VIII. Outpatient Hospital Services

A. In-State Outpatient Hospital Service Reimbursement.

1. a. Except for critical access hospital services, and an individual in the Lock-In program, the department shall reimburse on an interim basis for in-state outpatient hospital services at a facility specific outpatient cost-to-charge ratio based on the facility's most recently filed Medicaid cost report.
   b. An outpatient cost-to-charge ratio shall be expressed as a percent of the hospital's charges.

2. A facility specific outpatient cost-to-charge ratio paid during the course of a hospital's fiscal year shall be designed to result in reimbursement, at the hospital's fiscal year end, equaling ninety-five (95) percent of a facility's total allowable Medicaid outpatient costs incurred during the hospital's fiscal year.

3. Except as established in item 4. of the In-State Outpatient Hospital Services section:

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

4. a. Under no circumstances shall the department's total reimbursement for outpatient hospital services exceed the aggregate limit established in 42 C.F.R. 447.321.
   b. If projections indicate for a given state fiscal year that reimbursing for outpatient hospital services at ninety-five (95) percent of allowable Medicaid costs would result in the department's total outpatient hospital service reimbursement exceeding the aggregate limit established in 42 CFR 447.321, the department shall proportionately reduce final outpatient hospital service reimbursement for each hospital to equal a percent of costs which shall result in total outpatient hospital reimbursement equaling the aggregate limit established in 42 CFR 447.321.

5. A service in a hospital emergency room that is determined to be non-emergency for a Lock-In recipient shall be reimbursed at $25.00.

6. In accordance with 42 USC 1396r-8(a)(7), a hospital shall include the corresponding National Drug Code (NDC) when billing a physician administered drug in the outpatient hospital setting.

7. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 6 will be bundled with the fixed rate payment and not reimbursed separately.

6. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 5 will be bundled with the fixed rate payment and not reimbursed separately.

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

C. Critical Access Hospital Outpatient Service Reimbursement.

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

2. A critical access hospital shall comply with the cost reporting requirements established in subsection E of the Outpatient Reimbursement section of the state plan.

3. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 5 will be bundled with the fixed rate payment and not reimbursed separately.

D. Outpatient Hospital Laboratory Service Reimbursement.

1. In accordance with 1903(i)(7), Outpatient laboratory services will be paid at the Medicare technical component rate. A laboratory service with no established Medicare rate will be reimbursed by multiplying the facility-specific outpatient cost-to-charge ratio by billed charges with no year-end settlement. Laboratory services provided to a recipient on the same day as services listed in A.1 through 5 will be bundled with the fixed rate payment and not reimbursed separately.

2. Laboratory service reimbursement, in accordance with item 1 in the Outpatient Hospital Laboratory Service Reimbursement section, shall be:

a. Final; and

b. Not settled to cost.

3. An outpatient hospital laboratory service shall be reimbursed in accordance with item D.2 of the Outpatient reimbursement section of the state plan regardless of whether the service is performed in an emergency room setting or in a non-emergency room setting.

E. Cost Reporting Requirements.

1. Claims for services provided prior to January 5, 2009, will be reimbursed per State Plan Amendment 03-015 pages 20.12(f)-20.12(f)(3) effective August 1, 2003.

2. To assure that the Upper Payment Limit is not exceeded in SFY 2008-2009 (July 1, 2008 through June 30, 2009), two analyses will be performed :

   a. An analysis of the cost of providing outpatient services and the reimbursement projected for the rate year (using both payment methodologies during partial years) beginning July 1, 2008 and ending June 30, 2009.

   b. An analysis of the cost of providing outpatient services (based on the relative charges applied) for the period of January 5, 2009 and June 30, 2009; and the reimbursement projected based on the payment methodology in effect during this period.

3. As of January 5, 2009, an in-state outpatient hospital participating in the Medicaid program shall submit to the department a copy of the Medicare cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1, the Supplemental Medicaid Schedule KMAP–4 and the Supplemental Medicaid Schedule KMAP-6 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) The department shall grant an extension if an extension has been granted by Medicare. If an extension has been granted by Medicare, when the facility submits its cost report to Medicare it shall simultaneously submit a copy of the cost report to the department; or

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

4 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 completed cost report is received.

5 If a cost report indicates payment is due by a hospital to the department, the hospital shall submit the amount due or submit a payment plan request with the cost report.

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

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

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

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

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

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