907 KAR 1:031. Payments for home health services.

RELATES TO: 42 C.F.R. 440.70, 447.325, 42 U.S.C. 1396a-d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Kentucky Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method for determining amounts payable by the Medicaid Program for home health agency services that are provided to Kentucky's Medicaid-eligible recipients.

Section 1. Definitions.

(1) "Allowable cost" means that portion of the home health agency's cost that shall be allowed by the department in establishing reimbursement.

(2) "Cost report" means the Annual Medicaid Home Health/HCB Cost Report.

(3) "Cost report instructions" means the Annual Medicaid Home Health/HCB Cost Report Instructions.

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

(5) "Home health agency" or "HHA" means an agency defined pursuant to 42 C.F.R. 440.70(d).

(6) "Interim rate" means a rate set for a provider for tentative reimbursement, based on reasonable allowable cost of providing a covered service, which may result in reimbursement adjustments after an audit or review determines the actual allowable cost during an accounting period.

(7) "Medicaid upper limit" means the maximum amount the Medicaid Program shall reimburse, on a facility-by-facility basis, for a unit of service.

(8) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Medicare upper limit" means the maximum reimbursement amount allowed by Medicare specific to:

(a) Each Medicare participating provider;

(b) Each category of service; and

(c) A unit of service.

(10) "Necessary function" means that if an owner of an agency had not provided the services pertinent to the operation of the HHA, the facility would have had to employ another person to perform the service.

(11) "Owner" means a person or a related family member with a cumulative ownership interest of five (5) percent or more.

(12) "Projected cost report" means an Annual Medicaid Home Health/HCB Cost Report that reflects costs that can reasonably be expected to be incurred by a provider for a specific period of time ending in the future.

(13) "Public agency" means an agency operated by a federal, state, county, city or other local governmental agency or instrumentality.

(14) "Rate year" means a twelve (12) month period beginning July 1 and ending the following June 30.

(15) "Related family member" means:

(a) Husband or wife;

(b) Natural or adoptive parent, child, or sibling;

(c) Stepparent, stepchild, stepbrother, stepsister;

(d) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;
(e) Grandparent or grandchild;
(f) Spouse of grandparent or grandchild;
(g) Aunt or uncle; or
(h) Spouse of aunt or uncle.

(16) "Settled" or "settlement" means an amount by which a provider's interim Medicaid payment for a specified period of time is adjusted based on an audited or desk reviewed cost report for that same period of time.

(17) "Uniform desk review" or "UDR" means an analysis of a provider's Annual Medicaid Home Health/HCB Cost Report to determine if the data is adequate, complete, accurate, and reasonable.

(18) "Usual and customary charge" means the uniform amount which a medical provider charges the general public for a specific service or procedure.

Section 2. Reimbursement Requirement. A home health service shall be provided in accordance with 907 KAR 1:030 to be eligible for reimbursement.

Section 3. Payment to an In-state HHA.

(1) Except as provided in Section 14 of this administrative regulation, the department shall reimburse a Medicaid participating in-state HHA on the basis of an interim rate established pursuant to subsection (2) of this section for the following services:
(a) Speech therapy;
(b) Physical therapy;
(c) Occupational therapy;
(d) Medical social services;
(e) Home health aide services; and
(f) Skilled nursing services.

(2) The interim rate for a service pursuant to subsection (1) of this section shall be determined for each individual HHA as follows:
(a) The department shall use cost data for each category of service from an HHA's most recent available Annual Medicaid Home Health/HCB Cost Report as of May 31 immediately preceding the rate year to set the interim rate;
(b) Medicaid specific data for units of service shall be adjusted using the Medicaid paid claims data;
(c) Total cost data shall be increased for inflation using the most recent available HHA Market Basket National Forecast, as published by Standard and Poor's, by:
1. Trending the total cost data to the beginning of a rate year; and
2. Indexing cost data established pursuant to subparagraph 1 of this paragraph for inflationary cost increases projected to occur during the rate year;
(d) An average unit cost for a category of service shall be established by dividing the indexed cost established pursuant to paragraph (c)2 of this subsection by the total number of units of service that are reflected in the cost report pursuant to paragraph (a) of this subsection;
(e) If a nonpublicly-operated HHA is eligible to receive a cost containment incentive payment pursuant to Section 5 of this administrative regulation, the department shall determine the "average unit cost plus incentive" by adding the "incentive payment per visit amount" pursuant to Section 5(1) of this administrative regulation to the average unit cost established pursuant to paragraph (d) of this subsection;
(f) The interim rate for a publicly-operated HHA shall be the lesser of:
1. The average unit cost pursuant to paragraph (d) of this subsection; or
2. The Medicare upper limit as issued to the provider through a Medicare letter; and
(g) The interim rate for a nonpublicly-operated HHA shall be the lesser of the:

1. Maximum average unit cost as established pursuant to paragraph (d) or (e) of this subsection that the provider is eligible to receive;
2. Medicaid upper limit pursuant to Section 7 of this administrative regulation; or
3. Medicare upper limits.

(3) The department shall establish an interim payment not to exceed the allowable billed charge for an item listed in paragraphs (a) and (b) of this subsection by multiplying the provider's total cost to charge ratio for the items as reflected in the provider's most recent available cost report as of May 31 immediately preceding the rate year by the provider's billed charge for:

(a) Disposable medical supplies; and

(b) Enteral nutritional products.

(4) For a facility whose fiscal year ended on or after June 30, 2003, within eighteen (18) months following the end of the facility's fiscal year, payments made pursuant to subsection (3) of this section shall be:

(a) Settled to the lesser of the:

1. Allowable Medicaid cost, as established by the Kentucky Medicaid Medical Supply Cost Settlement Worksheet, that the department has:

a. Audited; or

b. Desk reviewed; or

2. Allowable billed charge reported by the Medicaid Management Information System (MMIS), except that a publicly-operated HHA furnishing services free of charge or at a nominal charge pursuant to 42 C.F.R. 413.13(f) shall be settled pursuant to subparagraph 1 of this paragraph; and

(b) Settled utilizing aggregation of costs in accordance with the Kentucky Medicaid Medical Supply Cost Settlement Worksheet Instructions.

(5)

(a) If a settlement pursuant to subsection (4) of this section indicates that the department has overpaid a provider, the excess payment to the provider shall be recovered pursuant to 907 KAR 1:671, Section 2.

(b) If a settlement pursuant to subsection (4) of this section indicates that the department has underpaid a provider, a payout shall be issued to the provider through the MMIS during the next cycle following the discovery of the underpayment.

Section 4. Payment to a New In-state HHA.

(1) An HHA that undergoes a change of ownership during a rate year shall continue to be reimbursed at the rate established for the previous owner for the remainder of the rate year.

(2) An HHA pursuant to subsection (1) of this section shall be reimbursed pursuant to Section 3 of this administrative regulation after the provider submits a cost report pursuant to Section 8 of this administrative regulation.

(3) An HHA that had not previously participated in the Medicaid Program under the current ownership or a previous ownership during the rate year shall be:

(a) Considered a new HHA; and

(b) Reimbursed at the interim rate equal to the lesser of:

1. Seventy (70) percent of the current Medicaid upper limit as established pursuant to Section 7(2)(e) of this administrative regulation; or
2. The current Medicare upper limits.

(4) A new HHA shall be reimbursed pursuant to subsection (3) of this section until a cost report is:

(a) Submitted pursuant to Section 8 of this administrative regulation; and

(b) Received by the department by May 31 preceding the rate year.

(5) If, during the initial period, a provider pursuant to subsection (3) of this section requests a rate adjustment, the department shall grant a rate change if the provider:

(a) Submits documentation indicating that the cost of providing services is significantly higher than the reimbursement rate that the provider is receiving; and

(b) Submits a projected cost report.

(6) When a new HHA's first cost report is received, interim payments for the cost report period shall be adjusted pursuant to Section 3(4) of this administrative regulation.

Section 5. Incentive Payment.

(1) If a nonpublicly-operated HHA's nonaggregated base year costs are below the Medicaid upper limits pursuant to Section 7 of this administrative regulation for the corresponding period of time, the HHA shall receive a cost containment incentive payment, pursuant to Section 3(2)(e) of this administrative regulation, in accordance with the following payment schedule:

INCENTIVE PAYMENT SCHEDULE

Percentage of Per Unit Cost to Upper Limit	Incentive Payment Per Visit Amount
95.01% - 100%	--
90.01% - 95%	$1.00
85.01% - 90%	$1.50
80.01% - 85%	$2.00
80% and below	$2.50

(2) An incentive payment shall:

(a) Be subject to verification of visits;

(b) Bear an inverse relationship to the current year basic per visit cost; and

(c) Be adjusted each July 1 during the interim rate setting process pursuant to Section 3 of this administrative regulation for the rate year.

(3) The portion of an interim rate equal to the "incentive payment per visit amount" shall not be subject to retrospective settlement pursuant to Section 3(4) of this administrative regulation.

Section 6. Payment to an Out-of-state HHA.

(1) An out-of-state HHA that provides a covered service inside the Commonwealth of Kentucky to an eligible Kentucky Medicaid recipient shall be paid pursuant to Section 3 of this administrative regulation.

(2) Except as provided in subsection (3) of this section, an out-of-state HHA that provides a covered service to an eligible Kentucky Medicaid recipient while the recipient is outside the Commonwealth of Kentucky shall be reimbursed the lesser of the agency's:

(a) Usual and customary billed charge;

(b) Medicare upper limit; or

(c) Medicaid upper limit.

(3) If an out-of-state HHA provides the following items to an eligible Kentucky Medicaid recipient while the recipient is outside the Commonwealth of Kentucky, reimbursement shall be paid at eighty (80) percent of the HHA's usual and customary actual billed charges for:

(a) Disposable medical supplies; and

(b) Enteral nutritional products.

Section 7. Establishment of Medicaid Upper Limits.

(1) Medicaid upper limits for the services pursuant to Section 3(1)(a) through (e) of this administrative regulation shall be established each year to be effective on July 1 for a nonpublicly-operated HHA.

(2) Medicaid upper limits shall be determined by the department as follows:

(a) Based on the Standard Metropolitan Statistical Area (SMSA) designation, a nonpublicly-operated HHA shall be classified as:

1. Urban; or
2. Rural.

(b) Two (2) sets of arrays pursuant to paragraph (a) of this subsection shall be established for each category of service pursuant to subsection (1) of this section.

(c) Each HHA's average unit cost per service as established pursuant to Section 3(2)(d) of this administrative regulation shall be:

1. Grouped pursuant to paragraph (b) of this subsection; and
2. Arrayed from lowest to highest.

(d) The median per unit cost for each of the ten (10) arrays pursuant to paragraph (c) of this subsection shall be based on the median number of Medicaid units pursuant to Section 3(2)(b) of this administrative regulation.

(e) Medicaid upper limits for a nonpublicly-operated HHA shall be set at 105 percent of the median per unit cost as established pursuant to paragraph (d) of this subsection.

(3) The following HHAs shall be exempt from the Medicaid upper limits, but shall be subject to the Medicare upper limits:

(a) A publicly-operated HHA; or

(b) A new HHA who does not have two (2) full years of operation.

(4) The Medicaid upper limit for skilled nursing services shall be the Medicare upper limit for skilled nursing services.

Section 8. Financial Data and Cost Reporting Requirements.

(1) Except for a provider identified in Section 6(2) of this administrative regulation, an HHA shall submit to the department a completed cost report:

(a) That includes workpapers utilized to prepare the cost report including:

1. Detail of how a reclassification or an adjustment was calculated;
2. A working trial balance; and
3. Schedules tying the trial balance to the cost report;

(b) On an annual basis, within five (5) months after the close of the HHA's fiscal year;

(c) Prepared in accordance with the Annual Medicaid Home Health/HCB Cost Report Instructions; and

(d) Pursuant to 42 C.F.R. 413.24(a), (b), (c), and (e).

(2) A thirty (30) day extension of time for submitting a cost report pursuant to subsection (1) of this section may be granted by the Director of the Division of Long Term Care and Disability Services or his designee if:

(a) A provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control;

(b) The provider submits a request for the extension in writing; and

(c) The request is received by the department within five (5) months after the close of the HHA's fiscal year.

(3) An HHA's payment shall be suspended if:

(a)

1. Time for submitting a cost report pursuant to subsection (1) or (2) of this section has lapsed; and
2. A cost report has not been submitted to the department;

(b) The department determines that the HHA does not maintain or no longer maintains records pursuant to subsection (4) of this section; or

(c) The provider fails to provide the department with access to records pursuant to:
1. 907 KAR 1:672, Section 2(6); or
2. Subsection (4) of this section.

(4) For a period of five (5) years from the date that the department issues a letter to an HHA detailing the Medicaid final settlement of a cost report, the HHA shall retain and make available to the department:
(a) Records and documents pursuant to 42 C.F.R. 413.20(a), (c), and (d); and
(b) Documentation of work or services performed if compensation is claimed by the:
1. Owner; or
2. A related family member of the:
a. Owner; or
b. Administrator.

(5) If during a twelve (12) month period an HHA contracts with a subcontractor for the provision of goods and services established pursuant to 907 KAR 1:030 costing or valued at $10,000 or more, the HHA shall include a clause in the contract that requires a subcontractor to make available to the department records and documents related to the provision of services consistent with the requirements pursuant to subsection (4) of this section.

(6) If the department is denied access to a subcontractor's records pursuant to subsection (4) of this section, the cost of goods or services furnished by the subcontractor shall become a nonallowable cost reported on a cost report.

(7) If an HHA has been voluntarily or involuntarily terminated from the Medicaid Program, reimbursement payments shall be withheld until:
(a) A cost report is received from the HHA provider for the period of time the provider participated in the Medicaid Program:
1. Beginning with the first day of the provider's fiscal year immediately preceding the provider's termination date; and
2. Ending on the date of termination of its provider agreement with the Medicaid Program; and
(b) A final settlement pursuant to Section 3(4) of this administrative regulation is completed by the department.

Section 9. Allowable HHA Cost.

(1) Except as limited pursuant to Section 10 of this administrative regulation, cost pursuant to subsection (2) of this section shall be allowable and eligible for reimbursement pursuant to this administrative regulation if costs are:
(a) Reflective of a provider's actual expenses of providing a service; and
(b) Related to Medicaid patient care pursuant to 42 C.F.R. 413.9.

(2) Except as limited by Section 10 of this administrative regulation, and subsection (1) of this section, the following costs shall be allowable:
(a) Allowable cost to related organizations pursuant to 42 C.F.R. 413.17;
(b) Costs of educational activities pursuant to 42 C.F.R. 413.85;
(c) Research costs pursuant to 42 C.F.R. 413.90;
(d) Value of services of nonpaid workers pursuant to 42 C.F.R. 413.94;
(e) Purchase discounts and allowances, and refunds of expenses pursuant to 42 C.F.R. 413.98; and
(f) Therapy and other services pursuant to 42 C.F.R. 413.106.

Section 10. Limitations on Allowable HHA Cost.

(1) Board of directors' fees.
(a) The cost of board of director's fees shall be limited annually to:
1.
a. Five (5) meetings for a single-facility organization; or

b. Twelve (12) meetings for a multiple-facility organization; and

2. $200 for each director of the board attending each meeting, including the cost of attending the meeting.

(b) The cost associated with a private club membership shall not be an allowable cost.

(2) Motor vehicles.

(a) An allowable motor vehicle cost shall be:

1. Limited to cost related to patient care; and

2. Documented sufficiently to support business use.

(b) An allowable cost associated with HHA facility-owned vehicles and mileage allowances shall be limited to the federal income tax mileage allowance.

(c) The costs associated with personal use of a facility-owned motor vehicle shall not be an allowable cost unless the value of the personal use of the vehicle is:

1. Included in the employee's W-2 statement; or

2. Reported on a Form 1099 in accordance with Internal Revenue Service regulations.

(d) An allowable cost pursuant to paragraph (c) of this subsection shall be considered compensation to the extent that:

1. Compensation to an owner does not exceed the owner's compensation limits pursuant to Section 11 of this administrative regulation; and

2. The total compensation package to a nonowner is reasonable pursuant to 42 C.F.R. 413.9(b).

(3) The cost associated with political contributions shall not be allowable.

(4) The following legal fees shall not be allowable costs:

(a) A legal fee associated with unsuccessful lawsuits against the Cabinet for Health and Family Services or the department;

(b) A legal fee incurred by the provider in an attempt to block the approval of a certificate of need for another provider;

(c) A legal fee associated with the acquisition of another HHA;

(d) A legal fee resulting from the commission of an illegal act by an:

1. HHA;

2. HHA's owner; or

3. HHA's agent; or

(e) A legal fee unrelated to patient care.

(5) Legal fees associated with successful lawsuits against the cabinet shall be limited to inclusion as allowable cost in the period:

(a) In which a suit is settled after a final decision has been issued that the lawsuit is successful;

(b) Agreed to by involved parties; or

(c) As ordered by the court.

(6) Travel expenses. The cost of travel expenses shall be limited to:

(a) Activities related to the educational needs of the:

1. Agency owners;

2. Directors; or

3. Staff;

(b) Reasonable and necessary cost pursuant to 42 C.F.R. 413.9(b) as determined in evaluating the:

1. Number of trips taken;

2. Expense associated with each trip;

3. Number of persons attending each function; and

4. Appropriateness of the training; and

(c) Trips taken within the forty-eight (48) contiguous United States.

Section 11. Owner's Compensation Limits.

(1) Compensation to an owner who is not an administrator shall:

(a) Be considered an allowable cost pursuant to 42 C.F.R. 413.102; and

(b) Exclude:

1. Board of directors' fees; and

2. Fringe benefits routinely provided to all employees.

(2) Compensation of a part-time owner-employee performing managerial functions shall not exceed the percent of time worked times eighty (80) percent of the applicable compensation limits for an owner administrator.

(3) A full-time owner-administrator or full-time owner-employee who performs nonmanagerial functions in an HHA other than the HHA with which he is primarily associated shall be limited to:

(a) Reasonable compensation from the nonprimary agency for not more than fourteen (14) hours per week supported by:

1. The owner's proof of performance of a necessary function; and

2. Documentation of time claimed for compensation; and

(b) A salary from the agency with which the person is primarily associated.

(4) Managerial functions performed in a nonprimary agency by a full-time owner-administrator or a full-time owner-employee of another agency shall not be considered an allowable cost.

(5) Compensation to an owner-administrator of a rural or urban HHA shall be:

(a) Limited to $60,579 beginning July 1, 1999;

(b) Increased on July 1 of each year by the inflation factor index for wages and salaries of the Home Health Agency Market Basket of Operating Cost as indicated by the National Forecasts supplied by Standard and Poor's, Inc.; and

(c) Published annually through a notification to all providers to advise of the revised limits for owner's compensation to be effective July 1 of each year.

Section 12. Audit Functions.

(1) All HHA provider costs applicable to a Medicaid beneficiary shall be subject to:

(a) Review or audit by the department; and

(b) A final retroactive settlement based upon an adjustment to an HHA provider's costs reported in a cost report for any reporting period under review or audit.

(2) The department shall perform a uniform desk review (UDR) of each provider's annual cost report.

(3) A summary of the UDR shall be used:

(a) To settle the cost report without audit; or

(b) To determine the extent to which audit verification is required.

(4) If indicated by the uniform desk review, an audit shall be conducted in accordance with the "Government Auditing Standards".

Section 13. Payment Amounts Effective July 1, 2002. A participating HHA shall be reimbursed for a home health service provided in accordance with 907 KAR 1:030 at the lesser of:

(1) The provider's usual and customary charge; or

(2) The Medicaid fixed upper payment limit per unit of service as established in Section 14 of this administrative regulation.

Section 14. Fixed Upper Payment Limits. The following rates shall be the fixed upper payment limits for home health services:

Service	Fixed Upper Payment Limit
Skilled Nursing	$87.15 per visit

Home Health Aide	$34.13 per visit
Speech Therapy	$85.05 per visit
Physical Therapy	$85.05 per visit
Occupational Therapy	$85.05 per visit
Medical Social Service	$68.25 per visit

Section 15. Supplemental Payments to Licensed County Health Departments.

(1) Beginning September 1, 2003, the department shall make supplemental payment to a licensed county health department home health agency equal to the difference between:

(a) Payments received for services on or after November 1, 2002 in accordance with Section 14 of this administrative regulation; and

(b) The estimated cost of providing services during the same time period.

(2) Based on a provider's most recently submitted annual cost report, estimated costs of providing services shall be determined by multiplying the cost per unit by the number of units provided during the period.

(3) If a provider's cost as estimated from its most recently submitted annual cost report is less than the payments received under Section 14 of this administrative regulation, the department shall recoup any excess payments.

Section 16. Reimbursement Review and Appeal. An HHA may appeal a department decision as to the application of this administrative regulation as it impacts the provider's reimbursement in accordance with 907 KAR 1:671, Sections 8 and 9.

Section 17. Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) The "Annual Medicaid Home Health/HCB Cost Report", Department for Medicaid Services, May 1991 edition;

(b) "The Annual Medicaid Home Health/HCB Cost Report Instructions", Department for Medicaid Services, May 1991 edition;

(c) The "Government Auditing Standards", 1994 edition, as issued by the Comptroller General of the United States;

(d) The "Kentucky Medicaid Medical Supply Cost Settlement Worksheet", Department for Medicaid Services, June 2003 edition; and

(e) The "Kentucky Medicaid Medical Supply Cost Settlement Worksheet Instructions", Department for Medicaid Services, June 2003 edition.

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

(2 Ky.R. 109; eff. 9-10-1975; 7 Ky.R. 692; eff. 4-1-1981; 12 Ky.R. 370; eff. 11-12-1985; Recodified from 904 KAR 1:031, 5-2-1986; 13 Ky.R. 380; eff. 9-4-1986; 14 Ky.R. 301; eff. 9-10-1987; 15 Ky.R. 678; eff. 9-21-1988; 16 Ky.R. 270; eff. 9-20-1989; 1511; eff. 3-8-1990; 17 Ky.R. 562; eff. 10-14-1990; 18 Ky.R. 539; eff. 10-6-1991; 19 Ky.R. 2148; eff. 6-7-1993; 20 Ky.R. 447; eff. 10-13-1993; 26 Ky.R. 1248; 1567; eff. 2-1-2000; 29 Ky.R. 1128; 1648; eff. 12-18-2002; 30 Ky.R. 727; 1527; eff. 1-5-2004; 32 Ky.R. 401; 681; eff. 10-14-2005; 33 Ky.R. 589; 1556; eff. 1-5-2007; Crt eff. 12-6-2019.)