1 AN ACT relating to hospital rate improvement programs and making an
2 appropriation therefor.
3 ***Be it enacted by the General Assembly of the Commonwealth of Kentucky:***
4 ➔SECTION 1. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO
5 READ AS FOLLOWS:
6 ***As used in Sections 1 to 4 of this Act:***
7 ***(1) "Assessment" means the hospital assessment authorized by Section 2 of this Act;***
8 ***(2) "Commissioner" means the commissioner of the Department for Medicaid***
9 ***Services;***
10 ***(3) "Department" means the Department for Medicaid Services;***
11 ***(4) "Excess disproportionate share taxes" means any excess provider tax revenues***
12 ***collected under KRS 142.303 that are not needed to fund the state share of***
13 ***hospital disproportionate share payments under KRS 205.640 in the event federal***
14 ***disproportionate share allotments are reduced;***
15 ***(5) "Intergovernmental transfer" means any transfer of money by or on behalf of a***
16 ***public agency for purposes of qualifying funds for federal financial participation***
17 ***in accordance with 42 C.F.R. sec. 433.51;***
18 ***(6) "Long-term acute hospital" means an in-state hospital that is certified as a long-***
19 ***term care hospital under 42 U.S.C. sec. 1395ww(d)(1)(B)(iv);***
20 ***(7) "Managed care" means the provision of Medicaid benefits through managed***
21 ***care organizations under contract with the department pursuant to 42 C.F.R. sec.***
22 ***438;***
23 ***(8) "Managed care gap" means the difference between the maximum actuarially***
24 ***sound amount that can be included in managed care rates for hospital inpatient***
25 ***services provided by qualifying hospitals and out-of-state hospitals and the***
26 ***amount of total payments for hospital inpatient services provided by qualifying***
27 ***hospitals and out-of-state hospitals paid by managed care organizations. For***

1 ***purposes of the managed care gap, total payments shall include only those***
2 ***supplemental payments made to a qualifying hospital pursuant to a state plan***
3 ***amendment in effect on January 1, 2019, and shall exclude payments established***
4 ***under Sections 1 to 4 of this Act;***
5 ***(9) "Managed care organization" means an entity contracted with the department to***
6 ***provide Medicaid benefits pursuant to 42 C.F.R. sec. 438;***
7 ***(10) "Non-state government-owned hospital" means the same as non-state***
8 ***government-owned or operated facilities in 42 C.F.R. sec. 447.272 and represents***
9 ***one (1) group of hospitals for purposes of estimating the upper payment limit;***
10 ***(11) "University hospital" means a state university teaching hospital, owned or***
11 ***operated by either the University of Kentucky College of Medicine or the***
12 ***University of Louisville School of Medicine, including a hospital owned or***
13 ***operated by a related organization pursuant to 42 C.F.R. sec. 413.17;***
14 ***(12) "Pediatric teaching hospital" means the same as in KRS 205.565;***
15 ***(13) "Private hospitals" means the same as privately-owned and operated facilities in***
16 ***42 C.F.R. sec. 447.272 and represents one (1) group of hospitals for purposes of***
17 ***estimating the upper payment limit;***
18 ***(14) "Program year" means the state fiscal year during which an assessment is***
19 ***assessed and rate improvement payments are made;***
20 ***(15) "Psychiatric access hospital" means an in-state psychiatric hospital licensed***
21 ***under KRS Chapter 216B that:***
22 ***(a) Is not located in a Metropolitan Statistical Area;***
23 ***(b) Provides at least sixty-five thousand (65,000) days of inpatient care as***
24 ***reflected in the department's hospital rate data for state fiscal year 1998-***
25 ***1999;***
26 ***(c) Provides at least twenty percent (20%) of inpatient care to Medicaid eligible***
27 ***recipients as reflected in the department's hospital rate data for state fiscal***

1 ***year 1998-1999; and***
2 ***(d) Provides at least five thousand (5,000) days of inpatient psychiatric care to***
3 ***Medicaid recipients in a state fiscal year;***
4 ***(16) "Qualifying hospital" means a Medicaid-participating, in-state hospital licensed***
5 ***under KRS Chapter 216B including a long-term acute hospital, but excluding a***
6 ***university hospital and a state mental hospital defined in KRS 205.639;***
7 ***(17) "Qualifying hospital disproportionate share percentage" means a percentage***
8 ***equal to the amount of hospital provider taxes paid pursuant to KRS 142.303 by***
9 ***qualifying hospitals in state fiscal year 2016-2017 divided by the amount of***
10 ***hospital provider taxes paid pursuant to KRS 142.303 by all hospitals in state***
11 ***fiscal year 2016-2017;***
12 ***(18) "University hospital disproportionate share percentage" means a percentage***
13 ***equal to the amount of hospital provider taxes paid pursuant to KRS 142.303 by***
14 ***university hospitals and state mental hospitals, as defined in KRS 205.639, in***
15 ***state fiscal year 2016-2017 divided by the amount of hospital provider taxes paid***
16 ***pursuant to KRS 142.303 by all hospitals in fiscal year 2016-2017;***
17 ***(19) "Upper payment limit" or "UPL" means the methodology permitted by federal***
18 ***regulation to achieve the maximum allowable amount on aggregate hospital***
19 ***Medicaid payments to non-state government-owned hospitals and private***
20 ***hospitals under 42 C.F.R. sec. 447.272. A separate UPL shall be estimated for***
21 ***non-state government-owned hospitals and private hospitals; and***
22 ***(20) "UPL gap" means the difference between the UPL and amount of total fee-for-***
23 ***service payments paid by the department for hospital inpatient services provided***
24 ***by non-state government-owned hospitals and private hospitals to Medicaid***
25 ***beneficiaries and excluding payments established under Sections 1 to 4 of this***
26 ***Act. A separate UPL gap shall be estimated for the non-state government-owned***
27 ***hospitals and private hospitals.***

1 ➔SECTION 2. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO
2 READ AS FOLLOWS:
3 ***(1) To the extent allowable under federal law, the department shall develop the***
4 ***following programs to increase Medicaid reimbursement for inpatient hospital***
5 ***services provided by a qualifying hospital to Medicaid recipients:***
6 ***(a) A program to increase inpatient reimbursement to qualifying hospitals***
7 ***within the Medicaid fee-for-service program in an aggregate amount***
8 ***equivalent to the UPL gap; and***
9 ***(b) A program to increase inpatient reimbursement to qualifying hospitals***
10 ***within the Medicaid managed care program in an aggregate amount***
11 ***equivalent to the managed care gap.***
12 ***(2) On an annual basis prior to the start of each program year, the department shall***
13 ***determine:***
14 ***(a) The maximum allowable UPL for inpatient services provided in the***
15 ***Kentucky Medicaid fee-for-service program;***
16 ***(b) The fee-for-service UPL gap;***
17 ***(c) A per discharge uniform add-on amount to be applied to Medicaid fee-for-***
18 ***service discharges at qualifying hospitals for that program year, determined***
19 ***by dividing the UPL gap by total fee-for-service hospital inpatient***
20 ***discharges at qualifying hospitals in the data used to calculate the UPL gap.***
21 ***Claims for discharges that already receive an enhanced rate at qualifying***
22 ***hospitals that also are classified as a pediatric teaching hospital or as a***
23 ***psychiatric access hospital shall be excluded from the calculation of the per***
24 ***discharge uniform add-on, unless the department is required to include***
25 ***these claims to obtain federal approval;***
26 ***(d) The maximum actuarially sound managed care gap for inpatient services;***
27 ***and***

1 ***(e) A per discharge uniform add-on amount to be applied to Medicaid managed***
2 ***care discharges at qualifying hospitals for that program year in an amount***
3 ***that is calculated by dividing the managed care gap by total managed care***
4 ***in-state qualifying hospital inpatient discharges in the data used to calculate***
5 ***the managed care gap. Claims for discharges that already receive an***
6 ***enhanced rate at qualifying hospitals that also are classified as a pediatric***
7 ***teaching hospital or as a psychiatric access hospital shall be excluded from***
8 ***the calculation of the per discharge uniform add-on, unless the department***
9 ***is required to include these claims to obtain federal approval.***
10 ***At least thirty (30) days prior to the beginning of each program year, the***
11 ***department shall provide each qualifying hospital the opportunity to verify the***
12 ***base data to be utilized in both the fee-for-service and managed care gap***
13 ***calculations, with data sources and methodologies identified.***
14 ***(3) On a quarterly basis in the program year, the department shall:***
15 ***(a) Calculate a fee-for-service quarterly supplemental payment for each***
16 ***qualifying hospital using fee-for-service claims for inpatient discharges***
17 ***paid in the quarter to the qualifying hospital multiplied by the uniform add-***
18 ***on amount determined in subsection (2)(c) of this section;***
19 ***(b) Calculate a managed care quarterly supplemental payment for each***
20 ***qualifying hospital to be paid by each managed care organization using***
21 ***managed care encounter claims for inpatient discharges received in the***
22 ***quarter multiplied by the uniform add-on amount determined in subsection***
23 ***(2)(e) of this section;***
24 ***(c) Make the quarterly supplemental payment calculated under paragraph (a)***
25 ***of this subsection;***
26 ***(d) Provide each managed care organization with a listing of the supplemental***
27 ***payments to be paid by each managed care organization to each qualifying***

1 ***hospital;***
2 ***(e) Provide each managed care organization with a supplemental capitation***
3 ***payment to cover the managed care organization's quarterly supplemental***
4 ***payments to be paid to qualifying hospitals in the quarter;***
5 ***(f) Determine the amount of state funds necessary to obtain federal matching***
6 ***funds that, in the aggregate, equal the total quarterly supplemental***
7 ***payments to be paid to all qualifying hospitals in both the fee-for-service***
8 ***and the Medicaid managed care programs;***
9 ***(g) Determine a per discharge hospital assessment for the quarter for each***
10 ***qualifying hospital, which shall be calculated by first applying towards the***
11 ***state share calculated under paragraph (f) of this subsection the qualifying***
12 ***hospital disproportionate share percentage of the excess disproportionate***
13 ***share taxes and then dividing the remaining state share by the total***
14 ***discharges reported by all in-state qualifying hospitals on the Medicare cost***
15 ***reports filed by those qualifying hospitals in the calendar year two (2) years***
16 ***prior to the program year;***
17 ***(h) Determine each qualifying hospital's quarterly assessment by multiplying***
18 ***the assessment established in paragraph (g) of this subsection by the***
19 ***hospital's total discharges from the qualifying hospital's Medicare cost***
20 ***reports filed in the calendar year two (2) years prior to the program year;***
21 ***and***
22 ***(i) Provide each qualifying hospital with a notice of the qualifying hospital's***
23 ***quarterly assessment, that shall state the total amount due from the***
24 ***assessment, the date payment is due, the total number of paid claims for***
25 ***inpatient discharges used to calculate the qualifying hospital's quarterly***
26 ***supplemental payments, and the amount of quarterly supplemental***
27 ***payments due to be received by the qualifying hospital from the department***

1 ***and each Medicaid managed care organization.***
2 ***(4) In calculating the quarterly supplemental payments under subsection (3)(a) and***
3 ***(b) of this section for qualifying hospitals that are also classified as a pediatric***
4 ***teaching hospital or as a psychiatric access hospital, no add-on shall be applied to***
5 ***the paid claims for the services for which that hospital also receives supplemental***
6 ***payments pursuant to state plan methodologies in effect on January 1, 2019.***
7 ***(5) Each qualifying hospital shall receive four (4) quarterly supplemental payments***
8 ***in the program year, as determined under subsection (3) of this section.***
9 ***(6) Medicaid managed care organizations shall pay the supplemental payments to***
10 ***qualifying hospitals within five (5) business days of receiving the supplemental***
11 ***capitation payment from the department.***
12 ***(7) A qualifying hospital shall pay its quarterly assessment no later than ten (10)***
13 ***days from the date the qualifying hospital is notified of the assessment from the***
14 ***department. A non-state government-owned hospital may make payment of its***
15 ***assessment through an intergovernmental transfer.***
16 ***(8) The department shall complete the actions required under subsection (3) of this***
17 ***section within forty-five (45) days after the close of the quarter.***
18 ***(9) Qualifying hospitals may notify the department of errors in the data used to make***
19 ***a quarterly supplemental payment by providing documentation within thirty (30)***
20 ***days of receipt of a quarterly supplemental payment from a Medicaid managed***
21 ***care organization. If the department agrees that an error occurred in a qualifying***
22 ***hospital's quarterly supplemental payment, the department shall reconcile the***
23 ***payment error through an adjustment in the qualifying hospital's next quarterly***
24 ***supplemental payment.***
25 ***(10) The programs in this section shall not be implemented if federal financial***
26 ***participation is not available. A qualifying hospital shall have no obligation to***
27 ***pay an assessment if any federal agency determines that federal financial***

1 ***participation is not available for any assessment. Any assessments received by the***
2 ***department that cannot be matched with federal funds shall be returned pro rata***
3 ***to the qualified hospitals that paid the assessments.***
4 ***(11) The department may implement the hospital rate improvement programs only if***
5 ***Medicaid state plan amendments required for federal financial participation are***
6 ***approved by the United States Centers for Medicare and Medicaid Services.***
7 ***(12) The assessment authorized under Sections 1 to 4 of this Act shall be restricted for***
8 ***use to accomplish the inpatient reimbursement increases established under this***
9 ***section. The Commonwealth shall not maintain or revert funds received under***
10 ***Sections 1 to 4 of this Act to the state general fund except that the department***
11 ***may receive two hundred fifty thousand ($250,000) dollars in state funds each***
12 ***program year to administer the programs. The department shall not reduce***
13 ***Medicaid fee-for-service reimbursement rates in effect as of October 1, 2018, for***
14 ***acute care hospitals and July 1, 2019, for hospitals paid on a per diem basis.***
15 ***(13) The department shall promulgate administrative regulations to implement the***
16 ***provisions of Sections 1 to 4 of this Act.***
17 ➔SECTION 3. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO
18 READ AS FOLLOWS:
19 ***(1) There is hereby established in the State Treasury the hospital Medicaid***
20 ***assessment fund for the purpose of holding assessments collected under Section 2***
21 ***of this Act and funds transferred pursuant to Section 4 of this Act.***
22 ***(2) All assessments collected shall be deposited into the fund and transferred to the***
23 ***department on a quarterly basis to be distributed only for the purpose of***
24 ***administering the provisions of Section 2 of this Act.***
25 ***(3) Any fund amounts remaining in the fund after the cessation of the collection of***
26 ***the assessment under Section 2 of this Act shall be refunded to qualifying***
27 ***hospitals on a pro rata basis based upon the assessments paid by each qualifying***

1 ***hospital for the program year that ended immediately before the cessation of the***
2 ***collection of the assessment.***
3 ***(4) Notwithstanding KRS 45.229, fund amounts not expended at the close of a fiscal***
4 ***year shall not lapse but shall be carried forward into the next fiscal year and***
5 ***shall be used to reduce the assessments in the subsequent program year.***
6 ***(5) Any interest earnings of the fund shall become a part of the fund and shall not***
7 ***lapse.***
8 ***(6) Moneys deposited into the fund are hereby appropriated for the purposes set forth***
9 ***in this section and shall not be appropriated or transferred by the General***
10 ***Assembly for any other purpose.***
11 ➔SECTION 4. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO
12 READ AS FOLLOWS:
13 ***Beginning in state fiscal year 2020 and continuing thereafter, the qualifying hospital***
14 ***disproportionate share percentage of the excess disproportionate share taxes shall be***
15 ***transferred to the hospital Medicaid assessment fund and used for the state matching***
16 ***dollars for the payments made under Section 2 of this Act. The university hospital***
17 ***disproportionate share percentage of the excess disproportionate share taxes shall be***
18 ***used for the state matching dollars for supplemental payments to university hospitals.***