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

July 8, 2019

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

RE: State Plan Amendment (SPA) 19-0004

Dear Ms. Steckel:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 19-0004. Effective May 10, 2019 this amendment proposes to revise the reimbursement to state university teaching hospitals. Specifically, the amendment will provide a new supplemental payment for the direct and indirect costs of graduate medical education outside of managed care.

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 May 10, 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,

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: 19-004

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
May 10, 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 $9,595,677
b. FFY 2020 $38,382,709

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-A, Page 13.1 - 14.1
Att. 4.19-A, Page 10 - 10.1

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Att. 4.19-A, Page 13.1 - 14 – same
Attachment 4.19, Page 14.1 – New
Att. 4.19-A, Page 10 – Same
Att. 4.19-A, Page 10.1 - New

10. SUBJECT OF AMENDMENT: The purpose of this SPA is to revise Kentucky's reimbursement to state university teaching hospital by providing an additional payment for the direct costs of graduate medical education.

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: 4/15/19

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
JUL 08 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
MAY 10 2019

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

Pen & Ink changes in block 4 authorized by the state. May 10, 2019

FORM HCFA-179 (07-92)

2. Acute Care Hospital Services

f. Effective October 1, 2015, the hospital-specific capital IME factor shall be taken from the Medicare Inpatient Prospective Payment System (IPPS) Final Rule Data Files and Tables published by CMS.

g. The capital IME factor shall be updated in accordance with Item "R." below.

5) a. Effective May 10, 2019, the department shall make an annual IME payment to state university teaching hospitals (as defined in subparagraph 5.c), in addition to the adjustments specified in subparagraphs 3.b and 4.b, equal to:

(1) The total of all operating base payments, as determined under subparagraph 3.a, received by the hospital during the previous year multiplied by the sum of one (1) and the adjusted hospital-specific education (IME) factor determined in accordance with subparagraph b, plus

(2) The total of all capital base payments, as determined under subparagraph 4.a, received by the hospital during the previous year multiplied by the sum of one (1) and the adjusted hospital-specific education (IME) factor determined in accordance with subparagraph b, plus

(3) The total of all inpatient operating and capital base hospital payments received from managed care organizations in the previous year multiplied by the sum of one (1) and the adjusted hospital-specific education (IME) factor determined in accordance with subparagraph b, minus

(4) The amount of IME adjustments to the operating base rate received during the previous year pursuant to subparagraph 3.b, minus

(5) The amount of IME adjustments to the capital base rate received during the previous year pursuant to subparagraph 4.b, minus

(6) The amount of IME adjustments received from managed care organizations during the previous year.

b. The adjusted hospital-specific operating IME factor shall be calculated pursuant to 42 C.F.R. § 412.105(d) substituting the count of FTE residents in the resident-to-bed ratio in the formula described therein with the number of FTE residents reported on Worksheet E Part A, Lines 10 and 11, Column 1 of the Medicare cost report..

c. For purposes of this paragraph, a state university teaching hospital is a hospital that is owned or operated by a state university or a state university-related party organization, with a state university-affiliated graduate medical education program.

d. The fee-for-service portion of the state university teaching hospital IME payments equals the amount determined under 5.a(1) plus 5.a(2) minus the amounts determined under 5.a(4) and 5.a.(5). Only the fee-for-service portion of the teaching hospital IME payments shall count towards the upper payment limit described in Attachment A.

F. 1) The department shall make a cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each DRG as established as follows.

2) A cost outlier shall be subject to QIO review and approval.

3) A discharge shall qualify for a cost outlier payment if its estimated cost, as calculated in Item "F" (4) below, exceeds the DRG's outlier threshold, as calculated in Item "F" (5) below.

4) a. The department shall calculate the estimated cost of a discharge:
   (1) For purposes of comparing the discharge cost to the outlier threshold; and
   (2) By multiplying the sum of the hospital-specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.

   b. (1) A Medicare operating and capital-related cost-to-charge ratio shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
   (2) The Medicare operating and capital cost-to-charge ratios shall be updated in accordance with Item "R." below.

5) a. The department shall calculate an outlier threshold as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold.

   b. (1) Beginning October 1, 2015, the fixed loss cost threshold shall equal the Medicare fixed loss cost threshold established for Federal Fiscal Year 2016.
   (2) The fixed loss cost threshold shall be updated in accordance with Item "R." below.

6) a. For specialized burn DRGs as established by Medicare, a cost outlier payment shall equal ninety (90) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

   b. For all other DRGs, a cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

G. 1) The department shall establish DRG relative weights obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect under Item "D." above. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

2) Relative weights shall be revised to match the grouping software version for updates in accordance with Item "R." below.

H. The department shall separately reimburse for a mother's stay and a newborn's stay based on the DRGs assigned to the mother's stay and the newborn's stay.

I. 1) If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.

2) For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

2. Acute Care Hospital Services

O. Reimbursement for Sole Community Hospitals.
An operating rate for sole community hospitals shall be calculated as described below:

1) a. For each sole community hospital, the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
b. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables, located at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.
c. Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with Item "R." below.

2) a. The department shall compare the rate referenced in paragraph 1) above with the operating rate calculated in Item "E(3)" above.
b. The higher of the two rates compared in "2) a." above shall be utilized as the operating rate for sole community hospitals.

P. Reimbursement for Medicare Dependent Hospitals.

1) a. For a Medicare-dependent hospital, the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
b. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
c. Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with the reimbursement updating procedures in Item "R." below.

2) a. The department shall compare the Medicare-dependent hospital rate referenced in paragraph 1) above with the operating rate calculated in Item "E(3)" above.
b. If the Item "E(3)" operating rate is higher, it shall be utilized as the hospital's operating rate for the period.

3) a. If the rate referenced in paragraph (1) is higher, the department shall calculate the arithmetic difference between the two (2) rates.
b. The difference shall be multiplied by seventy-five (75) percent.
c. The resulting product shall be added to the Item "E(3)" operating rate to determine the hospital's operating rate for the period.

4) If CMS terminates the Medicare-dependent hospital program, a hospital that is a Medicare-dependent hospital at the time that CMS terminates the program shall receive operating rates as calculated in Item "E(3)" above.

Q. Direct Graduate Medical Education (DGME) Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs.

1) The department shall provide a base DGME (Base DGME) payment to in-state hospitals for the direct costs of a graduate medical education program approved by Medicare as established below.
a. A Base DGME payment shall be made:
(1) Separately from the per discharge and per diem payment methodologies; and
(2) On an annual basis corresponding to the hospital's fiscal year.

2. Acute Care Hospital Services

b. The department shall determine an annual Base DGME payment amount for a hospital:
(1) Total direct graduate medical education costs shall be obtained from a facility's as-filed CMS 2552 cost report, worksheet E-4, line 25.
(2) (a) The facility's Medicaid utilization shall be calculated by dividing Medicaid fee-for-service covered days during the cost report period, as reported by the Medicaid Management Information System, by total inpatient hospital days, as reported on worksheet E-4, line 27 of the CMS 2552 cost report.
(b) The resulting Medicaid utilization factor shall be rounded to six (6) decimals.
(3) The total graduate medical education costs shall by multiplied by the Medicaid utilization factor to determine the total graduate medical education costs related to the fee-for-service Medicaid program.
(4) Medicaid program graduate medical education costs shall then be multiplied by ninety-five (95) percent to determine the annual Base DGME payment amount

2) Effective beginning May 10, 2019, the department shall provide a supplemental direct graduate medical education (Supplemental DGME) payment for the direct costs of graduate medical education incurred by eligible in-state hospitals as established in "2) a." below:
a. In-state hospitals eligible for Supplemental DGME shall include:
(1) Those hospitals receiving direct graduate medical education payments from the department as of April 1, 2019; and
(2) Any hospital which sponsors a graduate medical education program affiliated with a state university on or after April 1, 2019.
b. A Supplemental DGME Payment shall be made
(1) Separately from the per discharge and per diem payment methodologies;
(2) In addition to any Base DGME payment made pursuant to paragraph 1); and
(3) On an annual basis corresponding to the hospital's fiscal year.
c. The annual Supplemental DGME Payment shall equal the difference between the Total DGME Amount determined under "2) d." minus any Base GME payments made under "1)", any GME payments received through outpatient cost settlements, and any DGME payments received from managed care organizations.
d. The department shall determine a Total DGME Amount equal to the product of:
(1) Total DGME costs, obtained from Worksheet B, Part 1, Line 118, Columns 21 and 22, and
(2) The hospital's Medicaid utilization, calculated by dividing the total number of Medicaid inpatient days (including both fee for service and managed care days) by total inpatient days.
e. The Supplemental DGME payment shall be calculated prior to the determination of the Intensity Operating Allowance described in Item V. Only the portion of the Supplemental DGME payment associated with Medicaid fee for service days shall count towards the upper payment limit described in Attachment A.

2. Acute Care Hospital Services

R. Reimbursement Updating Procedures.

1) a. The department shall annually update the Medicare grouper software to the most current version used by the Medicare program. The annual update shall be effective October 1 of each year, except as provided below.

b. If Medicare does not release a new grouper version effective October 1 of a given year

(1) The current grouper effective prior to October 1 shall remain in effect until a new grouper is released; and

(2) When the new grouper is released by Medicare, the department shall update the Medicare grouper software to the most current version used by the Medicare program.

c. The department shall not update the Medicare grouper software more than once per federal fiscal year which shall be October 1 through September 30 of the following year.

2) At the time of the grouper update, all DRG relative weights and geometric length-of-stay values shall be updated to match the most recent relative weights and geometric length-of-stay values effective for the Medicare program.

3) a. Annually, on October 1, all values obtained from the Medicare IPPS Final Rule Data Files and Tables shall be updated to reflect the most current Medicare IPPS final rule in effect. Final Rule Data Files and Tables can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

b. (1) Within thirty (30) days after the Centers for Medicare and Medicaid Services publishes the Medicare IPPS Final Rule Data Files and Tables for a given year, the department shall send a notice to each hospital containing the hospital's data from the Medicare IPPS Final Rule Data Files and Tables to be used by the department to establish diagnosis related group rates on October 1.