AN ACT relating to hospital rate improvement programs and declaring an emergency.

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

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

As used in KRS 205.6405 to 205.6408:

(1) "Assessment" means the hospital assessment authorized by KRS 205.6406;

(2) "Commissioner" means the commissioner of the Department for Medicaid Services;

(3) "Department" means the Department for Medicaid Services;

(4) "Excess disproportionate share taxes" means any excess provider tax revenues collected under KRS 142.303 that are not needed to fund the state share of hospital disproportionate share payments under KRS 205.640 due to federal disproportionate share allotments being reduced and limited to the portion of provider tax revenues collected under KRS 142.303 necessary to fund the state share of the difference between the unreduced disproportionate share allotment and the reduced disproportionate share allotment;

(5) "Intergovernmental transfer" means any transfer of money by or on behalf of a public agency for purposes of qualifying funds for federal financial participation in accordance with 42 C.F.R. sec. 433.51;

(6) "Long-term acute hospital" means an in-state hospital that is certified as a long-term care hospital under 42 U.S.C. sec. 1395ww(d)(1)(B)(iv);

(7) "Managed care" means the provision of Medicaid benefits through managed care organizations under contract with the department pursuant to 42 C.F.R. sec. 438;

(8) "Managed care gap" means**:**

(a) For hospital inpatient services, the difference between the maximum actuarially sound amount that can be included in managed care rates for hospital inpatient services provided by qualifying hospitals ~~[and out-of-state hospitals]~~and the amount of total payments for hospital inpatient services

provided by qualifying hospitals ~~[and out-of-state hospitals]~~paid by managed care organizations. For purposes of the managed care gap, total payments shall ~~[include only those supplemental payments made to a qualifying hospital and shall]~~exclude payments established under KRS 205.6405 to 205.6408; ***and***

(b) For hospital outpatient services, the difference between the maximum actuarially sound amount that can be included in managed care rates for hospital outpatient services provided by qualifying hospitals and the amount of total payments for hospital outpatient services provided by qualifying hospitals paid by managed care organizations. For purposes of the managed care gap, total payments shall exclude payments established under KRS 205.6405 to 205.6408;

(9) "Managed care organization" means an entity contracted with the department to provide Medicaid benefits pursuant to 42 C.F.R. sec. 438;

(10) "Non-state government-owned hospital" means the same as non-state government-owned or operated facilities in 42 C.F.R. sec. 447.272 and represents one (1) group of hospitals for purposes of estimating the upper payment limit;

(11) "University hospital" means a state university teaching hospital, owned or operated by either the University of Kentucky College of Medicine or the University of Louisville School of Medicine, including a hospital owned or operated by a related organization pursuant to 42 C.F.R. sec. 413.17;

(12) "Pediatric teaching hospital" means the same as in KRS 205.565;

(13) "Private hospitals" means the same as privately owned and operated facilities in 42 C.F.R. sec. 447.272 and represents one (1) group of hospitals for purposes of estimating the upper payment limit;

(14) "Program year" means the state fiscal year during which an assessment is assessed and rate improvement payments are made;

(15) "Psychiatric access hospital" means an in-state psychiatric hospital licensed under KRS Chapter 216B that:

(a) Is not located in a Metropolitan Statistical Area;

(b) Provides at least sixty-five thousand (65,000) days of inpatient care as reflected in the department's hospital rate data for state fiscal year 1998-1999;

(c) Provides at least twenty percent (20%) of inpatient care to Medicaid-eligible recipients as reflected in the department's hospital rate data for state fiscal year 1998-1999; and

(d) Provides at least five thousand (5,000) days of inpatient psychiatric care to Medicaid recipients in a state fiscal year;

(16) "Qualifying hospital" means a Medicaid-participating, in-state hospital licensed under KRS Chapter 216B, including a long-term acute hospital, but excluding a university hospital and a state mental hospital defined in KRS 205.639. The department may, but is not required to, exclude critical access hospitals ***and rural emergency hospitals*** from the definition of "qualifying hospital" for purposes of calculating the quarterly assessments. Notwithstanding the permission referenced in this subsection, or any other provision of the law to the contrary, the department may include critical access hospitals ***and rural emergency hospitals*** for purposes of calculating and paying the quarterly supplemental payments authorized in KRS 205.6406;

(17) "Qualifying hospital disproportionate share percentage" means a percentage equal to the amount of hospital provider taxes paid pursuant to KRS 142.303 by qualifying hospitals in state fiscal year 2016-2017 divided by the amount of hospital provider taxes paid pursuant to KRS 142.303 by all hospitals in state fiscal year 2016-2017;

(18) "University hospital disproportionate share percentage" means a percentage equal to the amount of hospital provider taxes paid pursuant to KRS 142.303 by university

hospitals and state mental hospitals, as defined in KRS 205.639, in state fiscal year 2016-2017 divided by the amount of hospital provider taxes paid pursuant to KRS 142.303 by all hospitals in fiscal year 2016-2017;

(19) "Upper payment limit" or "UPL" means the methodology permitted by federal regulation to achieve the maximum allowable amount on aggregate hospital Medicaid payments to non-state government-owned hospitals and private hospitals under 42 C.F.R. sec. 447.272. A separate UPL shall be estimated for non-state government-owned hospitals and private hospitals; and

(20) "UPL gap" means the difference between the UPL and amount of total fee-for-service payments paid by the department for hospital inpatient services provided by non-state government-owned hospitals and private hospitals to Medicaid beneficiaries and excluding payments established under KRS 205.6405 to 205.6408. A separate UPL gap shall be estimated for the non-state government-owned hospitals and private hospitals.

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

(1) To the extent allowable under federal law, the department shall develop the following programs to increase Medicaid reimbursement for inpatient ***and outpatient*** hospital services provided by a qualifying hospital to Medicaid recipients:

(a) A program to increase inpatient reimbursement to qualifying hospitals within the Medicaid fee-for-service program in an aggregate amount equivalent to the UPL gap;~~[and]~~

(b) A program to increase inpatient reimbursement to qualifying hospitals within the Medicaid managed care program in an aggregate amount equivalent to the managed care gap ***for inpatient services; and***

(c) A program to increase outpatient reimbursement to qualifying hospitals within the Medicaid managed care program in an aggregate amount

equivalent to the managed care gap for outpatient services.

(2) On an annual basis prior to the start of each program year, the department shall determine:

(a) The maximum allowable UPL for inpatient services provided in the Kentucky Medicaid fee-for-service program;

(b) The fee-for-service UPL gap for applicable ownership groups;

(c) A per discharge uniform add-on amount to be applied to Medicaid fee-for-service discharges at qualifying hospitals for that program year, determined by dividing the UPL gap for the applicable ownership group by total fee-for-service hospital inpatient discharges at qualifying hospitals in the data used to calculate the UPL gap. Claims for discharges that already receive an enhanced rate at qualifying hospitals that also are classified as a pediatric teaching hospital or as a psychiatric access hospital shall be excluded from the calculation of the per discharge uniform add-on, unless the department is required to include these claims to obtain federal approval;

(d) The maximum managed care gap for inpatient services;~~[and]~~

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

(f) The maximum managed care gap for outpatient services; and

(g) A uniform add-on amount to be paid to each qualifying hospital to

supplement Medicaid managed care payments for outpatient services performed by the qualifying hospital in a program year. The uniform add-on amount payable to each qualifying hospital shall be:

1. A uniform percentage increase calculated by dividing the managed care gap for outpatient services by the total payments from managed care to in-state qualifying hospitals for outpatient services taken from the data used to calculate the managed care gap for outpatient services unless a different method for calculating the uniform add-on amount is required by the Centers for Medicare and Medicaid Services; and

2. Made as a lump-sum payment to each qualifying hospital on a quarterly basis unless a different method for paying qualifying hospitals the uniform add-on amount is required by the Centers for Medicare and Medicaid Services.

At least thirty (30) days prior to the beginning of each program year, the department shall provide each qualifying hospital the opportunity to verify the base data to be utilized in both the fee-for-service and managed care gap calculations ***for both inpatient and outpatient services***, with data sources and methodologies identified.

(3) On a quarterly basis in the program year, the department shall:

(a) Calculate a fee-for-service quarterly supplemental payment for each qualifying hospital using fee-for-service claims for inpatient discharges paid in the quarter to the qualifying hospital multiplied by the uniform add-on amount determined in subsection (2)(c) of this section;

(b) Calculate a managed care quarterly supplemental payment for each qualifying hospital to be paid by each managed care organization using managed care encounter claims for inpatient discharges received in the quarter multiplied by the uniform add-on amount determined in subsection (2)(e) of this section;

(c) ***Calculate a managed care quarterly supplemental payment for each***

qualifying hospital to be paid by each managed care organization as determined in subsection (2)(g) of this section;

(d) Make the quarterly supplemental payment calculated under paragraph (a) of this subsection;

(e)~~[(d)]~~ Provide each managed care organization with a listing of the supplemental payments ***as calculated under paragraphs (b) and (c) of this subsection*** to be paid by each managed care organization to each qualifying hospital ***for both inpatient and outpatient services***;

(f)~~[(e)]~~ Provide each managed care organization with a supplemental capitation payment to cover the managed care organization's quarterly supplemental payments to be paid to qualifying hospitals ***for both inpatient and outpatient services*** in the quarter;

(g)~~[(f)]~~ Determine the amount of state funds necessary to obtain federal matching funds that~~[, in the aggregate,]~~ equal the total quarterly supplemental payments to be paid to all qualifying hospitals in both the fee-for-service and the Medicaid managed care programs ***authorized by this section***;

(h)~~[(g)]~~ ***For purposes of the inpatient program authorized by subsection (1)(b) of this section,*** determine a per discharge hospital ***inpatient*** assessment for the quarter for each qualifying hospital, which shall be calculated by first applying towards the state share ***determined***~~[calculated]~~ under paragraph ***(g)***~~[(f)]~~ of this subsection the qualifying hospital disproportionate share percentage of the excess disproportionate share taxes and then dividing the remaining state share by the total discharges reported by all in-state qualifying hospitals on the Medicare cost report filed by those qualifying hospitals in the calendar year two (2) years prior to the program year;

(i)~~[(h)]~~ Determine each qualifying hospital's quarterly ***inpatient*** assessment by multiplying the assessment established in paragraph ***(h)***~~[(g)]~~ of this subsection

by the hospital's total discharges from the qualifying hospital's Medicare cost report filed in the calendar year two (2) years prior to the program year;~~[and]~~

(j)~~[(i)]~~ ***For purposes of the outpatient program authorized by subsection (1)(c) of this section, determine each qualifying hospital's assessment to be contributed to the state's share of this outpatient program as calculated under paragraph (g) of this subsection. Each qualifying hospital's outpatient assessment shall be a percentage of the state share calculated as the qualifying hospital's total outpatient net revenue divided by the total outpatient net revenue of all qualifying hospitals on the Medicare cost reports filed in the calendar year two (2) years prior to the program year;***

(k) Determine each qualifying hospital's quarterly outpatient assessment by multiplying the outpatient portion of the assessment established in paragraph (g) of this subsection by the hospital's percentage established in paragraph (j) of this subsection; and

(l) Provide each qualifying hospital with a notice sent on the same day as the distribution to managed care organizations of the supplemental capitation payments pursuant to paragraph ***(f)***~~[(e)]~~ of this subsection, of the qualifying hospital's quarterly assessment, that shall state the total amount due from the assessment, the date ***assessment***~~[payment]~~ is due, the total number of ***inpatient*** paid claims ***and total outpatient payments***~~[for inpatient discharges]~~ used to calculate the qualifying hospital's quarterly supplemental ***distribution***~~[payments]~~, and the amount of quarterly supplemental ***distribution*** payments ***for inpatient and outpatient services*** due to be received by the qualifying hospital from the department and each Medicaid managed care organization.

(4) In calculating the quarterly supplemental payments under subsection (3)(a)***, (b),*** and ***(c)***~~[(b)]~~ of this section for qualifying hospitals that are also classified as a pediatric

teaching hospital or as a psychiatric access hospital, no add-on shall be applied to the paid claims for the services for which that hospital also receives supplemental payments pursuant to state plan methodologies and managed care contracts in effect on January 1, 2019.

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

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

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

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

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

(10) The programs in this section shall not be implemented if federal financial participation is not available or if the provider tax waiver is not approved. A

qualifying hospital shall have no obligation to pay an assessment if any federal agency determines that federal financial participation is not available for any assessment. Any assessments received by the department that cannot be matched with federal funds shall be returned pro rata to the qualified hospitals that paid the assessments.

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

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

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

(14) If the department submits, and the United States Centers for Medicare and Medicaid Services (CMS) approves, a supplemental payment formula that permits the managed care gap to be calculated based upon a percentage of average commercial rates (ACR) that results in a total annual supplemental payment greater than eighty percent (80%) of ACR ***for both inpatient and outpatient services,*** instead of the Medicare upper payment limit, then the hospital rate improvement programs ***for qualifying hospitals*** shall be modified as follows:

(a) The amount of funds the department may receive to administer the programs

as stated in subsection (12) of this section shall be replaced by an administrative fee that shall be calculated to be an amount equal to four percent (4%) of the assessment collected under this section. The administrative fee payable under this paragraph shall accrue only for supplemental payments attributable to state fiscal year 2021-2022 and for state fiscal years thereafter so long as CMS approves the supplemental payment formula in accordance with this subsection. The administrative fee shall be paid within thirty (30) days after supplemental payments ***for inpatient and outpatient services*** are issued to qualifying hospitals; and

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

(15) To the extent federal matching funds are available, the department may create a program to increase outpatient reimbursement to qualifying hospitals within the Medicaid fee-for-service program in an aggregate amount equivalent to the UPL gap.

➔Section 3. If the Cabinet for Health and Family Services or the Department for Medicaid Services determines that a state plan amendment, waiver, or any other authorization from a federal agency is necessary prior to the implementation of any provision of Section 2 of this Act, the cabinet or department shall, within 90 days after the effective date of this Act, request the state plan amendment, waiver, or authorization and shall only delay full implementation of those provisions for which a waiver or authorization was deemed necessary until the waiver or authorization is granted.

➔Section 4. Notwithstanding any other statute to the contrary, the amendments to Sections 1 and 2 of this Act shall be retroactive to January 1, 2023.

➔Section 5. Whereas hospitals are severely stressed by the shortage of health care providers, an emergency is declared to exist, and this Act takes effect upon its passage

and approval by the Governor or upon its otherwise becoming a law.