Kansas Hospital Association

To: Kansas Department of Health and Environment
From: Jaron Caffrey, Vice President of Government Relations & Policy
Date: August 11, 2026
RE: KDHE Stakeholder Meeting and Hospital Requests

Thank you for the opportunity to provide input on behalf of our 124 community hospital members. We appreciate KDHE's partnership in strengthening Kansas' health care ecosystem and believe strategic budget and policy investments will help ensure Kansans can receive the best care possible no matter where they live in our state.

In Kansas, 81 percent of our hospitals had a negative operating margin in 2024, and our hospitals' average cash on hand sits at 69 days, while the national average is 200 days. Meanwhile, in the last three years hospital operating expenses have increased by more than 38 percent. Kansas hospitals are now relying on more than $110 million in city and county tax support, while shouldering approximately $2 billion of uncompensated care, leaving more hospitals increasingly vulnerable to service reductions and facility closures.

We are grateful for the work of KDHE staff and leadership to ensure the Provider Assessment Program is implemented as the state legislature intended and to comply with new federal requirements. We believe there are several opportunities to build upon the progress made over the past few years that can be addressed in the next budget to strengthen the ability of Kansans to receive the right care at the right time.

Update the Behavioral Health Bed Add-On Payment

Kansas hospitals continue to struggle with the cost of caring for behavioral health patients. As the agency and legislature continue to evaluate supplying the number of beds needed to address growing demand across the state, we ask that the agency seek additional state funds for the identified non-state hospitals that have behavioral health beds. The current appropriation of $10 million should be increased to $11 million to account for a hospital that has added 8 beds since last year and another hospital looking to add 20 beds, while also providing a slight inflationary adjustment.

Request for Alignment of Payment Methodologies

KHA requests that KDHE evaluate the current Medicaid Intermediate Swing Bed (ISB) reimbursement methodology in light of a recent federal change that has created an unintended financial burden for Critical Access Hospitals.

As you know, CMS, through our Medicare Administrative Contractor (WPS), recently determined that the methodology previously used to establish Kansas' statewide Nursing Facility (NF) rate for Medicare cost report swing bed carve-outs did not comply with federal regulations. Specifically, CMS concluded that the statewide average NF rate should be calculated using a straight average of NF rates rather than a weighted average based on Medicaid patient days. WPS has implemented this corrected methodology prospectively beginning with calendar year 2026. While hospitals understand and support compliance with federal requirements, the change has created a significant disconnect between Medicare cost reporting requirements and Kansas Medicaid reimbursement for Intermediate Swing Bed services.

Today, Critical Access Hospitals are required to remove costs from their Medicare cost reports using a NF rate that is substantially higher than the Medicaid reimbursement rate paid for those same patient days. As a result, hospitals are effectively required to carve out more allowable costs than Medicaid reimburses, creating a financial loss on Medicaid ISB residents before considering the additional impact on overhead cost allocation.

For example, under the previous methodology, the Medicare cost report carve-out and the Medicaid reimbursement rate were generally aligned. Under the new methodology, however, a hospital caring for ten Medicaid ISB days could receive approximately $1,940 in Medicaid reimbursement while being required to remove approximately $2,660 from allowable Medicare costs, resulting in an immediate loss before considering the associated reduction in Medicare reimbursement resulting from the higher cost report carve-out.

This issue is particularly significant for rural communities with CAHs, many of which rely on their swing bed programs to provide local post-acute care services. As the gap between the Medicaid payment rate and the federally required cost report carve-out widens, hospitals are increasingly faced with financial disincentives to continue serving Medicaid ISB residents. Without adjustments, this could ultimately reduce access to local post-acute care for Medicaid beneficiaries, increase pressure on already limited NF capacity, and require patients to travel farther from their communities to receive needed services.

We recognize that the annual Medicaid Intermediate Swing Bed rate is developed using established state methodology and historical claims data. However, because the Medicare cost reporting requirements have fundamentally changed, we believe it is appropriate to review whether the current reimbursement methodology continues to adequately recognize the actual costs hospitals are now required to absorb under federal regulations.

Accordingly, KHA respectfully requests that KDHE evaluate the current Medicaid ISB reimbursement methodology and consider modifications that better align Medicaid reimbursement with the federally required Medicare cost report carve-out methodology. Aligning these methodologies would improve consistency, reduce unintended financial losses for hospitals, and help preserve access to Intermediate Swing Bed services throughout rural Kansas.

Health Care Upskilling and Training Grant Program

This program was established in the last fiscal year to help health care facilities expand the skills and capabilities of their existing workforce in response to persistent recruitment challenges across Kansas. Hospitals, clinics, and long-term care facilities received grants that enabled them to upskill health care professionals in communities throughout the state. KDHE awarded the full $1 million appropriation to 28 organizations, demonstrating strong demand for the program. However, significant need remained unmet due to funding limitations. An additional 19 organizations applied or expressed interest but could not receive support largely because available HCUT funds had been fully obligated. Collectively, these organizations proposed workforce upskilling projects totaling more than $728,000, demonstrating the substantial demand for and value of this program. KHA recommends reauthorizing the HCUT Grant Program with a $2 million appropriation to expand this successful workforce development initiative and help ensure communities have greater access to health care professionals practicing at the top of their licensure.

Centralized Credentialing

KHA encourages KDHE to maintain the centralized credentialing provisions included in KanCare 3.0 for future MCO contracts. Additionally, we hope that the agency will continue to participate and convene necessary stakeholders in conjunction with the credentialing verification organization being piloted within the Rural Health Transformation Program to move the state closer to a true centralized credentialing process that will reduce unnecessary administrative burdens and costs across the health care ecosystem.

We appreciate KDHE's continued partnership and look forward to working collaboratively to advance these priorities. Each of these recommendations reflects practical opportunities to strengthen access to care, support the health care workforce, and improve the long-term sustainability of Kansas hospitals and the patients they serve.