2. Acute Care Hospital Services

A. DRG-Based Methodology

1) An eligible in-state acute care hospital shall be paid for all covered inpatient acute care services on a fully-prospective per discharge basis.

B. Effective for discharges on or after October 1, 2015, the department's reimbursement shall equal ninety-five (95) percent of a hospital's Medicare DRG payment excluding the following Medicare reimbursement components:

1) A Medicare low-volume hospital payment;
2) A Medicare end stage renal disease payment;
3) A Medicare new technology add-on payment;
4) A Medicare routine pass-through payment;
5) A Medicare ancillary pass-through payment;
6) A Medicare value-based purchasing payment or penalty;
7) A Medicare readmission penalty in accordance with Item "M" below;
8) A Medicare hospital-acquired condition penalty in accordance with Item "M" below;
9) Any type of Medicare payment implemented by Medicare after October 1, 2015; or
10) Any type of Medicare payment not described below.

C. 1) For covered inpatient acute care services, in an in-state acute care hospital, the total hospital-specific per discharge payment shall be the sum of:
   a. A DRG base payment; and
   b. If applicable, a cost outlier payment.
2) The resulting payment shall be limited to ninety-five (95) percent of the calculated value.
3) If applicable, a transplant acquisition fee payment shall be added pursuant to Item "L" below.

D. 1) The department shall assign a DRG classification to each unique discharge billed by an acute care hospital.
2) a. The DRG assignment shall be based on the most recent Medicare Severity DRG (MS-DRG) grouping software released by the Centers for Medicare and Medicaid Services beginning with version 32 on October 1, 2015 unless CMS releases version 33 on October 1, 2015.
   b. If CMS releases version 33 on October 1, 2015, the department shall make interim payments for dates of service beginning October 1, 2015 based on version 32 and then retroactively adjust claims for dates of service beginning October 1, 2015 using version 33.
   c. The grouper version shall be updated in accordance with the Reimbursement Updating Procedures outlined below in Item R.

2. Acute Care Hospital Services

3) In assigning a DRG for a claim, the department shall exclude from consideration any secondary diagnosis code associated with a never event.

E. 1) A DRG base payment shall be the sum of the Medicare operating base payment and the capital base payment calculated as described in paragraphs 3) and 4) below.

2) All calculations in this subsection shall be subject to special rate-setting provisions for sole community hospitals found in Item O and Medicare dependent hospitals found in Item P.

3) a. The Medicare operating base payment shall be determined by multiplying the hospital-specific operating rate by the DRG relative weight.

b. If applicable, the resulting product of subparagraph "a." of this paragraph shall be multiplied by the sum of one (1) and a hospital-specific operating indirect medical education (IME) factor determined in accordance with subparagraph "g." below.

c. Beginning October 1, 2015, the hospital-specific operating rate referenced in subparagraph "a." above shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS as described in subparagraphs "d." through "g." below. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

d. The Medicare IPPS standard amount established for operating labor costs from Table 1 shall be multiplied by the wage index from Table 3 associated with the final Core Based Statistical Area (CBSA) assigned to the hospital by Medicare, inclusive of any Section 505 adjustments applied by Medicare, as reported in the IPPS impact file.

e. The resulting product of subparagraph "d." shall be added to the Medicare IPPS standard amount for non-labor operating costs.

f. The operating rate shall be updated in accordance with Item "R" below.

g. (1) Beginning October 1, 2015, the hospital-specific operating IME factor shall be taken from the Federal Fiscal Year 2016 Medicare Inpatient Prospective Payment System (IPPS) Final Rule Data Files and Tables published by CMS.

(2) The operating IME factor shall be updated in accordance with Item "R" below.

4) a. The capital base payment shall be determined by multiplying the hospital-specific capital rate by the DRG relative weight.

b. If applicable, the resulting product of subparagraph "a." above shall be multiplied by the sum of one (1) and a hospital-specific capital indirect medical education factor determined in accordance with subparagraph "g." below.

c. Beginning October 1, 2015, the hospital-specific capital rate referenced in subparagraph "a." above shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS as described in subparagraphs "d" through "g" below. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

d. The Medicare IPPS standard amount established for capital costs shall be multiplied by the geographic adjustment factor (GAF) associated with the final CBSA assigned to the hospital by Medicare.

e. The capital rate shall be updated in accordance with Item "R" below.

2. Acute Care Hospital Services

f. Effective October 1, 2015, the hospital-specific capital IME factor shall be taken from the Medicare Inpatient Prospective Payment System (IPPS) Final Rule Data Files and Tables published by CMS.

g. The capital IME factor shall be updated in accordance with Item "R." below.

5) a. Effective May 10, 2019, the department shall make an annual IME payment to state university teaching hospitals (as defined in subparagraph 5.c), in addition to the adjustments specified in subparagraphs 3.b and 4.b, equal to:

(1) The total of all operating base payments, as determined under subparagraph 3.a, received by the hospital during the previous year multiplied by the sum of one (1) and the adjusted hospital-specific education (IME) factor determined in accordance with subparagraph b, plus

(2) The total of all capital base payments, as determined under subparagraph 4.a, received by the hospital during the previous year multiplied by the sum of one (1) and the adjusted hospital-specific education (IME) factor determined in accordance with subparagraph b, plus

(3) The total of all inpatient operating and capital base hospital payments received from managed care organizations in the previous year multiplied by the sum of one (1) and the adjusted hospital-specific education (IME) factor determined in accordance with subparagraph b, minus

(4) The amount of IME adjustments to the operating base rate received during the previous year pursuant to subparagraph 3.b, minus

(5) The amount of IME adjustments to the capital base rate received during the previous year pursuant to subparagraph 4.b, minus

(6) The amount of IME adjustments received from managed care organizations during the previous year.

b. The adjusted hospital-specific operating IME factor shall be calculated pursuant to 42 C.F.R. § 412.105(d) substituting the count of FTE residents in the resident-to-bed ratio in the formula described therein with the number of FTE residents reported on Worksheet E Part A, Lines 10 and 11, Column 1 of the Medicare cost report..

c. For purposes of this paragraph, a state university teaching hospital is 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.

d. The fee-for-service portion of the state university teaching hospital IME payments equals the amount determined under 5.a(1) plus 5.a(2) minus the amounts determined under 5.a(4) and 5.a.(5). Only the fee-for-service portion of the teaching hospital IME payments shall count towards the upper payment limit described in Attachment A.

F. 1) The department shall make a cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each DRG as established as follows.

2) A cost outlier shall be subject to QIO review and approval.

3) A discharge shall qualify for a cost outlier payment if its estimated cost, as calculated in Item "F" (4) below, exceeds the DRG's outlier threshold, as calculated in Item "F" (5) below.

4) a. The department shall calculate the estimated cost of a discharge:
   (1) For purposes of comparing the discharge cost to the outlier threshold; and
   (2) By multiplying the sum of the hospital-specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.

   b. (1) A Medicare operating and capital-related cost-to-charge ratio shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
   (2) The Medicare operating and capital cost-to-charge ratios shall be updated in accordance with Item "R." below.

5) a. The department shall calculate an outlier threshold as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold.

   b. (1) Beginning October 1, 2015, the fixed loss cost threshold shall equal the Medicare fixed loss cost threshold established for Federal Fiscal Year 2016.
   (2) The fixed loss cost threshold shall be updated in accordance with Item "R." below.

6) a. For specialized burn DRGs as established by Medicare, a cost outlier payment shall equal ninety (90) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

   b. For all other DRGs, a cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

G. 1) The department shall establish DRG relative weights obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect under Item "D." above. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

2) Relative weights shall be revised to match the grouping software version for updates in accordance with Item "R." below.

H. The department shall separately reimburse for a mother's stay and a newborn's stay based on the DRGs assigned to the mother's stay and the newborn's stay.

I. 1) If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.

2) For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

2. Acute Care Hospital Services

3) a. The department shall calculate an average daily discharge rate by dividing the DRG base payment by the Medicare geometric mean length-of-stay for a patient's DRG classification.
b. The Medicare geometric length-of-stay shall be obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect under subparagraph "c." below.
c. The geometric length-of-stay values shall be revised to match the grouping software version for updates in accordance with Item "R." below.

4) Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five (95) percent of the amount calculated for each.

5) For a hospital receiving a transferred patient, the department shall reimburse the standard DRG payment established in Item "D." above.

J. 1) The department shall reimburse a transferring hospital for a transfer from an acute care hospital to a qualifying post-acute care facility for selected DRGs as a post-acute care transfer.

2) The following shall qualify as a post-acute care setting:
a. A skilled nursing facility;
b. A cancer or children's hospital;
c. A home health agency;
d. A rehabilitation hospital or rehabilitation distinct part unit located within an acute care hospital;
e. A long-term acute care hospital; or
f. A psychiatric hospital or psychiatric distinct part unit located within an acute care hospital.

3) A DRG eligible for a post-acute care transfer payment shall be in accordance with 42 U.S.C. 1395ww(d)(4)(J).

4) a. The department shall pay each transferring hospital an average daily rate for each day of a stay.
b. A transfer-related payment shall not exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.
c. A DRG identified by CMS as being eligible for special transfer payment in the Medicare IPPS Final Rule Data Files and Tables, shall receive fifty (50) percent of the full DRG payment plus the average daily rate for the first day of the stay and fifty (50) percent of the average daily rate for the remaining days of the stay up to the full DRG base payment. The Medicare IPPS release is found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. DRG special transfer payment indicators will be updated in accordance with Item "R" below.
d. A DRG that is referenced in paragraph 3) of this subsection and not referenced in subparagraph "c." above shall receive twice the average daily rate for the first day of the stay and the average daily rate for each following day of the stay prior to the transfer.
e. Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five (95) percent of the amount calculated for each.

5) a. The average daily rate shall be the base DRG payment allowed divided by the Medicare geometric mean length-of-stay for a patient's DRG classification.
b. The Medicare geometric mean length-of-stay shall be determined and updated in accordance with Item "I(3)" above.

2. Acute Care Hospital Services

K. The department shall reimburse a receiving hospital for a transfer to a rehabilitation or psychiatric distinct part unit the facility-specific distinct part unit per diem rate, in accordance with 907 KAR 10:815 (published 5/3/11), for each day the patient remains in the distinct part unit.

L. 1) The department shall reimburse for an organ transplant on a prospective per discharge method according to the recipient's DRG classification.

2) a. The department's organ transplant reimbursement shall include an interim reimbursement followed by a final reimbursement.

b. The final reimbursement shall:

(1) Include a cost settlement process based on the Medicare 2552 cost report form; and

(2) Be designed to reimburse hospitals for ninety-five (95) percent of organ acquisition costs.

c. (1) An interim organ acquisition payment shall be made using a fixed-rate add-on to the standard DRG payment using the rates below:

(a) Kidney Acquisition - $65,000;
(b) Liver Acquisition - $55,000;
(c) Heart Acquisition - $70,000;
(d) Lung Acquisition - $65,000; or
(e) Pancreas Acquisition - $40,000.

(2) Upon receipt of a hospital's as-filed Medicare cost report, the department shall calculate a tentative settlement at ninety-five (95) percent of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified above.

(3) Upon receipt of a hospital's finalized Medicare cost report, the department shall calculate a final reimbursement which shall be a cost settlement at ninety-five (95) percent of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified above.

(4) The final cost settlement shall reflect any cost report adjustments made by CMS.

M. Payment Adjustment for Provider Preventable Conditions

Effective June 1, 2012, and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFR2 434, 438 and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Never Events (NE), Other Provider Preventable Conditions (OPPCs) and Additional Other Provider Preventable Conditions (AOPPC).

Payments for Health Care Acquired Conditions (HCACs) shall be adjusted in the following manner:

For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC.

For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number of days associated with the diagnoses not present on admission for any HCAC. The number of reduced days shall be based on the average length of stay (ALOS) on the diagnosis tables published by the ICD vendor used by the Medicaid agency. For example, an inpatient claims with 45 covered days identified with an HCAC diagnosis having an ALOS of 3.4, shall be reduced to 42 covered days.

2. Acute Care Hospital Services

Also, consistent with the requirement of 42 CFR 447.26(c):

(c)(2) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(c)(3) Reductions in provider payment may be limited to the extent that the following apply:

i. The identified provider preventable conditions would otherwise result in an increase in payment.

ii. The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.

(c)(5) Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

Health Care-Acquired Conditions

The state identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A:

☒ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-A

☒ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

N. Preadmission Services for an Inpatient Acute Care Service.

A preadmission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:

1) Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and
2) Exclude a service furnished by a home health agency, a skilled nursing facility, or hospice, unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.

2. Acute Care Hospital Services

O. Reimbursement for Sole Community Hospitals.
An operating rate for sole community hospitals shall be calculated as described below:

1) a. For each sole community hospital, the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
b. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables, located at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.
c. Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with Item "R." below.

2) a. The department shall compare the rate referenced in paragraph 1) above with the operating rate calculated in Item "E(3)" above.
b. The higher of the two rates compared in "2) a." above shall be utilized as the operating rate for sole community hospitals.

P. Reimbursement for Medicare Dependent Hospitals.

1) a. For a Medicare-dependent hospital, the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
b. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
c. Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with the reimbursement updating procedures in Item "R." below.

2) a. The department shall compare the Medicare-dependent hospital rate referenced in paragraph 1) above with the operating rate calculated in Item "E(3)" above.
b. If the Item "E(3)" operating rate is higher, it shall be utilized as the hospital's operating rate for the period.

3) a. If the rate referenced in paragraph (1) is higher, the department shall calculate the arithmetic difference between the two (2) rates.
b. The difference shall be multiplied by seventy-five (75) percent.
c. The resulting product shall be added to the Item "E(3)" operating rate to determine the hospital's operating rate for the period.

4) If CMS terminates the Medicare-dependent hospital program, a hospital that is a Medicare-dependent hospital at the time that CMS terminates the program shall receive operating rates as calculated in Item "E(3)" above.

Q. Direct Graduate Medical Education (DGME) Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs.

1) The department shall provide a base DGME (Base DGME) payment to in-state hospitals for the direct costs of a graduate medical education program approved by Medicare as established below.
a. A Base DGME payment shall be made:
(1) Separately from the per discharge and per diem payment methodologies; and
(2) On an annual basis corresponding to the hospital's fiscal year.

2. Acute Care Hospital Services

b. The department shall determine an annual Base DGME payment amount for a hospital:
(1) Total direct graduate medical education costs shall be obtained from a facility's as-filed CMS 2552 cost report, worksheet E-4, line 25.
(2) (a) The facility's Medicaid utilization shall be calculated by dividing Medicaid fee-for-service covered days during the cost report period, as reported by the Medicaid Management Information System, by total inpatient hospital days, as reported on worksheet E-4, line 27 of the CMS 2552 cost report.
(b) The resulting Medicaid utilization factor shall be rounded to six (6) decimals.
(3) The total graduate medical education costs shall by multiplied by the Medicaid utilization factor to determine the total graduate medical education costs related to the fee-for-service Medicaid program.
(4) Medicaid program graduate medical education costs shall then be multiplied by ninety-five (95) percent to determine the annual Base DGME payment amount

2) Effective beginning May 10, 2019, the department shall provide a supplemental direct graduate medical education (Supplemental DGME) payment for the direct costs of graduate medical education incurred by eligible in-state hospitals as established in "2) a." below:
a. In-state hospitals eligible for Supplemental DGME shall include:
(1) Those hospitals receiving direct graduate medical education payments from the department as of April 1, 2019; and
(2) Any hospital which sponsors a graduate medical education program affiliated with a state university on or after April 1, 2019.
b. A Supplemental DGME Payment shall be made
(1) Separately from the per discharge and per diem payment methodologies;
(2) In addition to any Base DGME payment made pursuant to paragraph 1); and
(3) On an annual basis corresponding to the hospital's fiscal year.
c. The annual Supplemental DGME Payment shall equal the difference between the Total DGME Amount determined under "2) d." minus any Base GME payments made under "1)", any GME payments received through outpatient cost settlements, and any DGME payments received from managed care organizations.
d. The department shall determine a Total DGME Amount equal to the product of:
(1) Total DGME costs, obtained from Worksheet B, Part 1, Line 118, Columns 21 and 22, and
(2) The hospital's Medicaid utilization, calculated by dividing the total number of Medicaid inpatient days (including both fee for service and managed care days) by total inpatient days.
e. The Supplemental DGME payment shall be calculated prior to the determination of the Intensity Operating Allowance described in Item V. Only the portion of the Supplemental DGME payment associated with Medicaid fee for service days shall count towards the upper payment limit described in Attachment A.

2. Acute Care Hospital Services

R. Reimbursement Updating Procedures.

1) a. The department shall annually update the Medicare grouper software to the most current version used by the Medicare program. The annual update shall be effective October 1 of each year, except as provided below.

b. If Medicare does not release a new grouper version effective October 1 of a given year

(1) The current grouper effective prior to October 1 shall remain in effect until a new grouper is released; and

(2) When the new grouper is released by Medicare, the department shall update the Medicare grouper software to the most current version used by the Medicare program.

c. The department shall not update the Medicare grouper software more than once per federal fiscal year which shall be October 1 through September 30 of the following year.

2) At the time of the grouper update, all DRG relative weights and geometric length-of-stay values shall be updated to match the most recent relative weights and geometric length-of-stay values effective for the Medicare program.

3) a. Annually, on October 1, all values obtained from the Medicare IPPS Final Rule Data Files and Tables shall be updated to reflect the most current Medicare IPPS final rule in effect. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

b. (1) Within thirty (30) days after the Centers for Medicare and Medicaid Services publishes the Medicare IPPS Final Rule Data Files and Tables for a given year, the department shall send a notice to each hospital containing the hospital's data from the Medicare IPPS Final Rule Data Files and Tables to be used by the department to establish diagnosis related group rates on October 1.

2. Acute Care Hospital Services

(2) The notice referenced above shall request that the hospital:
(a) Review the information; and
(b) If the hospital discovers that the data in the notice sent by the department does not match the data published by the Centers for Medicare and Medicaid Services, notify the department of the discrepancy prior to October 1.

4) All Medicare IPPS final rule values utilized shall be updated to reflect any correction notices issued by CMS, if applicable.

5) Other than an adjustment resulting from an appeals decision requiring an amendment, the department shall make no other adjustment.

S. Readmissions.

1) An unplanned inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.

2) Reimbursement for an unplanned readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.

T. Reimbursement for Out-of-State Hospitals.

1) The department shall reimburse an acute care out-of-state hospital for inpatient care on a fully prospective per discharge basis except for the following hospitals:
a. A children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and a bordering state; and
b. Vanderbilt Medical Center.

2) For eligible inpatient acute care service in an out-of-state acute care hospital the total hospital-specific per discharge payment shall be calculated in the same manner as an in-state hospital with modifications to rates used as described below.

3) The DRG payment parameters listed below shall be modified for out-of-state hospitals not specifically excluded in paragraph 1).
a. The operating rate used in the calculation of the operating base payment described in Item "E(3)(a)" shall equal the average of all in-state acute care hospital operating rates calculated in accordance with Item "E(3)" multiplied by eighty (80) percent, excluding any adjustments made for:
(1) Sole community hospitals; or
(2) Medicare-dependent hospitals.
b. The capital rate used in the calculation of the capital base payment described in Item "E(4)(a)" shall equal the average of all in-state acute care hospital capital rates calculated in accordance with Item "E(4)" multiplied by eighty (80) percent.
c. The DRG relative weights used in the calculation of the operating base payment described in Item "E(3)(a)" and the calculation of the capital base payment described in Item "E(4)(a)" shall be reduced by twenty (20) percent.

2. Acute Care Hospital Services

d. The following provisions shall not be applied:
(1) Medicare indirect medical education cost or reimbursement;
(2) Organ acquisition cost settlements;
(3) Disproportionate share hospital distributions; and
(4) Any adjustment mandated for in-state hospitals pursuant to KRS 205.638.

e. The Medicare operating and capital cost-to-charge ratios used to estimate the cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, shall be determined by calculating the arithmetic mean of all in-state cost-to-charge ratios established in accordance with Item "F(4)" above.

4) The department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, and except for Vanderbilt Medical Center, the average operating rate and average capital rate paid to in-state children's hospitals.

5) The department shall reimburse for inpatient care provided by Vanderbilt Medical Center using the hospital-specific Medicare base rate extracted from the CMS IPPS Pricer Program in effect at the time that the care was provided multiplied by eighty-five (85) percent.

6) The out-of-state hospitals referenced in paragraphs 4) and 5) shall not be eligible to receive indirect medical education reimbursement, organ acquisition cost settlements, or disproportionate share hospital payments.

7) a. The department shall reimburse a hospital referenced in subsection 4) or 5) of this section a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG.
b. A cost outlier shall be subject to quality improvement organization review and approval.
c. The department shall determine the cost outlier threshold for an out-of-state claim regarding a hospital using the same method used to determine the cost outlier threshold for an in-state claim as described in Item F above.

U. Certified Public Expenditures.

1) a. The department shall reimburse an in-state public government-owned or operated hospital the full cost of a Medicaid fee-for-service inpatient service provided during a given state fiscal year via a certified public expenditure (CPE).
b. A payment shall be limited to the federal match portion of the hospital's uncompensated care cost for inpatient Medicaid fee-for-service recipients.

2) To determine the amount of costs eligible for a CPE, a hospital's allowed days shall be multiplied by routine cost per diems found on worksheet D-1 Part II, lines 38 and 42-47 of the CMS 2552-10 cost report. Allowed ancillary charges shall be multiplied by cost-center specific cost-to-charge ratios from the hospital's 2552-10 cost report found on worksheet C part I, column 9.

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

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4) a. An interim CPE reconciliation settlement shall be processed upon receipt of a facility's as-filed 2552-10 cost report.
b. Subsequent to a final cost report being submitted to the department, a final CPE settlement shall be reconciled with the actual costs reported to determine the final CPE for the period.
c. If any difference between actual cost and submitted costs remains, the department shall reconcile any difference with the provider.

V. Intensity Operating Allowance Inpatient Supplement Payments.

1) A State owned or operated University Teaching Hospital, including a hospital operated by a related party organization as defined at 42 CFR 413.17, which is operated as part of an approved School of Medicine, shall be based on the upper payment limits as required by 42 CFR 447.272 and will be determined prospectively each year based on the difference between the total payments made by Medicaid, excluding DSH, and the estimated Medicare payments for the same services. The Medicare payments will be determined based on the Medicare Principles of Reimbursement in accordance with 42 CFR 412 and 413.

2) The detailed formula to determine the supplemental payments is described in Exhibit B incorporated as part of this attachment.

3) The prospective supplemental payments will be reconciled annually to the final cost report filed for the rate year or prospective payment period.

4) Any payments made under this section are subject to the payment limitations as specified in 42 CFR 447.271, whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

5) Payments made under this section shall be prospectively determined quarterly amounts, subject to a year-end reconciliation.

6) In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by CMS, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.

7) Pediatric Teaching Hospital

A state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

a. Calculated by determining the difference between Medicaid costs as stated on the audited Medicare 2552-10 cost report filed as of June 1 each year and payments received for the Medicaid recipients (i.e., Medicare, KMAP, TPL, and Medical Education); and including,
b. An additional quarterly payment of $250,000 ($1 million annually).

(Medicaid recipients shall not include recipients receiving services reimbursed through a Medicaid managed care contract.)

W. Supplemental Payments for DRG Psychiatric Access Hospitals

1) For services provided on and after April 2, 2001 the Department shall provide supplemental payments to certain hospitals to assure access to psychiatric services for patients in rural areas of the Commonwealth. To qualify for psychiatric access payments a hospital must meet the following criteria:

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a. The hospital is not located in a Metropolitan Statistical Area (MSA);
b. The hospital provides at least 65,000 days of inpatient care as reflected in the Department's Hospital Rate data for Fiscal Year 1998-99;
c. The hospital provides at least 20% of inpatient care to Medicaid eligible recipients as reflected in the Department's Hospital Rate data for State Fiscal Year 1998-99; and
d. The hospital provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.

2) Each qualifying hospital will receive a psychiatric access payment amount based on its proportion of the hospital's Medicaid psychiatric days to the total Medicaid psychiatric days for all qualifying hospitals applied to the total funds for these payments. Payments will be made on a quarterly basis in according with the following:

$$\frac{\text{Medicaid patient days}}{\text{Total Medicaid patient days}} \times \text{Fund} = \text{Payment}$$

3) Total Medicaid payments to a hospital from all sources shall not exceed Medicaid charges plus disproportionate share payments. A hospital's disproportionate share payment shall not exceed the sum of the payment shortfall for Medicaid services and the costs of the uninsured. The fund shall be an amount not to exceed $6 million annually.

X. Appalachian Regional Hospital System supplemental payments.

All DRG hospitals operating in the Commonwealth of Kentucky that belong to the Appalachian Regional Hospital System will receive an adjusted payment equal to the difference between what Medicaid pays for inpatient services and what Medicare would pay for those same services to Medicaid eligible individuals or its proportionate share of $7.5 million, whichever is lower. The Upper Payment Limit as defined in 42 CFR 447.272 will be applied on a facility-specific basis as described in Exhibit A. These payments will be made on a quarterly basis within 30 days of the end of the quarter.

Y. Supplemental Payments for Privately-Owned and Non-State Government-Owned Hospitals

1) On an annual basis prior to the start of each program year, the Department shall separately determine each of the following items for privately-owned and non-state government-owned hospitals respectively:
a. The maximum allowable UPL for inpatient services provided in the Kentucky Medicaid fee-for-service program;
b. The fee-for-service UPL gap;
c. A per discharge uniform add-on amount to be applied to Medicaid fee-for-service discharges at qualifying hospitals for that program year, determined by dividing the UPL gap by total fee-for-service hospital inpatient discharges at qualifying hospitals in the data used to calculate the UPL gap. Claims for discharges that already receive an enhanced rate at qualifying hospitals that also are classified as a pediatric teaching hospital or as a psychiatric access hospital shall be excluded from the calculation of the per discharge uniform add-on.

2. Acute Care Hospital Services

2) On a quarterly basis in the program year, the Department shall separately determine each of the following items for privately-owned and non-state government-owned hospitals respectively:
   a. Calculate a fee-for-service quarterly supplemental payment for each qualifying hospital using fee-for-service claims for inpatient discharges paid in the quarter to the qualifying hospital multiplied by the uniform add-on amount determined in item Y(1)(c) of this Section;
   b. Make the quarterly supplemental payment calculated under item Y(2)(a) of this Section;
   c. Provide each qualifying hospital with a notice of the qualifying hospital's quarterly payment, that shall state the total number of paid claims for inpatient discharges used to calculate the qualifying hospital's quarterly supplemental payments, and the amount of quarterly supplemental payments due to be received by the qualifying hospital from the Department.

3) In calculating the quarterly supplemental payments under item Y(2)(a) of this Section for qualifying hospitals that are also classified as a pediatric teaching hospital or as a psychiatric access hospital, no add-on shall be applied to the paid claims for the services for which that hospital also receives supplemental payments pursuant to state plan methodologies in effect on January 1, 2019.

4) Each qualifying hospital shall receive four (4) quarterly supplemental payments in the program year, as determined under item Y(2) of this Section.

Z. Supplemental DRG Payments

1) The Department will pay no more in the aggregate for inpatient hospital services than the inpatient Upper Payment Limit, as set forth in 42 CFR 447.253(b)(2) and 42 CFR 447.272. The Department will determine the inpatient Upper Payment Limit by estimating what would be paid for inpatient hospital services under the Medicare principles of reimbursement. The methodology used by the Department to calculate the inpatient Upper Payment Limits can be found in Attachment 4.19-A Exhibit A.

2) An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility in accordance with applicable federal regulations.
   a. For the purpose of this attachment, Medicaid patient days shall not include enrollee days which means a day of an inpatient hospital stay of a Medicaid recipient who is enrolled with a managed care organization.
   b. A payment made under the Supplemental DRG payments shall not duplicate a payment made via Disproportionate share hospital distributions.

2. Acute Care Hospital Services

AA. Per Diem Methodology: Payment for Rehabilitation or Psychiatric or Substance Abuse Care in an In-State Acute Care Hospital.

1) Distinct Part Unit (DPU)

The department shall reimburse for rehabilitation or psychiatric care in an in-state acute care hospital that has a Medicare-designated rehabilitation or psychiatric distinct part unit on a per diem basis as follows:

a. On a facility-specific per diem basis equivalent to the per diem cost reported for Medicare distinct part unit patients on the most recently received Medicare cost report prior to the rate year. Routine costs for the distinct part unit will be determined by multiplying allowed days by worksheet D-1 Part I, Title XIX - Subprovider, line 38. Ancillary costs will be determined by multiplying allowed charges by the cost center specific cost-to-charge ratio found on worksheet C part I, column 9 of the 2552-10 cost report.

b. Reimbursement for an inpatient rehabilitation or psychiatric service shall be determined by multiplying a hospital's rehabilitation or psychiatric per diem rate by the number of allowed patient days.

c. A rehabilitation or psychiatric per diem rate shall be the sum of a rehabilitation or psychiatric operating per diem rate and a rehabilitation or psychiatric capital per diem rate, as appropriate.

(1) The rehabilitation or psychiatric operating cost-per-day amounts used to determine the rehabilitation or psychiatric operating per diem rate shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric cost basis (as appropriate), excluding capital costs and medical education costs, by the number of Medicaid rehabilitation or psychiatric patient days in the base year.

(2) The Medicaid rehabilitation or psychiatric cost basis and patient days shall be based on Medicaid claims for patients with a rehabilitation or psychiatric diagnosis (as appropriate) with dates of service in the base year. The rehabilitation or psychiatric operating per diem rate shall be adjusted for inflation in accordance with Section (5)(A)(1) of this attachment.

d. Computation of rates.

(1) A rehabilitation or psychiatric capital per diem rate shall be facility-specific and shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric capital cost basis by the number of Medicaid rehabilitation or psychiatric patient days (as appropriate) in the base year.

(2) The Medicaid rehabilitation or psychiatric capital cost basis and patient days shall be based on Medicaid claims for patients with rehabilitation or psychiatric diagnoses (as appropriate) with dates of service in the base year.

(3) The rehabilitation or psychiatric capital per diem rate shall not be adjusted for inflation.

2) Non Distinct Part Unit (Non-DPU)

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 projected payment basis using:

(1) A facility specific per diem basis equivalent to its aggregate projected payments for DRG services divided by its aggregate projected Medicaid paid days.

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

(a) Aggregate projected payments and aggregate projected Medicaid paid days for non-per diem DRG services as calculated by the model established in section (2)A;

(b) Actual prior year payments inflated by the inflation factor provided by IHS Markit; and

(c) Per diem DRG service Medicaid days; and

b. In compliance with provisions for the use of a universal rate year and taking into consideration Medicaid policy with regard to unallowable costs as shown in (1)D and F of this attachment.

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

A. 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 including both psychiatric or substance abuse care where applicable.

B. The department shall calculate a per diem rate by:

1) For rates effective July 1, 2015 through June 30, 2019, using a hospital's fiscal year 2014 Medicare cost report, allowable cost and paid days to calculate a base cost per day for the hospital. Routine costs will be determined by multiplying allowed days by worksheet D-1 Part I, Title XIX, line 38. Ancillary costs will be determined by multiplying allowed charges by the cost center specific cost-to-charge ratio found on worksheet C part I, column 9 of the 2552-10 cost report. Rates will be re-based every four years with adjustments for inflation in non-rebase years, in accordance with section 5 of this attachment. For future rebasing periods beginning July 1, 2019, using the most recently received hospital fiscal year Medicare cost report at the time of rate-setting;

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

3) 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;

4) 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;

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

5) Applying a parity factor equivalent to aggregate cost coverage established by the DRG reimbursement methodology described in the diagnostic related group hospital reimbursement portion of the state plan; and

6) Applying available provider tax funds on a pro-rata basis to the pre-provider tax per diem calculated in paragraphs 1 through 5 of this subsection.

C. 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. 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.

D. 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.

E. 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 is submitted by the hospital.

2) Upon submission 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)B of this attachment.