907 KAR 10:815. Per diem inpatient hospital reimbursement.

RELATES TO: KRS 13B.140, 205.510(16), 205.637, 205.639, 205.640, 205.641, 216.380, 42 C.F.R. Parts 412, 413, 440.10, 440.140, 447.250-447.280, 42 U.S.C. 1395f(l), 1395tt, 1395ww(d)(5)(F), 1395x(mm), 1396a, 1396b, 1396d, 1396r-4

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(2), 205.637(3), 205.640(1), 205.641(2), 216.380(13), 42 C.F.R. 447.252, 447.253, 42 U.S.C. 1396a, 1396r-4

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a 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 provisions related to per diem inpatient hospital reimbursement including provisions necessary to enhance reimbursement pursuant to KRS 142.308 and 205.638.

Section 1. Definitions.

(1) "Base year" means the state fiscal year cost reporting period used to establish a per diem rate.

(2) "Capital costs" means capital related expenses including insurance, taxes, interest, and depreciation related to plant and equipment.

(3) "CMS" means Centers for Medicare and Medicaid Services.

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

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

(6) "Diagnosis related group" or "DRG" means a clinically-similar grouping of services that can be expected to consume similar amounts of hospital resources.

(7) "Distinct part unit" means a separate unit within an acute care hospital that meets the qualifications established in 42 C.F.R. 412.25.

(8) "DRG service" means a discharge, excluding crossover claims or no pay claims, assigned a discharge classification by the diagnosis related group grouper used by the department pursuant to 907 KAR 10:825, whether the discharge is reimbursed by discharge or via a per diem basis.

(9) "GII" means Global Insight, Incorporated.

(10) "Indexing factor" means the percentage that the cost of providing a service is expected to increase during the universal rate year.

(11) "Inflation factor" means the percentage that the cost of providing a service has increased, or is expected to increase, for a specific period of time.

(12) "Long-term acute care hospital" or "LTAC hospital" means a hospital that meets the requirements established in 42 C.F.R. 412.23(e).

(13) "Medical education cost" means a direct cost that is:

(a) Associated with an approved intern and resident program; and

(b) Subject to limits established by Medicare.

(14) "Operating cost" means allowable routine, ancillary service, or special care unit cost related to inpatient hospital care.

(15) "Parity factor" means a factor applied to a per diem rate to establish cost coverage parity with diagnosis related group hospital reimbursement.

(16) "Per diem rate" means a hospital's all-inclusive daily rate as calculated by the department.

(17) "Psychiatric hospital" means a hospital meeting the licensure requirements established in 902 KAR 20:180.

(18) "Rebase" means to redetermine per diem rates using more recent data.

(19) "Rehabilitation hospital" means a hospital meeting the licensure requirements established in 902 KAR 20:240.

(20) "State-designated free-standing rehabilitation teaching hospital that is not state-owned or operated" means a hospital not state-owned or operated which:

(a) Provides at least 3,000 days of rehabilitation care to Medicaid-eligible recipients in a fiscal year;

(b) Provides at least fifty-one (51) percent of the statewide total of inpatient acute rehabilitation care to Medicaid-eligible recipients;

(c) Provides physical and occupational therapy services to Medicaid recipients needing inpatient rehabilitation services in order to function independently outside of an institution post-discharge;

(d) Is licensed as an acute hospital limited to rehabilitation; and

(e) Is a teaching hospital.

(21) "Swing bed" means a bed approved pursuant to 42 U.S.C. 1395tt to be used to provide either acute care or extended skilled nursing care to a recipient.

(22) "Third party payor" means a payor of a third party pursuant to KRS 205.510(16).

(23) "Trending factor" means the inflation factor as applied to that period of time between a facility's base fiscal year end and the beginning of the universal rate year.

(24) "Universal rate year" means the twelve (12) month period under the prospective payment system, beginning July of each year, for which a payment rate is established for a hospital regardless of the hospital's fiscal year end.

(25) "Weighted average" means an average that reflects an individual element's proportionality to all elements.

Section 2. Payment for Rehabilitation or Psychiatric Care in an In-State Acute Care Hospital.

(1) For rehabilitation care in an in-state acute care hospital that has a Medicare-designated rehabilitation or psychiatric distinct part unit, the department shall reimburse:

(a) A facility specific per diem rate based on the most recently received Medicare cost report received prior to the rate year, trended and indexed to the current state fiscal year; and

(b) In accordance with Sections 6 and 9 of this administrative regulation.

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

1. Aggregate projected payments and aggregate projected Medicaid paid days for non-per diem DRG services as calculated by the model established in 907 KAR 10:825;

2. Actual prior year payments inflated by the GII; and

3. Per diem DRG service Medicaid days; and

(b) In accordance with Sections 6 and 9 of this administrative regulation.

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

(1) 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.

(2) The department shall calculate a per diem rate by:

(a) Using a hospital's state fiscal year 2005 cost report, allowable cost and paid days to calculate a base cost per day for the hospital;

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

(c) 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;

(d) 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;

(e) Applying a parity factor equivalent to aggregate cost coverage established by the DRG reimbursement methodology established in 907 KAR 10:825; and

(f) Applying available provider tax funds on a pro-rata basis to the pre-provider tax per diem calculated in paragraphs (a) through (e) of this subsection.

Section 4. 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 of this administrative regulation.

Section 5. Payment for Critical Access Hospital Care.

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

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

(3)

(a) A critical access hospital shall comply with the cost reporting requirements established in Section 10 of this administrative regulation.

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

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

(5) The department shall reimburse for care in a federally defined swing bed in a critical access hospital pursuant to 907 KAR 1:065.

Section 6. 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.

Section 7. In-State Hospital Reimbursement Updating Procedures.

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

(a) An operating and professional component per diem rate shall be inflated from the midpoint of the previous universal rate year to the midpoint of the current universal rate year using the GII; and

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

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

(3) Except for an adjustment resulting from an appeal in accordance with Section 21 of this administrative regulation, the department shall make no other adjustment.

Section 8. Use of a Universal Rate Year.

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

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

Section 9. Cost Basis.

(1) An allowable Medicaid cost shall:

(a) Be a cost allowed after a Medicaid or Medicare audit;

(b) Be in accordance with 42 C.F.R. Parts 412 and 413;

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

(d) Not include a cost listed in Section 11 of this administrative regulation.

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

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

(a) A critical access hospital; or

(b) A facility with a rate based on un-audited data.

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

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

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

Section 10. In-State Hospital Cost Reporting Requirements.

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

(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. If an extension has been granted by Medicare, the cost report shall be submitted simultaneously with the submittal of the Medicare cost report.

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

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

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

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

Section 11. Unallowable Costs.

(1) The following shall not be allowable cost for Medicaid reimbursement:

(a) A cost associated with a political contribution;

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

(c) A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity,

subject to the limitations of subparagraphs 1 and 2 of this paragraph

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

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

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

(3) A Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted to the department with an annual cost report.

Section 12. Trending of an In-state Hospital's Cost Report Used for Rate Setting Purposes.

(1) An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the department, either audited or un-audited, shall be trended to the beginning of the universal rate year to update an in-state hospital's Medicaid cost.

(2) The trending factor, referenced in subsection (1) of this section, to be used shall be the inflation factor prepared by GII for the period being trended.

Section 13. In-State Hospital Indexing for Inflation.

(1) After an allowable Medicaid cost has been trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost in the universal rate year.

(2) The department shall apply the inflation factor prepared by GII for the universal rate year as the indexing factor.

Section 14. 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) Artificially 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.

Section 15. 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.

Section 16. Reimbursement for Out-of-state Hospitals.

(1) 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.

(a) The psychiatric operating per diem rate shall be the median operating rate, excluding graduate medical education cost or any provider tax cost, per day for all in-state acute care hospitals that have licensed psychiatric beds pursuant to 902 KAR 20:180.

(b) The psychiatric 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 beds pursuant to 902 KAR 20:180, Psychiatric hospitals; operation and services.

(c) The per diem rate shall not include any adjustment mandated for in-state hospitals pursuant to 2006 Ky Acts ch. 252.

(2) For care provided by an out-of-state freestanding psychiatric hospital, the department shall reimburse a per diem rate comprised of a psychiatric operating per diem rate and a capital per diem rate.

(a) The psychiatric operating per diem rate shall equal seventy (70) percent of equal the median operating rate, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding psychiatric hospitals.

(b) The psychiatric capital per diem rate shall equal seventy (70) percent of the median psychiatric capital per diem cost for all in-state freestanding psychiatric hospitals.

(c) The per diem rate shall not include any adjustment mandated for in-state hospitals pursuant to 2006 Ky Acts ch. 252.

(3) 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 minus any adjustment mandated for in-state hospitals pursuant to 2006 Ky Acts. ch. 252.

(4) The department shall apply the requirements of 42 C.F.R. 447.271 on a claim-specific basis to payments made via this section of this administrative regulation.

Section 17. Supplemental Payments. In addition to a payment based on a rate developed under Section 2, 3, or 4 of this administrative regulation, the department shall:

(1) Make quarterly supplemental payments to an in-state hospital which qualifies as a psychiatric access hospital in an amount:

(a) Equal to the hospital's uncompensated costs of providing care to Medicaid recipients and individuals not covered by a third party payor, not to exceed $6 million annually; and

(b) Consistent with the requirements of 42 C.F.R. 447.271; and

(2) Make an annual payment to an in-state state-designated free-standing rehabilitation teaching hospital that is not state-owned or operated in an amount:

(a) Determined on a per diem or per discharge basis equal to the nonreimbursed costs of providing care to Medicaid recipients. Costs shall be the amount of cost identified on a hospital's most recent cost report received by the department for a fiscal year reduced by the cost of care covered by third parties and

(b) Equal to the amount of per diem payments pursuant to this administrative regulation or per discharge diagnosis related group payments pursuant to 907 KAR 10:825 received by the hospital for Medicaid recipients not covered by third parties.

Section 18. Certified Public Expenditures.

(1) The department shall reimburse an in-state public government-owned hospital the full cost of inpatient care via a certified public expenditure (CPE) contingent upon approval by CMS.

(2) To determine the amount of costs eligible for a CPE, an in-state hospital's allowed charges shall be multiplied by the hospital's operating cost-to-total charges ratio.

(3) The department shall verify whether or not a given CPE is allowable as a Medicaid cost.

(4)

(a) Subsequent to a cost report being submitted to the department and finalized, a CPE shall be reconciled with the actual costs reported to determine the actual CPE for the period.

(b) If any difference between actual cost and submitted cost remains, the department shall reconcile any difference with the provider.

Section 19. Access to Subcontractor's Records. If a hospital has a contract with a subcontractor for services costing or valued at $10,000 or more over a twelve (12) month period:

(1) The contract shall contain a provision granting the department access:
(a) To the subcontractor's financial information; and
(b) In accordance with 907 KAR 1:672; and
(2) Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

Section 20. New Provider, Change of Ownership, or Merged Facility.
(1) If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the rate in effect at the time of the change of ownership.
(2) Until a fiscal year end cost report is available, a newly constructed or newly participating hospital shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification.
(a) A prospective per diem shall be set based on the operating budget and projected number of patient days for care not subject to a diagnosis related group method of reimbursement.
(b) A prospective per diem rate set in accordance with paragraph (a) of this subsection shall be tentative and subject to settlement at the time the first audited fiscal year end report is available to the department.
(c) During the projected rate year, the budget shall be adjusted if indicated and justified by the submittal of additional information.
(3) If two (2) or more separate entities merge into one (1) organization, the department shall:
(a) Merge the latest available data used for rate setting;
(b) Combine bed utilization statistics, creating a new occupancy ratio;
(c) Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs;
(d) Compute on a weighted average the rate of increase control applicable to each entity, based on the reported paid Medicaid days for each entity taken from the cost report previously used for rate setting;
(e) If one (1) of the entities merging has disproportionate status and the other does not, retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid;
(f) Recognize an appeal of the merged per diem rate in accordance with 907 KAR 1:671; and
(g) Require each provider to submit a Medicaid cost report for the period:
1. Ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end; and
2. Starting with the day of the merger and ending on the fiscal year end of the merged entity in accordance with Section 10 of this administrative regulation.

Section 21. Appeals.
(1) An administrative review shall not be available for a facility or service reimbursed via the per diem methodology for the determination of the requirement, or the proportional amount, of any budget neutrality adjustment used in the calculation of the per diem rate.
(2) An administrative review shall be available for a calculation error in the establishment of a per diem rate.
(3) An appeal shall comply with the review and appeal provisions established in 907 KAR 1:671.

Section 22. Incorporation by Reference.
(1) The following material is incorporated by reference:
(a) "Supplemental Medicaid Schedule KMAP-1", January 2007 edition; and
(b) "Supplemental Medicaid Schedule KMAP-4", January 2007 edition.

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

(34 Ky.R. 1605; 2190; 2406; eff. 6-6-2008; Recodified from 907 KAR 1:815; eff. 5-3-2011; Crt eff. 7-23-2018.)