Request

The state of Kansas respectfully requests a technical amendment to the current 1115 Waiver’s budget neutrality (BN) calculation. This change will allow the State to institute comprehensive reforms intended to bring the Health Care Access Improvement Program (HCAIP) more in line with CMS directed payment policies, resulting in payments tied more directly to utilization of services, and improvement in the quality of those services. We understand that CMS has a responsibility to closely scrutinize any request for revisions to budget neutrality during a waiver period, and we hope that this document provides the relevant justification for doing so considering Kansas’ unique circumstances.

Introduction

In July 2019 an amendment to the KanCare 1115 demonstration was submitted to account for proposed structural changes to the program to increase transparency and improve access to care that had resulting impacts on program budget neutrality. The existing waiver program was initially approved in 2012 for a 5-year period through December 31, 2017. In October 2017, a temporary one-year extension of the program was granted through December 31, 2018 and a 5-year renewal was granted at the end of 2018 through December 31, of 2023.

Factors for Supporting the KanCare Technical Amendment Approval

We understand CMS’ concerns regarding the requested adjustments to the budget neutrality calculations; however, we believe that Kansas’ unique circumstances more than justify the proposed revisions.

1) Alignment of HCAIP with State and CMS Priorities

Currently under HCAIP, hospitals and professionals receive enhanced rates for services based on utilization. The proposed program changes will continue to be made through base rate adjustments; however, the directed payment authority allows the state to better monitor program spending. The program will be aligned with quality goals, increase transparency, and allow for improved program monitoring and control. While still linked to utilization, the new program will also provide an enhanced focus on outcomes.

Under the current program, providers are reimbursed on a fee for service basis, as there is a percentage tied to each code specific to HCAIP. The current HCAIP methodology for reimbursing providers is no longer in line with the Kansas managed care service delivery model, as there is no direct link to the quality strategy, and there is no incentive tied to improving outcomes. Kansas is seeking to align the provider assessment model to be more reflective of the current environment, where providers are eligible to earn enhanced payments for improving health outcomes. This strategy syncs the efforts of the providers and the managed care organizations with the goals of the Medicaid program, and the resulting program will be directly tied to the State’s quality strategy. This is the direction that CMS has asked states to move, and the new program design will put Kansas on track to achieve that goal.

As Administrator Verma said in her address at the Fall NAMD Conference on November 12, 2019, “(W)e must be more innovative in how we operate our programs. We should not ration care but instead make how we pay for care, more rational. In other words, Medicaid must move towards value-based care.”
Approving our BN amendment request will provide the path to update the HCAIP program, thus moving the Kansas Medicaid program that direction.

2) Protecting Rural Hospitals
Since 2010 over 110 rural hospitals have closed nationally. Five of those closures were Kansas hospitals. Being a largely rural state, Kansas is committed to ensuring access to care for our Medicaid enrollees by protecting rural providers. More than half of all hospitals in Kansas are designated as critical access hospitals (CAHs), and an additional 21 are non-CAH rural hospitals. CAHs do not pay the HCAIP assessment, but they do receive the HCAIP-funded rate enhancements. Without these needed revisions to HCAIP, the already low hospital reimbursement rates will likely need to be cut. Any decrease in rates will severely jeopardize our provider network, putting the health of rural Kansans at risk.

The HCAIP program funds more than hospital rates, as mandated by state statute. It provides supports for physician rates as well – a critical component of the Kansas Medicaid program. Without these change to the provider assessment, physician rates would also have to be reduced, putting at risk the primary care safety net in Kansas. One of the primary objectives of the KanCare model is to increase primary care visits, while simultaneously reducing costly inpatient hospital stays. With the risk of reducing physician rates absent an update to the HCAIP program, the efforts behind this strategy would be unnecessarily hampered. Sufficient reimbursement rates across the provider spectrum are a key component of providing a balanced network, maintaining the efficacy of managed care.

3) Technical Amendment
Managed care can be authorized through various authorities, and the technical amendment under consideration would be a change completed by the state to support the integrity of the managed care program and provider capacity regardless of the source of program authority. This change does not require a new expenditure authority but can be considered a technical BN adjustment to align the program with the state legislative requirements.

CMS committed to making a technical amendment to the current BN calculation to correct a CMS omission of base data from the approved calculations that was discovered by the State’s actuary prior to the submission of the HCAIP amendment request. Given that the changes related to the new HCAIP amendment are technical in nature, CMS would simply need to calculate the effect of the data omission in concert with the HCAIP changes, thus making one single technical amendment to the BN calculation. The HCAIP specific changes to the BN calculation will be applied equally to both the base and the with waiver sides of the equation; the State will maintain the trend rates and condensed MEG structure that were given during waiver renewal and will make no other substantive changes to the calculation. The State recognizes that there are sure to be substantive benefits to the program as a result of these changes, but the mere fact that there are substantive benefits does not preclude the amendment from being technical in nature; the two are not mutually exclusive.

In addition, many years of managed care and cost containment actions by the state of Kansas created substantial savings for both the state and federal government. Those savings resulted in artificially low trend factors that now jeopardize the state’s ability to assure access and comply with the requirement that rates are consistent with efficiency, economy, and quality of care. Had the proposed rate changes been implemented prior to the waiver the spending would have been included as part of the with and without waiver calculations and therefore would not have had a material impact on budget neutrality.
As CMS and KDHE work to correct the budget neutrality calculation, base spending should be adjusted to reflect a more accurate base spending that includes directed payments.

4) Most Recent Waiver Negotiation
As part of this waiver renewal, the without waiver budget neutrality was rebased at the request of CMS in alignment with the August 2018 Budget Neutrality Guidance, three years ahead of the proposed schedule of approvals occurring after January 2021. This resulted in Kansas giving up well over a billion dollars in accrued savings prior to the required timeframe. As Kansas was renewing its waiver, CMS released new phase-down guidance to states, which appeared to be aimed at states with decades of accrued savings in their programs. The interpretation of this new guidance was communicated to Kansas a year after its BN submission, and had a significant adverse impact on the Kansas calculations, greatly diminishing the State’s ability to have any flexibility or add any innovation to the program. Kansas had two of its MEGs placed on an accelerated phase-down schedule, even though the KanCare program was only in its sixth year of existence.

While Kansas applauds and supports CMS’ efforts to control costs across programs, the State has again found itself in a situation where CMS guidance appears to be directed at ensuring outlier states do not manipulate calculations, while limiting other states’ abilities to make any changes to their programs. If CMS imposes restrictions on Kansas’ ability to make a technical amendment to its budget neutrality, Kansas will be unable to move in the direction that CMS is encouraging states to move with reimbursement (pay for value rather than pay for volume).

5) Timing/Legislative Intervention
Kansas had been reviewing alternatives to the HCAIP program for some time prior to its submission to CMS, as the legislature and other stakeholders were concerned that the current program had become less transparent in a managed care delivery system. Several studies were commissioned to determine the program specifics and its impact on State spending. In early 2018, after receiving conflicting reports, the Kansas Legislature halted changes to the current HCAIP program and ordered a Legislative Audit of the program. This audit was conducted over the summer of 2018 and was delivered to the Legislature during an interim committee hearing in September of 2018 – well after the 2018 session had ended, and only a few months before the 1115 Waiver was to be renewed. The timing of these events precluded KDHE from having the legislative authority to update the provider assessment and from including the changes in the newest BN calculation.

Conclusion
The State has demonstrated that there was a confluence of unique circumstances impacting the timing of the request, which will allow CMS to view this request as unique to Kansas. By granting approval of this technical amendment, CMS will allow Kansas to make needed reforms to its HCAIP program, ensuring the program is aligned with CMS’ goal of shifting toward value-based reimbursement and incentivizing improved outcomes. The State thanks CMS for this opportunity to discuss this request and looks forward to a favorable outcome.
Background on HCAIP Program

In 2013, Kansas shifted virtually the entire Medicaid population into KanCare, a comprehensive managed care program, through an 1115 Demonstration Waiver. With this shift, in addition to the creation of a fixed uncompensated care pool, Kansas committed to continue to utilize the Kansas HCAIP, the hospital provider assessment fund, to fund Medicaid rate enhancements previously in place for inpatient and outpatient hospital payments as well as certain professional fees. These enhancements were set at approximately 25.8% for inpatient and outpatient services. For professional services, the level of enhancement varied by line item on the fee schedule but averaged about 50%. Since then, Kansas has made small adjustments to the enhanced rates for inpatient and outpatient services (current levels are 23.1%), but the structure of the program remains intact.

Despite the rate enhancement expenditures varying based on the utilization of Medicaid services, the state collected a fixed amount from HCAIP assessment. Therefore, as the years progressed, KDHE and state policymakers raised concerns that the HCAIP collection was not sufficient to fully fund the rate enhancements. Between 2015 and 2018, the state conducted analyses and audits to try to estimate the total enhancements funded by the program; however, as the enhancements were paid directly from the managed care organizations to hospitals and professionals through claims, expenditures were difficult to track. By 2019, the consensus was that the program was overspent and if the program structure was not revised, providers could face cuts to reimbursement to make up the difference.

To create transparency and a more sustainable program for both the KDHE and hospitals, a new HCAIP structure was proposed in 2019 House Substitute for Senate Bill 25. This new structure draws on the federal authority granted under 42 CFR § 438.6 to convert the historical rate enhancements to base rate increases utilizing directed payments—payments that improve the state’s ability to track expenditures, that require annual reassessment, and that tie to the state’s quality goals. The revised program also provides additional funding for base rate increases to hospitals, as payment levels have been largely stagnant (within 5 percent) over the last ten years.

The table below details the differences between the current HCAIP structure and the proposed HCAIP structure.

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<tr>
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<th>Current HCAIP Structure</th>
<th>Proposed HCAIP Structure</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td><strong>Assessment Rate</strong></td>
<td>Fixed at 1.83%</td>
<td>Fixed at 3.00%</td>
<td>Increased collection to address program overspend, increase rate enhancements; still well below allowable limit, and lags spending of</td>
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<td><strong>Assessment Base</strong></td>
<td>Fixed at 2010 Inpatient Net Revenue</td>
<td>Starts at 2016 Total Net Revenue, Rolls Forward Annually</td>
<td>Better aligned assessment base with current utilization</td>
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<td><strong>UCC Pool</strong></td>
<td>Fixed $41 Million Spending, With</td>
<td>Fixed Spending $41 Million Spending, All</td>
<td>Streamlined uncompensated care payments per CMS request</td>
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<td><strong>Targeted Adjustments</strong></td>
<td><strong>Hospitals Receive Uniform Adjustment</strong></td>
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<td><strong>Enhancements to Inpatient and Outpatient Hospital Rates</strong></td>
<td>Fee Schedule Adjustment Included in Claims, Difficult to Track</td>
<td>Directed Payment, Quarterly Based on Services Provided, Continuously Tracked at the State Level</td>
<td>Improved program transparency and enhance access to care. In current structure included on both with and without waiver.</td>
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<td><strong>GME and Professional Fee Payments</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Continued to support access to medical education and professional services. In current structure included on both with and without waiver.</td>
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<td><strong>Program Over/Under Spend</strong></td>
<td>Yes, Varies Across Years, Difficult to Track</td>
<td>No</td>
<td>Spending will be continuously tracked and rates will be adjusted as needed consistent with state legislation</td>
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