

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Fiscal Management

(Amended at ARRS Committee)

907 KAR 10:840. Hospital Rate Improvement Program.

RELATES TO: KRS 205.6405, 205.6406, 205.6407, 205.6408, 205.6411, 216.380, 42 C.F.R. 413.17, 433.51, 438.340, 438.6, 440.140, 447.271, 447.272, 42 U.S.C. 1396a, 1395ww

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, 205.6406(13), 205.6412(3), 42 C.F.R. 447.252, 447.253, 42 U.S.C. 1396a

CERTIFICATION STATEMENT:

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has the 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, established in 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) or 205.6411(4), as appropriate.
- (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 established 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 established 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.
- (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 shall adjust the qualifying hospital's future quarterly supplemental payment to account for any warranted 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), (i), and (k); and
 - (b) Provide notice to each qualifying hospital in accordance with KRS 205.6406(3)(l).
- (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. Kentucky Trauma Hospital Rate Improvement (K-THRI).

(1) If consistent with federal approval, the department shall operate K-THRI as a supplemental payment arrangement that provides an average commercial rate reimbursement for inpatient hospital services, outpatient hospital services, and professional services.

(a) The methodology for determining a rate increase shall be applied equally to all providers within K-THRI.

(b) Adjustments to payments shall be made as necessary to ensure that aggregate hospital rate improvement program payments and K-THRI payments do not exceed the statewide average commercial rate limit.

(c) K-THRI payments shall be made by distribution to each Medicaid managed care organization through a quarterly supplemental capitation payment.

(d) The department shall submit with, or prior to, the K-THRI payment directions to the Medicaid managed care organization for the payment of the quarterly K-THRI payment to qualifying hospitals.

(e) 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 K-THRI supplemental payment within five (5) business days of receipt of the quarterly K-THRI 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.

(f) The payments received by the K-THRI providers shall be reconciled to actual utilization on a quarterly basis after a reasonable claims runout period. Future payments shall be withheld or increased in order to reconcile K-THRI hospitals to the amount of the enhanced payment.

(2)

- (a) Twenty (20) percent of the amount calculated shall be determined by the department and withheld by the managed care organization.
 - (b) The amount withheld shall be subject to the qualifying hospital meeting the same requirements established pursuant to the separate university directed payment program established pursuant to 42 C.F.R. 438.6. The quality measures shall be identical to the performance measures that academic hospitals meet under the separate university directed payment program for academic hospitals.
 - (c) In order to be eligible for a quality performance payment, a K-THRI provider shall meet the same number of performance targets on the annual metrics listed pursuant to paragraph (b) of this section.
 - (d) If less than the established performance target metrics are met, there shall be no partial payment of the quality performance payment.
 - (e) The initial performance targets shall be a two (2) percent improvement over the most recent program year's established targets.
 - (f) In order to qualify for evaluation pursuant to this subsection a measure shall have at least twenty (20) cases in the K-THRI hospital during the evaluation period. A measure that does not meet the twenty (20) case threshold shall be considered as a reporting-only measure and shall not be included in determining the value-based payments.
- (3) Consistent with KRS 205.6412, in order to be eligible for the K-THRI portion of the HRIP program, a provider shall:
- (a) Have a trauma center that has received a designation as of Level II, III, or IV;
 - (b) Be located in a county with a higher proportion of residents enrolled in Medicaid than the statewide median; and
 - (c) Have an agreement with a university-affiliated graduate medical education program or a pediatric teaching hospital to host and provide clinical rotations at that facility to train providers.
- (4) The methodology for determining a rate increase pursuant to this section shall be applied to all qualifying hospitals equally as a uniform dollar increase.

Section 5. 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 6. 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.

(907 KAR 010:840. 46 Ky.R. 2006, 2456; eff. 6-2-2020; 51 Ky.R. 1821, 52 Ky.R. 59; eff. 7-30-2025.)

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