HMO Privilege Fee and Supplemental Medicaid Reimbursement; HB 2079

HB 2079 creates law to allow supplemental Medicaid reimbursement for certain providers of ground emergency medical transportation services and creates an intergovernmental transfer program relating to Medicaid managed care, ground emergency medical transport services, and those services provided by certain emergency medical services personnel in pre-stabilization and preparation for transport.

In addition, the bill increases the annual privilege fee assessed on every health maintenance organization (HMO), changes the privilege fee payment structure, creates a priority system for use of revenue from the assessment, changes accounting procedures for the portion of the assessment dedicated to the Kansas Newborn Screening Fund, and establishes a limit on the amount to be transferred to the Kansas Newborn Screening Fund.

Supplemental Medicaid Reimbursements

In addition to the rate of payment that a provider otherwise receives for Medicaid ground emergency medical transportation services, a provider is eligible for supplemental Medicaid reimbursement to the extent provided by law, if a provider meets the following conditions during the reporting period:

- Provides ground emergency medical transportation services to Medicaid beneficiaries;

- Is enrolled as a Medicaid provider for the period being claimed; and

- Is owned or operated by the State, a political subdivision, or local government, that employs or contracts with persons or providers who are licensed or permitted to provide emergency medical services in the state of Kansas, including hospitals and private entities to the extent permissible under federal law.

The bill requires an eligible provider's supplemental reimbursement be calculated and paid, as follows:

- The supplemental reimbursement to an eligible provider will be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to federal law;

- The amount certified in conformity with federal regulations and eligible for federal financial participation, when combined with the amount received from all other sources of reimbursement from the Medicaid program, cannot exceed or be less than 100.0 percent of actual costs for ground emergency medical transportation services, as determined pursuant to the Medicaid state plan; and

- The supplemental Medicaid reimbursement will be distributed exclusively to eligible providers under a payment methodology based on ground emergency medical transportation services provided to Medicaid beneficiaries by eligible providers on a per-transport basis or other federally permissible basis.

The Kansas Department of Health and Environment (KDHE) is required to obtain approval from the federal Centers for Medicare and Medicaid Services (CMS) for the payment methodology to be utilized prior to making any supplement Medicaid reimbursement payments.

The bill states the Legislature's intent to enact the provisions of the bill without any State General Fund (SGF) expenditures.

An eligible provider, as a precondition to receiving the supplemental Medicaid reimbursements, is required to enter into and maintain an agreement with KDHE for the purposes of implementing the payments and reimbursing KDHE for the costs of administering the payments.

The non-federal share of the supplemental Medicaid reimbursement submitted to CMS for purposes of claiming federal financial participation will be paid only with funds from governmental entities owned and operated by the State, a political subdivision, or local government that employs or contracts with persons or providers who are licensed or permitted to provide emergency medical services in Kansas, including hospitals and private entities to the extent permissible under federal law and who are certified as described below.

Participation in the supplemental Medicaid reimbursement program by an eligible provider is voluntary. In order to seek supplemental Medicaid reimbursement, an applicable governmental entity is required to do the following:

- Certify, in conformity with federal regulations, the claimed expenditures for the ground emergency medical transportation services are eligible for federal financial participation;

- Provide evidence supporting the certification as specified by KDHE;

- Submit data, as specified by KDHE, to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation; and

- Keep, maintain, and have readily retrievable any records specified by KDHE to fully disclose reimbursement amounts to which the eligible provider is entitled, and any other records required by CMS.

KDHE is required to promptly seek any necessary federal approvals for the implementation of supplemental Medicaid reimbursements and is allowed to limit the reimbursements to those costs allowable under Title XIX of the federal Social Security Act. If federal approval is not obtained for implementation of the supplemental Medicaid reimbursements, the section of the bill related to the reimbursements will not be implemented.

KDHE is required to submit claims for federal financial participation for the expenditures allowable under federal law for the services related to requirements for participation in the reimbursements. KDHE is also required to submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures allowable under federal law.

KDHE will be able to utilize intergovernmental transfers or certified public expenditures to implement the supplemental Medicaid reimbursement subject to provisions and requirements of the bill.

Intergovernmental Transfer Program

KDHE is required to design, and implement, in consultation and coordination with providers eligible for the program, an intergovernmental transfer program (Program) relating to Medicaid managed care, ground emergency medical transport services, and those services provided by emergency medical services personnel at the emergency medical responder, emergency medical technician, advanced emergency medical technician, and paramedic levels in the pre-stabilization and preparation for transport.

A provider is eligible to transfer public funds to the State pursuant to the Program in an applicable reporting period only if the provider meets both of the following conditions:

- Provides ground emergency medical transport services to Medicaid managed care enrollees pursuant to a contract or other arrangement with a Medicaid managed care plan; and

- Is owned or operated by the State, a political subdivision, or local government that employs or contracts with persons or providers who are licensed or permitted to provide emergency medical services in Kansas, including hospitals and private entities to the extent permissible under federal law.

To the extent intergovernmental transfers are voluntarily made by and accepted from an eligible provider described above or a governmental entity affiliated with an eligible provider, KDHE is required to make increased capitation payments to applicable Medicaid managed care plans. The increased capitation payments are required to be at least actuarially determined amounts to the extent permissible under federal law. Funds associated with intergovernmental transfers must be used to fund additional payments to Medicaid managed care plans.

Medicaid managed care plans must enter into contracts or contract amendments with eligible providers for the disbursement of increased capitation payments related to intergovernmental transfers.

The Program developed will be implemented on the date federal approval is obtained, and only to the extent intergovernmental transfers from the eligible provider, or the governmental entity with which it is affiliated, are provided for that purpose.

KDHE must implement the Program and increased capitation payments on a retroactive basis, as approved by CMS and to the extent permissible by federal law. Participation in the

Program is voluntary on the part of the transferring entities for purposes of all applicable federal laws.

The bill requires the Program be implemented without any additional SGF expenditures. As a condition of participation in the Program, eligible providers or the governmental entity affiliated with an eligible provider must agree to reimburse KDHE for any costs associated with implementing the Program. Intergovernmental transfers are subject to a fee of up to 20.0 percent of the non-federal share paid to KDHE and may not count as a cost of providing the services not to exceed 120.0 percent of the total amount.

As a condition of participation in the Program, Medicaid managed care plans, eligible providers, and governmental entities affiliated with eligible providers are required to comply with any requests for information or similar data requirements imposed by KDHE for the purpose of obtaining supporting documentation necessary to claim federal funds or to obtain federal approvals.

The Program will be implemented only if and to the extent federal financial participation is available and not otherwise jeopardized and any necessary federal approvals have been obtained.

KDHE will be allowed to return or not accept intergovernmental transfers, or adjust payments as necessary, to comply with federal Medicaid requirements.

The bill requires the State and KDHE to implement whatever program CMS approves for use under the act.

HMO Privilege Fee and Medical Assistance Fee Fund

The annual privilege fees assessed on every HMO will be increased to 5.77 percent for the reporting period beginning January 1, 2018.

The bill directs the moneys collected from this annual assessment be deposited to the credit of the Medical Assistance Fee Fund (in KDHE). The bill also creates the Community Mental Health Center Improvement Fund to be used by KDHE and restricts use of the moneys in this fund for purposes related to community mental health centers (CMHCs).

The bill specifies that moneys in the Medical Assistance Fee Fund must be expended in the following priority:

- First, restore any reductions initiated during calendar year 2016 to provider reimbursement rates for state Medicaid services;

- Second, $3.5 million in FY 2018, and $5.0 million every fiscal year thereafter, will be transferred to the Community Mental Health Center Improvement Fund to be used for purposes related to CMHCs. The amount transferred cannot exceed $5.0 million in any one fiscal year;

- Third, the estimated amount necessary to fund the Newborn Screening Program for the ensuing fiscal year will be transferred to the Kansas Newborn Screening Fund. Such amount cannot exceed $2.5 million in any one fiscal year; and

- Fourth, any remaining moneys would be expended for the purpose of Medicaid medical assistance payments.

The bill also removes the July 1, 2018, sunset date on the increased privilege fee.

[*Note*: Under previous law, the privilege fee was established at 3.31 percent for the period beginning January 1, 2015, and ending December 31, 2017, and 2.00 percent on and after January 1, 2018. In addition, the moneys collected from the privilege fee were to be deposited to the credit of the SGF, except during the period beginning July 1, 2015, and ending on June 30, 2018, when the moneys were to be deposited to the credit of the Medical Assistance Fee Fund.]

HMO Privilege Fee and Payments

Starting January 1, 2018, each HMO must submit a report to the Commissioner of Insurance (Commissioner), on or before March 31 and September 30 each year, containing an estimate of the total amount of all charges to enrollees expected to be collected during the current calendar year.

Upon filing each March 31 report, HMOs are required to submit payment equal to half of the privilege fee assessed for the current calendar year based on the reported estimate. Upon filing each September 30 report, HMOs will submit a payment equal to the balance of the privilege fee assessed for the current calendar year based upon the reported estimate.

Formerly, privilege fee payments were submitted annually on or before March 1 and based on actual collections in the previous calendar year.

Any amount owed by an HMO during any calendar year in excess of the estimated amount will be assessed by the Commissioner and will be due and payable upon issuance of the assessment. Any amount overpaid by an HMO will be reconciled upon assessment of privilege fees in the ensuing calendar year and credited against future privilege fee assessments or refunded in cases when the HMO is no longer doing business in Kansas.

Kansas Newborn Screening Fund

On or before July 1 of each year, the Director of Accounts and Reports is required to determine the amount credited to the Medical Assistance Fee Fund from the privilege fee assessment and transfer the estimated amount necessary to fund the Newborn Screening Program for the ensuing fiscal year to the Kansas Newborn Screening Fund. The amount cannot exceed $2.5 million in any one fiscal year.

The transfers had been determined and made monthly from a portion of the privilege fee revenue transferred to the SGF, although the revenue has been deposited in the Medical Assistance Fee Fund since July 1, 2015.