1 General Overview

A. Effective for discharges on or after October 1, 2015, the Department will pay for acute care inpatient hospital services provided to a Medicaid recipient who is not enrolled with a managed care organization under a diagnosis related group (DRG) based methodology using the CMS Medicare Severity Diagnosis Related Grouper (MS-DRG) grouper. The methodology will be the Medicare Inpatient Prospective Payment System as described in this State Plan. The revised system will utilize the hospital specific Medicare operating and capital base rates, and the Medicare-established relative weights. Hospital services not paid for using the DRG-based methodology will be paid for using per diem rates or as otherwise stated in this plan.

The following will be excluded from the DRG methodology:

1) Services provided in Critical access hospitals. Reimbursement procedures are described in section 4, beginning on page 22 of this document;
2) Services provided in Free-standing rehabilitation hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
3) Services provided in Long-term acute care hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
4) Psychiatric services, including substance abuse, in Acute care hospitals. Reimbursement procedures are described in section 2(Z), beginning on page 18 of this document;
5) Services provided in Free-standing psychiatric hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
6) Rehabilitation services in Acute care hospitals. Reimbursement procedures are described in section 2(Z), beginning on page 18 of this document; and

B. Appeals and Review Process.

1) Matters Subject to an Appeal. A hospital may appeal whether the Medicare data specific to the hospital that was extracted by the Department in establishing the hospital's reimbursement was the correct data.

2) Appeal Process.

a. An appeal shall comply with the requirements and provisions established in this section.
b. (1) A request for a review of an appealable issue shall be received by the department within sixty (60) calendar days of the date of receipt by the provider of the department's notice of rates set under Regulation 907 KAR 10:830, revised 9/4/2015.
(2) The request referenced in paragraph (1) of this subsection shall:
(a) Be sent to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, 6th Floor, Frankfort, Kentucky 40621-0002; and
(b) Contain the specific issues to be reviewed with all supporting documentation necessary for the departmental review.
c. (1) The department shall review the material referenced in subsection (b) of this section and notify the provider of the review results within 30 days of its receipt except as established in paragraph (2) of this subsection.

1 Overview (continued)

B. Appeals and Review Process (continued)

(2) If the provider requests a review of a non-appealable issue under 907 KAR 10:830 (revised 9/4/2015), the department shall:
(a) Not review the request; and
(b) Notify the provider that the review is outside of the scope of 907 KAR 10:830 (revised 9/4/2015).

d. (1) A provider may appeal the result of the department's review, except for a notification that the review is outside the scope of 907 KAR 10:830 (revised 9/4/2015), by sending a request for an administrative hearing to the Division for Administrative Hearings (DAH) within thirty (30) days of receipt of the department's notification of its review decision.

(2) A provider shall not appeal a notification that a review is outside of the scope of 907 KAR 10:830 (revised 9/4/2015).

e. (1) An administrative hearing shall be conducted in accordance with KRS Chapter 13B.

(2) Pursuant to KRS 13B.030, the Secretary of the Cabinet for Health and Family Services delegates to the Cabinet for Health and Family Services, Division for Administrative Hearings (DAH) the authority to conduct administrative hearings under 907 KAR 10:830 (revised 9/4/2015).

(3) A notice of the administrative hearing shall comply with KRS 13B.050.

(4) The administrative hearing shall be held in Frankfort, Kentucky no later than ninety (90) calendar days from the date the request for the administrative hearing is received by the DAH.

(5) The administrative hearing date may be extended beyond the ninety (90) calendar days by:
(a) A mutual agreement by the provider and the department; or
(b) A continuance granted by the hearing officer.

(6) (a) If the prehearing conference is requested, it shall be held at least thirty (30) calendar days in advance of the hearing date.
(b) Conduct of the prehearing conference shall comply with KRS 13B.070.

(7) If a provider does not appear at the hearing on the scheduled date, the hearing officer may find the provider in default pursuant to KRS 13B.050(3)(h).

(8) A hearing request shall be withdrawn only under the following circumstances:
(a) The hearing officer receives a written statement from a provider stating that the request is withdrawn; or
(b) A provider makes a statement on the record at the hearing that the provider is withdrawing the request for the hearing.

(9) Documentary evidence to be used at the hearing shall be made available in accordance with KRS 13B.090.

(10) The hearing officer shall:
(a) Preside over the hearing; and
(b) Conduct the hearing in accordance with KRS 13B.080 and 13B.090.

(11) The provider shall have the burden of proof concerning the appealable issues under 907 KAR 10:830 (revised 9/4/2015).

1 Overview (continued)

B. Appeals and Review Process (continued)

(12) (a) The hearing officer shall issue a recommended order in accordance with KRS 13B.110.
(b) An extension of time for completing the recommended order shall comply with the requirements of KRS 13B.110 (2) and (3).
(13) (a) A final order shall be entered in accordance with KRS 13B.120.
(b) The cabinet shall maintain an official record of the hearing in compliance with KRS 13B.130.
(c) In the correspondence transmitting the final order, clear reference shall be made to the availability of judicial review pursuant to KRS 13B.140, 13B.150, and KRS 13B.160.

C. Adjustment of rates.

1) Final rates are not adjusted except for correction of errors, to make changes resulting from the dispute resolution or appeals process, if the decision determines that rates were not established in accordance with the approved State Plan, Attachment 4.19-A, or to make changes resulting from Federal Court orders including to the extent necessary action to expand the effect of a Federal Court order to similarly situated facilities. .

2) New rates shall be set for each universal rate year, and at any point in the rate year when necessitated by a change in the applicable statute or regulation subject to a state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS), if applicable.

D. Use of a Universal Rate Year

1) A universal rate year shall be established for rates in this attachment as follows:
a. For DRG rates, excluding non-distinct part unit (non-DPU) psychiatric and rehabilitation hospital rates, the universal rate year shall be October 1 through September 30 of the following year.
b. For Psychiatric Residential Treatment Facility (PRTF) rates, the universal rate year shall be November 1 through October 31 of the following year.
c. For all other hospital rates referenced in this attachment, the universal rate year shall be July 1 through June 30 of the following year, or as specifically stated throughout this attachment.

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

E. Cost Reporting Requirements.

1) The department follows the Medicare Principles of reimbursement found in 42 CFR 413 and the CMS Publication 15 to determine allowable cost. Additional cost report requirements are as follows:

1 Overview (continued)

E. Cost Reporting Requirements (continued)

2) An in-state hospital participating in the Medicaid program shall submit to the department a copy of a Medicare cost report form CMS 2552-10 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 as follows:

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; and

b. Except as follows, 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; or

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

3) 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.

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

5) An in-state hospital shall submit to the department a final Medicare-audited cost report upon completion by the Medicare intermediary along with an electronic cost report file (ECR).

F. Unallowable Costs

1) The following shall not be allowable cost for Medicaid reimbursement unless otherwise noted:

a. A cost associated with a political contribution;

b. The allowability of legal fees is determined in accordance with the following:

(1) A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet for Health and Family Services is not allowable;
(2) 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. Cost associated with travel and related expenses must take into consideration the following:

1 Overview (continued)

F. Unallowable Costs (continued)

(1) 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 is not allowable.
(2) A cost for a training or educational purpose outside the Commonwealth of Kentucky shall be allowable.
(3) 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 the Supplemental Medicaid Schedule KMAP-1.

3) The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report.

G. Trending of an In-state Hospital's Cost Report Used for Non-DRG 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 from the midpoint of the cost report year to the beginning of the universal rate year to update an in-state hospital's Medicaid cost. This methodology applies for all rate setting throughout this attachment.

2) The trending factor to be used shall be the inflation factor prepared by IHS Markit, a market basket data indexing and forecasting firm for the period being trended.

H. Indexing for Inflation of an In-state Hospital's Cost Report Used for Rate Setting Purposes.

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 to the midpoint in the universal rate year. This methodology applies for all rate setting throughout this attachment.

2) The department shall use the inflation factor prepared IHS Markit as the indexing factor for the universal rate year.

I. 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. Part 413;
c. Include an in-state hospital's provider tax; and
d. Not include a cost in the Unallowable Costs listed in Section (1)F of this attachment.

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

1 Overview (continued)

I. Cost Basis. (continued)

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.

J. 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, published on January 4, 2008, Provider enrollment, disclosure, and documentation for Medicaid participation; and

2) Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

K. New Provider, Change of Owner or Merged Facility

1) The Department shall reimburse a new acute care hospital based on the Medicare IPPS Final Rule Data Files and Tables inputs in effect at the time of the hospital's enrollment with the Medicaid program as described in section (2) of this attachment. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

2) If no applicable rate information exists in the Medicare IPPS Final Rule Data Files and Tables for a given period for an in-state acute care hospital, the Department shall use, for the in-state acute care hospital, the average of all in-state acute care hospitals for the operating rate, capital rate, and outlier cost-to-charge ratio, excluding any adjustments made for sole community hospitals or Medicare dependent hospitals.

3) If a hospital undergoes a change of ownership, the new owner shall be reimbursed at the rate in place at the time of the ownership change.

1 Overview (continued)

K. New Provider, Change of Owner or Merged Facility (continued)

4) A merged facility of two or more entities.

a. The merger of two per diem facilities shall:
(1) Merge the latest available data used for rate setting.
(2) Combine bed utilization statistics, creating a new occupancy ratio.
(3) Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs.
(4) 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.
(5) Recognize an appeal of the merged per diem rate on Conditions of Medicaid provider participation, withholding overpayments, administrative appeal process, and sanctions.

5) Cost report submission

a. Require each provider to submit a Medicaid cost report for the period ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end.
b. A Medicaid cost report for the period starting with the day of the merger and ending on the fiscal year end for the merged entity shall also be filed with the department in accordance with this attachment.

L. Payment Not to Exceed Charges or the Upper Payment Limits.

1) The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges plus disproportionate share payments, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges, the state will recoup payments in excess of allowable charges plus disproportionate share payments.

2) The state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement. Medicare upper payment limits as required by 42 CFR 447.272 will be determined in advance of the fiscal year from cost report and other applicable data from the most recent rate setting as compared to reimbursement for the same period. Cost data and reimbursement shall be trended forward to reflect current year upper payment limits. See Exhibit A for detail description and formula for UPL demonstration.

M. Public Process for Determining Rates for Inpatient Hospitals. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

N. The Hospital Provider Tax is described in Kentucky Revised Statute 142.303, revised June 26, 2007.

1 Overview (continued)

O. As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Department for Medicaid Services will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Beginning with the Medicaid State Plan year 2011 DSH audit through the Medicaid State Plan year 2018 DSH audit, DSH payments made to hospitals may be adjusted based on the results of the federally-mandated DSH audits as follows:

1) DSH payments found in the DSH audit process for a given state fiscal year that exceed the hospital specific uncompensated care cost (UCC) DSH limits will be recouped from hospitals to reduce their payments to their limit. Any payments that are recouped from hospitals as a result of the DSH audit will be redistributed to hospitals that are shown to have been paid less than their hospital-specific DSH limits. Redistributions will occur proportionately to the original distribution of DSH funds not to exceed each hospital's specific UCC DSH limit. If DSH funds cannot be fully redistributed within the original distribution pool , due to the hospital specific limits, the excess funds will be redistributed to the other distribution pools in proportion to the original DSH payments made by the state.

2) If the Medicaid program's original DSH payments did not fully expend the federal DSH allotment for any state fiscal year, the remaining DSH allotment will be retroactively paid to hospitals that are under their hospital-specific DSH limit reflecting the potential redistributions in #1 above. These additional DSH payments will be made in proportion to the original DSH payments, and will be limited to each hospital's specific DSH limit.

Beginning with the Medicaid State Plan year 2019 DSH audit, payments made to hospitals may be adjusted based on the results of the federally-mandated DSH audits in accordance with Section 8b. of this attachment.

Effective retroactively to February 21st, 2024, and effective for affected services provided through June 30, 2024, all Inpatient Hospital Providers that are providing inpatient services are eligible to receive interim payments for FFS (Fee for Service) Claim types in amounts representative of up to thirty days (30) of claims payments for FFS that are not otherwise paid as a result of the Change Healthcare cybersecurity incident. The average 30-day payment is based on the total claims for FFS paid to the Kentucky Medicaid provider, inclusive of all Medicaid base payments for FFS claims made under the Medicaid State Plan, between August 1, 2023, and October 31, 2023, divided by three (3). The payment will be made for services provided through June 30, 2024, on a formal request only basis from the provider. This is not an advanced payment or prepayment prior to services furnished by providers, this is an interim payment based on services provided but the rendering provider is unable to submit the appropriate claim(s) due to the cybersecurity incident. These payments will be reconciled to the final payment amount the provider was eligible to receive under the Medicaid State Plan for FFS claims during the timeframe for which it was receiving interim payments under this provision. The reconciliation will be completed within 60 days following the last day of the quarter in which the state is able to again process payments for claims *following the resolution of the Change Healthcare cybersecurity incident. If the reconciliation results in discovery of an overpayment to the provider, the state will attempt to recoup the overpayment amounts within 60 days and will return the federal share within the timeframe specified in 42 CFR 433.316 and 433.320 regardless of whether the state actually recoups* the overpayment amount from the provider, unless an exception applies under 42 CFR part 433, subpart F. If the reconciliation results in an underpayment to the provider, the state will make an additional payment to the provider in the amount of the underpayment within 60 days. The state will follow all applicable Program Integrity requirements relating to interim payments to providers and the associated reconciliation process. The state will ensure that the Individual, Group and Entity Provider Types receiving payments under this interim methodology for FFS will continue to furnish medical and professional care to Medicaid beneficiaries during the interim payment period and that access to services is not limited.