8b. Disproportionate Share Hospital Provisions (Applicable to Medicaid State Plan year 2019 and each year thereafter)

d. For any hospital that is newly enrolled in the Medicaid program and lacks at least six (6) months of cost report information, the department shall calculate a proxy amount for the hospital's uncompensated care costs. A newly enrolled hospital's uncompensated care costs proxy amount shall be determined by first dividing the total uncompensated care costs for all non-newly enrolled hospitals in the appropriate pool by the total number of hospital beds, excluding swing beds, reported on the Medicaid cost reports by those hospitals and then multiplying the resulting uncompensated care cost per bed by the new hospital's total number of hospital beds, excluding swing beds. Any uncompensated care costs proxy amounts calculated for newly enrolled hospitals shall be used in the determination of initial uncompensated care factors for all other hospitals in the appropriate pool.

e. The department may make adjustments to a Medicaid DSH survey filed by a hospital to correct information that is incomplete or inaccurate as determined by limited review.

f. If a hospital has a negative uncompensated care cost, its uncompensated care costs shall be excluded from the calculation of any uncompensated care costs proxy amount for newly enrolled hospitals and uncompensated care factors for the appropriate pool.

g. The department shall calculate an initial DSH payment pursuant to item D(1) of this Section and shall notify each hospital of their calculation.

h. Hospitals shall notify the department of any adjustments in the department's initial calculations.

i. The department shall make any necessary adjustments and shall issue an initial DSH payment to each hospital in one (1) lump-sum payment on or before November 30, for the disproportionate share funds available during the corresponding federal fiscal year. If the finalized federal disproportionate share allotment for the Commonwealth has not been published through the Federal Register by November 15, the department may pay a portion but no less than ninety percent (90%) of the expected annual payment prior to the publication of the annual final federal allotment. If a partial initial payment is made, the remaining amount shall be paid within sixty (60) days after the date upon which notice of the Commonwealth's finalized federal allotment is published through the Federal Register.

8b. Disproportionate Share Hospital Provisions (Applicable to Medicaid State Plan year 2019 and each year thereafter) (continued)

j. Hospital-specific disproportionate share hospital (DSH) limit means the limitation required under 42 U.S.C. sec. 1396r-4(g) and corresponding regulations that a DSH payment may not exceed a hospital's uncompensated costs of providing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and uninsured individuals.

2) a. Each hospital's total initial DSH payment shall be reconciled to a final DSH payment using the examined Medicaid DSH surveys and shall correspond to the applicable state fiscal year DSH payment year.

2 Rate Groups

(a) Rate group one (1) criteria shall be for a recipient who:
1. Is twelve (12) years of age or younger;
2. Is male or female; and
3. Is sexually reactive; or
(i) Has a severe and persistent aggressive behavior;
(ii) Does not have mental retardation or a developmental disability; and
(iii) Has an intelligence quotient higher than seventy (70).

(b) Rate group two (2) criteria shall be for a recipient who:
1. Is twelve (12) years of age or younger;
2. Is male or female; and
3. Is sexually reactive; and
(i) Has a severe and persistent aggressive behavior;
(ii) Does not have mental retardation or a developmental disability; and
(iii) Has an intelligence quotient higher than seventy (70).

(c) Rate group three (3) criteria shall be for a recipient who:
1. Is thirteen (13) years of age or older;
2. Is male or female; and
3. Is sexually reactive; or
(i) Has a severe and persistent aggressive behavior;
(ii) Does not have mental retardation or a developmental disability; and
(iii) Has an intelligence quotient higher than seventy (70).

(d) Rate group four (4) criteria shall be for a recipient who:
1. Is thirteen (13) years of age or older;
2. Is male or female; and
3. Is sexually reactive; and
(i) Has a severe and persistent aggressive behavior;
(ii) Does not have mental retardation or a developmental disability; and
(iii) Has an intelligence quotient higher than seventy (70).

(e) Rate group four (4) criteria also includes the following for a recipient who:
1. Is under twenty-two (22) years of age;
2. Is male or female; and
3. Is sexually reactive; or
(i) Has a severe and persistent aggressive behavior;
(ii) Has mental retardation or a developmental disability; and
(iii) Has an intelligence quotient lower than seventy (70).

C. The per diem rates referenced in subsection (2) of this section, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:
(a) Including all care and treatment costs;
(b) Including costs for all ancillary services;
(c) Including capital costs;
(d) Including room and board costs; and
(e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program:

D. The department shall annually evaluate each per diem rate for Level II PRTF services and costs by reviewing the most recent, reliable claims data and cost report data to analyze treatment patterns, technology, and other factors that may alter the cost of efficiently providing Level II PRTF services.

E The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.

(10) Reimbursement for Out-of-state Hospitals.

A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.

1. The all-inclusive DRG payment amount:
   a. Shall be based on the patients diagnostic category; and
   b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:

8b. Disproportionate Share Hospital Provisions (Applicable to Medicaid State Plan year 2019 and each year thereafter)

b. Using the examined Medicaid DSH surveys, the department shall make a final determination of whether an acute care hospital qualifies as a MIUR or as a LIUR hospital, which are defined in items D(1)(c)(1) and D(1)(c)(2) of this Section. Any qualifying hospital will be deemed an essential hospital. Critical access hospital status will also be confirmed to make a final determination of essential hospital status.

c. The department shall calculate a final DSH payment as follows:

(1) Each university hospital shall receive a final DSH payment equal to one hundred percent (100%) of the hospital's total uncompensated costs so long as the total final DSH payments to all university hospitals do not exceed the maximum allotment to the university pool as set forth in item D(3)(a) of this Section. If total uncompensated care cost for the pool exceeds the pool's maximum allotment, the final uncompensated care factor for university hospitals shall be determined by calculating the percentage of each hospital's total uncompensated care costs toward the sum of the total uncompensated care costs for all hospitals within the university pool. In this event, each hospital's final DSH payment shall be calculated by multiplying the hospital's uncompensated care factor by the total fund allocated to the hospitals within the respective pool under item D(3)(a) of this Section;

(2) For hospitals in the acute care pool and the psychiatric pool, the department shall recalculate each hospital's uncompensated care factor using examined data. The final uncompensated care factor for each hospital that qualifies as an essential hospital shall be computed using two hundred percent (200%) of the hospital's total uncompensated care costs using examined data;

(3) If a hospital has a negative uncompensated care cost, their uncompensated care cost will be excluded in the calculation of uncompensated care factors; and

(4) The department shall compare each hospital's initial DSH payment with the hospital's final DSH payment and with the hospital's hospital-specific DSH limit to determine if any underpayment or an overpayment exists. The department shall notify hospitals of the amount of any overpayment to be paid to the department and the due date for repayment, if applicable.

d. If an overpayment is identified, repayment shall be made by the hospital following resolution of all appeals.

e. Hospitals shall notify the department of any corrections to the department's calculations.

8b. Disproportionate Share Hospital Provisions (Applicable to Medicaid State Plan year 2019 and each year thereafter) (continued)

f. If a hospital's initial DSH payment was less than the hospital's final DSH payment, the department shall pay the hospital the amount of the difference, following resolution of all appeals.

g. Any funds remaining after the reconciliation process shall be redistributed pursuant to item D(3) of this Section.

3) Disproportionate share payments remaining after reconciling each hospital's initial DSH payment with the hospital's final DSH payment shall be distributed to other hospitals in the acute care pool, university pool, or to private psychiatric hospitals in the psychiatric pool as follows:

a. Funds shall first be distributed to all hospitals in the same pool as the hospitals from which the overpayments were recovered, and the funds shall be distributed in a proportional manner in relation to each hospital's remaining total uncompensated care costs in accordance with the hospital's examined DSH survey for the applicable DSH year;

b. In the proportional distribution, the distribution factor for each hospital that qualifies as an essential hospital shall be computed using two hundred percent (200%) of the hospital's total remaining uncompensated care costs; and

c. If DSH funds remain after making this distribution to other hospitals in the same pool, funds shall be distributed proportionally to hospitals in the acute care pool, university pool, and private psychiatric hospitals in the psychiatric pool in relation to each hospital's remaining total uncompensated care costs in accordance with the hospital's examined Medicaid DSH survey for the applicable DSH year.

4) Disproportionate share payments made to a hospital shall not exceed the hospital's hospital-specific DSH limit.

5) a. An in-state hospital participating in the Medicaid Program shall submit a Medicaid DSH survey corresponding to the hospital's cost reporting period to the department no later than sixty (60) days following the hospital's submission of their annual cost report, unless an extension has been granted by the commissioner. A new in-state hospital lacking six (6) months of cost report information necessary to calculate an initial DSH payment shall submit a limited DSH survey to determine eligibility immediately prior to the department's initial DSH payment calculation. A hospital may submit corrections to an applicable Medicaid DSH survey.

9. Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

A. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A

B. Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

Level I PRTF

To be reimbursable under the Medicaid Program, Level I PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level I PRTF services in accordance with Attachment 3.1-A, Section 16 - Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 22 years of age.

1 The department shall reimburse for Level I PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of $500; or the usual and customary charge

2 The per diem rate shall be increased annually by the Medicare Economic Index.

3 The per diem or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:

(a) Including all care and treatment costs;
(b) Including costs for all ancillary services;
(c) Including capital costs;
(d) Including room and board costs; and
(e) Excluding the costs of drugs as drugs shall be covered and reimbursed under Kentucky's pharmacy program in accordance with 907 KAR Chapter 23.

Level II PRTF

To be reimbursable under the Medicaid program, Level II PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level II PRTF services in accordance with Attachment 3.1-A, Section 16 - Inpatient Psychiatric Residential Treatment facility Services for Level I and II for Individuals under 22 years of age.

1 The department shall reimburse a per diem rate as follows for Level II PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of $600; or the usual and customary charge.

2 The per diem rate shall be increased annually by the Medicare Economic Index.

C. The per diem rates, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:
(a) Including all care and treatment costs;
(b) Including costs for all ancillary services;
(c) Including capital costs;
(d) Including room and board costs; and
(e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program

D. The department shall annually evaluate each per diem rate for Level II PRTF services and costs by reviewing the most recent, reliable claims data and cost report data to analyze treatment patterns, technology, and other factors that may alter the cost of efficiently providing Level II PRTF services.

E The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.

F. (1) The department's reimbursement for a bed reserve day which qualifies as a bed reserve day for a recipient not enrolled in a managed care organization shall be:

(a) Seventy-five (75) percent of the rate established if the Level I or II PRTF's occupancy percent is at least eighty-five (85) percent; or

(b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is less than eighty-five (85) percent.

(c) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:

i. Is in Medicaid payment status in a Level I or II PRTF;

ii. Has been in the Level I or II PRTF overnight for at least one (1) night;

iii. Is reasonably expected to return requiring Level I or II PRTF care; and

iv. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital

(2) The department's reimbursement for a therapeutic pass day which qualifies as a therapeutic pass day for a recipient not enrolled in a managed care organization shall be:

(a) 100 percent of the rate established if the Level I or II PRTF's occupancy percent is at least fifty (50) percent; or

(b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is below fifty (50) percent.

(c) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:

i. Is in Medicaid payment status in a Level I or II PRTF;

ii. Has been in the Level I or II PRTF overnight for at least one (1) night;

iii. Is reasonably expected to return requiring Level I or II PRTF care; and

iv. Has not exceeded the therapeutic pass day limit established; or

v. Received an exception to the limit.

vi. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.

vii. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

(3) (a) A Level I or II PRTF's occupancy percent shall be based on a midnight census.

(b) An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.

(c) An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.

(10) Reimbursement for Out-of-state Hospitals.

A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.

1. The all-inclusive DRG payment amount:
   a. Shall be based on the patients diagnostic category; and
   b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus: