CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Fiscal Management
(Amendment)

907 KAR 10:840. 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, 447.271, 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), 205.6411, 205.6412, 42 C.F.R. 447.252, 447.253, 42 U.S.C. 1396a

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.

(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) 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. 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 requirements established pursuant to an annual listing of twenty-one (21) performance quality measures established by the department. The quality measures shall be identical to the performance measures that academic hospitals meet under the separate hospital rate improvement program for academic hospitals.

(c) In order to be eligible for a quality performance payment, a K-THRI provider shall meet the performance target on at least seven (7) of the twenty-one (21) annual metrics listed pursuant to paragraph (b) of this section.

(d) If less than seven (7) of the twenty-one (21) metrics are met, there shall be no partial payment of the quality performance payment. For illustrative purposes only, a K-THRI provider meeting criteria for five (5) of the twenty-one (21) metrics would not receive any partial or pro-rated quality withhold 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 under 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. ~~[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.

LISA D. LEE, Commissioner
ERIC C. FRIEDLANDER, Secretary

APPROVED BY AGENCY: February 16, 2025

FILED WITH LRC: February 24, 2025 at 8:05 a.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on May 27, 2025, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by

May 19, 2025, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends virtually will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until May 31, 2025. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-7476; fax 502-564-7091; email CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person:Krista Quarles

(1) Provide a brief summary of:

(a) What this administrative regulation does:
This administrative regulation establishes the reimbursement provisions and requirements for the Hospital Rate Improvement Program.

(b) The necessity of this administrative regulation:
This administrative regulation is necessary to establish the Hospital Rate Improvement Program as required by state statute.

(c) How this administrative regulation conforms to the content of the authorizing statutes:
This administrative regulation conforms to the content of the authorizing statutes by establishing the reimbursement provisions and requirements for the private hospital rate improvement program.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes:
This administrative regulation assists with the effective administration of the statutes by implementing a private hospital rate improvement program.

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

(a) How the amendment will change this existing administrative regulation:
The amendments create a new Section 4 of the administrative regulation that establishes the Kentucky Trauma Hospital Rate Improvement (K-THRI). The new program is required by KRS 205.6411-.6412 and is required to have federal approval. If approval is received, the program will allow for an enhanced quarterly add-on payment to qualifying providers that will include inpatient, outpatient, and professional services. The K-THRI program will include a requirement to meet at least 7 of 21 quality metrics each year. 20% of the potential funds will be withheld and subject to meeting the quality metrics in order to receive payment.

(b) The necessity of the amendment to this administrative regulation:
This amendment is necessary to provide an additional type of hospital rate improvement program for hospitals that qualify pursuant to KRS 205.6411-.6412.

(c) How the amendment conforms to the content of the authorizing statutes:
This amendment conforms to the content of the authorizing statutes by establishing K-THRI as required by KRS 205.6411-.6412.

(d) How the amendment will assist in the effective administration of the statutes:
This amendment assists with the affective administration of the statutes by establishing an additional hospital rate improvement program as required by KRS 205.6411-.6412.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation:
DMS anticipates that at least 9 hospitals will qualify for this expanded program.

(4) Provide an analysis of how the entities identified in question (3) will 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) will have to take to comply with this administrative regulation or amendment:

Regulated entities will be able to participate in K-THRI.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3):

Regulated entities will experience no new costs in complying with this administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3):

Recipients will be able to participate in the expanded funds available under K-THRI.

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

(a) Initially:

KRS 205.6412 requires that state general funds not be used to administer this program. The non-federal share of this state directed payment is estimated to be $27,349,525. The total dollar amount is estimated to be $136,747,624.

(b) On a continuing basis:

KRS 205.6412 requires that state general funds not be used to administer this program. In the first year, the non-federal share of this state directed payment will be $27,349,525. The total dollar amount is estimated to be $136,747,624.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation:

Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.

(7) Provide an assessment of whether an increase in fees or funding will 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 will be necessary to implement the amendments.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees:

The amendment does not establish or increase any fees.

(9) TIERING: Is tiering applied?

Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FISCAL IMPACT STATEMENT

(1) Identify each state statute, federal statute, or federal regulation that requires or authorizes the action taken by the administrative regulation.

KRS 205.560, 205.8405, 205.520, 194A.030, 42 CFR.455

(2) Identify the promulgating agency and any other affected state units, parts, or divisions:

Department for Medicaid Services is the promulgating agency, other agencies have not been identified.

(a) Estimate the following for the first year:

Expenditures:KRS 205.6412 requires that state general funds not be used to administer this program. The non-federal share of this state directed payment is estimated to be $27,349,525. The total dollar amount is estimated to be $136,747,624.

Revenues:The Department does not anticipate revenues as a result of this administrative regulation.

Cost Savings:The Department does not anticipate cost savings as a result of this administrative regulation.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?

KRS 205.6412 requires that state general funds not be used to administer this program. The non-federal share of this state directed payment is estimated to be $27,349,525. The total dollar amount is estimated to be $136,747,624. DMS does not expect a change to revenues or cost savings in subsequent years.

(3) Identify affected local entities (for example: cities, counties, fire departments, school districts):

N/A

(a) Estimate the following for the first year:

Expenditures:KRS 205.6412 requires that state general funds not be used to administer this program. The non-federal share of this state directed payment is estimated to be $27,349,525. The total dollar amount is estimated to be $136,747,624.

Revenues:The department does not anticipate revenues as a result of this administrative regulation.

Cost Savings:The department does not anticipate cost savings as a result of this administrative regulation.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?

DMS does not expect additional expenditures, revenues, or cost savings for local entities as a result of this regulation.

(4) Identify additional regulated entities not listed in questions (2) or (3):

Additional regulated entities certain qualifying hospitals.

(a) Estimate the following for the first year:

Expenditures:KRS 205.6412 requires that state general funds not be used to administer this program. The non-federal share of this state directed payment

is estimated to be $27,349,525. The total dollar amount is estimated to be $136,747,624.

Revenues:Qualifying hospitals will have the opportunity to receive average commercial rate reimbursement for additional services.

Cost Savings:The department does not anticipate cost savings as a result of this administrative regulation.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?
The preprint will need to be resubmitted each year. As proposed, the non-federal share of this state directed payment is estimated to be $27,349,525. The total dollar amount is estimated to be $136,747,624.

(5) Provide a narrative to explain the:

(a) Fiscal impact of this administrative regulation:
The administrative regulation implements KRS 205.6411-.6412. KRS 205.6412 requires that state general funds not be used to administer this program. The non-federal share of this state directed payment is estimated to be $27,349,525. The total dollar amount is estimated to be $136,747,624.

(b) Methodology and resources used to determine the fiscal impact:
The department worked with stakeholders and third party fiscal agents and experts to implement KRS 205.6411-.6412. The program establishes an additional rate enhancement program for certain qualifying hospitals.

(6) Explain:

(a) Whether this administrative regulation will have an overall negative or adverse major economic impact to the entities identified in questions (2) - (4). ($500,000 or more, in aggregate)
The administrative regulation will not have a major economic impact – as defined by KRS 13A.010 – on regulated entities.

(b) The methodology and resources used to reach this conclusion:
This administrative regulation will provide additional reimbursement for qualifying hospitals.

FEDERAL MANDATE ANALYSIS COMPARISON

(1) Federal statute or regulation constituting the federal mandate.
42 C.F.R. 438.6

(2) State compliance standards.
KRS 194A.030(2) requires the Department for Medicaid Services to "serve as the single state agency in the commonwealth to administer Title XIX of the Federal Social Security Act.". KRS 205.6412 requires DMS to establish an additional hospital rate improvement program.

(3) Minimum or uniform standards contained in the federal mandate.
42 C.F.R. 438.6 governs state directed payment arrangements utilizing managed care organizations.

(4) Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?
The amendment will not impose stricter than federal requirements.

(5) Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.
The amendment will not impose stricter than federal requirements.