908 KAR 3:060. "Means test" for determining patient liability and per diem rates.

RELATES TO: KRS Chapter 13B, 210.710, 210.720, 210.730

STATUTORY AUTHORITY: KRS 194A.050, 210.710(4), 210.720(2), 210.720(3), 210.750

NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.050 requires the Secretary of the Cabinet for Health and Family Services to promulgate administrative regulations necessary to operate the programs and fulfill the responsibilities vested in the cabinet. KRS 210.720(2) requires the secretary of the Cabinet for Health and Family Services to establish the patient cost per day for board, maintenance, and treatment for state owned facilities at frequent intervals which shall be the uniform charge for persons receiving those services. KRS 210.750 authorizes the secretary to promulgate administrative regulations to carry out the provisions of KRS 210.710 to 210.760. KRS 210.710(4) and 210.720(3) require the secretary to adopt a "Means test" for determining the ability to pay of the patient or person responsible for the patient for board, maintenance, and treatment at a facility owned by the state. This administrative regulation establishes the "Means test" for making that determination and establishes the patient cost per day for board, maintenance, and treatment at state owned facilities.

Section 1. Definitions.

(1) "Allowed deduction" means an amount disregarded or deducted from income and assets for the purpose of determining the ability to pay for services rendered by a facility.

(2) "Available assets" means resources of the patient or person responsible for the patient in accordance with KRS 210.720(3), less the allowed deductions.

(3) "Deductible" means an amount that a patient or person responsible for the patient is expected to pay toward the patient's care by a third-party payor such as Medicare or a private insurance company.

(4) "Facility" is defined in KRS 210.710(2).

(5) "Income" means funds received by the patient or person responsible for the patient and includes the following:

(a) Salaries;

(b) Wages;

(c) Self-employed gross revenues, less operating expenses;

(d) Benefit payments, except for Supplemental Security Income payments;

(e) Social Security payments;

(f) Rents;

(g) Royalties;

(h) Pensions;

(i) Retirement payments;

(j) Veteran's Administration payments;

(k) Black lung benefits;

(l) Railroad retirement benefits;

(m) Gifts;

(n) Settlements;

(o) Trust receipts;

(p) Alimony, but does not include child support payments;

(q) Interest income; and

(r) Income from investments.

(6) "Patient" means a person admitted to a facility.

(7) "Person responsible for the patient" is defined in KRS 210.710(5).

(8) "Personal Needs Allowance" means an amount of resources deducted from income for the patient's personal needs, including clothing and other miscellaneous items

required by the patient.

(9) "Poverty Guidelines" means the federal poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services, under the authority of 42 U.S.C. 9902(2).

Section 2. Determination of the Ability to Pay for Services Rendered at Facilities.

(1) The facility shall apply the means test to each patient who is admitted to the facility for treatment.

(2)

(a) The means test shall include a determination of the responsible party or parties to pay for the patient's care, which shall be documented using the Patient or Responsible Party Financial Record form.

(b) This form shall be explained to the patient or person responsible for the patient and signed by all parties.

(c) If the patient or person responsible for the patient refuses to sign, this refusal shall be noted on the form along with the date the form was discussed.

(d) Refusal to sign the form shall not absolve the liability of the patient or person responsible for the patient to pay for services rendered.

(3) The amount a patient or person responsible for the patient is required to pay for services shall be the lesser of:

(a) The cost per patient day in accordance with Section 7 of this administrative regulation, less any amount paid by Medicare, Medicaid, and other third-party payment sources; or

(b) The amount the patient is able to pay calculated in accordance with this administrative regulation.

(4) The facility shall determine the financial resources available to the patient or person responsible for the patient including:

(a) Insurance and third-party payors;

(b) Income received or expected to be received during the period of hospitalization; and

(c) Available assets.

(5) Allowed deductions shall be calculated as the patient and the number of the patient's dependents.

(a) A patient's legally-recognized spouse and each individual less than eighteen (18) years of age who is in the patient's care shall be classified as dependents for purposes of calculating the poverty guidelines.

(b) Allowed deductions for the patient plus the patient's dependents shall be as follows:

1. One (1) shall be $2,000;

2. Two (2) shall be $4,000; or

3. Three (3) or more shall be $4,000 plus fifty (50) dollars added for each additional member over the initial two (2).

(6) The following shall be allowed deductions from income:

(a) Federal income taxes;

(b) State income taxes;

(c) Social security taxes;

(d) Normal retirement contributions;

(e) Unpaid medical and dental bills;

(f) Health insurance premiums;

(g) Medicare Part B insurance premiums;

(h) Long-term care insurance premiums;

(i) A personal needs allowance of forty (40) dollars per month;

(j) Student loan payments;

(k) Bed-hold reservation costs at another facility for up to fourteen (14) days as long as the patient's stay is expected to be shorter than the reservation period;

(l) Child support payments;

(m) Life insurance premiums if the patient's estate or a funeral home is the named beneficiary on the policy; and

(n) A basic maintenance allowance, derived from the current Poverty Guidelines, for the size of the patient's family, if the following conditions are met:

1. The patient was maintaining a residence immediately prior to admission;

2. The residence will continue to be maintained during the period of hospitalization and resources of the patient are needed for this effort; and

3. Facility staff expects the patient's hospital stay to be three (3) months or less in duration.

(7) An estimated income tax related deduction of twenty-five (25) percent of total income shall be allowed instead of the actual wage taxes contained in subsection (6) of this section. A patient or person responsible for the patient may request that actual tax amounts be used instead of the estimated deduction, if the person can substantiate the actual tax amounts.

(8) The following shall be excluded from the calculation of available assets:

(a) Prepaid burial plans of up to $1,500 per family member;

(b) Automobiles;

(c) Housing structures;

(d) Land;

(e) Retirement accounts;

(f) Pension funds;

(g) Trust funds that cannot be accessed;

(h) The applicable allowed deduction; and

(i) Other assets that are exempted under state law, if any.

Section 3. Calculation of the Amount the Patient or Person Responsible for the Patient is Able to Pay.

(1) The facility shall calculate the ability to pay amount utilizing either the Ability to Pay Worksheet or the Deductible Ability to Pay Worksheet as appropriate and by using the following formula:

(a) Determine the total amount of income of the patient or person responsible for the patient;

(b) Determine the amount of allowed deductions from income in accordance with Section 2(5) and (6) of this administrative regulation;

(c) Subtract the allowed deductions from income; and

(d) The remaining available income shall be divided by 365 to obtain the average daily income of the patient or person responsible for the patient.

(2) If the patient or person responsible for the patient has available assets, the facility shall:

(a) Determine the amount of available assets; and

(b) Include available assets that remain after the deduction in the patient or person responsible for the patient's ability to pay amount.

(3) Payments to be made on behalf of the patient by a third-party, such as Medicare, Medicaid, or private insurance companies, shall be subtracted from the facility's per diem rate as contained in Section 7 of this administrative regulation. Any remaining liability shall be satisfied as follows, with the exception of ability to pay amounts arising from deductibles:

(a) The available income of the patient or person responsible for the patient shall first be applied to the patient's liability for services;

(b) Any liability that remains after application of the average available income shall be satisfied by available assets; and

(c) The applicable average income per day and available asset amount per day shall be combined to determine the ability to pay amount. The ability to pay amount shall be charged for each day the patient is in the facility.

(4) Ability to pay liabilities arising from deductibles shall first be applied to available assets of the patient or person responsible for the patient with any remaining liability being satisfied with available income.

(5) If the Department for Medicaid Services performs an income assessment for a Medicaid patient residing in a nursing facility, intermediate care facility for an individual with an intellectual disability, or psychiatric hospital in accordance with 907 KAR 20:035, that Medicaid income assessment shall be relied upon instead of the ability to pay provisions established in this administrative regulation.

(6)

(a) After the ability to pay is determined for the patient or person responsible for the patient, a Patient or Responsible Party Financial Agreement and Assignment form shall be completed.

(b) This form shall be explained to the patient or person responsible for the patient and signed by all parties.

(c) If the patient or person responsible for the patient refuses to sign, this refusal shall be noted on the form including the date the form was discussed.

(d) Refusal to sign the form shall not absolve the liability of the patient or person responsible for the patient to pay for services rendered.

(7) The patient liability shall be calculated based on the United States Department of Health and Human Services poverty guidelines.

Section 4. Revisions to Ability to Pay Amounts.

(1) Facility staff shall update a patient's ability to pay amount to incorporate changes that take place subsequent to the initial determination. These changes may include:

(a) Income revisions;

(b) Asset revisions, including exhaustion of available assets;

(c) Change in allowed deductions;

(d) Change in a dependent of the patient or person responsible for the patient; or

(e) Change regarding the status of the person responsible for the patient.

(2) Upon a change to the ability to pay information, a revised Ability to Pay Worksheet or Deductible Ability to Pay Worksheet shall be prepared along with a revised Patient or Responsible Party Financial Record form and a revised Patient or Responsible Party Financial Agreement and Assignment form. The revised forms shall be presented to the patient or person responsible for the patient in the same manner as the original forms.

Section 5. Failure to Provide Financial Information or to Assign Benefits.

(1) If the patient or person responsible for the patient fails to or will not provide the information necessary to calculate the ability to pay amount, the maximum charge provided in Section 2(3)(a) of this administrative regulation shall be assessed.

(2) If the patient or person responsible for the patient fails to sign the assignment provision contained in the Patient or Responsible Party Financial Agreement and Assignment form, the maximum charge provided in Section 2(3)(a) of this administrative regulation shall be assessed.

Section 6. Payment Hardship, Appeal and Waiver Procedures.

(1) Payment hardships.

(a) If the patient or person responsible for the patient believes that payment of the ability to pay amount results in a financial hardship, the patient or person responsible

for the patient may request to make installment payments.

(b) This request shall be made in writing to the facility's patient billing supervisor and shall include documentation to support the claimed hardship.

(c) The patient billing supervisor shall review the financial hardship request and render a payment plan decision within fifteen (15) days from the receipt of the hardship request. If there is financial hardship, the patient billing supervisor shall allow minimum monthly payments based on what the patient can reasonably afford.

(2) Appeals.

(a) If the patient or person responsible for the patient is aggrieved by the facility charges or a payment plan determined in accordance with this administrative regulation, that person may appeal the determination to the facility director or the facility director's designee for informal resolution within thirty (30) days of the ability to pay amount or payment plan being calculated.

(b) The facility director or the facility director's designee shall review the appeal and issue a determination within thirty (30) days of receipt.

(c) If the patient or person responsible for the patient is dissatisfied with the informal resolution, that person may file an appeal within thirty (30) days of the facility's response to the Director of the Division of Administration and Financial Management, Department for Behavioral Health, Developmental and Intellectual Disabilities, 275 E Main Street, Frankfort, Kentucky 40621. The director shall arrange for an administrative hearing in accordance with KRS Chapter 13B.

(d) The appeal request shall fully explain the patient's, or person responsible for the patient's, position and shall include all relevant documentation supporting the claim of financial hardship.

(3) Waivers.

(a) The director of each facility may waive payment of the facility's charges under this administrative regulation if waiver is in the best interest of all parties, based on the factors provided in paragraph (c) of this subsection.

(b) The Director of the Division of Administration and Financial Management shall have the authority to waive payment at any facility within the department if waiver is in the best interest of all parties, based on the factors provided in paragraph (c) of this subsection.

(c) When making a waiver determination, the following factors shall be considered:

1. Income;
2. Overall family debt;
3. Assets; and
4. Other information relating to the current financial situation of the patient or the person responsible for the patient.

Section 7. Per Diem Rates.

(1) Facilities owned by the state shall charge a per diem rate for room and board and a separate charge for each treatment service listed in subsection (3) of this section.

(2) The per diem rate for room and board for each facility shall be calculated using the equations on the Kentucky Facility Per Diem Rate Form.

(3) A separate charge shall be imposed if the following treatment services are provided at a Department for Behavioral Health, Developmental and Intellectual Disabilities facility:

(a) Physician's services;
(b) EEG;
(c) EKG;
(d) Occupational therapy;
(e) Physical therapy;
(f) X-ray;

(g) Laboratory;
(h) Speech therapy;
(i) Hearing therapy;
(j) Psychology;
(k) Pharmacy;
(l) Respiratory therapy;
(m) Anesthesia;
(n) Electroshock therapy;
(o) Physician assistant;
(p) Advanced practice registered nurse; and
(q) Outpatient clinic services.

Section 8. Board, Maintenance, and Treatment Charges. The cost per day for board, maintenance, and treatment charges shall be established using the last available Behavioral Health, Developmental and Intellectual Disability (BHDID) annual finance report. Current rates shall be posted at http://dbhdid.ky.gov/kdbhdid and at each facility.

Section 9. Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) "DBHDID 3:060-1 Ability to Pay Worksheet", November 2016;

(b) "DBHDID 3:060-2 Deductible Ability to Pay Worksheet", November 2016;

(c) "DBHDID 3:060-3 Patient or Responsible Party Financial Agreement and Assignment", November 2016;

(d) "DBHDID 3:060-4 Patient or Responsible Party Financial Record", November 2016; and

(e) "Kentucky Facility Per Diem Rate Form", November 2016.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Behavioral Health, Developmental and Intellectual Disabilities, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

(3 Ky.R. 736; eff. 6-1-1977; 9 Ky.R. 502; 685; eff. 11-3-1982; Recodified from 902 KAR 12:050, 3-7-1989; TAm eff. 4-27-2016; 43 Ky.R. 1689; eff. 6-2-2017.; Cert eff. 4-17-2024)