

205.6412 Rate improvement programs for certain qualifying hospitals -- Terms -- Eligibility -- Federal participation and approval required for implementation of programs. (Effective July 15, 2026)

To the extent permitted under federal law and in addition to, and separate from, the programs developed pursuant to KRS 205.6406, the department shall develop programs to improve quality of and access to care for residents of the Commonwealth enrolled in the state's Medicaid program by increasing Medicaid reimbursement rates for qualifying hospitals in accordance with the following:

- (1) A qualifying hospital shall be eligible to earn enhanced add-on payments from Medicaid managed care organizations based on the qualifying hospital's average commercial rate for services provided, including but not limited to inpatient hospital services, outpatient hospital services, and professional services, if the qualifying hospital:
 - (a)
 1. Is a participant in the hospital rate improvement program developed pursuant to KRS 205.6406;
 2. Is a Level II, III, or IV trauma center;
 3. Is located in a county in which the percentage of the county's population enrolled in the state's Medicaid program exceeds the statewide median Medicaid enrollment percentage for all counties as posted by the Cabinet for Health and Family Services in the December edition of the Monthly Medicaid Counts by County report for the calendar year preceding the year in which the preprint is submitted; and
 4. Has an agreement for clinical rotations to train providers with a university-affiliated graduate medical education program; or
 - (b) Is a pediatric teaching hospital as defined in KRS 205.565, except that a hospital qualifying for enhanced add-on payments under this subparagraph shall only be eligible to receive enhanced add-on payments for services delivered to a patient who is eighteen (18) years of age or younger;
- (2)
 - (a) Within sixty (60) days after July 15, 2016, the Department for Medicaid Services shall submit a Medicaid preprint with a January 1, 2026, effective date to the federal Centers for Medicare and Medicaid Services seeking authorization to implement the state-directed payment program described in this subsection.
 - (b) If the preprint required to be submitted under paragraph (a) of this subsection is approved by the federal Centers for Medicare and Medicaid Services, a qualifying hospital shall be eligible to earn enhanced add-on payments from Medicaid managed care organizations based on the equivalent Medicare rate for services, including but not limited to physician and nonphysician professional services, provided to Medicaid beneficiaries by the qualifying hospital's affiliated physician groups or physicians or other professionals employed by or contracted with the qualifying hospital if the qualifying hospital has an agreement to train providers with a state-owned university-affiliated graduate medical education program;
- (3) For state-directed payments authorized under this section:

- (a) There shall be an identified source of funding, which shall be separate from the assessment authorized in KRS 205.6406 and shall not be from the general fund, for the nonfederal share that is in compliance with the requirements of the United States Centers for Medicare and Medicaid Services;
 - (b) A qualifying hospital shall be required to report the same quality measures as are applicable under:
 - 1. The state university teaching hospital Medicaid directed payment plan for the payment program authorized under subsection (1) of this section; and
 - 2. Similarly approved payment programs active in the Commonwealth for the payment program authorized under subsection (2) of this section; and
 - (c) Reimbursement for qualifying hospitals under this section shall only apply to patients covered by a Medicaid managed care organization;
- (4) The state-directed payment programs authorized under this section shall be separate and distinct from any state-directed payment program authorized under KRS 205.6406, and the department shall only implement the program described in this section if:
- (a) Medicaid documentation required for federal financial participation is approved by the United States Centers for Medicare and Medicaid Services;
 - (b) The United States Centers for Medicare and Medicaid Services agrees to consider the program through its own preprint and without affecting or altering any other state-directed payment program; and
 - (c)
 - 1. A source of funding that complies with subsection (3)(a) of this section has been identified and is available to meet the requirement for the nonfederal share or state match funds for a state-directed payment program.
 - 2. If a source of funding for the nonfederal share or state match funds required for a state-directed payment program becomes unavailable, the department shall terminate the state-directed payment program;
- (5) If the federal Centers for Medicare and Medicaid Services or any other federal agency at any time after July 15, 2026, seeks, for any reason, to recoup funds associated with a state-directed payment program authorized under this section:
- (a) The state shall not be liable for providing reimbursement to the federal government; and
 - (b) The qualifying hospitals that received a state-directed payment under this section shall be liable for all reimbursement that may be owed to the federal Centers for Medicare and Medicaid Services or any other federal agency; and
- (6) The department shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement the programs described in this section.

Effective: July 15, 2026

History: Amended 2026 Ky. Acts ch. 117, sec. 1, effective July 15, 2026. -- Created 2024 Ky. Acts ch. 90, sec. 3, effective July 15, 2024.