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State/Territory Name: Kentucky

State Plan Amendment (SPA) #: 19-0005

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

September 16, 2019

Carol Steckel, Commissioner
Department for Medicaid Services
275 East Main Street – 6WA
Frankfort, KY 40621-0001

RE: State Plan Amendment (SPA) 19-0005

Dear Ms. Steckel:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 19-0005. This amendment proposes to implement new supplemental payment program for qualifying hospitals that are private and non-state government owned. Pediatric teaching hospitals and psychiatric access hospitals are excluded as they currently receive an enhanced rate. The state will calculate the maximum allowable FFS UPL for inpatient services and then determine the per discharge uniform amount.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2019. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Anna Dubois at (850) 878-0916.

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: 19-005

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
July 1, 2019

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:
42 CFR 430.12(b)

7. FEDERAL BUDGET IMPACT:
a. FFY 2019 $875,000
b. FFY 2020 $3,5000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-A, Page 18 –
Att. 4.19-A, Page 18.1
Att. 4.19-A, Page 19

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Att. 4.19-A, Page 18 – Same
Att. 4.19-A, Page 18.1 - New
Att. 4.19-A, Page 19 - Same

10. SUBJECT OF AMENDMENT: The purpose of this SPA is to revise Kentucky's reimbursement to privately-owned and non-state government owned hospitals

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:

13. TYPED NAME: Carol H. Steckel

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 6/17/19

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
07/17/19

18. DATE APPROVED:09/16/19

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/19

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

2. Acute Care Hospital Services

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: