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State/Territory Name: Kentucky

State Plan Amendment (SPA) #: 17-0007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

February 8, 2018

Mr. Stephen P. Miller
Commissioner
Commonwealth of Kentucky
Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6 W-A
Frankfort, KY 40621

RE: State Plan Amendment (SPA) 17-0007

Dear Mr. Miller:

We have reviewed the proposed amendment to Attachments 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 17-007. Effective December 21, 2017 this amendment modifies the state's reimbursement methodology for the disproportionate share hospital payments to be consistent with the payments authorized by the state statute and regulations.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of December 21, 2017. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely,

//s//

Kristin Fan
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 17-007

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 21, 2017

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 – $0
b. FFY 2018 – $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page Att. 4.19-A, Page 26-31

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT:
The purpose of this SPA is to make a technical change to DSH reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME: Stephen P. Miller

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 12/20//17

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/21/2017

18. DATE APPROVED: 02/08/18

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
12/21/17

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Kristin Fan

22. TITLE:
Director, FMG

23. REMARKS: Approved with the following changes to block # 7 and 10.

Block # 7 changed to read: 7a FFY 2018 0 and 7b FFY 2019 0.

Block # 10 changed to read: The purpose of the amendment is to make a change to the DSH Reimbursement.

8. Disproportionate Share Hospital Provisions

A. Definition. A disproportionate share hospital or DSH means an in-state hospital that:

1) Has an inpatient Medicaid utilization rate of one (1) percent or higher; and
2) Meets the criteria established in 42 U.S.C. 1396r-4(d).
3) Has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.
4) Meets the requirements established in section 1923(d) of the Act.

B. Disproportionate Share Hospital Distribution General Provisions. A DSH distribution shall:

1) Be made to a qualified hospital;
2) Be based upon a hospital's proportion of inpatient and outpatient indigent care from the preceding state fiscal year, excluding university teaching hospitals;
3) Be a prospective amount. For example, a DSH distribution made to a hospital in October 2007 shall be applied to the reimbursement for the state fiscal year beginning July 1, 2007 and ending June 30, 2008;
4) Not be subject to settlement or revision based on a change in utilization during the year to which it applies;
5) Be made on an annual basis;
6) Be made from a hospital's share of the allocated pool or total disproportionate share funds with the following allocation into three (3) pools: forty-three and ninety-two hundredths percent (43.92%) allocated to acute care hospitals; thirty-seven percent (37%) allocated to university hospitals; and nineteen and eight hundredths percent (19.08%) allocated to private psychiatric hospitals and state mental hospitals, up to the maximum dollar cap from the annual federal allotment;
7) "Type I hospital" means an in-state disproportionate share hospital with 100 beds or less that participates in the Medicaid Program;
8) "Type II hospital" means an in-state disproportionate share hospital with 101 beds or more that participates in the Medicaid Program, except for a hospital that meets the criteria for a Type III or Type IV hospital;
9) "Type III hospital" means an in-state disproportionate share state university teaching hospital, owned or operated by either the University of Kentucky or the University of Louisville Medical School; and
10) "Type IV hospital" means an in-state disproportionate share hospital participating in the Medicaid Program that is a state-owned psychiatric hospital.

C. Disproportionate Share Hospital Distribution to a DRG-Reimbursed Acute Care Hospital. Effective December 21, 2017, the department shall determine a DSH distribution to a DRG-reimbursed acute care hospital by:

1) Multiplying the final SFY 2013-2014 indigent share factor by the total fund allocated to the acute care pool. The 2013-2014 indigent share factors were determined by::
   a. Determining a hospital's average reimbursement per discharge;
   b. Dividing the hospital's average reimbursement per discharge by Medicaid days per discharge;

8. Disproportionate Share Hospital Provisions (continued)

c. Multiplying the amount established in paragraph b by the hospital's total number of inpatient indigent care days for the most recently completed state fiscal year to establish the hospital's inpatient indigent care cost for purposes of this section;
d. Determining an in-state hospital's outpatient indigent care cost for purposes of this section by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with 803 KAR 25:091 (Published 10/25/2011);
e. Combining the inpatient indigent care cost established in paragraph (c) with the outpatient indigent care cost established in paragraph (d) to establish a hospital's indigent care cost total; and
f. Comparing the total indigent care cost for each DRG-reimbursed hospital to the indigent care costs of all hospitals receiving DSH distributions under the acute care pool to establish a DSH distribution on a pro rata basis:
(1) Annual distribution to acute care hospitals shall be calculated by multiplying the final SFY 2013-2014 indigent care factor by the total fund allocated to the acute care pool.

D. Disproportionate Share Hospital Distribution to a Critical Access Hospital, Rehabilitation Hospital or Long Term Acute Care Hospital. Effective December 21, 2017, the department shall determine a DSH distribution to a critical access hospital, rehabilitation hospital, or long term acute care hospital by:

1) Multiplying the final SFY 2013-2014 indigent share factor by the total fund allocated to the acute care pool. The 2013-2014 indigent share factors were determined by:

a. Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection (2) of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and
b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with 803 KAR 25:091;
c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and
d. Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to state statute establishing a hospital's DSH distribution on a pro rata basis.

(1) Annual distribution to critical access hospitals, rehabilitation hospitals, or long term acute care hospitals shall be calculated by multiplying the final SFY 2013-2014 indigent care factor by the total fund allocated to the acute care pool.

8. Disproportionate Share Hospital Provisions (continued)

E. Disproportionate Share Hospital Distribution to a Private Psychiatric Hospital. Effective December 21, 2017, the department shall determine a DSH distribution to a private psychiatric hospital by:

1) Multiplying the final SFY 2013-2014 indigent share factor by the total fund allocated to the private psychiatric pool. The 2013-2014 indigent share factors were determined by:
   a. Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection 2 of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and
   b. Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge by the Department of Labor in accordance with 803 KAR 25:091 (published 10/25/11) or by establishing an inpatient equivalency;
   c. Combining the inpatient indigent care cost established in paragraph (a) with the outpatient indigent care cost established in paragraph (b) to establish a hospital's indigent care cost total; and
   d. Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis.
      (1) Annual distribution to private psychiatric hospitals shall be calculated by multiplying the final SFY 2013-2014 indigent care factor by the total fund allocated to the private psychiatric pool.

F. Disproportionate Share Hospital Distribution to a State Mental Hospital. The Department shall determine a DSH distribution to a state mental hospital by:

1) Comparing each state mental hospital's costs of services provided to individuals meeting the indigent eligibility criteria established in subsections H and I of this Section, minus any payment made by or on behalf of the individual to the hospital; and
2) Using the DSH funding allocated to state mental hospitals to establish a state mental hospital's DSH distribution on a pro rata basis.

G. Disproportionate Share Hospital Distribution to a University Hospital. The department's DSH distribution to a university hospital shall be based on the hospital's historical proportion of the costs of services to Medicaid recipients, minus reimbursement paid related to Diagnostic related group (DRG) inpatient hospital reimbursement, or the nondiagnostic related group inpatient hospital reimbursement and supplemental or IOA payments, plus the costs of services to indigent and uninsured patients minus any distributions made on behalf of indigent and uninsured patients; and

8. Disproportionate Share Hospital Provisions (continued)

H. Indigent Care Eligibility.

1) Prior to billing a patient and prior to submitting the cost of a hospital service to the department as uncompensated, a hospital shall use the indigent care eligibility form, DSH-001, Application for Disproportionate Share Hospital Program, to assess a patient's financial situation to determine if:
   a. Medicaid or Kentucky Children's Health Insurance Program (KCHIP) may cover hospital expenses; or
   b. A patient meets the indigent care eligibility criteria.
2) An individual referred to Medicaid or KCHIP by a hospital shall apply for the referred assistance, Medicaid or KCHIP, within thirty (30) days of completing the DSH-001, Application for Disproportionate Share Hospital Program, at the hospital.

I. Indigent Care Eligibility Criteria.

1) A hospital shall receive disproportionate share hospital funding for an inpatient or outpatient medical service provided to an indigent patient under the provisions of this attachment if the following apply:
   a. The patient is a resident of Kentucky;
   b. The patient is not eligible for Medicaid or KCHIP;
   c. The patient is not covered by a third-party payor;
   d. The patient is not in the custody of a unit of government that is responsible for coverage of the acute care needs of the individual;
   e. The hospital shall consider all income and countable resources of the patient's family unit and the family unit shall include:
      (1) The patient;
      (2) The patient's spouse;
      (3) The minor's parent or parents living in the home; and
      (4) Any minor living in the home;
   f. A household member who does not fall in one (1) of the groups listed in paragraph (e) of this subsection shall be considered a separate family unit;
   g. Countable resources of a family unit shall not exceed:
      (1) $2,000 for an individual;
      (2) $4,000 for a family unit size of two (2); and
      (3) Fifty (50) dollars for each additional family unit member;
   h. Countable resources shall be reduced by unpaid medical expenses of the family unit to establish eligibility; and
   i. The patient or family unit's gross income shall not exceed the federal poverty limits published annually in the Federal Register and in accordance with KRS 205.640.

2) Except as provided in subsection (3) of this section, total annual gross income shall be the lessor of:
   a. Income received during the twelve (12) months preceding the month of receiving a service; or
   b. The amount determined by multiplying the patient's or family unit's income, as applicable, for the three (3) months preceding the date the service was provided by four (4).

8. Disproportionate Share Hospital Provisions (continued)

3) A work expense for a self-employed patient shall be deducted from gross income if:
   a. The work expense is directly related to producing a good or service; and
   b. Without it the good or service could not be produced.
4) A hospital shall notify the patient or responsible party of his eligibility for indigent care.
5) If indigent care eligibility is established for a patient, the patient shall remain eligible for a period not to exceed six (6) months without another determination.

J. Indigent Care Eligibility Determination Fair Hearing Process.

1) If a hospital determines that a patient does not meet indigent care eligibility criteria as established in subsections H and I of this Section, the patient or responsible party may request a fair hearing regarding the determination within thirty (30) days of receiving the determination.
2) If a hospital receives a request for a fair hearing regarding an indigent care eligibility determination, impartial hospital staff not involved in the initial determination shall conduct the hearing within thirty (30) days of receiving the hearing request.
3) A fair hearing regarding a patient's indigent care eligibility determination shall allow the individual to:
   a. Review evidence regarding the indigent care eligibility determination;
   b. Cross-examine witnesses regarding the indigent care eligibility determination;
   c. Present evidence regarding the indigent care eligibility determination; and
   d. Be represented by counsel.
4) A hospital shall render a fair hearing decision within fourteen (14) days of the hearing and shall provide a copy of its decision to:
   a. The patient or responsible party who requested the fair hearing; and
   b. The department.
5) A fair hearing process shall be terminated if a hospital reverses its earlier decision and notifies, prior to the hearing, the patient or responsible party who requested the hearing.
6) A patient or responsible party may appeal a fair hearing decision to a court of competent jurisdiction in accordance with state statute on judicial review of final order.

K. Merged Facility.

If two (2) separate entities merge into one (1) organization and one (1) of the merging entities has disproportionate status and the other does not, the department shall retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid.

8. Disproportionate Share Hospital Provisions (continued)

L. Payment Limits: Limit on Amount of Disproportionate Share Payment to a Hospital.

1) Payments made under these provisions do not exceed the OBRA '93 limits described in 1923 (g) of the Social Security Act. This limit is the sum of the following two measurements that determine uncompensated costs: (a) Medicaid shortfall; and (b) costs of services to uninsured patients less any payments received. Medicaid shortfall is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the non-disproportionate share hospital payment method under this state plan. The cost of services to the uninsured includes inpatient and outpatient services. Costs shall be determined by multiplying a hospital's cost to charge ratio by its uncompensated charges. Uninsured patients are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

2) The final hospital-specific DSH limit will be determined retrospectively through the annual DSH examination. For a given state fiscal year DSH examination, in the event DSH payments are found to exceed the limits described in subsection 1 above, funds may be redistributed in accordance with state plan, Attachment 4.19.A, Section (1)(O).

3) Limit on Amount of Disproportionate Share Payment to a Hospital

a. A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for Medicaid recipient services and the costs of uninsured patients. (Section 1923(g) of the Social Security Act.)
b. Payment Shortfall for Medicaid Recipient Services. The payment shortfall for Medicaid recipient services is the amount by which the costs of inpatient and outpatient services provided Medicaid recipients exceed the payments made to the hospital for those services excluding disproportionate share payments.
c. Unrecovered Cost of Uninsured/indigent Patients. The unrecovered cost of uninsured/indigent patients is the amount by which the costs of inpatient and outpatient services provided to uninsured/indigent patients exceed any cash payments made by or on behalf of them. An uninsured/indigent patient is an individual who has no health insurance and meets income standards established in state law.

4) The disproportionate share hospital payment shall be an amount that is reasonably related to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.