Medicaid Overview | November 2019

Agenda

Current Medicaid Program
- Overview
- Populations Covered
- Numbers Served
- Expenditures

Financial Estimates on Medicaid Expansion
- Expanding Medicaid to 138% of FPL
- Estimates on Pending Legislation Found in HB2066, HB2102, SB54
- Cost Estimates of Alternative
- Guardrails/Recent CMS Decisions

Medicaid Waivers
- Types
- Populations Served and Services Covered
- Submission and Approval Process
- Implementation of Waivers

HCAIP
- Current Program and Status of Program Updates

How Does Medicaid Work In Kansas?

Single State Medicaid Agency (SSMA) – KDHE – responsibilities:

- Maintains State Plan, and has accountability for 1115 Waiver
- Sets eligibility policy, within federal guidelines, to allow people to apply for Medicaid
- Contracts for Medicaid Management Information System (MMIS) and Kansas Eligibility Enforcement System (KEES)
- Contracts with three Managed Care Organizations (MCOs)
- Primary contact with Centers for Medicare and Medicaid Services (CMS) at the federal level for drawing down federal funds, Maintaining program integrity and combating fraud and abuse, and Submitting federal reports

General Application Requirements

- An application must be received
- The applicant must be able to act on their own behalf – at least 18 years old – Guardian and/or Conservator has to apply
- To qualify for medical coverage, persons must be a US citizen or eligible non-citizen. Foster Care Medical can cover any non-citizen child
- The applicant must be a resident of Kansas
- The applicant must provide all needed information and cooperate with the application process
- All persons residing in the household must be included on the application
- Financial requirements vary, depending on which population one is classified as (i.e. – Family Medical, Disabled, Pregnant, etc.)

Populations Served and Services Covered

Populations Served

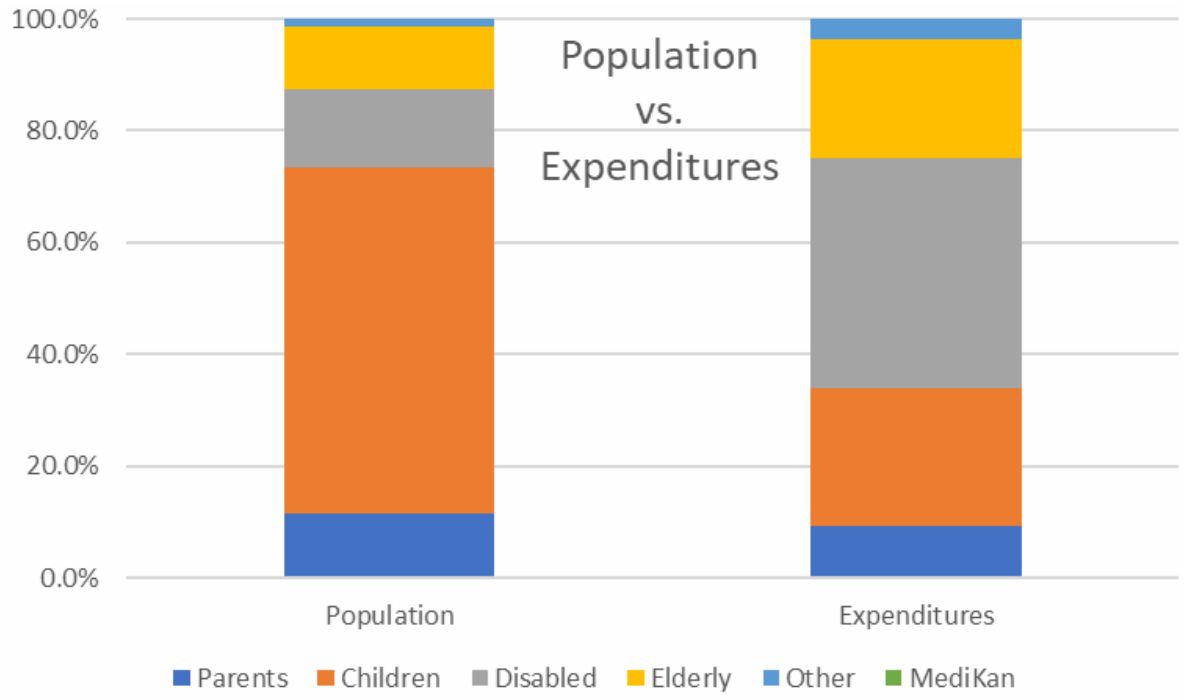
Average Monthly Members in Kansas Medical Assistance Programs: FY 12-18

Population	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Families	227,999	231,982	240,765	257,513	272,553	282,078	267,032
Disabled	64,209	63,742	63,398	62,420	61,678	61,817	61,942
CHIP	47,235	51,691	56,753	54,652	49,502	38,364	39,578
Aged	40,876	42,271	43,832	43,969	44,050	45,557	46,885
Foster Care and Adoption	14,516	15,004	15,287	16,025	16,708	16,927	17,536
Other Populations	1,168	1,262	1,330	1,379	1,486	1,425	1,442
MediKan	766	566	588	692	803	1,248	1,107

Current Medicaid Program

- Parents and Children account for 73% of the population, but only 34% of the expenditures
  - A large portion of the expansion population will be parents, which under-index on a population to expenditure basis

	% of Total	
	Population	Expenditures
Parents	11.5%	9.2%
Children	62.0%	24.7%
Disabled	13.8%	41.1%
Elderly	11.4%	21.3%
Other	1.2%	3.6%
MediKan	0.2%	0.1%



Income Limits by State – Non Expansion States

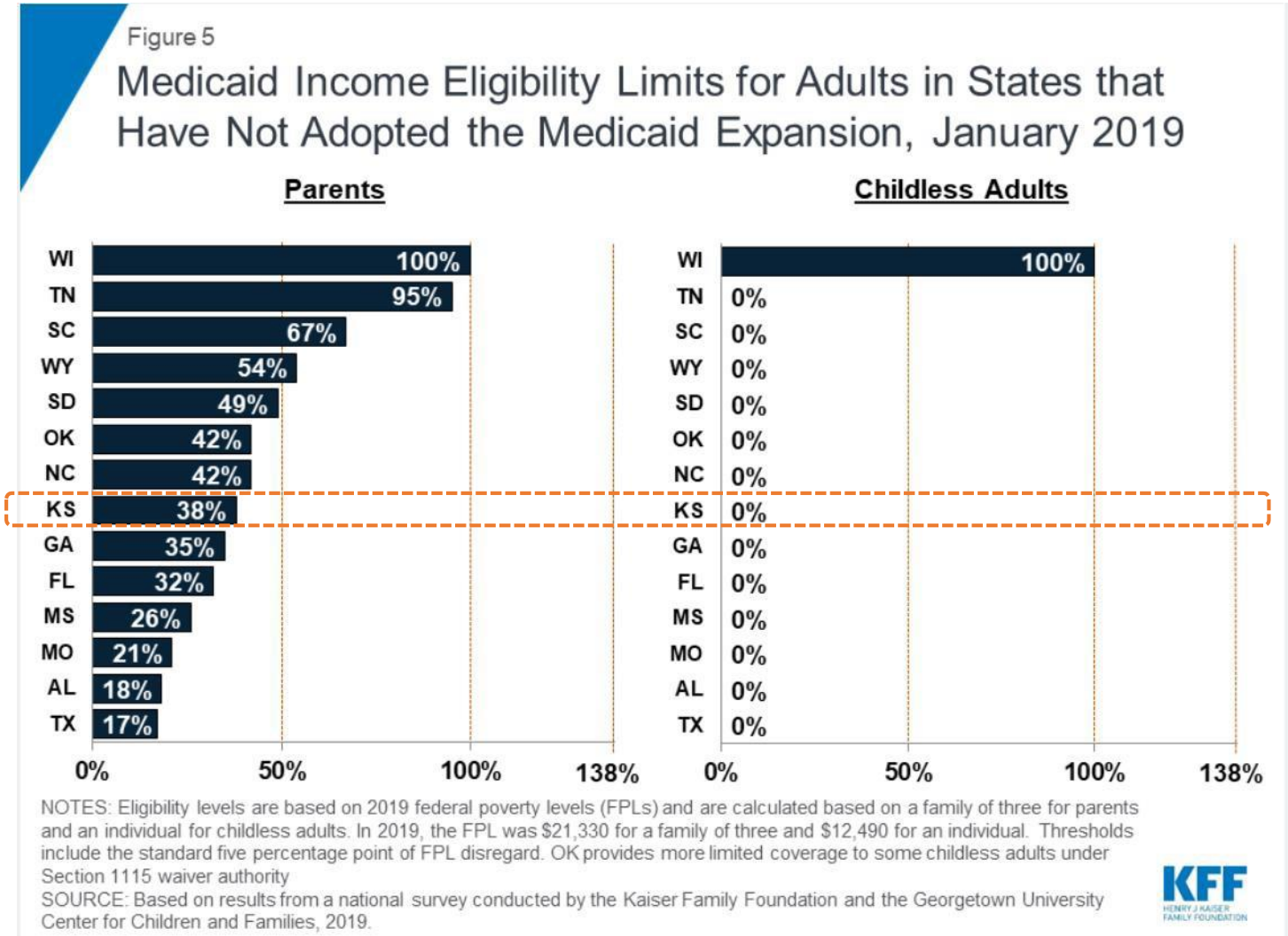


Figure 5 – Medicaid Income Eligibility Limits for Adults in States that Have Not Adopted the Medicaid Expansion, January 2019

- Kansas has the 7th lowest income eligibility threshold in the United States
- Childless adults are categorically ineligible for Medicaid in Kansas today

Income Limits by State – Non Expansion States

Table 3: Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level, January 20191				
State	Percent of the Federal Poverty Level		Annual Income	
	Parents (in a family of three)	Other Adults (for an individual)	Parents (in a family of three)	Other Adults (for an individual)
Median	138%	138%	$29,435	$17,236
Alabama	18%	0%	$3,839	$0
Florida	32%	0%	$6,825	$0
Georgia	35%	0%	$7,465	$0
Kansas	38%	0%	$8,105	$0
Mississippi	26%	0%	$5,545	$0
Missouri	21%	0%	$4,479	$0
North Carolina	42%	0%	$8,958	$0
Oklahoma11	42%	0%	$8,958	$0
South Carolina	67%	0%	$14,291	$0
South Dakota	49%	0%	$10,451	$0
Tennessee	95%	0%	$20,263	$0
Texas12	17%	0%	$3,626	$0
Wisconsin16	100%	100%	$21,330	$12,490
Wyoming	54%	0%	$11,518	$0

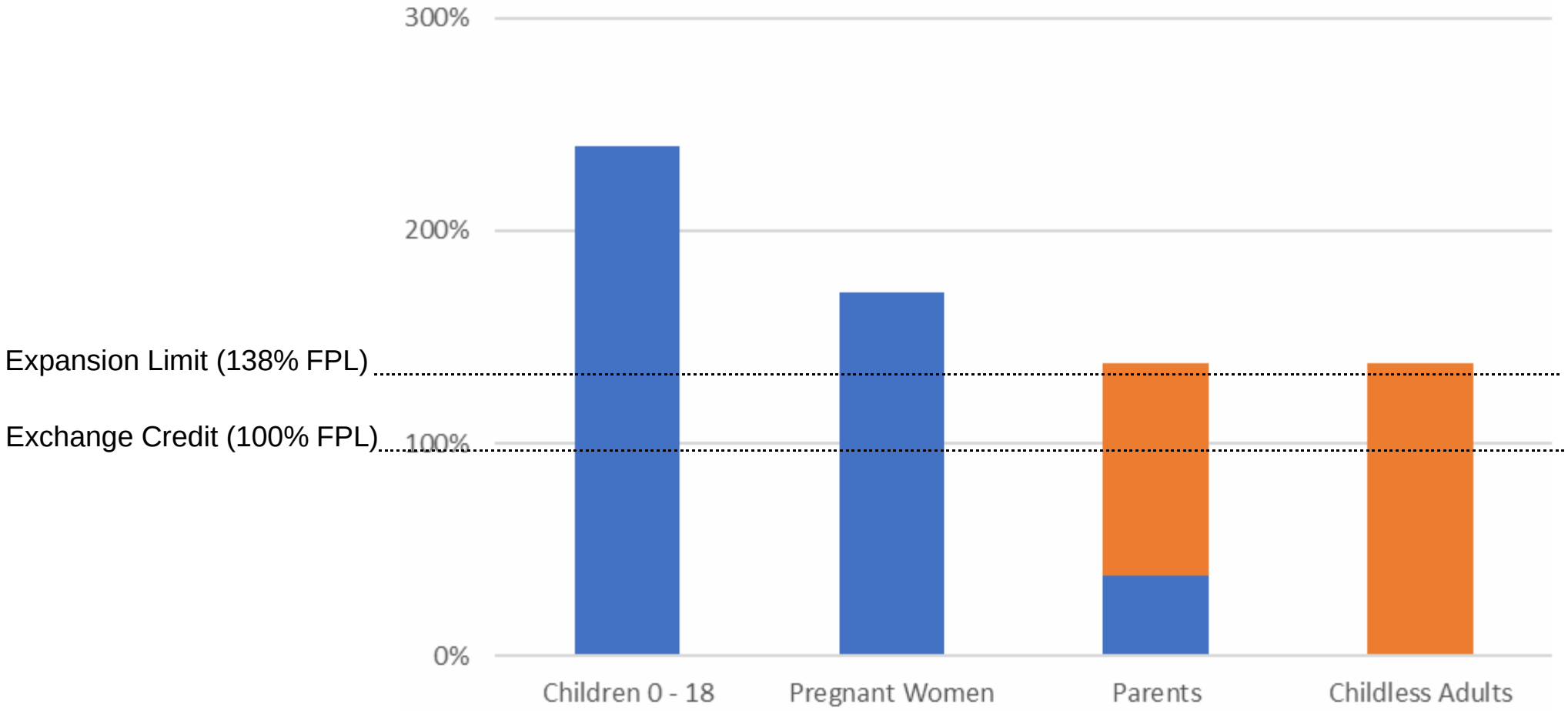
SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.

Table presents rules in effect as of January 1, 2019.

- Parents and Caretakers in Kansas can earn no more than $8,105 per year (family of three) to be eligible for Medicaid
- Under expansion, annual income threshold for family of three would be $28,188

Kansas Eligibility Guidelines

- Parents and Childless Adults make up entirety of expansion population
  - Current Parents income max – 38% of FPL
  - Current Childless Adult income max – 0% FPL



Medicaid Coverage Requirements

Mandatory

- Physician services
- Lab and x-ray services
- Inpatient hospital
- Outpatient Hospital
- Early and periodic screening diagnostic and treatment (EPSDT) services for individuals under 21
- Family planning
- Rural and federally qualified health center (FQHC) services
- Nurse midwife services
- Nursing facility (NF) services for individuals 21 and over
- Home health for certain populations

Optional

- Prescription drugs
- Clinic services
- Dental services, dentures
- Physical therapy and rehab
- Prosthetic devices, eyeglasses
- Primary care case management
- Institutions for individuals with intellectual disabilities, formerly intermediate care facilities for the mentally retarded (ICF/MR) services
- Inpatient psychiatric care for individuals under 21
- Personal care services
- Hospice services
- Alcohol and Drug Treatment

Expansion Medicaid

- Essential Health Benefits ("Benchmark Coverage")
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Pregnancy, maternity, and newborn care
  - Mental health and substance use disorder services
  - Prescription Drugs
  - Rehabilitative and Habilitative services
  - Laboratory services
  - Preventive services
  - Pediatric services

Required minimum coverage

Financial Estimate of Medicaid Expansion

Fiscal Impacts for Expansion Scenarios

SB54/HB2102/HB2066

Alternate Plans

Federal Financing of Medicaid in Kansas

FMAP (Federal Medical Assistance Percentage)

- KLRD posted a memo on February 15, 2019, which details FMAP process (separate handout)
  - The FMAP rate for a state is calculated based on a three-year average of per capita personal income for state residents compared to the national average
  - FFY21 FMAP rates are based on CY16 – CY18 per capita income data

- Since FFY2000, Kansas has seen a base FMAP range between 54.74% and 63.03%, with an average of 58.87%
  - Kansas FMAP for FFY20 is 59.16% and for FFY21 it is 59.68%

- The expansion population would be eligible for an FMAP of 90% for CY20 and beyond
  - *"The newly eligible FMAP (described in section 1905(y)(1) of the Act) is 100 percent in calendar years 2014-2016, 95 percent in calendar year 2017, 94 percent in calendar year 2018, 93 percent in calendar year 2019, and 90 percent in calendar years 2020 and beyond." – CMS FAQ letter on FMAPs, May 2012*

Financial Estimate of Medicaid Expansion

Key Assumptions from Current Expansion Bills (HB2066)

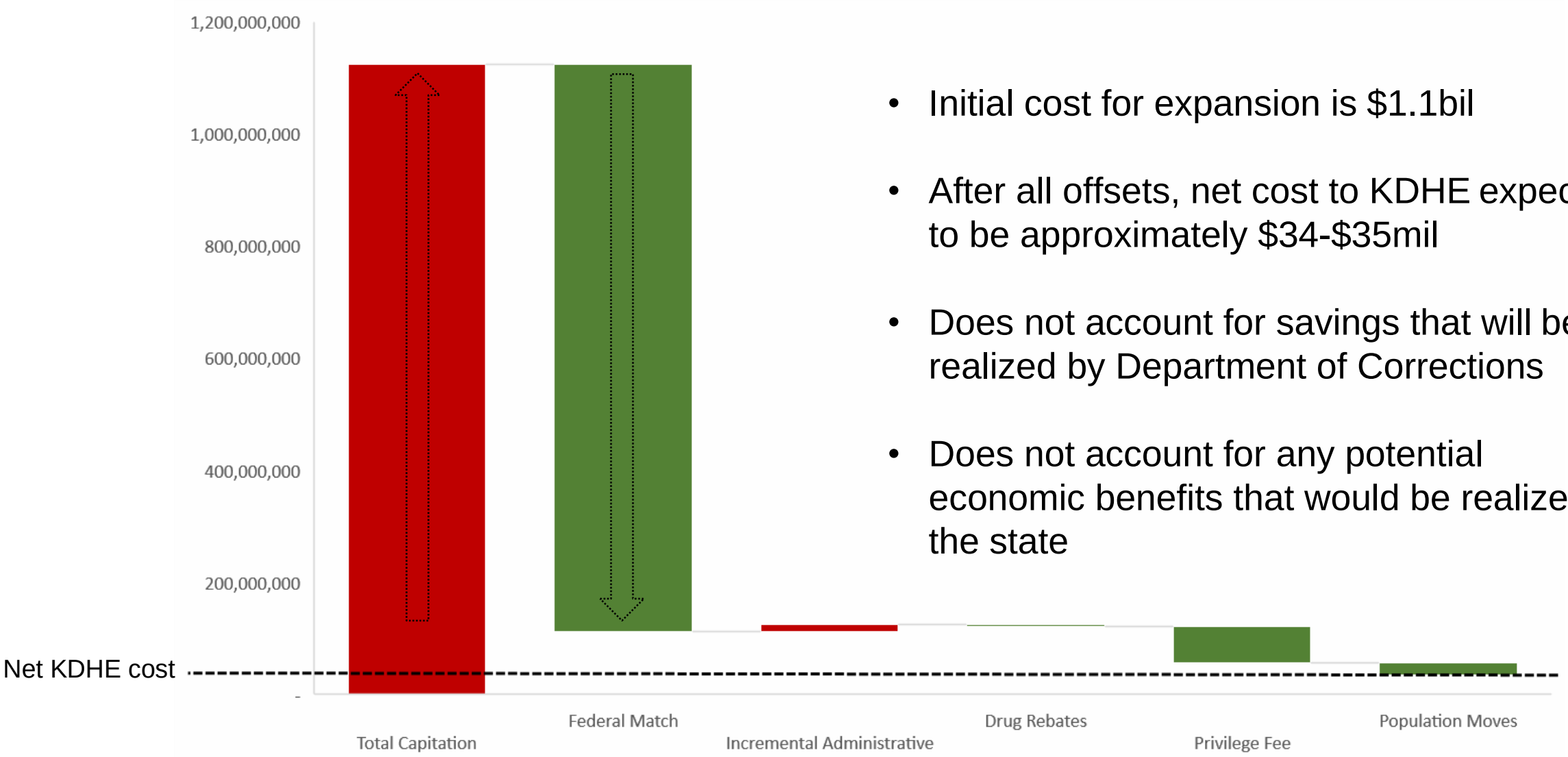
- 150k newly eligible
  - Would equate to a 36% increase in total population; this is in line with national average (35%), but above states that have most recently expanded (22%)
  - KEES system has information on approximately 80k potential members in Kansas

- $625 PMPM capitation payment
  - Base for calculation was TAF population, then indexed up/down for Childless Adult/Parent cohorts, and accounts for mix of costs between the two cohorts

- Offsets – including privilege fee, incremental drug rebates, etc. – to reduce total cost
  - Also in official fiscal note is the savings that will be realized in the Department of Corrections, due to increased ability to draw down federal funds for expansion population

- Only looks at KDHE budget; does not account for other economic benefits realized across the state

Financial Estimate of Medicaid Expansion



- Initial cost for expansion is $1.1bil
- After all offsets, net cost to KDHE expected to be approximately $34-$35mil
- Does not account for savings that will be realized by Department of Corrections
- Does not account for any potential economic benefits that would be realized by the state

Financial Estimate of Medicaid Expansion

Share of Medicaid Expansion Costs (in millions)

Ohio Actual and Forecasted Experience

	SFY 2019	SFY 2020	SFY 2021
Total Group VIII cost	$4,814	$5,074	$5,348
Match rate (state fiscal year)	*6.5%*	*8.5%*	*10.0%*
Ohio share of Group VIII cost	**$313**	**$431**	**$534**
Drug rebates	($43)	($58)	($72)
DRC medical expense savings	($18)	($18)	($18)
Enhanced FMAP for hospital UPL	($40)	($38)	($36)
MCO member-month tax	($198)	($198)	($198)
MCO HIC tax	($45)	($48)	($50)
Net Impact on Ohio	**($31)**	**$72**	**$161**
Effective match rate	*0.0%*	*1.4%*	*3.0%*

- Net gain to state in SFY19
- In SFY20, Fed match drops by 2ppts,increasing effective state match by corresponding amount

Kansas Projected Experience

Total Capitation	**1,125**
FMAP	90%
Federal Share Capitation	(1,013)
Incremental Administrative	13
Drug Rebates	(4)
Privilege Fee	(65)
Population Moves	(21)
Net State Share	**35**
Effective Match Rate	**3.1%**

Similar Effective Match rate projection in 90/10 year

Population Offsets - MediKan

What is MediKan

- MediKan Medical Assistance Program
  - MediKan is a state-only funded medical assistance program for disabled adults with very low resources and income
  - Assistance under the program is time-limited to a fixed 12 month coverage period
  - Provides a limited benefit package
  - Eligibility handled through dedicated unit of State staff

- With Expansion, the MediKan population likely to move to an Expansion population
  - Goes from 100% State funded to 10% State funded
  - Provides full State Plan benefit package

Financial Estimate of Medicaid Expansion

Dept of Corrections to save approx. $2mil with Medicaid Expansion

- Fiscal notes for SB54 and HB2102 contained analysis from Department of Corrections showing that they would realize savings of approximately $2mil with Expansion
  - Since July 1, 2012, KDHE and KDOC have had a process in place to use Medicaid funding to pay for inpatient services when an inmate is in a hospital for more than 24 hours
  - Inmate must meet all required eligibility criteria and have a qualifying event
  - Requires an application and supporting documentation
  - Many cases today require presumptive disability determination, but that need would diminish under Expansion
  - Both agencies have dedicated staff to work on these cases

Eligibility Process for Restrictive Settings

All processes handled by dedicated unit of State staff

Prisons incarceration/Pre-Release planning:	State hospital releases	Mental Health Institutions- Discharge planning	County jails incarceration/releases

Incarcerations:
• The Dept of Correction sends a monthly file to KDHE which contains a list of people incarcerated in State Prisons.
• KDHE performs a data match against its Medicaid database.
• Matches are reported to the dedicated specialized unit who performs a secondary validation of the report through KASPER before terminating eligibility.
Releases:
• The Dept of Corrections staff sends applications and supporting documents to a Specialty email box managed by the specialty unit.
• Application is processed and remains on hold until the Release notification is received from KDOC (Kansas Department of Corrections)
• When the unit is notified of the release, staff completes processing of the application.
• The unit also has a monthly conference call with KDOC to monitor the cases in process.
	• Applications, Discharge plan paperwork and PMDT (Presumptive Medical Disability Team) paperwork are emailed to the specialized unit by the KDADS (Kansas Department for Aging and Disability Services) contact up to 90 days prior to the release date
	• The specialized unit processes the application, notifies the KDADs contact and waits until notified of the actual discharge
	• Upon discharge, KDADs notifies the KDHE staff of the release; KDHE completes processing of the application and notifies KDADS and the beneficiary of the outcome.
		• Applications, Discharge plan paperwork and PMDT paperwork are emailed to the specialized unit by the KDADS (Kansas Department for Aging and Disability Services) contact up to 90 days prior to the release date
		• The specialized unit processes the application, notifies the KDADs contact and waits until notified of the actual discharge
		• Upon discharge, KDADs notifies the KDHE staff of the release; KDHE completes processing of the application and notifies KDADS and the beneficiary of the outcome.
			KDHE secured a contract with a company named APPRISS who provides a daily file of people entering and exiting the jails. The interface with APPRISS was implemented August 5th, 2019. KDHE performs a data match against its Medicaid database and generates a report for its specialized unit to work:
			• All newly incarcerated individuals who have Medicaid/Medikan coverage, have their coverage terminated in accordance with program guidelines until KDHE receives notice of their release.
			• Newly released inmates that were Medicaid/Medikan prior to incarceration are treated as follows:
			  • Incarcerated less than 90 days---- Eligibility is reinstated within the same Medical program
			  • Incarcerated more than 90 days---- are deemed eligible for Medikan for 3 months until a review is conducted.

Impact of Premiums (from HB2066)

- If premiums are assessed to the expansion population, states are required to return 90% of the premiums to the Federal government
- Once Federal share is returned, and administrative cost to operate the program is accounted for, the impact is expected to be between -$900k and +$900k (if against entire population)

Medicaid Expansion Premium $25 Fee Impact

Premium assessed on population between 0% and 138% of FPL

	Benes by Bucket		Premium Months Paid		Bene Suspensions		Premium Received		Capitation Avoidance		Total Impact	
Bene Type by Payment Habits	% Total	Count	Per Bene	Total	# Benes	# Months	All Funds	State Share	All Funds	State Share	All Funds	State Share
Pays 3/3 Months	42%	62,625	12	751,500	-	-	$ 18,787,500	$ 1,878,750	$ -	$ -	$ 18,787,500	$ 1,878,750
Pays 2/3 Months	42%	62,625	8	501,000	-	-	$ 12,525,000	$ 1,252,500	$ -	$ -	$ 12,525,000	$ 1,252,500
Pays 1/3 Months	10%	15,000	4	60,000	-	-	$ 1,500,000	$ 150,000	$ -	$ -	$ 1,500,000	$ 150,000
Pays 1/3 Months Suspended Once	6%	8,250	3	24,750	8,250	3	$ 618,750	$ 61,875	$ 15,468,750	$ 1,546,875	$ 16,087,500	$ 1,608,750
Pays 0/3 Months Suspended Permanetly	1%	1,500	-	-	1,500	6	$ -	$ -	$ 5,625,000	$ 562,500	$ 5,625,000	$ 562,500
Total	**100%**	**150,000**	**9**	**1,337,250**	**9,750**		**$ 33,431,250**	**$ 3,343,125**	**$ 21,093,750**	**$ 2,109,375**	**$ 54,525,000**	**$ 5,452,500**
									Less Administrative Cost		$ (9,090,803)	$ (4,545,402)
									Net Impact		**$ 45,434,197**	**$ 907,099**

*From CHIP data, Assumed 5.5% of Bene's will become non-compliant but reinstate and 1% will become Non-compliant and not reinstate.

*Didn't account for the $100 Family max, due to children being covered on CHIP.

*Assumed 150,000 Expanded Benificiaries from KDHE Expansion analysis.

*Assumed $625 PMPM capitation

Guardrails from CMS

Each of these Medicaid coverage-related waiver proposals has been turned down by the Trump Administration based on policy or legal grounds

- Lifetime enrollment limits (Arizona)
- Asset test (New Hampshire)
- Drug testing as a condition of eligibility (Wisconsin)
- Federal Medicaid funding for work supports in conjunction with work/community engagement requirements (General Guidance)
- Enhanced match rate (90/10) for partial expansion (Utah and others)
- Enhanced match rate for enrollment caps; enrollment caps viewed as partial expansion (Utah)

Financial Estimate of "Partial" Medicaid Expansion

- CMS has denied requests from other states to receive enhanced funding (90/10 match), if they expand to anything less than 138% of FPL
  - *"CMS will continue the existing policy of only approving section 1115 demonstrations under which the section 1905(y)(1) match rate is provided if the demonstration covers the entire adult expansion group." – CMS Administrator Seema Verma, August 2019*

- If Kansas were to only expand to 100% of FPL and not receive enhanced funding (CMS policy), this would cost the State $221 million more than full expansion, while covering approximately 50,000 fewer lives

	Full vs. Partial (at 90/10 FMAP - not CMS approved)			Full vs. Partial (at regular FMAP - CMS likely)		
	Full	Partial	Increase / Decrease	Full	Partial	Increase / Decrease
FPL	138.0%	100.0%	-38.0%	138.0%	100.0%	-38.0%
FMAP	90.0%	90.0%	0.0%	90.0%	59.6%	-30.5%
New Members	150,000	100,000	(50,000)	150,000	100,000	(50,000)
PMPM	625	625	-	625	625	-
Total Capitation	1,125,000,000	750,000,000	(375,000,000)	1,125,000,000	750,000,000	(375,000,000)
Fed Share	1,012,500,000	675,000,000	(337,500,000)	1,012,500,000	446,625,000	(565,875,000)
State Share	112,500,000	75,000,000	(37,500,000)	112,500,000	303,375,000	190,875,000
Admin/Other	13,010,155	13,010,155	-	13,010,155	13,010,155	-
Offsets	(90,431,454)	(60,117,510)	30,313,944	(90,431,454)	(60,117,510)	30,313,944
Net State Cost	**35,078,701**	**27,892,645**	**(7,186,056)**	**35,078,701**	**256,267,645**	**221,188,944**

Utah Plans and Timelines

UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Expansion: At A Glance

July 2019

This chart outlines the provisions of Senate Bill 96 (2019 General Session). The Bridge Plan will take effect on April 1, 2019 and will remain in place until one of the other three options is approved by CMS. If the Per Capita Cap Plan does not receive federal approval by January 1, 2020, the Fallback Plan will be requested by March 15, 2020. If no waiver approval is received by July 1, 2020, then the State will implement the Full Expansion Plan.

Expansion Plan Provisions	Bridge	Per Capita Cap	Fallback	Full Expansion
Timeline	Effective April 1, 2019	Upon CMS Approval (Submit Waiver to CMS Spring 2019)	Upon CMS Approval (Submit Waiver to CMS by March 15, 2020)	July 1, 2020 (if needed)
Federal Poverty Level	100%*	100%*	138%	138%
Authority	Waiver	Waiver	Waiver	State Plan
Presumptive Eligibility (PE)	Yes	No Hospital PE	No Hospital PE	Yes
Self-Sufficiency Requirement (Work Requirement)	Yes (effective January 1, 2020)	Yes	Yes*	No
Authority to Cap Expansion Enrollment	Yes*	Yes*	Yes	No
Lock-out for Program Requirements/Violations	No	Yes	Yes	No
Require Enrollment in Employer's Plan with Premium Reimbursement	Yes (effective January 1, 2020)	Yes	Yes*	No
12-month Continuous Eligibility	No	Yes	No	No
Use Federal Funds for Housing Supports	No	Yes	No	No
Use of Federal Funds Limited by Per Capita Cap	No	Yes	No	No
Benefit Plan for Adults Without Dependent Children	Traditional Medicaid	Traditional Medicaid	Traditional Medicaid	ABP Traditional
Benefit Plan for Parents	Non-Traditional Medicaid	Non-Traditional Medicaid	Non-Traditional Medicaid	ABP Traditional
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	No	No	No	Yes
Dental Benefits	Emergency Only	Emergency Only	Emergency Only	Emergency Only
Funding (% federal/% state)	70/30	90/10**	90/10	90/10
Counties Provide Match for Behavioral Health	No	No	No	No
Delivery System	Fee for Service - except Parents 45-60% FPL (Managed Care after January 1, 2020 - Except Rural Counties)	Managed Care (except Rural Counties)	Managed Care (except Rural Counties)	Managed Care (except Rural Counties)

* SB 96 required provisions for implementation

**90% federal match available up to per capita cap limit

- Utah voters passed Expansion on a ballot initiative during the November 2018 election
- Legislature amended the plan to include a series of waivers, including partial expansion, in February 2019
- CMS denied Utah application for enhanced funding on less-than-full expansion in August 2019
- Expansion implementation timeline now more than a year behind original schedule

Waiver Discussion

Types, Timelines and Authorities

Medicaid Waiver Cost/Budget Requirements

- 1115 waivers must demonstrate budget neutrality – federal spending cannot exceed what would have been spent in the absence of the waiver
  - In KanCare, the waiver is used to mandate most populations enroll in a managed care plan

- 1915(c) or HCBS waivers must be cost neutral – per capita costs do not exceed average cost of institutional settings
  - Used to target services to specific populations

- 1332 waivers are not considered Medicaid waivers, as they are in a different section of the Affordable Care Act, and have different approval/authority paths than Medicaid waivers
  - This section of the Affordable Care Act grants no authority to waive anything in Title XIX (Medicaid)
  - Four main guardrails that must be adhered to, including deficit neutrality

1115 Research & Demonstration Waiver

- KanCare is operated under a comprehensive 1115 Waiver
    - The waiver governs the entire KanCare program, and each of the 1915(c) waivers (operated by KDADS) are under the 1115 umbrella
    - Authority to require most beneficiaries to receive all their services through managed care plans
    - Authority for MCOs to manage HCBS waiver services along with physical and behavioral health services
    - Over 100 special terms and conditions (STCs) that must be monitored
    - Quarterly reporting required for financial performance, as well as other measures

1115 Timelines / Costs

- KanCare currently operates under an 1115 waiver, which is approved through 12/31/23
  - Straight expansion could be implemented under an amendment to our current waiver
  - Would need to update the wavier to include expansion population, and update budget neutrality calculations

- Additional layers added to expansion plan would be handled one of two ways, with path to approval ultimately determined by CMS
  - Simple amendment to current waiver, including updating budget neutrality; does not necessarily require the assistance of a consultant, other than our current actuarial vendor
  - If CMS deems changes substantial, they would likely enforce the transparency requirements, which add time to the process through multiple public meetings
  - Each additional STC added to the waiver is a negotiating point with CMS

- 1115 Waiver application/amendment is a standalone application
  - Cannot assume any potential impact from a 1332 waiver submission

Details on Current 1115 Timeline to Approval

- Timelines for approval vary, depending on scope of change
    - Amendment to current waiver requires 120 days' notice to CMS that we intend to amend provisions of our waiver
        - If waiver amendment is not deemed as substantial, State would likely not be required to hold multiple public meetings, though the waiver and corresponding State Plan Amendment would be posted for public comment
        - Current actuarial vendor to recalculate Budget Neutrality to incorporate new eligibility groups into calculation
        - Anticipated timeline to complete could be as short as 7-9 months (actual timeline dependent on CMS requirements)

Details on Current 1115 Timeline to Approval

- Timelines for approval vary, depending on scope of change
  - New waiver applications have increased level of requirements from CMS, and would likely involve hiring a consultant to assist with the process
    - For reference, the current KanCare waiver renewal application took approximately 22 months to complete
    - Design began in March 2017, application submitted December 2017, approval granted December 2018
  - New waiver applications come with a lengthier list of requirements than that of a waiver renewal
  - Even if Expansion handled through amendment, CMS will determine whether changes are substantial enough to invoke the transparency requirements

1332 Waiver – Not a Medicaid Wavier

- Most states have used for reinsurance on exchange
  - Nearly every state grants authority to Insurance Department to file and administer waiver
  - General thought is to use federal savings as pass-through dollars to fund program

- Must meet four statutory guardrails to be deemed complete

- Does not have overlap with Medicaid, and grants no waiver authority to Title XIX
  - When calculating budget neutrality for either waiver, assumptions of base and waiver must be separate and distinct

- Different approval path and timeline than Medicaid waivers, and savings cannot accrue across waiver types

1332 Waiver – What happened in Idaho?

- Idaho submitted 1332 waiver in an effort to allow choice between Medicaid and Exchange plans for population between 100% - 138% of FPL, while retaining subsidies on Exchange
  - As Expansion was passed by the legislature, the bill mandated choice for coverage (between Expansion and the Exchange)

- CMS sent letter to Idaho on August 29, 2019, informing the State that they did not meet the deficit neutrality guardrail for a 1332
  - CMS further stated that, even with revised application with correct elements included, application would not be approvable as State would not be able to demonstrate compliance with deficit neutrality guardrail

1332 Waiver – What happened in Idaho?

- Idaho's 400 page application had two fundamental flaws
  - The deficit neutrality calculation did not use the same underlying assumptions on the with waiver and without waiver sides of the equation
    - Assumed no Medicaid Expansion in the base calculation, but assumed Medicaid Expansion in the waiver calculation (crossed assumptions between programs)
  - Starting point was to have 100%-138% population automatically enrolled in the exchange, with the option to move to Medicaid
    - Studies have shown that the PMPM for the exchange is higher than that of Medicaid, and federal government covers >90% on the exchange, making deficit neutrality impossible to achieve in this scenario
- New application will have different starting point, as well as cost mitigating levers built in

HCAIP
Health Care Access Improvement Program

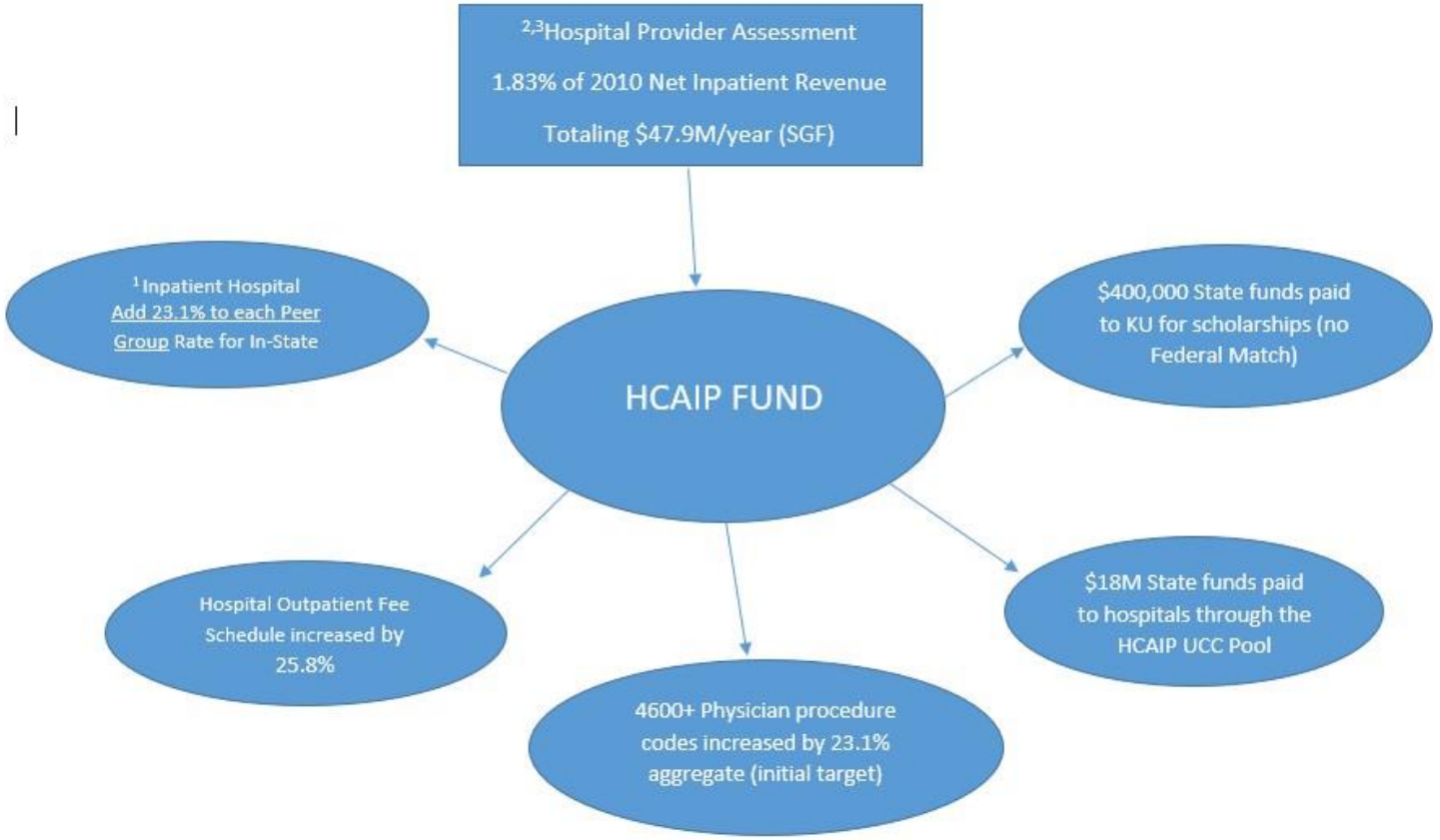
General Overview – Current Program

- Certain hospitals pay provider assessment tax equal to 1.83% of 2010 net inpatient revenue
  - Brings in ~$47.9mil per year (State funds)
  - Funds are matched with Federal dollars for a net of ~$108.8mil per year

- Revenues are dispersed back to hospitals and physicians through various avenues
  - $0.4mil paid to KU for scholarships (no Federal match)
  - ~$41mil all funds paid to hospitals through UCC Pool ($18mil State)
  - Hospital IP increased by 23.1% and OP fees uniformly increased by 25.8%
  - Physician procedure codes increased by various amounts, baked into base
  - Hospitals to receive no less than 80% of revenues and Physicians to receive no more than 20%

- Revenues/Expenses tracked by KDHE, and reported to the HCAIP Panel
  - Revenues are collected semi-annually (due 11/30 and 05/31), and are deposited directly into the HCAIP fund
  - Expenditures are mostly paid directly from SGF, and are later journaled from the HCAIP fund to reimburse SGF

HCAIP



- [1]Out of State hospitals get paid Peer Group Two (inpatient) rate minus the 23.1% increase
- [2]Hospital providers that are State agencies, State educational institutions, State mental health, developmental disability and Critical Access Hospitals do not pay the provider assessment and may not participate in the HCAIP UCC Pool.
- [3]Hospitals pay into the fund every six months at the end of May and November.

Pending Changes to Program

- 2019 legislature directed KDHE to increase the provider assessment from 1.83% of net inpatient revenues to 3.0% of net inpatient and outpatient revenues; will also change base tax year to 2016
  - Will bring in ~$163.6mil of SGF, which will become ~$381.5mil All Funds

- Distribution of funds will have wholesale changes
  - Will no longer have the 23.1% inpatient and 25.8% outpatient add-ons
  - Funds will instead be distributed as a quarterly directed payment, based on Medicaid volume for each hospital
  - No change to the physician portion of the program

- Increase in program fund necessitates amending our 1115 waiver to account for the new monies in our budget neutrality
  - KDHE has been engaged in negotiations with CMS to gain their approval
  - New program cannot be implemented without CMS approval

- The hospital surcharge proposed in 20RS1873 of $31mil will be on top of current program (additional/separate assessment to hospitals)

Questions?