PERFORMANCE AUDIT REPORT

Medicaid: Comparing Health Care Provider Tax Revenues to Increased Provider Reimbursement Rates

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
Sept. 2018

R-18-010

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To: Members, Legislative Post Audit Committee

This report contains the findings, conclusions, and recommendations from our completed performance audit, *Medicaid: Comparing Health Care Provider Tax Revenues to Increased Provider Reimbursement Rates*. The audit was requested by Senator Jim Denning. The audit team included Andy Brienzo, Daria Milakhina, and Ben Rogers. Chris Clarke was the audit manager.

We would be happy to discuss the findings, conclusions, and recommendations presented in this report with any legislative committees, individual legislators, or other state officials.

Sincerely,

Justin Stowe
Legislative Post Auditor

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Medicaid: Comparing Health Care Provider Tax Revenues to Increased Provider Reimbursement Rates

Background Information

Through a mix of state and federal funds, Medicaid pays for health care services incurred by low income individuals. These services include doctor visits, hospital stays, lab services, and home health services. The federal government guarantees matching funds to states for qualifying Medicaid expenditures. The amount of this federal match varies by state and is calculated based on how each state's per capita income compares to the national average. In fiscal year 2018, the federal government covered about 55% of Kansas' Medicaid costs through matching funds.

To increase the federal funds for which a state is eligible, the federal Centers for Medicare and Medicaid Services (CMS) allows states to tax health care providers. The state uses the revenue it collects from these taxes to increase the rates it pays providers for qualified Medicaid services. This increases the state's total Medicaid expenditure amount and allows it to draw down more federal match funding as a result. Although providers must pay this tax, they subsequently benefit from increased state and federal Medicaid spending. Kansas assesses such taxes on hospitals and nursing facilities. Currently, 49 states and the District of Columbia have a health care provider tax of some kind.

Legislators have expressed concern the revenues raised by Kansas' hospital tax have not covered the state's share of the cost of the associated increased Medicaid reimbursement rates in recent years.

Objectives, Scope, and Methodology

On April 25, 2018, the Legislative Post Audit Committee approved Senator Jim Denning's request for an audit of the state's hospital tax. This performance audit answers the following question:

1. **Does the revenue generated by the state's hospital tax offset the state's cost of increased Medicaid reimbursements?**

To answer this question, we reviewed the results of two studies of Kansas' hospital tax commissioned by the Kansas Department of Health and Environment (KDHE). These studies were conducted by national consulting firms and completed during our audit. We tested the reliability of these reports by interviewing the consultants who worked on them and reviewing the methodologies and calculations they used to draw their conclusions. After determining these studies were reliable, we included their findings in our report. However, some of the information we reviewed is

proprietary and must be excluded from this report and kept confidential under K.S.A. 45-221(a)(2).

We interviewed KDHE staff and reviewed the controls the agency uses to ensure hospital tax fund expenditures comply with state law. We also attended the June 2018 meeting of the panel of stakeholders charged with overseeing Kansas' hospital tax.

To determine how Kansas' hospital tax compares to states with similar Medicaid systems, we reviewed documentation and interviewed staff from the Council of State Governments, Kaiser Family Foundation, National Conference of State Legislatures, and three comparison states.

We did not review the state's nursing facility tax as part of this audit. That is because this tax is administered as a separate program and is much smaller than the hospital tax program. Moreover, the requesting legislator expressed concerns solely about the expenditure of hospital tax funds through increased Medicaid reimbursement rates.

Compliance with Generally Accepted Government Auditing Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Medicaid is a Jointly Funded Government Health Insurance Plan for Low Income Individuals

Medicaid covers medical and long-term care for low income children and families, pregnant mothers, the elderly, and individuals with disabilities. Congress originally established Medicaid as part of the 1965 Social Security Act to provide health insurance at little or no cost to individuals who may otherwise have difficulty paying for their coverage. Medicaid covers health care services including medical and dental services. States can also participate in optional Medicaid programs, such as the Home and Community Based Service waiver program.

In fiscal year 2018, federal funds covered about $2 billion (55%) of Kansas' Medicaid costs and state funds covered the remaining $1.6 billion (45%). As a program for low income individuals, Medicaid generally does not require beneficiaries to pay for their health care services. Instead, states and the federal government pay the costs associated with beneficiaries' medical and long-term care services. Each state has a cost-share arrangement with the federal government called the Federal Medical Assistance Percentage (FMAP). The total FMAP funding a state receives depends on its per capita income, with lower income states receiving more federal assistance. In fiscal year 2018, the federal government covered about 55% of Kansas' Medicaid costs through matching funds.

Kansas' Medicaid Program Uses a Managed Care Model that Involves Numerous Federal, State, and Private Entities

In 2013, Kansas implemented KanCare, which brought nearly all Medicaid beneficiaries in Kansas under the managed care model. Prior to the implementation of KanCare, low income children and adults were already served under a form of managed care. However, individuals with disabilities and the elderly were served under a fee-for-service model. Today, KanCare serves 95% of Kansas' Medicaid beneficiaries.

Although the Kansas Department of Health and Environment has primary responsibility for KanCare, other entities also have roles in the program. Given the size and complexity of Medicaid, several federal, state, and private entities are involved in the oversight and administration of the state's Medicaid program.

- **The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for overseeing states' Medicaid programs.** States must report to CMS periodically on the status of their Medicaid programs and solicit CMS' approval for any changes to their Medicaid state plans.

- **The Kansas Department of Health and Environment (KDHE) administers the state's Medicaid program.** KDHE is responsible for administering Kansas' Medicaid program and periodically reporting to CMS to ensure federal compliance. The agency also contracts with two private companies to process the state's Medicaid eligibility determinations and three private managed care organizations to process and pay Medicaid claims from health care providers.

- **Three private managed care organizations (MCOs) pay providers' Medicaid claims.** KDHE contracts with three MCOs to compensate health care providers when they treat Medicaid beneficiaries. The MCOs receive monthly payments from KDHE. KDHE contracts with an actuarial firm to calculate the monthly payments to the MCOs.

- **Private health care providers treat Medicaid beneficiaries.** Hospitals and non-hospital providers such as physicians, surgeons, and dentists provide health care services to Medicaid beneficiaries. The state's three MCOs then reimburse them for providing these services. These reimbursement payments are based on the Medicaid rate schedule established by KDHE.

Question 1: Does the Revenue Generated by the State's Hospital Tax Offset the State's Cost of Increased Medicaid Reimbursements?

During calendar years 2016, 2017, and 2018, the revenue generated by the state's hospital tax did not fully cover the state's share of the increased cost of Medicaid payments made to providers. *In 2004, Kansas created the Health Care Access Improvement Program (HCAIP) to increase funding for Medicaid (p. 5). As intended, HCAIP has increased Medicaid payments to health care providers (p. 7). However, two recent consultant studies found the HCAIP fund does not fully cover the state's share of the cost of HCAIP's increased Medicaid payments (p. 9). In addition, HCAIP funds were not distributed as required by law in calendar year 2016 (p. 10). The Kansas Department of Health and Environment is only recently aware of the magnitude and underlying causes of HCAIP's overspending problem, which will require legislative or HCAIP panel action to resolve (p. 12).*

We also reviewed the hospital taxes of three states similar to Kansas and found their taxes generate significantly more revenue than Kansas' hospital tax (p. 14).

In 2004, Kansas Created the Health Care Access Improvement Program to Increase Funding for Medicaid

The Legislature created the Health Care Access Improvement Program (HCAIP) in 2004 to increase the state's Medicaid reimbursement rates for health care providers. Legislators likely saw this as a way to encourage providers to participate in Medicaid.

HCAIP requires most Kansas hospitals to pay an annual tax based on their net inpatient operating revenues. When HCAIP started in 2005, the Legislature required each hospital to pay an annual tax equivalent to 1.83% of the net revenue it earned from providing inpatient services in 2001. In 2012, the Legislature updated the year used for this calculation to 2010. Hospitals will continue calculating their annual tax payments using their 2010 revenues until the Legislature amends the law.

Most hospitals in Kansas are required to pay this tax. However, the HCAIP statute exempts certain hospitals, including hospitals run by state agencies, state educational institutions, critical access hospitals, and any hospital operated by the Kansas Department of Aging and Disability Services that focuses on mental health or developmental disabilities.

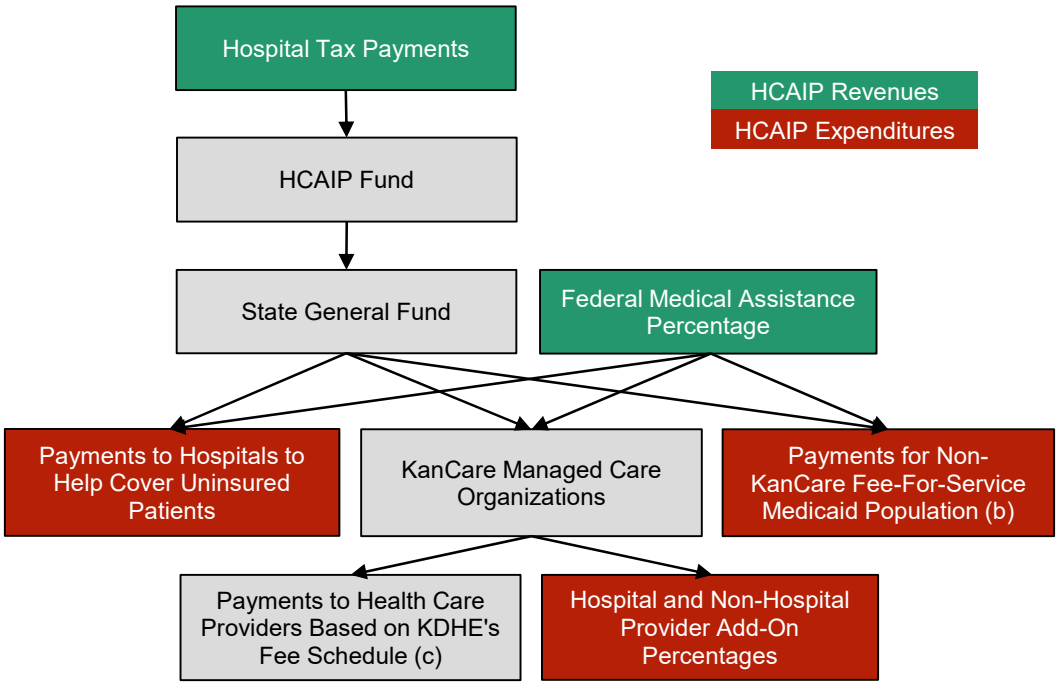
Hospital tax revenues are deposited in the HCAIP fund, which KDHE combines with federal matching funds to increase payments to health care providers. ***Figure 1-1*** on the following

page shows how the HCAIP tax collection and expenditure process works. As the figure shows, hospitals submit their annual tax payments to KDHE, which deposits them in the HCAIP fund. KDHE expends these funds in four primary ways, three of which increase the Federal Medical Assistance Percentage (FMAP) funds the federal government gives the state to match its Medicaid spending.

- **HCAIP funds increase the Medicaid rates managed care organizations (MCOs) pay health care providers.** This increase is achieved by adding a specified percentage onto KDHE's Medicaid rate schedule. The rate increases are paid to both hospital and non-hospital providers (e.g., physicians, surgeons, and dentists) and matched with federal FMAP funds. This is the primary way KDHE expends HCAIP funds.

- **HCAIP funds also help cover hospitals' cost of providing care to uninsured patients.** Each year, Kansas hospitals receive about $41 million to help cover the services they provide to people who do not have Medicaid or private insurance. This expenditure includes federal FMAP funds.

Figure 1-1
HCAIP Revenue Collection and Distribution Process (a)



(a) Not shown is the fourth type of HCAIP expenditure--annual payments made to the University of Kansas Medical Center for medical education scholarships. There are no Federal Medical Assistance Percentage matching funds associated with these payments.
(b) A small portion of Medicaid beneficiaries are not in managed care. Fee-for-service payments for this population include both payments based on KDHE's fee schedule and HCAIP add-on percentages.
(c) Provider payments based on KDHE's fee schedule are funded using state general funds and Federal Medical Assistance Percentage funds, not HCAIP funds.
Source: LPA review of K.S.A. 65-6208, et seq., and information provided by the Kansas Department of Health and Environment.

- **HCAIP funds cover services provided to Kansas' remaining fee-for-service Medicaid population, which is not covered by KanCare.** These payments total approximately $5 million each year, including federal FMAP funds.

- **Finally, HCAIP funds are used for medical education scholarships for students at the University of Kansas Medical Center.** KDHE expends $400,000 in HCAIP funds each year for this purpose. This is the only HCAIP expenditure for which the federal government does not offer FMAP funds.

KDHE uses state general funds to pay HCAIP-related expenses and reimburses the state general fund with HCAIP funds. As ***Figure 1-1*** on the previous page shows, KDHE uses state general funds to pay the HCAIP expenditures described above. However, KDHE does not directly pay health care providers the HCAIP rate increases. Instead, the agency pays the MCOs a monthly amount that includes the estimated cost of the HCAIP rate increases. KDHE contracts with an actuarial firm to estimate the cost of the rate increases and total HCAIP expenses. KDHE then uses the HCAIP fund to reimburse the state general fund for the total estimated expenses. This complex payment structure makes it possible for total HCAIP expenditures to exceed HCAIP funds. As explained starting on page 9, the state general fund is not being fully reimbursed as intended.

KDHE administers HCAIP under the oversight of a stakeholder panel. The HCAIP statute charges KDHE with administering the state's hospital tax. This includes collecting hospitals' tax payments, administering the HCAIP fund, accounting for the HCAIP fund balance, and reporting on HCAIP to the stakeholder panel.

The HCAIP panel consists of members appointed by the Kansas Hospital Association, the Kansas Medical Society, the state's three MCOs, and the Kansas Association for the Medically Underserved. A KDHE representative is also on the panel. Statute gives the HCAIP panel the authority to determine how hospital tax revenues and the associated FMAP funds are to be used, including changes to the HCAIP rate increases, payments to hospitals to help cover the cost of treating uninsured patients, and medical education scholarships. The panel is also required to submit annual reports to the Legislature on the collection and distribution of HCAIP funds.

As Intended, HCAIP Has Increased Medicaid Payments to Health Care Providers

The Legislature's main purpose for HCAIP was to increase the amounts paid to health care providers for treating Medicaid beneficiaries. HCAIP has achieved this using the tax payments collected from hospitals and the associated federal matching funds. We refer to these two amounts together as HCAIP revenues.

Hospital tax revenues are returned to health care providers primarily through an add-on to the payments in KDHE's Medicaid rate schedule. KDHE establishes the minimum payments health care providers will receive as compensation for treating Medicaid beneficiaries. This rate schedule covers both hospital and non-hospital providers and outlines different payments for different types of services. Statute gives the HCAIP panel the authority to determine how revenues collected under HCAIP will be distributed to health care providers. The panel decided to do this largely through adding specified percentages onto KDHE's rate schedule.

- **For hospitals, the add-on percentage is currently 23.1% for any inpatient or outpatient Medicaid service.** For example, a hospital that provides a service for which the KDHE Medicaid rate schedule pays $100.00 would receive an additional $23.10 under HCAIP, for a total payment to the hospital of $123.10. In 2006, the HCAIP panel set hospitals' add-on percentage at 25.8% for both inpatient and outpatient services, but this rate was reduced in 2016 to 23.1%. However, hospitals continue to receive a 25.8% add-on for outpatient services.

- **For non-hospital providers, the add-on percentage varies by service.** However, the average add-on percentage across all services is intended to be 23.1%. This average calculation is based on how much each service was used in 2003, the most recent data available when HCAIP started in 2005. Larger add-ons were assigned to services KDHE wanted to encourage, such as preventative services. For example, an office visit to evaluate a new patient gets an add-on of between 65% and 105%. Conversely, removing a foreign body from the eye receives an add-on of only 0.1%.

In addition to these add-on percentages, the HCAIP panel gives about $41 million in state and federal funds to Kansas hospitals each year to help cover the cost of providing care to uninsured patients. It also allocates $400,000 each year to the University of Kansas Medical Center for medical education scholarships.

KDHE expects HCAIP to generate about $108.9 million in additional Medicaid funding during calendar year 2018. KDHE expects hospitals' tax payments to total $47.9 million during calendar year 2018. The associated federal funds contributed under FMAP are expected to be about $61 million, for total HCAIP revenues of about $108.9 million. These funds would not be available for increasing Medicaid payments to health care providers in the absence of HCAIP. Kansas spent a total of about $3.7 billion in state and federal funding on Medicaid during fiscal year 2018, which means HCAIP funds increased Kansas' Medicaid spending by about 3%.

However, Two Recent Consultant Studies Found the HCAIP Fund Does Not Cover the State's Share of the Cost of HCAIP's Increased Medicaid Payments

Legislators have expressed concerns that HCAIP expenditures might exceed revenues and state general funds may be used to cover the difference. While planning our audit, we discovered KDHE had already commissioned two studies of HCAIP that address this concern.

KDHE commissioned two studies to examine the HCAIP fund for calendar years 2016 through 2018. At the beginning of fiscal year 2018, the HCAIP fund appeared to have an excess balance of about $11.5 million. This prompted the Legislature to ask KDHE to reconcile the HCAIP fund for fiscal years 2016 and 2017 to determine the reason for the excess. In addition, KDHE had already been examining HCAIP's compliance with another statutory requirement. The agency therefore engaged two consulting firms to conduct separate studies of HCAIP, and these firms completed their reports in June 2018.

To determine if these studies were reliable for use as audit evidence, we interviewed the consultants who worked on them and reviewed the methodologies and calculations they used to draw their conclusions. We found both studies to be accurate and reliable and determined it would be appropriate to include their findings in our report.

These studies show that about $13 million in state general funds used to pay health care providers were not reimbursed by HCAIP funds in each year. The 2018 studies KDHE commissioned determined the portions of the payments made to the state's three MCOs that are attributable to HCAIP. The consultants added this amount to the other three HCAIP expenses (i.e., hospital payments to help cover services provided to uninsured patients, medical education scholarships, and services for Kansas' fee-for-service Medicaid population) to estimate total HCAIP expenditures from the state general fund in calendar year 2018. Then, they estimated whether those expenditures would be greater than total HCAIP revenues (i.e., hospitals' tax payments and the associated federal FMAP funds).

The studies found HCAIP expenditures will likely be greater than HCAIP revenues by about $29 million during calendar year 2018. Because the state receives a federal match for the state general funds it spends on Medicaid, this $29 million includes about $13 million in state general funds and about $16 million in FMAP funds. The two studies also applied this methodology to calendar years 2016 and 2017 and found the HCAIP fund was overspent by approximately $25-30 million during each of these years as well. As a result, an estimated total of about $37 million in state general funds will be expended during calendar years 2016 through 2018.

Using state general funds to pay HCAIP expenditures appears to violate the Legislature's intent to have the HCAIP fund cover the state's share of HCAIP expenditures. The HCAIP statute (K.S.A. 65-6208, et seq.) does not clearly prohibit using state general funds to pay HCAIP expenditures. However, the purpose of the tax is to increase Medicaid payments to health care providers by matching federal funds to the hospital tax revenues. The law only authorizes using the HCAIP fund to increase provider payments and draw down federal match funding.

KDHE and members of the Kansas Legislature have interpreted the law as requiring HCAIP to fully reimburse state general fund expenditures. KDHE's interpretation of state law is that HCAIP expenditures must not exceed revenues. In addition, legislative concern that state general funds are being used for program expenditures was one of the reasons this audit was requested. Finally, at legislative direction, the HCAIP panel presented the 2016 Legislature a recommendation to ensure HCAIP fully reimburses the state general fund.

In Addition, HCAIP Funds Were Not Distributed as Required by State Law in Calendar Year 2016

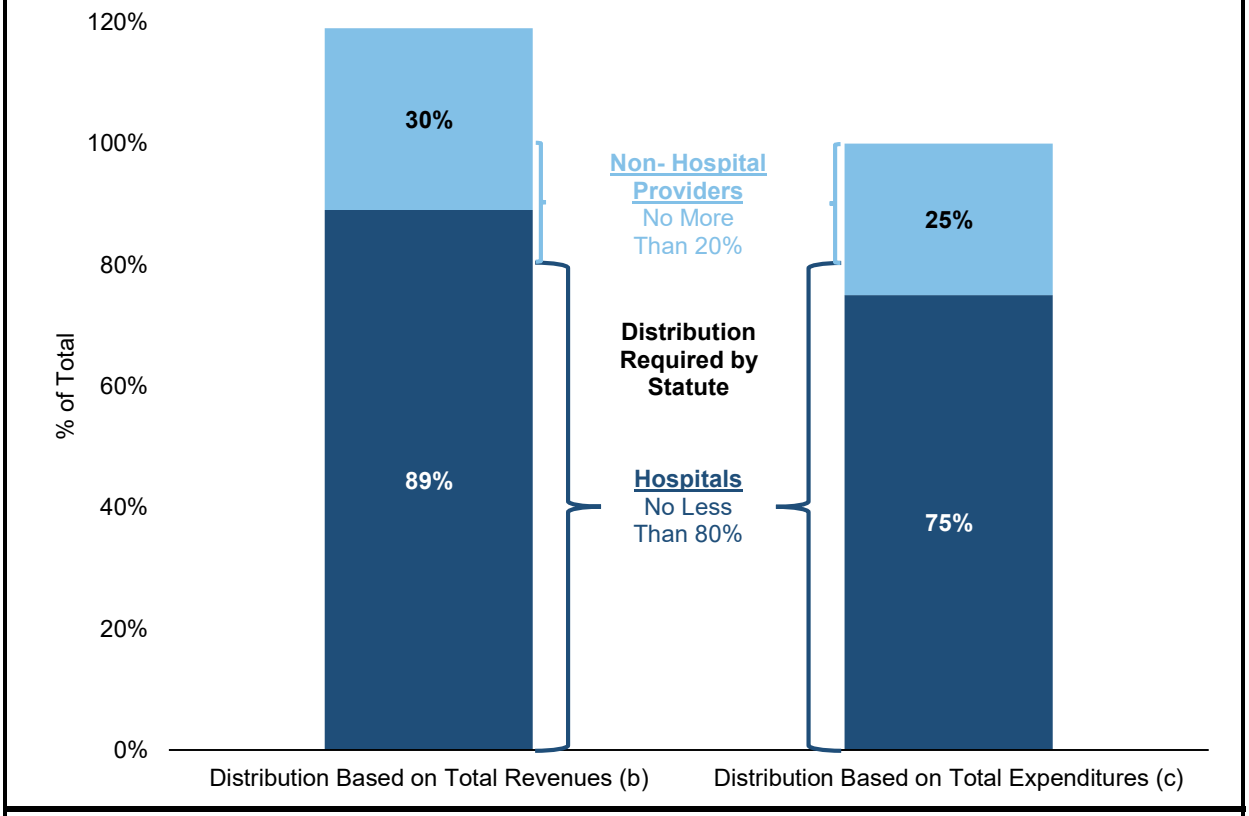
State law requires KDHE to distribute HCAIP funds to hospitals and non-hospital providers in specific proportions. The HCAIP statute (K.S.A. 65-6218) requires that no less than 80% of total HCAIP revenues be distributed to hospitals. This includes the Medicaid payment add-on percentages, payments to help cover services provided to uninsured patients, and fee-for-service payments for Medicaid patients outside KanCare. Further, the statute requires that no more than 20% of revenues be distributed to non-hospital providers and no more than 3.2% be used to fund medical education scholarships.

One consultant study found HCAIP did not comply with statute's distribution requirements during calendar year 2016. This study calculated HCAIP distributions in two ways: as a percentage of total HCAIP revenues and as a percentage of total HCAIP expenditures. The first method aligns with the precise language in state law. The second method accounts for the fact the HCAIP fund was supplemented with state general funds. The results of these calculations are shown in ***Figure 1-2*** on the following page. As the figure shows:

- **The first method shows the percentage paid to non-hospital providers violated the HCAIP statute.** As the figure shows, when the distribution is calculated using only HCAIP revenues, non-hospital providers received the equivalent of about 30% of these revenues, exceeding the 20% statutory maximum.

- **The second method shows the percentages paid to both hospital and non-hospital providers violated the HCAIP statute.** As the figure also shows, when the distribution is calculated using all HCAIP expenditures, hospitals received about 75% of total expenditures and non-hospital providers received about 25%. Both percentages violate state law because hospitals received less than their statutory minimum of 80% and non-hospital providers received more than their statutory maximum of 20%.

Figure 1-2
Percentage Distribution of HCAIP Funds (a)
(CY 2016)



(a) Not shown is the $400,000 used to fund medical education scholarships at the University of Kansas Medical Center each year. This amount makes up less than 0.5% of HCAIP expenditures regardless of the calculation method used.
(b) Includes hospitals' tax payments and FMAP funds. The percentages exceed 100% because HCAIP expenditures were greater than HCAIP revenues in CY 2016.
(c) Includes hospitals' tax payments, FMAP funds, and state general funds expended on HCAIP. The percentages equal 100% because this method accounts for the state general funds that were used to supplement the HCAIP fund in CY 2016.
Source: Consultant report commissioned by the Kansas Department of Health and Environment (audited).

Regardless of the method used, HCAIP fund distributions did not align with state law in 2016. The study did not review whether distribution requirements were met in calendar years 2017 or 2018.

KDHE is Only Recently Aware of the Magnitude and Underlying Causes of HCAIP's Overspending Problem, Which Will Require Legislative or HCAIP Panel Action to Resolve

To determine the reasons for the problems these studies identified, we reviewed documents and interviewed staff from KDHE and the two consulting firms. We also attended the June 2018 meeting of the HCAIP panel to hear the panel members' reactions to these issues.

Because of actuarial and accounting errors, KDHE officials told us they only recently became aware of the underlying causes of the HCAIP fund's overspending and distribution issues. The agency was made aware of these issues through the two contractor studies completed this year.

- **Prior to 2018, KDHE's former actuary underestimated total HCAIP expenditures because they did not calculate them correctly.** Under KanCare, KDHE contracts with three MCOs to compensate health care providers when they treat Medicaid beneficiaries. KDHE also contracts with an actuary to estimate the cost of the HCAIP rate increases paid through the MCOs so it can determine total HCAIP expenditures. KDHE then transfers this amount from the HCAIP fund to the state general fund to reimburse it.

  Until January 2018, KDHE's former actuary did not include the add-on payments for non-hospital providers when calculating how much of the MCOs' monthly payments was attributable to HCAIP. KDHE staff told us this caused them to underestimate annual HCAIP expenditures by about $28 million, including about $12 million in state general funds. It appears KDHE's former actuary did not sufficiently understand how HCAIP's non-hospital provider add-on percentages were supposed to work to include them in its calculations.

- **Prior to 2018, KDHE did not track all funds that should have been transferred from the HCAIP fund to the state general fund, masking negative fund balances.** KDHE officials told us state fiscal policy prohibited KDHE staff from making HCAIP fund transfers when the fund hit a zero balance. However, KDHE officials said the agency began to track negative fund balances for reporting purposes starting in about 2013. As a result, the HCAIP fund appeared to have a zero balance at the end of each year when it should have had an increasingly large negative balance. The state general fund was not being fully reimbursed for HCAIP expenditures during this time.

Because of personnel changes over the years, current KDHE staff told us they do not know why these issues were not adequately analyzed, communicated, or corrected.

Although KDHE now has more accurate information on the HCAIP fund balance, the agency does not have the authority to independently ensure HCAIP revenues cover HCAIP expenditures. This is because fund revenues are controlled by statute and expenditures are determined by the HCAIP panel.

- **State law sets hospitals' tax amounts using 2010 revenues, which has caused HCAIP revenues to remain flat over time.** The formula for determining the amounts hospitals pay into the HCAIP fund each year is set in statute as 1.83% of each hospital's net inpatient revenues from a specified base year. When the tax began in 2005, this base year was 2001. In 2012, the Legislature updated the base year to 2010. Leaving the base year the same for long periods of time may prevent HCAIP revenues from keeping up with expenditure increases, such as from growth in Kansas' Medicaid population.

  Although the size of the hospital tax has remained flat over time, the value of the tax has slightly decreased because of inflation. Hospital tax revenues have been about $47.9 million each year since the base year was updated in 2012. That year, the value of total annual hospital tax revenues was $47.9 million. In 2017, the value of these revenues was equivalent to only about $44.6 million because of inflation.

- **The HCAIP oversight panel set non-hospital provider add-on amounts in 2005, and those rates have caused HCAIP expenditures to increase significantly over time.** Although the HCAIP add-on rates for hospitals are uniform across all services, the add-on rates for non-hospital providers vary by service. Higher rates were assigned to services KDHE wanted to encourage, such as preventative services. KDHE staff told us the HCAIP panel used 2003 service usage information to set an overall average add-on of 23.1% when HCAIP began in 2005.

  KDHE staff told us that although use of these services has changed over time, the rates have not. The services receiving higher rate increases are now more commonly used, dramatically increasing HCAIP expenditures. The current overall average add-on rate has risen from 23.1% to about 55% for non-hospital providers.

The HCAIP panel met in June 2018 to review the results of KDHE's two consultant studies and begin correcting the problems the studies identified. The panel agreed it should find solutions to HCAIP's overspending and percentage distribution problems during its next meeting, which is scheduled for October 2018. In the meantime, the panel members voted to take several actions intended to more immediately improve KDHE's administration and monitoring of the HCAIP fund. This included several actions meant to ensure the HCAIP fund balance is accurate and useful for decision making:

- **Making a one-time correcting entry of about $12 million.** This accounts for transfers from the HCAIP fund to the state general fund for HCAIP expenditures incurred during fiscal year 2018.

- **Using the consultants' improved methodologies for HCAIP fund calculations and transfers going forward.** This will ensure KDHE reporting to the HCAIP panel accurately reflects total HCAIP expenditures, including those covered by state general funds because they are not reimbursed by the HCAIP fund as intended.

- **Transferring funds from the HCAIP fund to the state general fund monthly rather than semi-annually**. This will ensure the HCAIP fund balance is more frequently updated.

- **Moving hospitals' tax payment due dates up one month.** This will increase the likelihood KDHE receives these payments in the fiscal years in which they are due, simplifying HCAIP fund accounting.

OTHER FINDINGS

Other States' Hospital Taxes are Designed to Generate More Revenue than Kansas' Hospital Tax

To determine how Kansas' hospital tax compares to those of peer states, we reviewed three states that have hospital taxes and serve about 75% or more of their Medicaid populations through MCOs: Michigan, Missouri, and Tennessee. Information about these states is summarized in ***Figure 1-3*** on the following page.

All three states have higher hospital tax rates than Kansas and apply these taxes more broadly by including both inpatient and outpatient revenues. As the figure shows, Kansas has the lowest tax rate of the states we reviewed and is the only state to exclude outpatient revenues from its tax payment calculations. This allows our comparison states to collect significantly more hospital tax revenue than Kansas. For example, Missouri collected $1.1 billion in hospital tax payments in fiscal year 2017, making this tax its third largest overall source of state revenue. When combined with the associated FMAP funds, this gave Missouri $3.1 billion in Medicaid funding that otherwise would not have been available.

Two states require automatic annual updates to the base years used to calculate hospitals' tax payments. As ***Figure 1-3*** shows, Michigan and Missouri require annual updates to their base years. These updates are made automatically and require hospitals to calculate their tax amounts using the most recent available revenue data. This helps ensure hospitals' tax payments keep up with growth in Medicaid expenditures. Like Kansas, Tennessee has not updated its base year in several years.

Michigan requires the state to retain a certain amount in its hospital tax fund. Michigan requires state retention of 13.2% of

FMAP funds collected under its hospital tax. It also required a one-time retention of about $92.9 million in fiscal year 2016. Both types of state-retained funds are specifically set aside to replace state general funds that would otherwise be spent on health care.

Figure 1-3
Comparison of Kansas and States with Similar Medicaid Programs and Hospital Taxes

	Michigan	Missouri	Tennessee	Kansas
Percent of Medicaid Clients Served by Managed Care Organizations	75%	76%	100%	95%
Year of Hospital Tax Enactment	2003	1991	2010	2004
Year of Most Recent Statutory or Regulatory Revision to Hospital Tax	2016	2017	2017	2014
Base Year for Calculating Hospital Tax Payment	Most recent available data	Most recent available data	2008	2010
Percentage for Calculating Hospital Tax Payment	4.3%	5.95%	4.52%	1.83%
Revenue Type Used for Calculating Hospital Tax Payment	Inpatient and Outpatient	Inpatient and Outpatient	Inpatient and Outpatient	Inpatient
Annual Hospital Tax Revenues in Millions (a)	$539	$1,121	$447	$48

(a) Excludes FMAP funds. Michigan: FY 2016 (LPA estimate); Missouri: FY 2017; Tennessee: FY 2018; Kansas: CY 2018.
Source: LPA review of state budget and other documentation and information provided by the Kaiser Family Foundation and National Conference of State Legislatures (unaudited).

Conclusion

Kansas' hospital tax successfully draws down federal funds and increases Medicaid payments for health care providers in Kansas. However, KDHE has not historically been proactive in monitoring this fund. As a result, the fund is overspent each year, meaning HCAIP expenditures are greater than revenues and state general funds are used to make up the difference. In the last three years alone, KDHE has used approximately $37 million in state general funds to subsidize increased Medicaid payments made to health care providers. This appears to violate the Legislature's intent that HCAIP revenues be sufficient to fully cover HCAIP expenditures.

Recommendations

Kansas Department of Health and Environment (KDHE)

1. To address HCAIP's percentage distribution problem (pp. 10-11), KDHE and the HCAIP panel should:
    a. Modify how HCAIP funds are distributed to ensure hospitals and non-hospital providers receive percentages that align with statute.
    b. Proactively monitor HCAIP fund expenditures to ensure HCAIP distribution percentages align with statute each year.

2. To address HCAIP's overspending problem (pp. 9-10), KDHE and the HCAIP panel should:
    a. Work with the Kansas Legislature to determine whether HCAIP is intended to be supplemented with state general funds.
    b. If not, develop a plan to ensure state general funds are fully reimbursed each year. This plan might include:
        i. Increasing revenues by raising the percentage and updating the base year used to calculate hospitals' annual tax payment amounts;
        ii. Increasing revenues by using both net inpatient and outpatient revenues to calculate hospitals' annual tax payment amounts; or
        iii. Decreasing expenditures by reducing HCAIP's Medicaid payment rate increases or the payments made to hospitals to help cover services provided to uninsured patients.
    c. Proactively monitor HCAIP fund expenditures to ensure state general funds are fully reimbursed each year.
    d. Present their plan to the Kansas Legislature for its consideration no later than July 1, 2019.

APPENDIX A
Agency Response

On August 24, 2018, we provided a copy of the draft audit report to the Kansas Department of Health and Environment. Its response is included in this appendix. Following the agency's written response is a table listing the department's specific implementation plan for each recommendation.

On September 10, 2018, we also provided a copy of the draft report to the Health Care Access Improvement Program panel. Its response is included in this appendix. Although the panel did not disagree with our findings, we made a minor wording change based on their response. We did not make substantial changes to our findings, conclusions, or recommendations. The panel declined to provide an itemized response to each of our recommendations.

STATE OF KANSAS

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

September 7, 2018

Justin Stowe, Legislative Post Auditor
Legislative Division of Post Audit
800 SW Jackson Street, Suite 1200
Topeka, KS 66612

Dear Mr. Stowe,

Thank you for the opportunity to review the Legislative Post Audit that your team recently completed, titled Medicaid: Comparing Health Care Provider Tax Revenues to Increased Provider Reimbursement Rates. Our Leadership team has had a chance to review the audit, and we are satisfied with the results of the audit and are in general agreement with the findings contained within the audit. We found the auditors assigned to this audit to be professional, unbiased and thorough.

We were happy to learn that your audit revealed that the methodology that KDHE – DHCF is now using to calculate the amount of money to expense against the HCAIP fund is sound. We were further pleased with the level of credibility you found with the work performed by our Actuary firm (Optumas), as well as our consulting partner (Navigant) as a part of this process. KDHE is committed to ensuring accurate accounting for this fund, as well as a transparent and collaborative partnership with the key stakeholders impacted by the use of this fund.

Attached to this letter, you will find our response to each of the recommendations put forth by the audit team. We are happy to answer any questions that your team might have.

Sincerely,

Adam C. Proffitt

Director, Program Finance and Informatics

Itemized Response to LPA Recommendations

Medicaid: Comparing Health Care Provider Tax Revenues to Increased Provider Reimbursement Rates

LPA Recommendation	Agency Action Plan
Question 1	
1. To address HCAIP's percentage distribution problem, KDHE and the HCAIP panel should:	
a. Modify how HCAIP funds are distributed to ensure hospitals and non-hospital providers receive percentages that align with statute.	Agency has communicated findings to HCAIP Panel; authority to change program lies outside of the Agency, but Agency will continue to ask for updates
b. Proactively monitor HCAIP fund expenditures to ensure HCAIP distribution percentages align with statute each year.	Agreed to monitor and report proactively; authority to change program lies outside of the agency
2. To address HCAIP's overspending problem, KDHE and the HCAIP panel should:	
a. Work with the Kansas Legislature to determine whether HCAIP is intended to be supplemented with state general funds.	Agency has cited Statute with understanding that program should be State budget neutral; will partner with Legislature and key stakeholders for final determination
b. If not, develop a plan to ensure state general funds are fully reimbursed each year. This plan might include:	
i. Increasing revenues by raising the percentage and updating the base year used to calculate hospitals' annual tax payment amounts;	Agency has communicated findings to HCAIP Panel; authority to change program lies outside of the Agency, but Agency will continue to ask for updates
ii. Increasing revenues by using both net inpatient and outpatient revenues to calculate hospitals' annual tax payment amounts; or	Agency has communicated findings to HCAIP Panel; authority to change program lies outside of the Agency, but Agency will continue to ask for updates
iii. Decreasing expenditures by reducing HCAIP's Medicaid payment rate increases or the payments made to hospitals to help cover services provided to uninsured patients.	Agency has communicated findings to HCAIP Panel; authority to change program lies outside of the Agency, but Agency will continue to ask for updates
c. Proactively monitor HCAIP fund expenditures to ensure state general funds are fully reimbursed each year.	Agreed to monitor and report proactively; authority to change program lies outside of the agency
d. Present their plan to the Kansas Legislature for its consideration no later than July 1, 2019.	Agency to defer to HCAIP Panel and key stakeholders to design new program, but will provide analytical support as needed, and will answer all questions posed by the Legislature

Stormont Vail Health

September 14, 2018

Mr. Justin Stowe
Legislative Post Auditor
Legislative Division of Post Audit
800 SW Jackson Street, Suite 1200
Topeka, Kansas 66612

Dear Mr. Stowe:

I want to begin by thanking you for the opportunity to respond on behalf the Health Care Access Improvement Panelto the post audit report "Medicaid: Comparing Health Care Provider Tax Revenues to Increased Provider Reimbursement Rates." I have served as the chairperson of the Health Care Access Improvement Panel since the program began in 2005. While the audit report provides a fair representation of the facts, there are several points that are important to developing a complete understanding of the program.

1. Providers have been and continue to be concerned about Medicaid reimbursement. Both the Kansas Hospital Association and the Kansas Medical Society had been studying the payment rates and looking for opportunities to increase those rates in 2004. At the same time, there was consideration at the federal level of reducing or eliminating other provider assessment programs around the country. The Kansas Legislature, concerned that the opportunity would be lost, worked with providers to develop the current program, which was specifically crafted to enhance provider rates, not replace current state dollars spent for the Medicaid program. In addition, the 1.83% assessment rate was agreed to because it allowed for the maximum benefit for providers with limited negative consequences – i.e., tax costs in general did not exceed the benefits for taxpaying hospitals. Increasing the tax rate without significant review would upset this delicate balance under the current tax structure.

2. The implementation of managed care has made this program very difficult for the agency and hospitals to track, which in turn made it difficult for the panel to administer. The audit indicates that in 2013 the agency began tracking negative balances in the fund because the fund itself could not be spent into a negative balance. According to the audit, this resulted in a "masking" of negative balance, since the fund was spent to zero each year. However, a review of the data available from the KANVIEW website of account revenues and expenditures from FY 2012 to FY 2017 indicates that the fund balance at the end of each year was as follows: in FY 2012, $15.6 million; in FY 2013, $3.8 million; in FY 2014, $16.2 million; in FY 2015, $12.7 million; in FY 2016, $14.3 million; and in FY 2017, $18.6 million. The agency internal tracking may have calculated a negative ending balance; however, actual expenditures from the fund by the agency do not support those calculations. The larger issue is the difficulty in

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tracking expenditures from the fund in a managed care environment under the current program.

3. The question driving this audit is whether the program is and should be self-sustaining. The audit specifically states, "several stakeholders have interpreted the law as requiring HCAIP to fully reimburse state general fund expenditures." This assertion is concerning, given that the audit objectives, scope and methodology do not indicate that any stakeholders were interviewed to determine their interpretation of the law regarding the HCAIP, nor am I aware of any stakeholders who were interviewed. In addition, the audit notes that the panel presented a recommendation to the 2016 Legislature to ensure the HCAIP fully reimburses the state general fund. While this statement is technically correct, there are several salient points that were omitted:

    a. The report was requested by the 2015 legislature in 2015 House Substitute for Senate Bill 112 Section 104(f), which directed the panel to provide a report to the 2016 legislature with a plan to address the long-term sustainability of the health care access improvement program with funding only from the assessment revenues. The report was not provided based on the belief by the panel that the program was required to operate only within the funds available.

    b. The panel report to the 2016 legislature dated March 15, 2016 reflected the final recommendation of the panel in response to the legislative directed – increasing the HMO privilege fee from 3.31% to 3.71% to generate approximately $13.1 million to cover the additional state general fund expenditures. The panel voted 8 to 1, with on MCO member absent, to pursue this solution. The KDHE representative cast the lone dissenting vote. This recommended solution was neither implemented nor pursued by the agency or the legislature. This final recommendation of the panel indicates a very clear belief that the provider tax was not expected to shoulder the entire burden of funding the program.

    c. The audit recommends KDHE and HCAIP panel implement a redistribution of funds to align the program with the statute. The panel agrees that the realignment must occur, however doing so will require the state to do one of two things: reduce rates to physicians or continue to fund the portion of physician rates not covered by the provider assessment funds.

    d. The audit uses the states of Missouri, Michigan and Tennessee as peers for program comparison. However, state provider assessments are very much like state Medicaid programs – complex, widely varied, and rarely useful as an apple to apples comparison. In all three states, they raise a significantly larger amount of revenue because not only it taxes both inpatient and outpatient rates, but because the entire basis for the tax is larger – more facilities – and their tax rate is closer to the federal limit of 6 percent.

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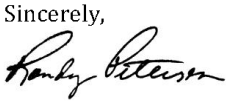
The audit brings to light a variety of issues related to the operation of the program and the need for a more transparent accountability process, a process that is already being developed by the panel and leadership at KDHE. The audit, as directed, is focused on whether or not the program is self-funded. We believe the audit ignores the more important question of whether or not the state pays Medicaid providers adequately, and if not, what is the state willing to commit to pay the healthcare providers that support the most vulnerable citizens in Kansas.

Sincerely,



Randy Peterson
Chair, Health Care Access Improvement Panel

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APPENDIX B
Cited References

This appendix includes a list of the studies and reports cited in this report.

1. Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018. (2017, October). *Kaiser Family Foundation*.

2. State Tax Actions Database. (2017, May). *National Conference of State Legislatures*.