STATEMENT OF EMERGENCY
907 KAR 10:840E

This emergency administrative regulation is being promulgated to implement the Hospital Rate Improvement Program authorized by KRS 205.6405 through 205.6408. This emergency administrative regulation is needed pursuant to KRS 13A.190(1)(a)2, to prevent a loss of state and federal funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation. The ordinary administrative regulation is identical to the emergency administrative regulation.

MATTHEW G. BEVIN, Governor
ADAM M. MEIER, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Fiscal Management
(New Emergency Administrative Regulation)

907 KAR 10:840E. Hospital Rate Improvement Program.

RELATES TO: KRS 45.229, 142.303, 205.565, 205.637, 205.638, 205.639, 205.640, 205.6405, 205.6406, 205.6407, 205.6408, 216.380, 42 C.F.R. 413.17, 433.51, 438.340, 440.140, 447.272, 42 U.S.C. 1396a, 1395ww

STATUTORY AUTHORITY: KRS 194A.030, 194A.050, 205.520, 205.560, 205.6406(13), 42 C.F.R. 447.252, 447.253, 42 U.S.C. 1396a

EFFECTIVE: October 30, 2019

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed, or opportunity presented, by federal law to qualify for federal funds. KRS 205.6406(13) requires the department to promulgate an administrative regulation to implement the Hospital Rate Improvement Program, KRS 205.6405 to 205.6408. This administrative regulation establishes the requirements for implementing the Hospital Rate Improvement Program for qualifying hospitals.

Section 1. Definitions. (1) "Assessment" is defined by KRS 205.6405(1).

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

(3) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(4) "Program year" is defined by KRS 205.6405(14).

(5) "Qualifying hospital" is defined by KRS 205.6405(16).

(6) "Received date" means the date a claim is accepted and approved into the Medicaid Management Information System and does not mean the date a claim is actually paid.

(7) "Upper payment limit" or "UPL" is defined by KRS 205.6405(19).

Section 2. Hospital Rate Improvement Program. (1) Prior to the start of each program year and in accordance with the payment methodology required by KRS 205.6406(2), the department shall calculate for each qualifying hospital:

(a) A per-discharge uniform add-on amount that the qualifying hospital is eligible to receive as a supplemental payment for the program year for Medicaid fee-for-service discharges; and

(b) A per discharge uniform add-on amount that the qualifying hospital is eligible to receive as a supplemental payment for the program year for Medicaid managed care discharges.

(2) With the exception of the initial implementation year, no less than thirty (30) days prior to the beginning of each program year, the department shall provide each qualifying hospital written notice of the total per-discharge uniform add-on amounts for both Medicaid fee-for-service and Medicaid managed care discharges. The notice shall include the data sources and methodologies used to arrive at the value for each variable upon which the qualifying hospital's per-discharge uniform add-on amounts shall be calculated for the program year.

(3) For each quarter in a program year, the department shall:

(a) Calculate each qualifying hospital's supplemental payments for Medicaid fee-for-service and Medicaid managed care in accordance with KRS 205.6406(3) through (11) by:

1. Excluding all inpatient claims with discharge dates preceding October 1, 2018 from enhanced payment calculations;

2. Reducing the number of inpatient claims eligible for enhanced reimbursement by the number of previously enhanced claims that have been voided in the Medicaid Management Information System; and

3. Excluding from enhanced payment calculations partial or adjusted inpatient claims that have previously received an enhanced payment;

(b) Make a quarterly Medicaid fee-for-service supplemental payment to each qualifying hospital, or its designee acting as a fiscal intermediary, in accordance with the methodology in KRS 205.6406(3)(a) and (c); and

(c) Make a quarterly Medicaid managed care supplemental payment to each qualifying hospital, or its designee acting as a fiscal intermediary, in accordance with the methodology in KRS 205.6406(3)(b), (d), and (e).

(4) Payment of the quarterly Medicaid managed care supplemental payment shall be made by distribution to each Medicaid managed care organization through a quarterly supplemental capitation payment.

(5) The department shall submit with, or prior to, the quarterly supplemental capitation payment directions to the Medicaid managed care organization for the payment of the quarterly Medicaid managed care supplemental payments to qualifying hospitals.

(6) In accordance with KRS 205.6406(6), each Medicaid managed care organization shall remit to each qualifying hospital, or its designee, as directed by the department the quarterly Medicaid managed care supplemental payment within five (5) business days of receipt of the quarterly supplemental capitation payment. The department shall establish contractual penalty provisions to require that each Medicaid managed care organization remit the required amounts within five (5) business days.

(7) In accordance with KRS 205.6406(9), a qualifying hospital may seek review by the department of any quarterly supplemental payment that the qualifying hospital suspects is in error and affects the amount of the quarterly supplemental payment by five (5) percent or more.

(a) The qualifying hospital shall submit a detailed listing of any disputed claim or claims for department consideration and potential updates to the Medicaid Management Information System.

(b) Once each claim is received and validated in the Medicaid Management Information System, the department may adjust the qualifying hospital's future quarterly supplemental payment to account for the correction.

(c) If the department determines that a correction is not warranted, the hospital may request an administrative appeal pursuant to 907 KAR 1:671.

(8) In order to receive a supplemental payment and to pay the assessment for that quarter, an entity shall be a qualifying hospital each day of a quarter for the program year.

(9) Medicaid Management Information System (MMIS) fee-for-service and managed care encounter data, queried by the claim received date, shall be utilized to calculate the quarterly payments.

(10) For each quarter in a program year, the department shall:

(a) Calculate each qualifying hospital's per-discharge hospital assessment in accordance with the methodology in KRS 205.6406(3)(g) and (h); and

(b) Provide notice to each qualifying hospital in accordance with KRS 205.6406(3)(i).

(11) A qualifying hospital's per-discharge hospital assessment shall be calculated using the Medicare cost report period ending in the calendar year that is two (2) calendar years prior to the first day of a program year. For example, for the program year beginning July 1, 2019, cost report periods ending in calendar year 2017 shall be utilized.

(a) If a qualifying hospital's cost report period referenced in this subsection is greater than or less than a normal calendar year of 365 days, the total discharges used in accordance with KRS 205.6406(3)(g) shall be annualized to a 365-day period.

(b) If a qualifying hospital is newly enrolled in the Medicaid program and does not have cost report information available for the period established in this subsection, the department may utilize the cost report information of a comparable hospital to approximate the newly enrolled hospital's utilization.

(12) A qualifying hospital shall pay its calculated per-discharge hospital assessment in accordance with KRS 205.6406(7).

(13) If a hospital assessment is not received in a timely manner, the department may deny or withhold future quarterly supplemental payments until the assessment is submitted.

(14) A qualifying hospital may authorize a third-party entity to serve as a fiscal intermediary to facilitate the implementation of this administrative regulation by providing letter notice to the department.

Section 3. Reporting Requirements (1) Throughout a program year, a qualifying hospital shall submit any documentation or information to the department that the department requests in a timely manner as designated by the department. This request may include any documentation pertaining to:

(a) Resolution of a quarterly supplemental payment that the qualifying hospital suspects is in error; or

(b) Quality metrics set forth in the department's Quality Strategy filed with the Centers for Medicare and Medicaid Services pursuant to 42 C.F.R. 438.340.

(2) If a qualifying hospital fails to provide the department with any requested documentation in a timely manner, the department may deny or withhold future quarterly supplemental payments, until the documentation is submitted.

Section 4. Upper Payment Limit. A supplemental payment referenced in this administrative regulation is not intended to cause aggregate Medicaid hospital reimbursement to exceed the aggregate statewide upper payment limit for privately-owned and non-state government-owned hospitals established in:

(1) 42 C.F.R. 447.271;

(2) 42 C.F.R. 447.272; or

(3) Any other applicable statute or administrative regulation.

Section 5. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

CAROL H. STECKEL, Commissioner
ADAM M. MEIER, Secretary
APPROVED BY AGENCY: October 29, 2019
FILED WITH LRC: October 30, 2019 at 4 p.m.
CONTACT PERSON: Donna Little, Deputy Executive Director, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; Phone: 502-564-6746; Fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services (DMS) hospital rate improvement program for care provided by inpatient acute care hospitals to Medicaid recipients. This administrative regulation serves to implement HB 320 from the 2019 Regular Session of the Kentucky General Assembly. Specifically, DMS is required to calculate supplemental payments, notify each qualifying hospital of total per-discharge uniform add-on amounts, and make quarterly supplemental payments. The administrative regulation also requires DMS to distribute supplemental payments to qualifying hospitals by means of a quarterly supplemental capitation payment to managed care organizations (MCOs). The MCOs then forward the payments to the qualifying hospitals. The MCOs are required to remit the payment within 5 days, and failure to forward the entire payment within 5 days will result in the department assessing contractual penalties. The administrative regulation also establishes requirements relating to the hospital specific assessments, and establishes departmental actions when a payment is not received in a timely manner.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish DMS's reimbursement provisions and penalty provisions for the hospital rate improvement program required by 2019 HB 320.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation implements the provisions of 2019 HB 320.

(d) How this administrative regulation currently assists or shall assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing a statutorily required hospital rate improvement program.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment shall change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment shall assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The amendment applies to all inpatient

acute care hospitals. Currently, there are approximately sixty-five (65) acute care hospitals participating in the Kentucky Medicaid program.

(4) Provide an analysis of how the entities identified in question (3) shall be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) shall have to take to comply with this administrative regulation or amendment. Participating hospitals will submit required assessments and comply with reporting requirements to enable the department to calculate each quarterly assessment.

(b) In complying with this administrative regulation or amendment, how much shall it cost each of the entities identified in question (3): Costs will vary by hospital and reporting period for the payment of assessments, the supplemental payments disbursed will likely exceed the amount of assessments.

(c) As a result of compliance, what benefits shall accrue to the entities identified in question (3): Acute care inpatient hospitals will benefit from enhanced rates available as part of this provider assessment program submitted as supplemental payments via the MCOs.

(5) Provide an estimate of how much it shall cost to implement this administrative regulation:

(a) Initially: DMS anticipates no additional costs to the department to implement this administrative regulation beyond the appropriation contained in 2019 HB 320.

(b) On a continuing basis: DMS anticipates no additional costs to the department to implement this administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds.

(7) Provide an assessment of whether an increase in fees or funding shall be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding shall be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is applied in that different reimbursement methodologies are utilized in relation to different hospital types. In addition in-state and out-of-state hospitals receive different reimbursement. However, the administrative regulation applies equally to all regulated entities within each hospital type.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30)

2. State compliance standards. KRS 205.520(3) states, "to qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Medicaid reimbursement for services is required to be consistent with efficiency, economy, and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to:

".. .. provide such methods and procedures relating to the utilization of, and the payment for,

care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

4. Shall this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The policy is not stricter or different than the federal standard.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) shall be impacted by this administrative regulation? The Department for Medicaid Services (DMS) shall be impacted by this administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(2), and 42 U.S.C. 1396a(a)(30).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue shall this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS anticipates that this administrative regulation will be revenue neutral to the department in the first year.

(b) How much revenue shall this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS anticipates that this administrative regulation will be revenue neutral to the department in subsequent years.

(c) How much shall it cost to administer this program for the first year? The costs associated with this program will be met by the appropriations contained in 2019 HB 320 in the first year of operation.

(d) How much shall it cost to administer this program for subsequent years? The costs associated with this program will be met by the appropriations to the department contained in 2019 HB 320 in subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation: