205.6406 Hospital rate improvement programs -- Calculation and payment of assessment on hospitals to provide state matching dollars for federal Medicaid funds -- Supplemental payments to hospitals -- Federal participation and approval required for implementation of programs.

(1) To the extent allowable under federal law, the department shall develop the following programs to increase Medicaid reimbursement for inpatient 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.

(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 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.

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

(d) Provide each managed care organization with a listing of the supplemental payments to be paid by each managed care organization to each qualifying hospital;

(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 in the quarter;

(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;

(g) Determine a per discharge hospital assessment for the quarter for each qualifying hospital, which shall be calculated by first applying towards the state share calculated under paragraph (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;

(h) Determine each qualifying hospital's quarterly assessment by multiplying the assessment established in paragraph (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

(i) 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 (e) of this subsection, of the qualifying hospital's quarterly assessment, that shall state the total amount due from the assessment, the date payment is due, the total number of paid claims for inpatient discharges used to calculate the qualifying hospital's quarterly supplemental payments, and the amount of quarterly supplemental payments 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) and (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 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.

Effective: June 27, 2019

History: Created 2019 Ky. Acts ch. 114, sec. 2, effective June 27, 2019.