

1 AN ACT relating to the hospital rate improvement program, making an
2 appropriation therefor, and declaring an emergency.

3 ***Be it enacted by the General Assembly of the Commonwealth of Kentucky:***

4 ➔Section 1. KRS 205.6405 is amended to read as follows:

5 As used in KRS 205.6405 to 205.6408:

- 6 (1) "Assessment" means the hospital assessment authorized by KRS 205.6406;
- 7 (2) "Commissioner" means the commissioner of the Department for Medicaid Services;
- 8 (3) "Department" means the Department for Medicaid Services;
- 9 (4) "Excess disproportionate share taxes" means any excess provider tax revenues
10 collected under KRS 142.303 that are not needed to fund the state share of hospital
11 disproportionate share payments under KRS 205.640 due to federal disproportionate
12 share allotments being reduced and limited to the portion of provider tax revenues
13 collected under KRS 142.303 necessary to fund the state share of the difference
14 between the unreduced disproportionate share allotment and the reduced
15 disproportionate share allotment;
- 16 (5) "Intergovernmental transfer" means any transfer of money by or on behalf of a
17 public agency for purposes of qualifying funds for federal financial participation in
18 accordance with 42 C.F.R. sec. 433.51;
- 19 (6) "Long-term acute hospital" means an in-state hospital that is certified as a long-term
20 care hospital under 42 U.S.C. sec. 1395ww(d)(1)(B)(iv);
- 21 (7) "Managed care" means the provision of Medicaid benefits through managed care
22 organizations under contract with the department pursuant to 42 C.F.R. sec. 438;
- 23 (8) "Managed care gap" means the difference between the maximum actuarially sound
24 amount that can be included in managed care rates for hospital inpatient services
25 provided by qualifying hospitals and out-of-state hospitals and the amount of total
26 payments for hospital inpatient services provided by qualifying hospitals and out-of-
27 state hospitals paid by managed care organizations. For purposes of the managed

- 1 care gap, total payments shall include only those supplemental payments made to a
2 qualifying hospital and shall exclude payments established under KRS 205.6405 to
3 205.6408;
- 4 (9) "Managed care organization" means an entity contracted with the department to
5 provide Medicaid benefits pursuant to 42 C.F.R. sec. 438;
- 6 (10) "Non-state government-owned hospital" means the same as non-state government-
7 owned or operated facilities in 42 C.F.R. sec. 447.272 and represents one (1) group
8 of hospitals for purposes of estimating the upper payment limit;
- 9 (11) "University hospital" means a state university teaching hospital, owned or operated
10 by either the University of Kentucky College of Medicine or the University of
11 Louisville School of Medicine, including a hospital owned or operated by a related
12 organization pursuant to 42 C.F.R. sec. 413.17;
- 13 (12) "Pediatric teaching hospital" means the same as in KRS 205.565;
- 14 (13) "Private hospitals" means the same as privately owned and operated facilities in 42
15 C.F.R. sec. 447.272 and represents one (1) group of hospitals for purposes of
16 estimating the upper payment limit;
- 17 (14) "Program year" means the state fiscal year during which an assessment is assessed
18 and rate improvement payments are made;
- 19 (15) "Psychiatric access hospital" means an in-state psychiatric hospital licensed under
20 KRS Chapter 216B that:
- 21 (a) Is not located in a Metropolitan Statistical Area;
- 22 (b) Provides at least sixty-five thousand (65,000) days of inpatient care as
23 reflected in the department's hospital rate data for state fiscal year 1998-1999;
- 24 (c) Provides at least twenty percent (20%) of inpatient care to Medicaid-eligible
25 recipients as reflected in the department's hospital rate data for state fiscal year
26 1998-1999; and
- 27 (d) Provides at least five thousand (5,000) days of inpatient psychiatric care to

- 1 Medicaid recipients in a state fiscal year;
- 2 (16) "Qualifying hospital" means a Medicaid-participating, in-state hospital licensed
3 under KRS Chapter 216B, including a long-term acute hospital, but excluding a
4 university hospital and a state mental hospital defined in KRS 205.639. *The*
5 *department may, but is not required to, exclude critical access hospitals from the*
6 *definition of "qualifying hospital" for purposes of calculating the quarterly*
7 *assessments. Notwithstanding the permission referenced in this subsection, or*
8 *any other provision of the law to the contrary, the department may include*
9 *critical access hospitals for purposes of calculating and paying the quarterly*
10 *supplemental payments authorized in KRS 205.6406;*
- 11 (17) "Qualifying hospital disproportionate share percentage" means a percentage equal to
12 the amount of hospital provider taxes paid pursuant to KRS 142.303 by qualifying
13 hospitals in state fiscal year 2016-2017 divided by the amount of hospital provider
14 taxes paid pursuant to KRS 142.303 by all hospitals in state fiscal year 2016-2017;
- 15 (18) "University hospital disproportionate share percentage" means a percentage equal to
16 the amount of hospital provider taxes paid pursuant to KRS 142.303 by university
17 hospitals and state mental hospitals, as defined in KRS 205.639, in state fiscal year
18 2016-2017 divided by the amount of hospital provider taxes paid pursuant to KRS
19 142.303 by all hospitals in fiscal year 2016-2017;
- 20 (19) "Upper payment limit" or "UPL" means the methodology permitted by federal
21 regulation to achieve the maximum allowable amount on aggregate hospital
22 Medicaid payments to non-state government-owned hospitals and private hospitals
23 under 42 C.F.R. sec. 447.272. A separate UPL shall be estimated for non-state
24 government-owned hospitals and private hospitals; and
- 25 (20) "UPL gap" means the difference between the UPL and amount of total fee-for-
26 service payments paid by the department for hospital inpatient services provided by
27 non-state government-owned hospitals and private hospitals to Medicaid

1 beneficiaries and excluding payments established under KRS 205.6405 to 205.6408.
2 A separate UPL gap shall be estimated for the non-state government-owned
3 hospitals and private hospitals.

4 ➔Section 2. KRS 205.6406 is amended to read as follows:

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

- 1 (d) The maximum managed care gap for inpatient services; and
- 2 (e) A per discharge uniform add-on amount to be applied to Medicaid managed
- 3 care discharges at qualifying hospitals for that program year in an amount that
- 4 is calculated by dividing the managed care gap by total managed care in-state
- 5 qualifying hospital inpatient discharges in the data used to calculate the
- 6 managed care gap. Claims for discharges that already receive an enhanced rate
- 7 at qualifying hospitals that also are classified as a pediatric teaching hospital
- 8 or as a psychiatric access hospital shall be excluded from the calculation of the
- 9 per discharge uniform add-on, unless the department is required to include
- 10 these claims to obtain federal approval.

11 At least thirty (30) days prior to the beginning of each program year, the department

12 shall provide each qualifying hospital the opportunity to verify the base data to be

13 utilized in both the fee-for-service and managed care gap calculations, with data

14 sources and methodologies identified.

- 15 (3) On a quarterly basis in the program year, the department shall:
- 16 (a) Calculate a fee-for-service quarterly supplemental payment for each qualifying
- 17 hospital using fee-for-service claims for inpatient discharges paid in the
- 18 quarter to the qualifying hospital multiplied by the uniform add-on amount
- 19 determined in subsection (2)(c) of this section;
- 20 (b) Calculate a managed care quarterly supplemental payment for each qualifying
- 21 hospital to be paid by each managed care organization using managed care
- 22 encounter claims for inpatient discharges received in the quarter multiplied by
- 23 the uniform add-on amount determined in subsection (2)(e) of this section;
- 24 (c) Make the quarterly supplemental payment calculated under paragraph (a) of
- 25 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 payments
7 to be paid to all qualifying hospitals in both the fee-for-service and the
8 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 share
13 taxes and then dividing the remaining state share by the total discharges
14 reported by all in-state qualifying hospitals on the Medicare cost report filed
15 by those qualifying hospitals in the calendar year two (2) years prior to the
16 program year;
- 17 (h) Determine each qualifying hospital's quarterly assessment by multiplying the
18 assessment established in paragraph (g) of this subsection by the hospital's
19 total discharges from the qualifying hospital's Medicare cost report filed in the
20 calendar year two (2) years prior to the program year; and
- 21 (i) Provide each qualifying hospital with a notice sent on the same day as the
22 distribution to managed care organizations of the supplemental capitation
23 payments pursuant to paragraph (e) of this subsection, of the qualifying
24 hospital's quarterly assessment, that shall state the total amount due from the
25 assessment, the date payment is due, the total number of paid claims for
26 inpatient discharges used to calculate the qualifying hospital's quarterly
27 supplemental payments, and the amount of quarterly supplemental payments

1 due to be received by the qualifying hospital from the department and each
2 Medicaid managed care organization.

3 (4) In calculating the quarterly supplemental payments under subsection (3)(a) and (b)
4 of this section for qualifying hospitals that are also classified as a pediatric teaching
5 hospital or as a psychiatric access hospital, no add-on shall be applied to the paid
6 claims for the services for which that hospital also receives supplemental payments
7 pursuant to state plan methodologies and managed care contracts in effect on
8 January 1, 2019.

9 (5) Each qualifying hospital shall receive four (4) quarterly supplemental payments in
10 the program year, as determined under subsection (3) of this section.

11 (6) Medicaid managed care organizations shall pay the supplemental payments to
12 qualifying hospitals within five (5) business days of receiving the supplemental
13 capitation payment from the department.

14 (7) A qualifying hospital shall pay its quarterly assessment no later than fifteen (15)
15 days from the date the qualifying hospital is notified of the assessment from the
16 department. A non-state government-owned hospital may make payment of its
17 assessment through an intergovernmental transfer. The department may delay or
18 withhold a portion of the supplemental payment if a hospital is delinquent in its
19 payment of a quarterly assessment.

20 (8) The department shall complete the actions required under subsection (3) of this
21 section expeditiously and within the same quarter as all required information is
22 received.

23 (9) Qualifying hospitals may notify the department of errors in the data used to make a
24 quarterly supplemental payment by providing documentation within thirty (30) days
25 of receipt of a quarterly supplemental payment from a Medicaid managed care
26 organization. If the department agrees that an error occurred in a qualifying
27 hospital's quarterly supplemental payment, the department shall reconcile the

1 payment error through an adjustment in the qualifying hospital's next quarterly
2 supplemental payment.

3 (10) The programs in this section shall not be implemented if federal financial
4 participation is not available or if the provider tax waiver is not approved. A
5 qualifying hospital shall have no obligation to pay an assessment if any federal
6 agency determines that federal financial participation is not available for any
7 assessment. Any assessments received by the department that cannot be matched
8 with federal funds shall be returned pro rata to the qualified hospitals that paid the
9 assessments.

10 (11) The department may implement the hospital rate improvement programs only if
11 Medicaid state plan amendments required for federal financial participation are
12 approved by the United States Centers for Medicare and Medicaid Services.

13 (12) The assessment authorized under KRS 205.6405 to 205.6408 shall be restricted for
14 use to accomplish the inpatient reimbursement increases established under this
15 section. The Commonwealth shall not maintain or revert funds received under KRS
16 205.6405 to 205.6408 to the state general fund, except that the department may
17 receive two hundred fifty thousand dollars (\$250,000) in state funds each program
18 year to administer the programs. The department shall not establish Medicaid fee-
19 for-service rate-setting methodology changes that result in rate reductions from
20 policies in effect as of October 1, 2018, for acute care hospitals and July 1, 2019,
21 for hospitals paid on a per diem basis.

22 (13) The department shall promulgate administrative regulations to implement the
23 provisions of KRS 205.6405 to 205.6408.

24 **(14) If the department submits, and the United States Centers for Medicare and**
25 **Medicaid Services (CMS) approves, a supplemental payment formula that permits**
26 **the managed care gap to be calculated based upon a percentage of average**
27 **commercial rates (ACR) that results in a total annual supplemental payment**

1 greater than eighty percent (80%) of ACR instead of the Medicare upper payment
2 limit, then the Hospital Rate Improvement Program shall be modified as follows:

3 (a) The amount of funds the department may receive to administer the
4 programs as stated in subsection (12) of this section shall be replaced by an
5 administrative fee that shall be calculated to be an amount equal to four
6 percent (4%) of the assessment collected under this section. The
7 administrative fee payable under this paragraph shall accrue only for
8 supplemental payments attributable to state fiscal year 2021-2022 and for
9 state fiscal years thereafter so long as CMS approves the supplemental
10 payment formula in accordance with this subsection. The administrative fee
11 shall be paid within thirty (30) days after supplemental payments are issued
12 to qualifying hospitals; and

13 (b) The department shall not be required under KRS 205.6408 to transfer any
14 excess disproportionate share taxes to the hospital Medicaid assessment
15 fund for use as state matching dollars for the payments made under this
16 section.

17 ➔Section 3. Whereas, ensuring necessary funding for hospitals is a compelling
18 and immediate need, an emergency is declared to exist, and this Act takes effect upon its
19 passage and approval by the Governor or upon its otherwise becoming a law.