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Health

L-2 Kansas Provider Assessments

Provider Assessment

A provider assessment is a mechanism used in maximizing the amount of federal funding for the state and collecting new state funds that may be used to draw down additional federal funds. This mechanism can result in increased Medicaid payments for the specified providers assessed for Medicaid eligible services.

In order to implement a provider assessment, the federal Center for Medicare and Medicaid Services (CMS) must first review and approve the provider assessment model designed by the state. CMS guidelines state that for a provider assessment to be approved, it must be uniformly enforced across all providers. Certain categories of providers can be excluded, but all providers of that category type then must be excluded from the assessment. In addition, CMS guidelines state that no provider within an assessed category is allowed to be excluded, even if that provider is negatively impacted. This means that all providers must be included in the provider assessment, even if some may experience a negative fiscal impact.

In FY 2012, 49 states had some form of Medicaid-related provider assessments. Currently Kansas has two implemented provider assessments: one for hospitals and one for nursing facilities. Another provider assessment is awaiting authorization by CMS for Home and Community Based Services providers for individuals with developmental disabilities. The models for provider assessments vary by state based on the population needs and structure of the provider system being assessed. For example, Connecticut assesses funds from nursing facilities based on how many Medicaid days a resident spends in a licensed nursing bed. However, in Kansas, the 2010 Legislature passed a version of a nursing facility provider assessment similar to the Iowa model that assesses funds annually based on licensed nursing facility beds.

Health Care Access Improvement Program

The Health Care Access Improvement Program (HCAIP), established by 2004 Senate Sub. for HB 2912, uses an annual assessment on inpatient services provided by hospitals and on non-Medicare premiums collected by health maintenance organizations (HMOs) to improve and expand health care in Kansas for low income persons. The assessment paid

by hospitals and HMOs is used as a state match to draw down additional federal funding. Some hospital providers that are state agencies, state educational institutions, or critical access hospitals are exempt from the provider assessment. The state mental health hospitals and developmental disability hospitals also are exempt. The hospital provider assessment amount is an annual assessment of 1.83 percent on hospital inpatient services of net inpatient operating revenue. The HMOs' assessment amount is an annual assessment of 5.9 percent of net revenue. No funds collected through HCAIP are allowed to be transferred to the State General Fund at any time.

The 2012 Legislature passed HB 2416 which changed a hospital's base fiscal year for net inpatient operating revenue used to calculate the hospital provider assessment. The bill amended the statute which addresses the annual assessment on inpatient services imposed on each hospital provider to base the assessment on an amount equal to 1.83 percent of each hospital's net inpatient operating revenue for FY 2010. If a hospital does not have a complete 12-month FY 2010, the assessment will be $200,000 until the hospital has completed it first 12-month fiscal year, at which time the assessment will be 1.83 percent of the net operating revenue of such hospital's first completed 12-month fiscal year.

The hospital portion of HCAIP stipulates that not less than 80.0 percent of the funds collected from the hospital provider assessment can be disbursed to hospital providers through a combination of Medicaid access improvement payments and increased Medicaid rates on designated diagnostic-related groupings, procedures, and codes. In FY 2012, this resulted in a net revenue of $47.6 million from all funding sources. In addition, no more than 20.0 percent of the funds collected from hospital provider assessment can be disbursed to doctors or dentists through increased Medicaid rates on designated procedures and codes. Finally, not more than 3.2 percent of the funds collected from the hospital provider assessment can be used to fund health care access improvement programs in undergraduate, graduate, or continuing medical education, including the Medical Student Loan Act.

The HMO's portion of HCAIP stipulates that no less than 53.0 percent of the funds collected from the HMO provider assessment can be disbursed to HMOs that have a contract with SRS through increased Medicaid capitation rates. In addition, no more than 30.0 percent of the funds collected from the HMO provider assessment can be disbursed to fund activities to increase access to dental care, primary care safety net clinics, increased Medicaid rates on designated procedures and codes for providers who are persons licensed to practice dentistry, and Home and Community-Based Services. Finally, not more than 17.0 percent of the funds collected from the HMO provider assessment can be disbursed to pharmacy providers through increased Medicaid rates.

Nursing Facility Provider Assessment

In 2010, Senate Sub. for Senate Sub. for Sub. for HB 2320 was enacted and established a provider assessment program for skilled nursing facilities for up to $1,950 on each licensed bed within skilled nursing care facilities, which includes nursing facilities for mental health and hospital long-term care units and excludes the Kansas Soldiers' Home and the Kansas Veterans' Home from the assessment. As of June 30, 2012, there were 307 licensed skilled nursing facilities in Kansas operating as Medicaid providers.

Skilled nursing care facility licensed beds that are excluded from qualifying to be assessed up to the full amount of $1,950 include: continuing care retirement facilities (defined as facilities which must hold a certificate of registration from the Commissioner of Insurance); small skilled nursing care facilities (defined as less than 46 licensed nursing beds); and high federal Medicaid volume skilled nursing care facilities (defined as facilities which have more than 25,000 federal Medicaid days). The amount assessed to these identified skilled nursing care facilities can not exceed one-sixth, or a maximum of $250, of the actual amount assessed for the other skilled nursing care facilities.

All funds collected through the Nursing Facility Provider Assessment are used to finance initiatives designed to maintain or increase the quantity and

quality of nursing care in licensed facilities. No funds can be transferred to the State General Fund at any time or used to replace existing funding. If any additional funds are available, they must be used for an increase of the direct health care costs center limitation up to 150.0 percent of the case mix adjusted median, and then for approved quality enhancement for skilled nursing facilities. At no point would any amount of the assessed funds be allowed to provide for bonuses or profit-sharing for any officer, employee, or parent corporation. Assessed funds may be used to pay employees who are providing direct care to a resident in a skilled nursing facility.

The provider assessment originally was to sunset after the first four years of implementation, which would be July 2014. After the first three years or July 2013, the assessment amount was to be adjusted to be no more than 60.0 percent of the assessment collected in previous years. During the first year of the Nursing Facility Provider Assessment, which started in July 2010, the assessment was used exclusively to pay for administrative expenses incurred by the Kansas Department on Aging (KDOA), increased nursing facility payments to fund covered services to Medicaid beneficiaries, restoration of the 10.0 percent provider reduction in effect for dates of service from January 1 through June 30, 2010, and restoration of funding for FY 2010 rebasing and inflation to be applied to rates in FY 2011. During the second year of the Nursing Facility Provider Assessment, the 2010 10.0 percent provider reduction no longer needed to be restored, but increased payments to nursing facilities, reimbursement of administration costs, and re-basing and inflation were applied. In FY 2012, the provider assessment resulted in $30.2 million from all funding sources for increased payments to providers.

The 2013 Legislature passed House Bill 2160 which amends the statute that created a provider assessment on licensed beds in skilled nursing care and eliminated the sunset provision in the law. The expiration of the assessment program was extended for two additional years, or until July 1, 2016. The bill also eliminated the provision directing that after the first three years the assessment amount was to be adjusted to no more than 60.0 percent of the assessment collected in previous years.

Developmental Disabilities Provider Assessment

Legislation enacted in 2011 (Senate Bill 210) created a provider assessment model for Home and Community Based Services/Developmental Disabilities (HCBS/DD) providers based assessments on the gross revenues received for providing services to individuals with developmental disabilities. Gross revenues exclude any charitable donations. The assessed funds may be used to draw down additional federal match funds that can be used for enhanced rates to providers.

Currently, HCBS/DD providers are waiting approval by CMS to participate in a provider assessment model. Should CMS authorize approval of this class of providers and then subsequently approve a Kansas waiver submission to add this provider class, then 2011 Senate Bill 210 establishes a provider assessment for developmental disabilities providers that would be implemented in the fiscal year these two authorization approvals are granted and would sunset four years after implementation. As of September 2013, the two authorization approvals have not occurred. Should this situation change, 2011 Senate Bill 210 requires the provider assessment to be implemented within 30 days of authorization approval. No funds generated by the provider assessment can be allowed to be transferred to the State General Fund at any time or be used to replace existing funding.

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