907 KAR 1:033. Payments for dual licensed pediatric facility services.

RELATES TO: KRS 205.520, 42 C.F.R. 447.250, 42 U.S.C. 1396a, b, d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), EO 2004-726

CERTIFICATION STATEMENT:

NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services has responsibility to administer the program of Medical Assistance. KRS 205.520(3) empowers the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation sets forth the method for determining amounts payable by the cabinet for dual licensed pediatric facility services.

Section 1. Dual Licensed Pediatric Facilities. The cabinet shall make payment to participating providers on the following basis:

(1) Method of reimbursement. A dual licensed pediatric facility shall be reimbursed on the basis of rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards. The payment shall be prospective in nature with no year end adjustment for routine costs of care. The nursing facility services payment principles as specified in 907 KAR 1:025 shall apply except for variations specified in this administrative regulation. The cost of ancillaries shall be excluded from the cost when computing the payment rate and shall be reimbursed separately (in accordance with nursing facility services payment principles) with a retroactive settlement.

(2) Composite rate. The facility(ies) shall be paid at a composite rate for a nursing facility day of care. The following procedures shall be followed in establishing the composite rate:

(a) The allowable cost for nursing facility days of care shall be determined based on prior year actual costs (or, in the case of a new facility, projected costs which are determined by the cabinet to be reasonable).

(b) The department shall set a uniform rate year (July 1 - June 30) for facilities in this class in the same manner as for nursing facilities, with allowable costs trended to the beginning of the rate year. The trended allowable costs shall then be indexed for the rate year; however, there shall be no administratively established upper limit. Fixed or capital costs shall be neither trended nor indexed. Since projected costs for new facilities reflect the best estimate of actual costs, these shall also be neither trended nor indexed.

(c) Allowable costs shall be then compared with the number of projected (for new facilities) bed days or the number of bed days based on the prior year's actual utilization to arrive at a per diem composite rate.

(d) An occupancy factor of ninety (90) percent shall be applied. In the case of new facilities the occupancy factor shall be waived during the first full fiscal year of participation in the program.

(e) The cost incentive and investment factor (CIIF) schedule shall be applied to prospective current year per diem cost in determination of a final prospective rate for each facility. The CIIF schedule shall be transmitted to appropriate providers.

(f) The component (cost center) limitations specified in 907 KAR 1:025 shall not be applicable.

Section 2. Rate Review and Adjustment. For a new facility, the composite rate shall be reconsidered to determine if an adjustment is necessary after two (2) full calendar quarters of actual experience in the program as specified in the nursing facility payment principles.

Section 3. Eligibility for Reimbursement. A facility shall be eligible for reimbursement from the department only when considered to be a participating vendor, and reimbursement shall be made only for covered services rendered Medicaid eligible recipients meeting patient status as determined in accordance with applicable administrative regulations.
(5 Ky.R. 297; eff. 11-1-1978; 8 Ky.R. 29; eff. 8-5-1981; 9 Ky.R. 66; eff. 8-11-1982; Recodified from 904 KAR 1:033, 5-2-1986; 18 Ky.R. 1622; eff. 1-10-1992; Crt eff. 12-6-2019; Crt eff 9-24-2026.)