

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



Center for Medicaid and State Operations (CMSO)

Ms. Elizabeth A. Johnson, Esq.
Commissioner
Department of Medicaid Services
Cabinet for Health and Family Services
275 East Main Street, 6W-A
Frankfort, KY 40621-0001

JUN 15 2009

RE: SPA 09-003

Dear Ms. Johnson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-003. Effective March 1, 2009 this amendment modifies the State's payment methodology for inpatient hospital services. Specifically, the amendment provides supplemental payments to providers reimbursed under the diagnosis related groups methodology. The supplemental payments will be paid over eight quarters and shall not exceed \$195,000,000 total funds.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of March 1, 2009. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332 or Venesa Day at (410) 786-8281.

Sincerely

A handwritten signature in black ink that reads "Cindy Mann". The signature is written in a cursive, flowing style.

Cindy Mann
Director
Center for Medicaid and State Operations (CMSO)

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
09-003

2. STATE
Kentucky

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 1, 2009

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

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
Title XIX, Section 1902(a)(13); 42 USC Part 447.200-299

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 - (\$75.83 million)
b. FFY 2010 - (\$59.0 million)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, page 19.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):
None

10. SUBJECT OF AMENDMENT:

This plan amendment provides for a supplemental payment for hospital inpatient services for hospitals paid using the diagnosis related group methodology

11. GOVERNOR'S REVIEW (*Check One*):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Elizabeth A. Johnson

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: March 31, 2009

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

6-25-09

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
MAR - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

Bill Rose

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMSO

23. REMARKS:

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.

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- 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.

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- 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.

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- 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;

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- 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 lesser 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:

Medicaid Days

Total Medicaid Days X Remaining Funds = 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:

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- 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:

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- a) 0.7065; 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.

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- 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.

OS Notification

State/Title/Plan Number: KY 09-003

Type of Action: SPA Approval

Required Date for State Notification:

Fiscal Impact: FY 2009 \$ 75,830,000
FY 2010 \$ 59,000,000

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0
Number of Potential Newly Eligible People: 0
Eligibility Simplification: No

Provider Payment Increase: Yes
Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail:

Effective March 1, 2009 this amendment modifies the State's payment methodology for setting payment rates for inpatient hospital services. Specifically, the amendment provides for supplemental payments to providers reimbursed under the diagnosis related groups methodology. The supplemental payments will be paid over eight quarters and shall not exceed \$195,000,000 total funds.

Other Considerations: This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

We do not recommend the Secretary contact the governor.

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