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

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: [illegible]

2. STATE: [illegible]

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

07/01/99

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.256 through 280

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ budget neutral
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B A

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

None

10. SUBJECT OF AMENDMENT:

Hospital prospective rate increase using a rate on rate methodology

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
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dennis Boyd

14. TITLE:
Commissioner

15. DATE SUBMITTED:
September 24, 1999

16. RETURN TO:

Dennis Boyd, Commissioner
Department for Medicaid Services
275 East Main Street
6th Floor
Frankfort, KY 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 30, 1999

18. DATE APPROVED:
November 14, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 1999

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasner

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

State agency authorized "pen and ink" change to block 8 to correct attachment to 4.19-A.

FORM HCFA-179 (07-92)

Instructions on Back

Hospital Reimbursement Methodology for State Fiscal Year 1999-2000.

1. The reimbursement rate for an acute care and rehabilitation hospital for the rate year beginning July 1, 1999 shall be determined by utilizing a rate on rate methodology. The calculated rate shall be determined by the department as follows:

   a. The department shall utilize a hospital's June 30, 1998 per diem rate that includes operating, professional, and capital cost components.

   b. The per diem rate shall be multiplied by the rate of increase of three (3) percent. This rate of increase is determined by an analysis of current rates, utilization, historical rates of increase, and annual budgetary limits.

2. Payments to psychiatric hospitals shall not be subject to this rate on rate methodology.