CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Fiscal Management
(Amended at ARRS Committee)

907 KAR 10:015. Payments for outpatient hospital services.

RELATES TO: KRS 205.520, 205.637, ***205.8451,*** 216.380, 42 C.F.R. 400.203, ***412.105,*** 413.70, 413.75, ***438.114,*** 440.2, 440.20(a), 447.321, 42 U.S.C. 1395l(h), ***(dd)(e)(1),*** 1396r-8(a)(7)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, 205.637(3), 205.6310, 205.8453, 42 U.S.C. 1396a, 1396b, 1396d

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has the responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes 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 establishes the method for determining amounts payable by the Medicaid Program for outpatient hospital services.

Section 1. Definitions.

(1) "Critical access hospital" or "CAH" means a hospital meeting the licensure requirements established in 906 KAR 1:110 and KRS 216.380.

(2) "Department" means the Department for Medicaid Services or its designee.

(3) "Emergency medical condition" is defined by 42 U.S.C. 1395dd(e)(1).

(4) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(5) "Finalized" means approved or final as determined by the Centers for Medicare and Medicaid Services (CMS).

(6) "Flat rate" means a set and final rate representing reimbursement in entirety with no subsequent cost settling.

(7) "Lock-in recipient" means a recipient enrolled in the department's lock-in program pursuant to 907 KAR 1:677.

(8) "Lock-in recipient's designated hospital" means the hospital designated to provide nonemergency care for a lock-in recipient pursuant to 907 KAR 1:677.

(9) "Nonemergency" means that a condition or situation does not require an emergency service pursuant to 42 C.F.R. 438.114[~~447.53~~].

(10) "Outpatient cost-to-charge ratio" means the ratio determined by dividing the ***Medicaid-adjusted*** costs reported on Supplemental Worksheet E-3, Part ***VII[~~III~~]***, ***[~~Page 12~~]*** column 2, line ***21[~~27~~]*** of the cost report by the ***Medicaid-adjusted*** charges reported on column 2, line ***12[~~20~~]*** of the same schedule.

(11) "Recipient" is defined by KRS 205.8451(9).

Section 2. In-State Outpatient Hospital Service Reimbursement.

(1)

(a) Except for critical access hospital services, outpatient hospital laboratory services, or a service referenced in subsection (6) of this section, the department shall reimburse on an interim basis for in-state outpatient hospital services at a facility specific outpatient cost-to-charge ratio based on the facility's most recently filed cost report.

(b) An outpatient cost-to-charge ratio shall be expressed as a percent of the hospital's charges.

(2) Except as established in subsection (6) of this section, a facility specific outpatient cost-to-charge ratio paid during the course of a hospital's fiscal year shall be designed to

result in reimbursement, at the hospital's fiscal year end, equaling ninety-five (95) percent of a facility's total outpatient costs incurred during the hospital's fiscal year.

(3) Except as established in subsections (4) and (6) of this section:

(a) Upon reviewing an in-state outpatient hospital's as submitted cost report for the hospital's fiscal year, the department shall preliminarily settle reimbursement to the facility equal to ninety-five (95) percent of the facility's total outpatient costs, excluding laboratory services, incurred in the corresponding fiscal year; and

(b) Upon receiving and reviewing an in-state outpatient hospital's finalized cost report for the hospital's fiscal year, the department shall settle final reimbursement, excluding laboratory services, to the facility equal to ninety-five (95) percent of the facility's total outpatient costs incurred in the corresponding fiscal year.

(4)

(a) The department's total reimbursement for outpatient hospital services shall not exceed the aggregate limit established in 42 C.F.R. 447.321.

(b) If projections indicate for a given state fiscal year that reimbursing for outpatient hospital services at ninety-five (95) percent of costs would result in the department's total outpatient hospital service reimbursement exceeding the aggregate limit established in 42 C.F.R. 447.321, the department shall proportionately reduce the final outpatient hospital service reimbursement for each hospital to equal a percent of costs which shall result in the total outpatient hospital reimbursement equaling the aggregate limit established in 42 C.F.R. 447.321.

(5) In accordance with 42 U.S.C. 1396r-8(a)(7), a hospital shall include the corresponding healthcare common procedure coding (HCPC) code if billing a revenue code of 250 through 261 or 634 through 636 for an outpatient hospital service.

(6)

(a) Except for a critical access hospital, the department shall reimburse a flat rate of twenty-five (25) dollars for a screening of a lock-in recipient to determine if an emergency medical condition exists.

(b) A hospital shall use revenue code 451 to bill for a service referenced in paragraph (a) of this subsection.

(c) A service or reimbursement for a service referenced in paragraph (a) of this subsection, shall not be included:

1. With a hospital's costs for reimbursement purposes; and
2. In any cost settlement between the department and hospital.

(7) In accordance with 907 KAR 10:014:

(a) Except for a service referenced in subsection (6) of this section, the department shall not reimburse for a nonemergency service, other than a screening in accordance with 907 KAR 10:014, Section 2(6)(a), provided to a lock-in recipient if provided by a hospital other than the lock-in recipient's designated hospital.

(b) The department shall not reimburse for a nonemergency service provided to a lock-in recipient in an emergency department of a hospital.

Section 3. Out-of-State Outpatient Hospital Service Reimbursement. Excluding services provided in a critical access hospital and laboratory services, reimbursement for an outpatient hospital service provided by an out-of-state hospital shall be ninety-five (95) percent of the average in-state outpatient hospital cost-to-charge ratio.

Section 4. Critical Access Hospital Outpatient Service Reimbursement.

(1) The department shall reimburse for outpatient hospital services in a critical access hospital as established in 42 C.F.R. 413.70(b) through (d).

(2) A critical access hospital shall comply with the cost reporting requirements established in Section ***8*** ~~***[6]***~~ of this administrative regulation.

Section 5. Outpatient Hospital Laboratory Service Reimbursement.

(1) The department shall reimburse for an in-state or out-of-state outpatient hospital laboratory service:

(a) At the Medicare-established technical component rate for the service in accordance with 907 KAR 1:028 if a Medicare-established component rate exists for the service; or

(b) By multiplying the facility's current outpatient cost-to-charge ratio by its billed laboratory charges if no Medicare rate exists for the service.

(2) Laboratory service reimbursement, in accordance with subsection (1) of this section, shall be:

(a) Final; and

(b) Not settled to cost.

(3) An outpatient laboratory hospital laboratory service shall be reimbursed in accordance with this section regardless of whether the service is performed in an emergency room setting or in a nonemergency room setting.

Section 6. Direct Graduate Medical Education Costs at In-State Hospitals with Graduate Medical Education Programs.

(1) If federal financial participation for outpatient direct graduate medical education (DGME) costs is not provided to the department, the department shall not reimburse eligible in-state hospitals for outpatient DGME costs.

(2)

(a) If federal financial participation for outpatient DGME costs is provided to the department, the department shall:

1. ~~***[(a)]***~~ Provide a supplemental outpatient DGME payment to in-state hospitals for the outpatient direct costs of a graduate medical education program approved by Medicare as established in this subsection.

2. ~~***[1.]***~~ Effective for the state fiscal year beginning July 1, 2024, the department shall make an annual outpatient DGME supplemental payment for the direct costs of graduate medical education incurred by in-state hospitals with a graduate medical education program approved by Medicare.

(b) ~~***[2.]***~~ A supplemental DGME payment shall be made:

1. ~~***[a.]***~~ Separately from the per visit and cost settlement payment methodologies;

2. ~~***[b.]***~~ On an annual basis; and

3. ~~***[c.]***~~ Using the hospital's cost report period ending in the calendar year one (1) year prior to the beginning of the state fiscal year. For example, for the state fiscal year beginning July 1, 2024, the cost report period ending in calendar year 2023 shall be utilized.

(c) ~~***[(b)]***~~ The annual supplemental DGME payment shall equal the difference between the supplemental DGME amount minus any DGME payments received through outpatient cost settlements and any outpatient DGME payments received from managed care organizations.

(d) ~~***[(c)]***~~ The department shall determine a supplemental DGME amount equal to the product of:

1. Total DGME costs, obtained from Worksheet B, Part 1, Line 118, Columns 21 and 22 of the hospital's Medicare cost report ***submitted pursuant to Section 8(1) of this administrative regulation*** ; and

2. The hospital's Medicaid outpatient net revenue, including both fee-for-service and managed care, divided by net revenue from Medicaid, obtained from Worksheet S-10, line 2 of the hospital's Medicare cost report ***submitted pursuant to Section 8(1) of this administrative regulation*** .

Section 7. Indirect Medical Education Payments at In-State Hospitals with Graduate Medical Education Programs.

(1) If federal financial participation for outpatient indirect medical education (IME) costs is not provided to the department, the department shall not reimburse eligible in-state hospitals for outpatient IME costs.

(2) If federal financial participation for outpatient IME costs is provided to the department, the department shall:

(a) As established in this subsection, provide a supplemental outpatient IME payment to a hospital that is owned or operated by a state university or a state university related party organization, with a state university affiliated graduate medical education program approved by Medicare.

(b) Effective for the state fiscal year beginning July 1, 2024, make an annual IME payment to state university teaching hospitals equal to:

1.

a. The total of all outpatient hospital base payments received from fee-for-service Medicaid during the previous year multiplied by the sum of one (1) and the adjusted hospital specific IME factor determined in accordance with ***paragraph (c) of this subsection*** ~~***[subparagraph 4. plus]***~~ ; ***and***

b. ~~***[2.]***~~ The total of all outpatient hospital base payments received from managed care organizations in the previous year multiplied by the sum of one (1) and the adjusted hospital specific IME factor in accordance with ***paragraph (c) of this subsection; and***

2. Minus ~~***[subparagraph 4., minus]***~~

~~***[3.]***~~ IME payments, if any, included in the outpatient cost settlement.

(c) ~~***[4.]***~~ The adjusted hospital-specific IME factor shall be calculated pursuant to 42 C.F.R. ~~***[§]***~~ 412.105(d), except that the count of FTE residents reported on Worksheet E , Part A, Lines 10 and 11, Column 1 of the Medicare cost report ***submitted pursuant to Section 8(1) of this administrative regulation*** shall be substituted for the numerator of the ratio of full-time equivalent residents to beds described in ***42 C.F.R. 412.105*** ~~***[paragraph]***~~ (d)(1) ~~***[therein]***~~ .

(d) ~~***[5.]***~~ The annual calculation described in this subsection shall utilize the hospital's cost report period ending in the calendar year one (1) year prior to the beginning of the state fiscal year. For example, for the state fiscal year beginning July 1, 2024, the cost report period ending in calendar year 2023 shall be utilized.

Section 8. Cost Reporting Requirements.

(1) An in-state outpatient hospital participating in the Medicaid Program shall submit to the department a copy of the Medicare cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1, the Supplemental Medicaid Schedule KMAP-4 and the Supplemental Medicaid Schedule KMAP-6.

(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.

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

1. The department shall grant an extension if an extension has been granted by Medicare. If an extension has been granted by Medicare, when the facility submits its cost report to Medicare, it shall simultaneously submit a copy of the cost report to the department.

2. If a catastrophic circumstance exists, as determined by the department (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) If a cost report indicates payment is due by a hospital to the department, the hospital shall submit the amount due or submit a payment plan request with the cost report.

(4) If a cost report indicates a payment is due by the hospital to the department and the hospital fails to remit the amount due or request a payment plan, the department shall suspend future payment to the hospital until the hospital remits the payment or submits a request for a payment plan.

(5) An estimated payment shall not be considered payment-in-full until a final determination of cost has been made by the department.

(6) A cost report submitted by a hospital to the department shall be subject to departmental audit and review.

(7) Within seventy (70) days of receipt from the Medicare intermediary, a hospital shall submit to the department a printed copy of the final Medicare-audited cost report including adjustments.

(8)

(a) If it is determined that an additional payment is due by a hospital after a final determination of cost has been made by the department, the additional payment shall be due by a hospital to the department within sixty (60) days after notification.

(b) If a hospital does not submit the additional payment within sixty (60) days, the department shall withhold future payment to the hospital until the department has collected in full the amount owed by the hospital to the department.

Section 9. ~~[Section 7.]~~ Federal Financial Participation. A provision established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

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

(2) Disapproves the provision.

Section 10. ~~[Section 8.]~~ Appeals. A hospital may appeal a decision by the department regarding the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 11. ~~[Section 9.]~~ Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) "Supplemental Worksheet E-3, Part ***VII~~[III, Page 12]~~***", ***December 2010~~[May 2004]~~*** edition~~["]~~;

(b) "Supplemental Medicaid Schedule KMAP-1", January 2007 edition;

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

(d) "Supplemental Medicaid Schedule KMAP-6", January 2007 edition.

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