SESSION OF 2017

CONFERENCE COMMITTEE REPORT BRIEF
HOUSE BILL NO. 2079

As Agreed to May 30, 2017

Brief*

HB 2079 would create law to allow supplemental Medicaid reimbursement for certain providers of ground emergency medical transportation services and would create 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 prestablization and preparation for transport.

In addition, the bill would increase the annual privilege fee assessed on every health maintenance organization (HMO), change the privilege fee payment structure, create a priority system for use of revenue from the assessment, change accounting procedures for the portion of the assessment dedicated to the Kansas Newborn Screening Fund, and establish 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 would otherwise receive for Medicaid ground emergency medical transportation services, a provider would be eligible for supplemental Medicaid reimbursement to the extent provided by law, if a provider meets the following conditions during the reporting period:

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- 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.

An eligible provider's supplemental reimbursement would be required to be calculated and paid as follows:

- The supplemental reimbursement to an eligible provider would 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, could not 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 would 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) would be 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 would state the Legislature's intent to enact the provisions of the bill without any State General Fund expenditures.

An eligible provider, as a precondition to receiving the supplemental Medicaid reimbursements, would be 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 would 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 would be voluntary. In order to seek supplemental Medicaid reimbursement, an applicable governmental entity would be 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 would be required to promptly seek any necessary federal approvals for the implementation of supplemental Medicaid reimbursements and would be 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 would not be implemented.

KDHE would be 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 would also be required to submit any necessary materials to the federal government to provide assurances that claims for federal financial participation would include only those expenditures allowable under federal law.

KDHE would 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 would be 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 prestabilization and preparation for transport.

A provider would only be eligible to transfer public funds to the State pursuant to the Program in an applicable reporting period if a 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 provider 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 would be required to make increased capitation payments to applicable Medicaid managed care plans. The increased capitation payments would be required to be at least actuarially determined amounts to the extent permissible under federal law. Funds associated with intergovernmental transfers would be required to be used to fund additional payments to Medicaid managed care plans.

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

The Program developed would 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.

KHDE would be required to 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 would be voluntary on the part of the transferring entities for purposes of all applicable federal laws.

The bill would specify the Program would be required to be implemented without any additional State General Fund expenditures. As a condition of participation in the Program, eligible providers or the governmental entity affiliated with an eligible provider, would be required to agree to reimburse KDHE for any costs associated with implementing the Program. Intergovernmental transfers would be subject to a fee of up to 20.0 percent of the non-federal share paid to KDHE and would not be allowed to 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 would be required to comply with any requests for information or similar data requirements imposed by KDHE for purpose of obtaining supporting documentation necessary to claim federal funds or to obtain federal approvals.

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

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

The State and KDHE would be required 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 would be increased to 5.77 percent for the reporting period beginning January 1, 2018.

The bill would direct the moneys collected from this annual assessment be deposited to the credit of the Medical Assistance Fee Fund (in KDHE). The bill would also create in the State Treasury, the Community Mental Health Center Improvement Fund to be used by the Kansas Department for Aging and Disability Services and would restrict use of the moneys in this fund for purposes related to Community Mental Health Centers.

The bill would specify 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, would be transferred to the Community Mental Health Center Improvement Fund to be used for purposes related to Community Mental Health Centers, the amount transferred could not 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 would be transferred to the Kansas Newborn Screening Fund and such amount could not 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 would also remove the July 1, 2018, sunset date on the increased privilege fee.

[*Note*: Under current law, the privilege fee is 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 are to be deposited to the credit of the State General Fund, except during the period beginning July 1, 2015, and ending on June 30, 2018, when the moneys are to be deposited to the credit of the Medical Assistance Fee Fund.]

HMO Privilege Fee and Payments

On and after January 1, 2018, each HMO would be required to 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 would be required to submit payment equal to half of the privilege fee that would be assessed for the current calendar year based on the reported estimate. Upon filing each September 30 report, HMOs would submit a payment equal to the balance of the privilege fee that would be assessed for the current calendar year based upon the reported estimate.

Currently, privilege fee payments are 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 would be assessed by the Commissioner and would be due and payable upon issuance of the assessment. Any amount overpaid by an HMO would 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 would be 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 could not exceed $2.5 million in any one fiscal year.

Currently, the transfers are to be determined and made monthly from a portion of the privilege fee revenue transferred to the State General Fund, although the revenue has been deposited in the Medical Assistance Fee Fund since July 1, 2015.

Conference Committee Action

The Conference Committee agreed to remove the contents of HB 2079 (pertaining to water district vehicles), insert the contents of HB 2180, as amended by the House Committee, and further agreed to amend the bill as follows:

- Change the start date of the privilege fee increase from July 1, 2017, to January 1, 2018, and remove the January 1, 2023, decrease;
- Add language to establish the semi-annual payment structure;

- Add language to specify the funding for the Newborn Screening Program would be transferred from the Medical Assistance Fee Fund and the maximum amount of the transfer would be $2.5 million per fiscal year;

- Change the amount of the privilege fee revenue dedicated to Community Mental Health Centers from $15.0 million in FY 2019 and beyond to $5.0 million per fiscal year and establish the amount would not exceed $5.0 million per fiscal year; and

- Add the contents of SB 186 (pertaining to supplemental Medicaid reimbursement), as passed by the Senate Committee of the Whole.

Fiscal Information for HB 2079 Conference Committee Report

Staff estimated HB 2079, as modified by the action of this Conference Committee, would increase revenue for FY 2018 by $108.6 million, all to the Medical Assistance Fee Fund, and would increase expenditures by $161.3 million, including $71.8 million from the State General Fund, for additional managed care organization (MCO) expenditures and restoration of Medicaid provider rate reductions resulting from the May 2016 State General Fund allotment. After the $3.5 million transfer for Community Mental Health Centers, additional revenue could be used to offset State General Fund expenditures, making the net effect a reduction in State General Fund expenditures of $33.3 million. [*Note*: including the Governor's recommendations for FY 2018, the net impact would be a reduction in State General Fund expenditures of $61.2 million.]

Staff estimated, for FY 2019, there would be increased revenue of $144.6 million, but a State General Fund revenue decrease of $72.5 million. There would be an estimated increase in expenditures of $226.7 million, including $100.6

million from the State General Fund. After the $5.0 million transfer for Community Mental Health Centers, the net effect would be a reduction in State General Fund expenditures of $111.5 million for FY 2019. [*Note*: including the Governor's recommendations for FY 2019, the net impact would be increased State General Fund expenditures of $11.2 million.]

In addition, according to the fiscal note prepared by the Division of the Budget on SB 186, as introduced, enactment of provisions related to supplemental Medicaid reimbursement and the intergovernmental transfer program would increase expenditures for KDHE by $577,925, including $288,963 from the State General Fund, for FY 2018 for a contract to train staff and collect and analyze cost data. The increase in revenue and expenditures of $6.3 million for FY 2019 would net to no impact. KDHE also estimates an additional 0.5 FTE position would be necessary for both FY 2018 and FY 2019 to implement the provisions. Any fiscal effect associated with provisions from SB 186 is not reflected in *The FY 2018 Governor's Budget Report.*

Background

HB 2079—Water District Vehicles

HB 2079, as introduced by the House Committee on Water and Environment, would have added water district vehicles to the list of vehicles that can be permanently registered in the state. The contents of HB 2079, as amended by the House Committee, were added to HB 2080 in Conference Committee. [*Note*: More background information on the original contents of HB 2079 is available in the Conference Committee Report Brief on HB 2080.]

SB 186—Supplemental Medicaid Reimbursement and Intergovernmental Transfer Program

SB 186 was introduced by the Senate Committee on Ways and Means. In the Senate Committee hearing,

proponent testimony was provided by a representative from the Kansas State Association of Fire Chiefs who stated the bill would provide financial relief at the local level for those who voluntarily elect to participate. Written-only proponent testimony was provided by representatives of the Kansas Legislative Policy Group and the California Fire Service.

Neutral testimony was provided by a representative of the Kansas Emergency Medical Services Board who provided general information on the impact of SB 186.

No opponent testimony was received.

The Senate Committee amended SB 186 to clarify several provisions, including specifying eligible providers under both sections further and adding language related to the consideration of federal law. The Senate Committee also made amendments to clarify KDHE would be permitted to use intergovernmental transfers or certified public expenditures to implement the supplemental Medicaid reimbursements.

In addition, the Senate Committee amended language related to intergovernmental transfers and Medicaid managed care plan.

HB 2180—HMO Privilege Fee

HB 2180 was introduced by the House Committee on Appropriations. In the House Committee hearing, representatives of the Association of Community Mental Health Centers of Kansas, Children's Alliance of Kansas, Inc., Genoa Pharmacy, Kansas Association for the Medically Underserved, Kansas Association of Chain Drug Stores, Kansas Healthcare Association, Kansas Hospital Association, Kansas Independent Pharmacy Service Corporation, LeadingAge Kansas, and Via Christi Hospitals testified in favor of HB 2180.

Written-only proponent testimony was received by HCA, Inc., High Plains Mental Health Center, Kansas Academy of Family Physicians, Kansas Association of Addiction Professionals, Kansas Medical Society, Kansas Pharmacists Association, and University of Kansas Health System. The proponents generally stated the proposed changes were critical in order to restore reduced reimbursement rates to providers that have caused strain on the Kansas health care system.

Representatives of Aetna, Blue Cross and Blue Shield of Kansas, and the Kansas Insurance Department testified in opposition of HB 2180. Blue Cross and Blue Shield of Kansas City provided written-only opponent testimony. The opponents noted concerns with the fee increase and stated the retroactive implementation of the fee would not allow health insurance companies the ability to collect the amount of the privilege fee in the current rates, resulting in a loss to the companies.

A KDHE representative provided neutral testimony providing details on the privilege fee and use of the fee revenues.

The House Committee amended HB 2180 to specify the increase of the privilege fee to the 5.77 percent would be for the reporting period beginning July 1, 2017, and ending December 31, 2022, only. The amendment also specified that on and after January 1, 2023, the privilege fee would return to 2.00 percent. The Committee also amended HB 2180 to prioritize expenditures from the Medical Assistance Fee Fund and specify $3.5 million for FY 2018 and $15.0 million every fiscal year thereafter would be dedicated for Community Mental Health Centers.

[*Note*: There were no amendments by the House Committee of the Whole and HB 2180 was passed as recommended by the House Committee. Additional fiscal information on the original contents of HB 2180 is available in the Supplemental Note on HB 2180.]

EMS Medicaid reimbursement; supplemental Medicaid reimbursement; intergovernmental transfer program; HMO privilege fee; MCO privilege fee; Newborn Screening Fund; Medical Assistance Fee Fund; Community Mental Health Center Improvement Fund

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