limits and Updating Procedures section 24 of this attachment.

2. As of October 15, 2007, the department shall reimburse for rehabilitation or psychiatric care provided in an in-state hospital that does not have a Medicare designated distinct part unit:

   a. On a facility-specific per diem basis equivalent to its aggregate projected payments for DRG services divided by its aggregate projected Medicaid covered days; and

   b. In accordance with the Reimbursement Limits and Updating Procedures section 24 of this attachment.

3. As of November 15, 2007, the department shall reimburse for rehabilitation or psychiatric care in an in-state acute care hospital that has a Medicare-designated rehabilitation or psychiatric distinct part unit on a per diem basis as follows:

   a. On a facility-specific per diem basis equivalent to the per diem cost reported for Medicare distinct part unit patients on the most recently received Medicare cost report prior to the rate year.

   b. Reimbursement for an inpatient rehabilitation or psychiatric service shall be determined by multiplying a hospital's rehabilitation or psychiatric per diem rate by the number of allowed patient days.

c. A rehabilitation or psychiatric per diem rate shall be the sum of a rehabilitation or psychiatric operating per diem rate and a rehabilitation or psychiatric capital per diem rate, as appropriate.

1) The rehabilitation or psychiatric operating cost-per-day amounts used to determine the rehabilitation or psychiatric operating per diem rate shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric cost basis (as appropriate), excluding capital costs and medical education costs, by the number of Medicaid rehabilitation or psychiatric patient days in the base year.

2) The Medicaid rehabilitation or psychiatric cost basis and patient days shall be based on Medicaid claims for patients with a rehabilitation or psychiatric diagnosis (as appropriate) with dates of service in the base year. The rehabilitation or psychiatric operating per diem rate shall be adjusted for:

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

b) The change in the Medicare published wage index from the base year to the universal rate year.

d. Computation of rates.

1) A rehabilitation or psychiatric capital per diem rate shall be facility-specific and shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric capital cost basis by the number of Medicaid rehabilitation or psychiatric patient days (as appropriate) in the base year.

2) The Medicaid rehabilitation or psychiatric capital cost basis and patient days shall be based on Medicaid claims for patients with rehabilitation or psychiatric diagnoses (as appropriate) with dates of service in the base year.

3) The rehabilitation or psychiatric capital per diem rate shall not be adjusted for inflation.

4. The department shall reimburse for rehabilitation or psychiatric care provided in an in-state hospital that does not have a Medicare-designated distinct part unit:

a. On a projected payment basis using:

1) A facility specific per diem basis equivalent to its aggregate projected payments for DRG services divided by its aggregate projected Medicaid paid days.

2) Aggregate projected payments and projected Medicaid paid days shall be the sum of:

a) Aggregate projected payments and aggregate projected Medicaid paid days for non-per diem DRG services as calculated by the model established in section (2)A;

b) Actual prior year payments inflated by the inflation factor provided by GII; and

c) Per diem DRG service Medicaid days; and

e. In compliance with provisions for the use of a universal rate year and taking into consideration Medicaid policy with regard to unallowable costs as shown in (1)D and F of this attachment.

(3) Payment for Long term Acute Care Hospital Care, In-State Freestanding Psychiatric Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.

A. The department shall reimburse for inpatient care provided to eligible Medicaid recipients in an in-state freestanding psychiatric hospital, in-state freestanding rehabilitation hospital, or LTAC hospital on a per diem basis.

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

1. Using a hospital's fiscal year 2005 Medicare cost report, allowable cost and paid days to calculate a base cost per day for the hospital;

2. Trending and indexing a hospital's specific cost, excluding capital cost, per day to the current state fiscal year;

3. Calculating an average base cost per day for hospitals within similar categories, for example rehabilitation hospitals, using the indexed and trended base cost per day,

4. Assigning no hospital a base cost per day equaling less than ninety-five (95) percent of the weighted average trended and indexed base cost per day of hospitals within the corresponding category;

5. Applying a parity factor equivalent to aggregate cost coverage established by the DRG reimbursement methodology described in the diagnostic related group hospital reimbursement portion of the state plan; and

6. An additional amount of three (3) million dollars will be distributed on a pro-rata basis and applied to the per diem as calculated in paragraphs 1. through 5. of this subsection.

C. From October 15, 2007 through November 14, 2007, the department shall reimburse the inpatient care provided to an eligible Medicaid recipient in an in-state psychiatric hospital previously designated as a primary referral and service resource for a child in the custody of the Cabinet for Health and Family Services at the median per diem rate paid of all freestanding psychiatric hospitals. Effective November 15, 2007, this provision is no longer relevant.

D. In-State Hospital Minimum Occupancy Factor.

1. If an in-state hospital's minimum occupancy is not met, allowable Medicaid capital costs shall be reduced by:

a. Increasing the occupancy factor to the minimum factor; and

b. Calculating the capital costs using the calculated minimum occupancy factor.

2. The following minimum occupancy factors shall apply:

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

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

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

E. Reduced Depreciation Allowance. The allowable amount for depreciation on a hospital building and fixtures, excluding major movable equipment, shall be sixty five (65) percent of the reported depreciation amount as shown in the hospital's cost reports.

F. Payment to a Newly-participating In-State Freestanding Psychiatric Hospital, Freestanding Rehabilitation Hospital or a Long Term Acute Care Hospital.

1. The department shall reimburse a newly-participating in-state freestanding psychiatric hospital, freestanding rehabilitation hospital or long term acute care hospital the minimum per diem rate paid to hospitals in their category until the first fiscal year cost report submitted by the hospital has been finalized.

2. Upon finalization of the first fiscal year cost report for a facility, the department shall reimburse the facility a per diem rate in accordance with Section (3)B of this attachment.

(4) Payment for Critical Access Hospital Care.

A. The department shall pay a per diem rate to a critical access hospital equal to the hospital's Medicare rate.

B. A critical access hospital's final reimbursement for a fiscal year shall reflect any adjustment made by CMS.

C. Cost Report Requirements.

a. A critical access hospital shall comply with the cost reporting requirements established in Section (1)E of this attachment in the In-State Hospital Cost Reporting Requirements section.

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

D. An out-of-state critical access hospital shall be reimbursed under the same methodology as an in-state critical access hospital.

E. The department shall reimburse for care in a federally defined swing bed in a critical access hospital at the same rate as established by the Centers for Medicare and Medicaid Services for Medicare.

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

(5) In-State Psychiatric, Rehabilitation, and Long-term Acute Care Hospitals Reimbursement Updating Procedures.

A. The department shall adjust an in-state hospital's per diem rate annually according to the following:

1) The Healthcare Cost Review, a publication prepared by Global Insight (GI) is used to obtain to update trending and indexing factors. The most recently received first-quarter publication is used for rate-setting. For trending and indexing factors the Total %MOVAVG line from Table 6.1CY, Hospital Prospective Reimbursement Market Basket, is used. The second quarter column of the respective year being trended/indexed to is used.

2) A capital per diem rate shall not be adjusted for inflation.

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

C. Except for an adjustment resulting from an audited cost report, the department shall make no other adjustment, except for correction of error, as a result of a change resulting from a dispute resolution or appeal to the extent rates were not set in accordance with the State Plan or Federal Court decision; or as a result of a properly promulgated policy change and approved by CMS through a State Plan amendment.

(6) Reimbursement for Out-of-state Hospitals for Critical Access Care, Long Term Acute Care, Rehabilitation Care and Psychiatric Care.

A. For inpatient psychiatric or rehabilitation care provided by an acute out-of-state hospital, the department shall reimburse a per diem rate comprised of an operating per diem rate and a capital per diem rate.

1. As of October 15, 2007, the psychiatric or rehabilitation operating per diem rate shall be the median operating cost, excluding graduate medical education cost or any provider tax cost, per day for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.

2. As of November 15, 2007, the psychiatric or rehabilitation operating per diem rate shall be the median psychiatric or rehabilitation operating per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.

3. As of October 15, 2007, the psychiatric or rehabilitation capital per diem rate shall be the median psychiatric capital per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.

4. As of November 15, 2007, the psychiatric or rehabilitation capital per diem rate shall be the median psychiatric or rehabilitation capital per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.

5. An out-of-state hospital's per diem rate shall not include:

a. A provider tax adjustment; or

b. Graduate medical education costs.

B. For care provided by an out-of-state freestanding long term acute care, critical access, or freestanding psychiatric hospital, the department shall reimburse a per diem rate comprised of an operating per diem rate and a capital per diem rate for each type of facility as appropriate.

1. The long term acute care, critical access, or psychiatric operating per diem rate shall equal the median operating cost, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding hospitals of the same type.

2. The long term acute care, critical access, or psychiatric capital per diem rate shall be the median capital per diem rate for all in-state freestanding hospitals of the same type.

3. An out-of-state hospital's per diem rate shall not include:

a. A provider tax adjustment; or

b. Graduate medical education costs.

C. For care in an out-of-state rehabilitation hospital, the department shall reimburse a per diem rate equal to the median rehabilitation per diem rate for all in-state rehabilitation hospitals except that an out-of-state hospital's per diem rate shall not include:

1. A provider tax adjustment; or

2. Graduate medical education costs.

D. The department shall apply the requirements of 42 C.F.R. 447.271 to payments made pursuant to the plan provisions shown in this section of this attachment.

(7) Supplemental Payments for a Free-standing In-state Rehabilitation Hospital:

A state designated rehabilitation teaching hospital that is not state-owned or operated shall receive an annual rehabilitation teaching supplement payment, determined on a per diem basis, in an amount calculated by determining the difference between Medicaid costs as stated on the cost settled audited cost report each year, and payments received for the Medicaid patients (i.e., Medicare, KMAP, TPL, and Medical Education.)

(8) Disproportionate Share Hospital Provisions

A. Definition. A disproportionate share hospital or DSH means an in-state hospital that:

1. Has an inpatient Medicaid utilization rate of one (1) percent or higher; and

2. Meets the criteria established in 42 U.S.C. 1396r-4(d).

3. Has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

4. Meets the requirements established in section 1923(d) of the Act.

B. Disproportionate Share Hospital Distribution General Provisions. A DSH distribution shall:

1. Be made to a qualified hospital;

2. Be based upon a hospital's proportion of inpatient and outpatient indigent care from the preceding state fiscal year;

3. Be a prospective amount. For example, a DSH distribution made to a hospital in October 2007 shall cover the state fiscal year beginning July 1, 2007 and ending June 30, 2008;

4. Not be subject to settlement or revision based on a change in utilization during the year to which it applies;

5. Be made on an annual basis;

6. Be made from a hospital's share of the allocated pool or total disproportionate share funds with the following allocation into three (3) pools: forty-three and ninety-two hundredths percent (43.92%) allocated to acute care hospitals; thirty-seven percent (37%) allocated to university hospitals; and nineteen and eight hundredths percent (19.08%) allocated to private psychiatric hospitals and state mental hospitals, or the maximum dollar cap from the annual federal allotment;

7. "Type I hospital" means an in-state disproportionate share hospital with 100 beds or less that participates in the Medicaid Program;

8. "Type II hospital" means an in-state disproportionate share hospital with 101 beds or more that participates in the Medicaid Program, except for a hospital that meets the criteria established in this administrative regulation for a Type III or Type IV hospital;

9. "Type III hospital" means an in-state disproportionate share state university teaching hospital, owned or operated by either the University of Kentucky or the University of Louisville Medical School; and

10. "Type IV hospital" means an in-state disproportionate share hospital participating in the Medicaid Program that is a state-owned psychiatric hospital.

C. Disproportionate Share Hospital Distribution to a DRG-Reimbursed Acute Care Hospital. The department shall determine a DSH distribution to a DRG-reimbursed acute care hospital by:

1. Determining a hospital's average reimbursement per discharge;

2. Dividing the hospital's average reimbursement per discharge by Medicaid days per discharge;

3. Multiplying the amount established in paragraph b by the hospital's total number of inpatient indigent care days for the most recently completed state fiscal year to establish the hospital's inpatient indigent care cost;

4. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report;

5. Combining the inpatient indigent care cost established in paragraph (c) with the outpatient indigent care cost established in paragraph (d) to establish a hospital's indigent care cost total; and

6. Comparing the total indigent care cost for each DRG-reimbursed hospital to the indigent care costs of all hospitals receiving DSH distributions under the acute care pool pursuant to the following procedure to establish a DSH distribution on a pro rata basis:

   a. The department shall calculate an indigent care factor for each hospital annually. The indigent care factor shall be determined by calculating the percentage of each hospital's annual indigent care costs toward the sum of the total annual indigent care cost for all hospitals within each respective pool. For purposes of this paragraph, "indigent care costs" means the hospital's inpatient and outpatient care as reported to the department multiplied by the hospital's Medicaid rate, or at a rate determined by the department in administrative regulation that, when multiplied by the hospital's reported indigent care, is equivalent to the amount that would be payable by the department under the fee-for-service Medicaid program for the hospital's total reported indigent care; and

   b. Each hospital's annual distribution shall be calculated by multiplying the hospital's indigent care factor by the total fund allocated to the acute care pool, university hospital pool, and the private psychiatric pool.

D. Disproportionate Share Hospital Distribution to a Critical Access Hospital, Rehabilitation

Hospital or Long Term Acute Care Hospital. The department shall determine a DSH distribution to a critical access hospital, rehabilitation hospital, or long term acute care hospital:

1. For the period beginning state fiscal year beginning July 1, 2007 and ending June 30, 2008 by:

   a. Multiplying the hospital's per diem rate in effect as of June 30, 2007 by its total number of inpatient indigent care days for the preceding state fiscal year (July 1, 2006 - June 30, 2007) to establish the hospital's inpatient indigent care cost;

   b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report;

   c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and

   d. Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to state regulations related to establishing a hospital's DSH distribution on a pro rata basis; and

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

   a. Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection (2) of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and

   b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report;

   c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and

   d. Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to state statute establishing a hospital's DSH distribution on a pro rata basis.

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

1. For the period beginning state fiscal year beginning July 1, 2007 and ending June 30, 2008 by:

   a. Multiplying the hospital's per diem rate in effect as of June 30, 2007 by its total number of inpatient indigent care days for the preceding state fiscal year (July 1, 2006 - June 30, 2007) to establish the hospital's inpatient indigent care cost;

b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used in the Medicare Cost Report hospital fee schedule or by establishing an inpatient equivalency;

c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and

d. Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis; and

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

a. Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection 2 of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and

b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge from the Medicare Cost Report fee schedule or by establishing an inpatient equivalency;

c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and

d. Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis.

F. Disproportionate Share Hospital Distribution to a State Mental Hospital. The Department shall determine a DSH distribution to a state mental hospital by:

1. Comparing each state mental hospital's costs of services provided to individuals meeting the indigent eligibility criteria established in subsections H and I of this Section, minus any payment made by or on behalf of the individual to the hospital; and

2. Using the DSH funding allocated to state mental hospitals to establish a state mental hospital's DSH distribution on a pro rata basis.

G. Disproportionate Share Hospital Distribution to a University Hospital. The department's DSH distribution to a university hospital shall be based on the hospital's historical proportion of the costs of services to Medicaid recipients, minus reimbursement paid according to the regulation related to Diagnostic related group (DRG) inpatient hospital reimbursement, or the nondiagnostic related group inpatient hospital reimbursement and supplemental or IOA payments, plus the costs of services to indigent and uninsured patients minus any distributions made on behalf of indigent and uninsured patients; and

H. Indigent Care Eligibility

1. Prior to billing a patient and prior to submitting the cost of a hospital service to the

department as uncompensated, a hospital shall use the indigent care eligibility form, DSH-001, Application for Disproportionate Share Hospital Program, to assess a patient's financial situation to determine if:

a. Medicaid or Kentucky Children's Health Insurance Program (KCHIP) may cover hospital expenses; or

b. A patient meets the indigent care eligibility criteria.

2. An individual referred to Medicaid or KCHIP by a hospital shall apply for the referred assistance, Medicaid or KCHIP, within thirty (30) days of completing the DSH-001, Application for Disproportionate Share Hospital Program, at the hospital.

I. Indigent Care Eligibility Criteria.

1. A hospital shall receive disproportionate share hospital funding for an inpatient or outpatient medical service provided to an indigent patient under the provisions of this attachment if the following apply:

a. The patient is a resident of Kentucky;

b. The patient is not eligible for Medicaid or KCHIP;

c. The patient is not covered by a third-party payor;

d. The patient is not in the custody of a unit of government that is responsible for coverage of the acute care needs of the individual;

e. The hospital shall consider all income and countable resources of the patient's family unit and the family unit shall include:

1) The patient;
2) The patient's spouse;
3) The minor's parent or parents living in the home; and
4) Any minor living in the home;

f. A household member who does not fall in one (1) of the groups listed in paragraph (e) of this subsection shall be considered a separate family unit;

g. Countable resources of a family unit shall not exceed:

1) $2,000 for an individual;
2) $4,000 for a family unit size of two (2); and
3) Fifty (50) dollars for each additional family unit member;

h. Countable resources shall be reduced by unpaid medical expenses of the family unit to establish eligibility; and

i. The patient or family unit's gross income shall not exceed the federal poverty limits published annually in the Federal Register and in accordance with KRS 205.640.

2. Except as provided in subsection (3) of this section, total annual gross income shall be the lessor of:

a. Income received during the twelve (12) months preceding the month of receiving a service; or

b. The amount determined by multiplying the patient's or family unit's income, as applicable, for the three (3) months preceding the date the service was provided by four (4).

3. A work expense for a self-employed patient shall be deducted from gross income if:

a. The work expense is directly related to producing a good or service; and

b. Without it the good or service could not be produced.

4. A hospital shall notify the patient or responsible party of his eligibility for indigent care.

5. If indigent care eligibility is established for a patient, the patient shall remain eligible for a period not to exceed six (6) months without another determination.

J. Indigent Care Eligibility Determination Fair Hearing Process.

1. If a hospital determines that a patient does not meet indigent care eligibility criteria as established in subsections H and I of this Section, the patient or responsible party may request a fair hearing regarding the determination within thirty (30) days of receiving the determination.

2. If a hospital receives a request for a fair hearing regarding an indigent care eligibility determination, impartial hospital staff not involved in the initial determination shall conduct the hearing within thirty (30) days of receiving the hearing request.

3. A fair hearing regarding a patient's indigent care eligibility determination shall allow the individual to:

a. Review evidence regarding the indigent care eligibility determination;
b. Cross-examine witnesses regarding the indigent care eligibility determination;
c. Present evidence regarding the indigent care eligibility determination; and
d. Be represented by counsel.

4. A hospital shall render a fair hearing decision within fourteen (14) days of the hearing and shall provide a copy of its decision to:

a. The patient or responsible party who requested the fair hearing; and
b. The department.

5. A fair hearing process shall be terminated if a hospital reverses its earlier decision and notifies, prior to the hearing, the patient or responsible party who requested the hearing.

6. A patient or responsible party may appeal a fair hearing decision to a court of competent jurisdiction in accordance with state statute on judicial review of final order.

K. Indigent Care Reporting Requirements.

1. On a quarterly basis, a hospital shall collect and report to the department indigent care patient and cost data.

2. If a patient meeting hospital indigent care eligibility criteria is later determined to be Medicaid or KCHIP eligible or has other third-party payor coverage, a hospital shall adjust its indigent care report previously submitted to the department in a future reporting period.

L. Merged Facility. If two (2) separate entities merge into one (1) organization and one (1) of the merging entities has disproportionate status and the other does not, the department shall retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid.

M. Payment Limits: Limit on Amount of Disproportionate Share Payment to a Hospital.

1. Payments made under these provisions do not exceed the OBRA '93 limits described in 1923 (g) of the Social Security Act. This limit is the sum of the following two measurements that determine uncompensated costs: (a) Medicaid shortfall; and (b) costs of services to uninsured patients less any payments received. Medicaid shortfall is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the non-disproportionate share hospital payment method under this state plan. The cost of services to the uninsured includes inpatient and outpatient services. Costs shall be determined by multiplying a hospital's cost to charge ratio by its uncompensated charges. Uninsured patients are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

2. Funds not distributed under the above provisions due to the limit in 1. may be redistributed to public hospitals who are located in the state's managed care region based on the following:

$$\frac{\text{Medicaid Days}}{\text{Total Medicaid Days}} \times \text{Remaining Funds} = \text{DSH Payment}$$

Funds available for redistribution will be allocated to state teaching hospitals (Type III) to cover their uncompensated costs and then to public non-state providers (Type I and Type II). Medicaid days shall be based on the number of inpatient Medicaid days reported on the most recently completed cost report. Medicaid days shall include days provided under FFS and through a managed care entity.

3. Limit on Amount of Disproportionate Share Payment to a Hospital

   a. A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for Medicaid recipient services and the costs of uninsured patients. (Section 1923(g) of the Social Security Act.)

   b. Payment Shortfall for Medicaid Recipient Services. The payment shortfall for Medicaid recipient services is the amount by which the costs of inpatient and outpatient services provided Medicaid recipients exceed the payments made to the hospital for those services excluding disproportionate share payments.

   c. Unrecovered Cost of Uninsured/Indigent Patients. The unrecovered cost of uninsured/indigent patients is the amount by which the costs of inpatient and outpatient services provided to uninsured/indigent patients exceed any cash payments made by or on behalf of them. An uninsured/indigent patient is an individual who has no health insurance and meets income standards established in state law.

4. The disproportionate share hospital payment shall be an amount that is reasonably related

to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(9) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A

B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

1. The PRTFs shall be paid a fixed per diem rate of $230 which shall be adjusted upward each biennium by 2.22 percent or the usual and customary charge, if less. The payments shall not exceed prevailing charges in the locality for comparable services provided under comparable circumstances. The fixed rate (upper limit) is the state's best estimate of the reasonable and adequate cost of providing the services. This rate is determined in the following manner:

a. Facilities that provide services that meet the criteria for PRTFs are requested to submit their actual costs for covered services. These costs shall include all care and treatment, staffing, ancillary services (excluding drugs), capital, and room and board costs.

b. The actual costs submitted by the facilities are compared to the costs estimated to operate a model PRTF. The costs of the model facility and current facilities are analyzed on the basis of their being reasonable and adequate to meet the costs which would be incurred in order to provide quality services in an economic and efficient manner.

c. From this analysis and a consideration of the comments from the facilities, a uniform per diem rate is established for all participating facilities.

d. This per diem rate is then adjusted for inflation by 2.22 percent biennium. This inflation rate is based upon the historic rate of inflation as applied to these facilities and their necessary increases in costs of providing the services.

2. The fixed rate or usual and customary charge, if less, covers total facility costs for PRTF services including the following: all care and treatment costs, staffing, costs for ancillary services (except drugs), capital costs, and room and board costs. The rate is established to be fair and adequate compensation for services provided to Medicaid beneficiaries.

(10) Reimbursement for Out-of-state Hospitals.

A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.

1. The all-inclusive DRG payment amount:

a. Shall be based on the patients diagnostic category, and

b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.

2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:

obsolete by 09-

1) An adjustment for provider; and

2) Graduate medical education.

3. The out-of-state hospital DRG base rate shall be determined as follows:

a. For an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, the DRG base rate shall equal the average DRG all-inclusive base rate paid to in-state children's hospitals. Children's hospitals shall be defined as hospitals designated as Children's hospitals by CMS under the Medicare inpatient prospective payment system.

b. For an out-of-state rural hospital, the DRG base rate shall equal the bottom quartile DRG all-inclusive base rate paid to in-state rural hospitals. Rural hospitals shall be defined as hospitals located in rural areas as designated by CMS in the Medicare inpatient prospective payment system.

c. For an out-of-state urban hospital, the DRG base rate shall equal the bottom quartile DRG all inclusive base rate paid to in state urban hospitals. Urban hospitals shall be defined as hospitals located in urban areas as designated by CMS in the Medicare inpatient prospective payment system.

3. An out-of-state provider shall not be eligible to receive high volume per diem add-on payments, indirect medical education reimbursement or disproportionate share hospital payments.

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

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

b. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.

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

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

B. As of November 15, 2007, the department shall reimburse an acute care out-of-state hospital, except for a children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and a bordering state, for inpatient care:

1. On a fully-prospective per discharge basis based on the patient's diagnostic category; and

2. An all-inclusive rate.

C. As of November 15, 2007, the all-inclusive rate referenced in subsection B.2 of this section shall:

1. Equal the facility-specific Medicare base rate multiplied by the Kentucky-specific DRG relative weights, except that the DRG relative weights shall exclude any provider tax adjustment for in-state hospitals;

2. Exclude:

   a. Medicare indirect medical education cost or reimbursement

   b. Direct graduate medical education cost payment amounts;

   c. High volume per diem add-on reimbursement;

   d. Disproportionate share hospital distributions;

   e. Any adjustment mandated for in-state hospitals; and

   f. Graduate medical education costs; and

3. Include a cost outlier payment if the associated discharge meets the cost outlier criteria;

   a. The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim;

   b. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges;

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

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

D. As of November 15, 2007, the department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, a DRG base rate equal to the average DRG base rate paid to in-state children's hospitals.

E. As of January 5, 2009, the department shall reimburse an acute care out-of-state hospital, except for a children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and bordering state, and except for Vanderbilt Medical Center, for inpatient care:

1. On a fully-prospective per discharge basis based on the patient's diagnostic category; and

2. An all-inclusive rate.

   a. The all-inclusive rate referenced in subsection (10)E.2. of this section shall:

      1) Equal the facility specific Medicare base rate multiplied by:

a) 0.7068; and

b) The Kentucky specific DRG relative weights after the relative weights have been reduced by twenty (20) percent;

2) Exclude:

a) Medicare indirect medical education cost or reimbursement;

b) High volume per diem add-on reimbursement;

c) Disproportionate share hospital distributions; and

d) An adjustment for the provider tax; and

3) Include a cost outlier payment if the associated discharge meets the cost outlier criteria established in item (2)A.15 of this attachment.

a) The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim;

b) The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges;

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

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

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

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

d. An out-of-state provider shall not be eligible to receive high volume per diem add-on payments, indirect medical education reimbursement or disproportionate share hospital payments.

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

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

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

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

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

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

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

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

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

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