The Rundown podcast transcript for Performance Audit report titled ***Examining Distributions from the Health Care Provider Tax*** – Released May 2021

Andy Brienzo, Host and Principal Auditor: [00:00]
Welcome to The Rundown. Your source for the latest news and updates from the Kansas Legislative Division of Post Audit, featuring LPA staff talking about recently released audit reports and discussing their main findings, key takeaways, and why it matters. I'm Andy Brienzo. In May 2021, LPA released a performance audit examining distributions of revenue from the Kansas Health Care Provider tax under the Health Care Access Improvement Program. I'm with Heidi Zimmerman, principal auditor at Legislative Post Audit, who supervised this audit. Welcome back to The Rundown, Heidi.

Heidi Zimmerman, Principal Auditor and Supervisor: [00:35]
Thanks for having me Andy.

Andy Brienzo, Host and Principal Auditor: [00:38]
First, why don't you give me an overview of how Medicaid works in Kansas and where the Health Care Access Improvement Program or HCAIP fits into this picture?

Heidi Zimmerman, Principal Auditor and Supervisor: [00:48]
Sure. So, Medicaid helps cover medical costs for certain low-income individuals and the state and the federal government share the costs of that program. In Kansas, though, we mostly use a managed care model of Medicaid called KanCare and under KanCare, the state pays a set amount for each Medicaid beneficiary each month to the states three managed care organizations, which we also call them MCOs and the MCOs then reimburse providers directly for the services that they provide. So, the purpose of the Health Care Access Improvement Program or HCAIP is to increase the number of providers willing to serve Medicaid beneficiaries by increasing the reimbursements that they are paid.

Andy Brienzo, Host and Principal Auditor: [01:34]
So, where did these HCAIP revenues come from and how are they used?

Heidi Zimmerman, Principal Auditor and Supervisor: [01:38]
So, under state law, HCAIP requires most Kansas hospitals to pay an annual tax that's based on their operating revenue. So, currently hospitals pay 1.83% of the inpatient net revenue that it earned back in 2010. So KDHE then combines those tax revenues with federal matching funds to increase reimbursement rates to healthcare providers, but the increase comes through something called an add-on percentage.

So, a provider's total reimbursement rate includes a standard rate for providing the service plus the add-on percentage. So, for example, if a standard rate to provide a certain service is a hundred dollars and the add-on percentage is 23%, then the provider would be reimbursed $123. So, HCAIP revenues are used to fund that add-on percentage

Andy Brienzo, Host and Principal Auditor: [02:33]
To answer question one, the team reviewed the top 20 non-hospital procedures that accounted for the most reimbursements. What did you find?

Heidi Zimmerman, Principal Auditor and Supervisor: [02:43]
So, health providers use a procedure code to report what service they provided to a Medicaid beneficiary. So, we used 2019 data from KDHE that showed how much Medicaid reimbursed non-hospital providers by each procedure code. So, non-hospital providers are providers like doctors and surgeons and dentists and we only looked at non-hospital providers in this audit because that was the focus of the audit, but what we found was that in 2019, the Medicaid program paid a total of $159.4 million across the almost 900 procedure codes that were paid to non-hospital providers. So, the top 20 out of that 900 though accounted for 74% of the total payments. So, many of those procedures that were in that top 20 were for routine things like doctor's office visits or physical therapy or vaccinations.

Andy Brienzo, Host and Principal Auditor: [03:43]
So, an aspect of question one was also to look at the add-on percentages for those services that generate the most in Medicaid payments. What did you find with those?

Heidi Zimmerman, Principal Auditor and Supervisor: [03:55]
So, those percentages ranged quite a bit across those top 20 codes. So, for example, the lowest add-on was only about 4% and that was for delivering a baby. Conversely, the largest add-on was almost 111%, and that was for a regular doctor's visit to an ophthalmologist. So, there was quite a large amount of variation across the 20. I should note here though that the intent was for the add-on percentages to average 25.8% across all the procedures. We estimated though that's actually about 49% and that's likely because the services with the larger add-on rates were used a lot more than originally predicted.

Andy Brienzo, Host and Principal Auditor: [04:41]
So, for question two, the team evaluated a couple of statutory requirements related to HCAIP's administration. What are these requirements and is HCAIP meeting them?

Heidi Zimmerman, Principal Auditor and Supervisor: [04:52]
Question two had us look at whether KDHE monitored HCAIP adequately and state law has two very specific requirements for HCAIP and we looked to see if the Department was monitoring for compliance with those things. So, the two things that state law requires, first, is HCAIP revenues. So, HCAIP revenues are the money from the hospital tax and the associated federal matching funds and statute

requires that those revenues be distributed in a specific way. So, not less than 80% of them need to go to hospital providers and not more than 20% need to go to non-hospital providers. Secondly, HCAIP is intended to be state general fund neutral. So, basically the expectation is that HCAIP does not use any state general funds, and it's basically self-sufficient. Statute does require that, but that piece is not actually gone into effect quite yet. So, right now what is in effect is that there is an expectation that it be state general fund neutral, but it is not yet legally required. So, the HCAIP program does not meet either one of these requirements. So, first non-hospital providers, like I said, should not receive more than 20% of the HCAIP distributions, but we found that they receive between 26% and 32%, depending on how it's calculated. Additionally, even though legislative intent is for HCAIP to be SGF neutral, we estimated that HCAIP spent about $12 million of state general fund money in fiscal year 2020.

Andy Brienzo, Host and Principal Auditor: [06:36]
Now the report noted that the state's managed care system, which you've mentioned a couple of times before, it makes it difficult for KDHE to monitor HCAIP. Why is that the case?

Heidi Zimmerman, Principal Auditor and Supervisor: [06:46]
So, as I mentioned before, under KanCare, the state does not directly pay providers. So, instead the state pays the MCOs and the MCOs pay the providers. So, under KanCare tracking those HCAIP expenditures is really based on an estimate of what portion of the MCO payments are attributable to HCAIP. So, this makes it more difficult to precisely track those HCAIP expenditures. Additionally, the process is really only backwards looking and it doesn't have a real mechanism for a real-time look. And so really the department only knows if the program is complying with state law after the fact.

Andy Brienzo, Host and Principal Auditor: [07:23]
How would HCAIP need to change to ensure better compliance?

Heidi Zimmerman, Principal Auditor and Supervisor: [07:29]
So, we've talked about two issues here. One is the distribution issue and the other is the state general fund neutrality. To ensure that the distribution complies with state law first HCAIP distributions to non-hospital providers would likely need to be reduced. We estimated that potentially by as much as 30% to get to that 80/20 split. Then those rates should be reviewed periodically to make sure they continue to comply over time. This is important because how services are used can change over time. So, just because rates are set for a particular outcome at one point does not guarantee that they will continue to behave in exactly that way for the long term so reviewing those rates on a pretty regular basis is important. To address the SGF neutrality issue, to really become SGF neutral the state really has two options. So, first they can increase revenues to the program or they can decrease the programs expenditures. So far though, the state has been unable to take either of those actions. So, in 2020, the legislature increased the hospital tax rate to increase revenues, but that change has not yet taken effect. Statue tied that increase to the Center for Medicare and Medicaid services approving certain changes to the

program. So, the Center for Medicare and Medicaid services is the federal agency that oversees Medicaid programs at the state level. So far CMS has denied approval for those changes. So, as a result, the increased tax rate has not taken effect, which means the program has not yet been able to increase its revenues. The second side of that was looking at expenditures. So, in terms of decreasing expenditures, that would largely occur by reducing reimbursement rates. KDHE has not attempted to reduce rates and some of the people we talked to told us that reducing reimbursements would potentially be detrimental to Medicaid. In this audit though, we did not really assess the likely outcomes of reducing rates on how many providers might continue to participate in the program.

Andy Brienzo, Host and Principal Auditor: [09:55]
Finally, what's the main takeaway of this audit?

Heidi Zimmerman, Principal Auditor and Supervisor: [09:58]
Medicaid is complex and those complexities have made it increasingly difficult for KDHE to really monitor and track the expenditures of this program. Further the problems that we identified, KDHE was aware that they existed, but they really lack the ability to independently fix those problems. So, if HCAIP is going to consistently comply with state law, both in terms of the distributions and that state general fund neutrality, it's really going to need some changes and not only are those changes kind of needed now, but they're probably going to be needed on a consistent basis in the future as well.

Andy Brienzo, Host and Principal Auditor: [10:40]
Heidi Zimmerman is a principal auditor at Legislative Post Audit. She supervised an audit examining Kansas Healthcare Access Improvement Program. Thank you again for joining me today Heidi.

Heidi Zimmerman, Principal Auditor and Supervisor: [10:51]
Thanks for having me Andy.

Andy Brienzo, Host and Principal Auditor: [10:52]
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