Kansas Medicaid DSH Reform Open Meeting

Kansas Historical Society and Museum
6425 SW 6th Avenue, Topeka, KS
July 24, 2018

AGENDA

- Background and DSH Reform Process
- Overview of Current DSH State Plan Amendment (SPA)
- Key Reform Objectives
- Proposed SPA Changes
- Discussion and Feedback
- Next Steps

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Background

Fall 2015 – KDHE approached KHA regarding potential changes to the Medicaid SPA. (Last major revisions were for the 2008 DSH year.)

Nov. 2015 – DSH Steering Committee convened first meeting.

Dec. 2015 – KHA hosted a DSH webinar open to all hospitals to allow discussion and to provide recommendations on potential DSH changes.

DSH Steering Committee Recommendations

February 3, 2016

- Revise Charity Care Definition for DSH Eligibility
- Review Transition Provision (Hold Harmless) for CAHs
- Add Vital Encounter Data Elements for the DSH Surveys
- Extend the DSH Survey Timelines
- Clarify Low Income Utilization Rate (LIUR) Calculation Within the SPA
- Review the Loss of DSH Payment Eligibility
- Review Medicaid Inpatient Utilization Rate (MIUR) Calculation for DSH Eligibility
- Provide DSH Education for Hospitals

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DSH Steering Committee Recommendations

- Make Initial Changes That Would Not Require a SPA Change
- Monitor Changes for a Minimum of One Year to Ensure No Unintended Consequences
- Consider Additional Changes Requiring SPA Changes
  - Develop Goals for SPA Changes
  - Model Various Changes

2017 DSH Changes – Charity Care

- Charity Care Definition Revision (for DSH Eligibility)
  - Charity Care is considered to be any unpaid charge for patients receiving hospital services where a reasonable effort has been made to collect the charge. Charges considered within this definition shall be accounted for on the date of write-off. Charity Care charges would include the following:
    a. Charges for hospital services approved as Charity Care within the hospital's Charity Care policy
    b. Charges for hospital services for unpaid Medicaid spend down amounts
    c. Charges for hospital services to uninsured patients that have been written off as bad debt after normal collection efforts. It would also include any uninsured discount not billed to the patient. Deductibles and coinsurance for insured patients written off to bad debt are not considered Charity Care charges. Documentation to support Charity Care must be maintained by the hospital and is subject to review

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2017 DSH Changes – Data

- Expanded Patient Encounter Data Sets
  - Include hospital patient account number
- Hospitals May Self-Report Data
  - Reconciliation must be submitted between self-reported data and data provided by the state
  - Revenue working trial balance by payer/contract
  - If submitting internally-generated data, patient detail ***must*** be submitted using the new Exhibit C format (DSH Survey Exhibit A-C Hospital-Provided Claims Data.xlsx on tab Exhibit C)

2017 DSH Changes –DSH Timelines

- Increased From 30 to 45 Calendar Days for Submission of DSH Survey
- Ability to Upload DSH Submission Using Myers & Stauffer Web Portal

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2017 DSH Changes – LIUR Calculation

- Resolved Conflicting Definitions of LIUR in the State Plan Amendment. (Definition From Section 6.1000(D) Used.)
  - Kansas Medicaid Fraction
    - Hospital cash subsidies have been removed from the denominator
    - Formula: (Medicaid Hospital Net Revenue + Hospital Cash Subsidies)/Net Inpatient Hospital Revenue

Potential Changes for 2020 DSH Program

- Carry Over from Feb. 3, 2016 DSH Steering Committee Recommendations
  - Transition Provision (Hold Harmless) for CAHs
  - Loss of DSH Payment Eligibility
  - MIUR Calculation for DSH Eligibility
  - Other

Reform Process

- Review the Federal Statutory Requirements of Medicaid DSH
- Review SPAs from Other States
- Develop a Set of Principles of Medicaid DSH Reform
- Establish Timeline for Implementation for 2020 DSH Year
- Review Various Models for Proposed SPA Changes
- Provide Open Meeting to Review Proposed Changes
- Allow Comment Period for Proposed Changes

Principles of Kansas Medicaid DSH

The Division of Health Care Finance is proposing reforms to the current Medicaid Disproportionate Share Hospital (DSH) program which currently provides over $45 million in federal funds annually to the state. The goals of these reforms are to:

- Maintain the state's support for the DSH program and devise a formula that always expends the maximum amount allowed by Federal regulations;
- Direct resources equitably towards hospitals that provide a high level of services to Medicaid beneficiaries and the uninsured;

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Principles of Kansas Medicaid DSH

*(*continued)

- Develop a methodology that updates the critical access hospital hold harmless provision (transition payment), and that is equitable to all critical access hospitals.
- Develop a transition period from the current Medicaid DSH plan to the revised DSH plan to protect the financial stability of DSH eligible hospitals.
- Review the formula to ensure payments are reasonably related to the cost of caring for the Medicaid eligible individuals and the uninsured for the State of Kansas.

Principles of Kansas Medicaid DSH

(continued)

- Treat losses equally whether attributable to Medicaid, or uninsured (inpatient or outpatient) services;
- Ensure the continued predictability and stability in DSH payments over time.

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Recommendations from March 6, 2018 DSH Steering Committee Meeting

- KDHE will review Section 1923(h) of the Federal requirements of Medicaid DSH regarding the 33% limit of DSH funds for Institution for Mental Disease (IMD) hospitals, to determine if that is a set percentage or a maximum percentage. Discussion was held that due to the behavioral health crisis in Kansas, we may not want to recommend any changes to lower this percentage.
- Review Section 6.3000-A(a) for out-of-state hospitals. In 2018, Children's Mercy of Kansas City, MO received $3.6 million, and Mercy Hospital, Joplin, MO received $131,000.

Recommendations from March 6 Meeting

(continued)

- Make no changes to Section 6.3000-A(b) for State-owned or operated teaching facilities, which is a separate funding for the University of Kansas Hospital. Currently, KU receives .25% of the Federal DSH allotment for the State of Kansas and has negative uncompensated care costs.
- Review the burden methodology contained in Section 6.300-D to determine if an adjustment should be made.

Recommendations from March 6 Meeting
(continued)

- Review the Transition Provisions outlined in Section 6.4000. Options discussed include:
  - A transition of the CAHs to a separate pool of DSH funds or a separate higher adjustment factor.
  - A transition period for all hospitals over a specified period (i.e. 3 years) to reduce or "smooth" the impact of the SPA changes.
  - A "cliff" provision that allows hospitals that lose eligibility to receive 50% of their previous year's DSH payment.

Recommendations from March 6 Meeting
(continued)

- Review the Medicaid DSH SPAs from neighboring states such as Iowa, Nebraska and Oklahoma for ideas to update the Kansas SPA.
- Myers and Stauffer should perform an analysis and review to explain the significant disparities in DSH payments from the top three hospitals and the other remaining hospitals.

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FY 2020 DSH SPA Timeline

Task		Responsibility	Start Date	Duration	Projected End Date
1	Initial SPA language drafted	DSH Steering Committee			7/20/2018
2	Draft approved	DSH Steering Committee	7/20/2018		7/20/2018
3	Draft submitted for AD Staff agenda	KDHE Institutional Reimbursement	7/25/2018		7/25/2018
4	KDHE Ad Staff review	KDHE Institutional Reimbursement	7/30/2018		7/30/2018
5	Deliver final draft & written notice to KDHE Contracts	KDHE Institutional Reimbursement	8/6/2018	8 days	8/14/2018
6	SPA draft sent to Secretary of State's office for placement on register for public comment	KDHE Contracts	8/14/2018	10 days	8/23/2018
7	Public Notification & Comment Period	Public & Tribal Nations	8/23/2018	30 days	9/24/2018
8	SPA submitted to CMS	KDHE Contracts	9/25/2018		9/25/2018
9	CMS Review Period (tentative)	CMS	10/1/2018	90 days	12/31/2018
10	SPA approved for effective date 1/2/2019	CMS	1/2/2019		1/2/2019

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT
DIVISION OF HEALTH CARE FINANCE
LANDON STATE OFFICE BUILDING
900 SW JACKSON, SUITE 900 N
TOPEKA, KS 66612-1220

PHONE: (785) 296-3981
FAX: (785) 296-4813
WWW.KDHEKS.GOV

GOVERNOR JEFF COLYER, M.D.
JEFF ANDERSEN, SECRETARY

Medicaid Disproportionate Share Hospital (DSH) Program Reform for Kansas

June 2018

The Kansas Department of Health and Environment (KDHE) is proposing reforms to the current Medicaid Disproportionate Share Hospital (DSH) program based on recommendations from a collaborative workgroup including the Kansas Hospital Association's (KHA) Medicaid DSH Steering Committee, and Myers and Stauffer, the State's Medicaid DSH contractor. The workgroup began meeting in the fall of 2015 with the overall goal of updating the DSH program to provide fair and equitable distribution of DSH funds to hospitals providing care to Medicaid beneficiaries and the uninsured.

The last major revisions to the DSH program were implemented in 2008. In the past ten years, there have been changes that have demonstrated a need for revision to the State Plan Amendment (SPA) for DSH, including: shifts in hospital losses due to uncompensated care, an increase in Medicaid enrollment, and most significantly, the implementation of managed care in Kansas (KanCare).

In February of 2016, the KHA Medicaid DSH Steering Committee submitted formal SPA reform recommendations to KDHE. Recommendations not requiring a new SPA were implemented in the 2017 DSH year. After careful review of the impact of those changes on the 2017 and 2018 DSH years, KDHE determined that additional changes to the DSH program should be considered.

The guiding principles of the DSH program reform, as identified by the collaborative, are to: a) Maintain the State's support for the DSH program and to continue to expend the maximum amount allowed by Federal regulations; b) Direct resources equitably toward hospitals that provide a high level of service to Medicaid beneficiaries and the uninsured; c) Formulate an allocation methodology that is equitable to critical access and rural hospitals; d) Treat losses equally whether attributable to Medicaid or uninsured inpatient and outpatient services; e) Improve predictability and stability of DSH payments over time; f) Develop a transition period from the current Medicaid DSH plan to the revised DSH plan to protect the financial stability of DSH eligible hospitals.

Review of Modeling

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Kansas Department of Health and Environment

DSH Payment Methodology

Planned 2018 formula adjustments building from prior 2008 reforms

Kansas Department of Health and Environment

Thank you to the Steering Committee and for all key stakeholder input over the past two years as we have considered many diverse perspectives in our final recommendations.

Kansas Hospital Association

Hospitals & KHA Staff

Myers and Stauffer LC Certified Public Accountants

Myers and Stauffer, LC

What is DSH?

- Federal law requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals.
- Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation (FFP) for total statewide DSH payments made to hospitals. Federal law also limits FFP for DSH payments through the hospital-specific DSH limit.
- Under the hospital-specific DSH limit, FFP is not available for state DSH payments that are more than the hospital's eligible uncompensated care cost, which is the cost of providing inpatient hospital and outpatient hospital services to Medicaid patients and the uninsured, minus payments received by the hospital on or on the behalf of those patients.

https://www.medicaid.gov/medicaid/finance/dsh/index.html

What DSH is not….

A lifeline or payment system intended to keep hospitals from closing.

Our responsibility….

To ensure an equitable formula is established that transparently disburses eligible funds to providers that serve a higher proportion of Medicaid and uninsured Kansans, and to routinely review that formula to ensure it is meeting disbursement objectives.

Concerns with past methodology:

- Instability – very large changes in DSH payments from one year to the next for any given hospital
- Inequity – communities are treated unequally by the DSH formula
- Methodology and outcomes are not frequently reviewed and has not kept pace with changes in the industry; the healthcare landscape is different today than in 2007

2018 Key DSH Reforms: Creation of a 500+ Bed Pool

- Prompted by limited DSH funds available and the percentage of the allotment these hospitals are being paid.
- Historically, 32% of the total non-IMD allotment. A slight change in the UCC of hospitals in this pool significantly impacts funds available to other hospitals.
- Establishment of this pool helps stabilize funds available for majority of Kansas hospitals receiving DSH payments.
- Substituting Medicaid and uninsured days to measure burden. This addresses some concerns of cost structure differences between hospitals while still capturing higher acuity. Hospitals in the pool with higher Medicaid days benefit from the methodology since the hospital would be allowed to include the days in their burden even with higher Medicaid payments (which would lower their true UCC)

2018 Key DSH Reforms: Combining CAH & Other Rural Hospitals

- All rural hospitals provide necessary and essential services to our Medicaid beneficiaries
- Develops a methodology that is equitable to all hospitals serving rural Kansans

Next steps:

- KDHE, KHA, and Myers & Stauffer will be available for discussion after the presentation today for any questions you may have about the projected impact on your hospital.
- Public Comment period will be publicized upon completion of the State Plan Amendment.

www.KanCare.ks.gov

For additional follow-up after today's session, please contact:

Rowena Regier
Institutional Reimbursement Manager
Kansas Department of Health and Environment
Division of Health Care Finance
900 SW Jackson #900 N
Topeka, KS 66612
rowena.regier@ks.gov
Office: 785.291.3625

Carla Williams, CPIP, MPA
Medicaid Reimbursement Analyst
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson, #900 N
Topeka, KS 66612
carla.williams@ks.gov
Office: 785.296.7762