Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

Effective with the date of service July 1, 2018 and forward, the Medicaid allowed amount will be increased by 4%.

The following points pertain to section 4.19A:

- The increase will not apply to State operated psychiatric hospitals.
- Psychiatric Residential Treatment Facilities (PRTFs): The payment increase will not apply to PRTF reimbursement in a similar manner.

Except as otherwise noted in the plan, the state-developed fee schedule rates are the same for both governmental and private providers for the above services. The agency's fee schedule rate was set as of July 1, 2018 and is effective for services provided on or after that date. The agency's established fee schedule rates are published on the agency's website at https://www.kmap-state-ks.us.

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

1.0000 Definitions

The following terms and definitions shall apply to reimbursement for inpatient hospital services.

a. "Admission" means the condition of entry into a hospital for the purpose of receiving inpatient medical treatment.

b. "Agency" means the Kansas Health Policy Authority (KHPA).

c. "Allowable cost" means the Medicare definition of allowable cost in effect for a hospital's fiscal year end.

d. "Border cities" mean those communities outside of the state of Kansas but within a 50 mile range of the state border.

e. "Cost outlier" means a general hospital inpatient stay with an estimated cost which exceeds the cost outlier limit established for the respective diagnosis related group.

f. "Cost outlier limit" means the maximum cost of a general hospital inpatient stay established according to a methodology specified by the Department for each diagnosis related group.

g. "Day outlier" means a general hospital inpatient stay which exceeds the day outlier limit established for the respective diagnosis related group.

h. "Day outlier limit" means the maximum general hospital inpatient length of stay established according to a methodology specified by the Department for each diagnosis related group.

i. "Diagnosis related groups (DRG)" means the classification system which arranges medical diagnoses into mutually exclusive groups.

j. "Diagnosis related groups (DRG) adjustment percent" means a percentage assigned by the Department to a diagnosis related group for purposes of computing reimbursement.

k. "Diagnosis related groups (DRG) daily rate" means the dollar amount assigned by the Department to a diagnosis related group for purposes of computing reimbursement when a rate per day is required.

l. "Diagnosis related groups (DRG) reimbursement system" means a reimbursement system in the Kansas Medicaid/MediKan Program for general hospital inpatient services which uses diagnosis related groups for determining reimbursement on a prospective basis.

m. "Diagnosis related groups (DRG) weight" means the numeric value assigned by the Department to a diagnosis related group for purposes of computing reimbursement.

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

1.0000 continued

n. "Discharge" means the condition of release from a hospital. A discharge occurs when the recipient leaves the hospital or dies. A transfer to another unit within a hospital (except to a swing bed), or a transfer to another general or state operated hospital is not a discharge.

o. "Discharging hospital" means (in instances of the transfer of a recipient) the hospital which discharges the recipient admitted from the last transferring hospital.

p. "Disproportionate share hospital" means a hospital which has a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Kansas, or a hospital whose low income utilization rate exceeds 25 percent. A disproportionate share hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid eligible individuals. This does not apply to a hospital whose inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services to the general population as of December 21, 1987. In the case of a hospital located in a rural area as defined by the Health Care Financing Administration, Executive Office of Management and Budget, the term "obstetrician" may include any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

q. "Estimated cost" means the cost of general hospital inpatient services provided to a recipient which is computed using a methodology specified by the Department.

r. "General hospital" means an establishment with an organized medical staff of physicians, with permanent facilities that include inpatient beds, with medical services, including physician services and continuous registered professional nursing services for not less than 24 hours of every day, and which provides diagnosis and treatment for patients.

s. "General hospital group" means the category to which a general hospital is assigned by the Department for purposes of computing reimbursement.

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1.0000 continued

t. "General hospital inpatient beds" means the number of beds as reported by the general hospital on the hospital and hospital health care complex cost report form excluding those beds designated as skilled nursing facility or intermediate care facility beds. For hospitals not filing the hospital and hospital health care complex cost report form the number of beds shall be obtained from the provider application for participation in the Kansas Medicaid/Medikan Program form.

u. "Group reimbursement rate" means the dollar value assigned by the Department to each general hospital group for a diagnosis related group weight of one.

v. "Large Public Kansas Teaching Hospital" is a public hospital located within the State of Kansas with a minimum of 200 inpatient beds and a minimum of 100 interns and residents.

w. "Length of stay as an inpatient in a general hospital" means the number of days an individual remains for treatment as an inpatient in a general hospital from and including the day of admission, to and excluding the day of discharge.

x. "Low income utilization rate" means the sum of (1) the fraction expressed as a percentage, the numerator of which is the sum for a period of the total revenues paid by Medicaid to the hospital for patient services and the amount of the cash subsidies for patient services received directly from state and local governments, and the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and (2) a fraction expressed as a percentage, the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies (as referred to above in [1]) in the period reasonably attributable to inpatient hospital services, not including contractual allowances and discounts other than for indigent patients not eligible for Medicaid and the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period. Medicaid revenue shall include payment made to the hospital from managed care entities on behalf of Medicaid beneficiaries.

y. "Medicaid inpatient utilization rate" means a fraction expressed as a percentage, the numerator of which is the hospital's number of inpatient days attributable to patients who for such days were eligible for Medicaid in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. The numerator shall include managed care patient days for Medicaid eligible beneficiaries.

z. "Metropolitan statistical area (MSA)" means a geographic area designated as such by the United States executive office of management and budget.

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

1.0000 continued

z. "Readmission" means the subsequent admission of a recipient as an inpatient into a hospital within 15 days of discharge as an inpatient from the same or another hospital participating in the DRG reimbursement system.

aa. "Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource use associated with all existing DRG categories and/or the creation or elimination of DRG categories.

bb. "Standard diagnosis related group DRG) amount" means the amount computed by multiplying the group reimbursement rate for the general hospital by the diagnosis related group weight.

cc. State-operated hospital' means an establishment operated by the State of Kansas with an organized medical staff of physicians, with permanent facilities that include inpatient beds, with medical services, including physician services and continuous registered professional nursing services for not less than 24 hours of every day, and which provides diagnosis and treatment for nonrelated patients.

dd. "Stay as an inpatient in a general hospital" means the period of time spent in a general hospital from admission to discharge.

ee. "Transfer" means the movement of an individual receiving hospital inpatient services from one hospital to another hospital, or different units within the same hospital, for additional related inpatient care after admission to the previous hospital, hospitals, or hospital units.

ff. "Transferring hospital" means the hospital which transfers a recipient to another hospital. There may be more than one transferring hospital for the same recipient until discharge.

gg. "Critical Access Hospital": Hospitals that are certified as critical access hospitals by Medicare.

hh. "Border city children's hospital" is defined as a comprehensive pediatric medical center with 200 beds or more, a level I pediatric trauma center, and at least a level IIIc intensive care nursery. The border city children's hospital must be located in a Kansas border city. A Kansas border city means those communities outside of the state of Kansas, but within a 50-mile range of the state border.

ii. "Hospital located in a frontier county": A hospital located within a county where the population is fewer than 6.90 persons/sq. mi. The population density is taken from the 2010 Census.

jj. "Hospital located in a rural county": A hospital located within a county where the population is 6.0 – 19.9 person/sq. mi. The population density is taken from the 2010 Census.

kk. "Hospital located in a densely-settled rural county": A hospital located within a county where the population is 20.0 - 39.9 persons/sq. mi. The population density is taken from the 2010 Census.

ll. "Large Hospital" is defined as any hospital in the State of Kansas with 500 or more available beds, as reported on the Medicare cost report, defined in Section 6.2000 B.

mm. "State Institutional Alternatives (SIA)" are defined as facilities that provide inpatient psychiatric treatment and are authorized by the Kansas Department of Aging and Disability Services (KDADS) to serve as an alternative to placement in a state mental health institution.

nn. "Rural Emergency Hospital (REH)" is defined as a licensed general hospital or a critical access hospital that applies for and receives licensure as a rural emergency hospital. REH facilities must meet regulatory requirements set by Medicare.

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2.0000 Reimbursement for Inpatient General Hospital Services According to Diagnosis Related Groups (DRGs)

2.1000 Hospital Participation Effective Date

Effective with services provided on or after October 1, 2000, general hospitals will be paid in accordance with the Kansas Medicaid/MediKan Diagnosis Related Groups (DRG) Reimbursement System described in 2.0000 and 3.0000. This does not include state-operated hospitals. State-operated hospitals are discussed in 4.0000.

2.2000 Billing Requirements

This section describes variations in how billings should be made by hospitals.

2.2100 General Billing

Under the DRG Reimbursement System a hospital may bill only upon discharge of the recipient except as noted in subsections 2.2200 and 2.2300.

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2.2200 Transfer Billing

A transferring hospital participating in the DRG Reimbursement System shall submit a bill at the time of transfer even though a transfer is not defined as a discharge. The method of computing reimbursement for a transferring hospital is different from that for a discharging hospital as discussed in subsections 2.5410 and 2.5440.

2.2300 Interim Billing

An interim bill is a claim which covers less than an entire inpatient stay. A general hospital may, at its option, submit interim billings for an inpatient stay longer than 180 consecutive days with the same DRG assignment. An inpatient stay qualifies for interim payment under the DRG Reimbursement System on the 180th day and at 180 day intervals thereafter in most cases. The following criteria apply:

a. The first interim bill shall begin with the date of admission, and all subsequent interim billings shall start with the day following the last date of service included on the preceding interim billing. There should be no duplication of days between any two consecutive interim bills.

b. Each interim bill shall include no less than 180 days of continuous inpatient stay with the exception of the following two situations where less than 180 days may have elapsed after the preceding interim bill:

- The final interim bill at the time of discharge.

- The combination interim/federal fiscal year end cut-off billing, because on Oct. 1 of each year a new 180 day interim billing cycle will begin.

2.3000 Hospital Grouping

The agency shall assign each general (non-CAH)hospital participating in the Kansas Medicaid/Medikan Program to a group as indicated below. The agency shall redetermine hospital group assignments annually. The agency shall notify in writing each general hospital of its group assignment. The cost reports with fiscal years ending on and before December 31 of the previous year shall be used to establish group placement. Effective December 29, 1995, hospitals shall be assigned to groups according to the following method.

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2.3000 continued

a. A general hospital assigned to group one shall be:

1. Located within a metropolitan statistical area in the state of Kansas and have a minimum of 200 general hospital inpatient beds; or
2. Located within the state of Kansas and within 10 miles of a general hospital meeting the criteria set forth in subsection a (1).

b. A general hospital assigned to group two shall be:

1. Located within a metropolitan statistical area in the state of Kansas and have less than 200 general hospital inpatient beds; or
2. Located outside of a metropolitan statistical area in the state of Kansas, and have a minimum of 100 general hospital inpatient beds; or
3. Located within the State of Kansas and within 10 miles of a general hospital meeting the criteria set forth in subsections b (1) or b (2); or

c. A general hospital shall be assigned to group three if it does not meet the criteria pursuant to subsections a or b above and it is located within the State of Kansas.

d. A general hospital shall be assigned to group one if it meets the criteria for assignment to both group one and group two.

e. Any hospital located outside of the State of Kansas, including border cities, shall be assigned to group four. These hospitals shall be assigned a payment rate which is the same as group two hospitals, except that the increase identified in section 2.5000 does not apply to Out-of-State hospitals.

f. Critical Access Hospital: Effective for dates-of-service on or after October 5, 2007, hospitals certified as critical access hospitals by Medicare are treated as critical access hospitals for Medicaid.

2.4000 The DRG Reimbursement System Components

The agency has used the DRG classification published by Centers for Medicare and Medicaid Services for developing the necessary components of the DRG Reimbursement System. In addition, effective Oct. 1, 1992, the Department has established new DRG classifications for neonatal services as indicated below.

789 Short stay neonates died or transferred (2 day maximum)
790 through 792 No longer used
793 Birth weight > 2000 grams, full term with major problems
794 Birth weight > 2000 grams, full term with other problems
795 Birth weight > 2000 grams, premature or full term, without complicating diagnoses
993 Birth weight < 1000 grams
994 Birth weight 1000 - 1499 grams
995 Birth weight 1500 - 2000 grams
996 Birth weight > 2000 grams, w/ respiratory distress syndrome
997 Birth weight > 2000 grams, premature w/ major problem

After the DRG number reassignments, all these claims became part of the total data base used for the DRG Reimbursement System.

Subsections 2.4100 through 2.4700 provide a discussion of the development of all the system components for use effective January 1, 2005. The discussion flows in the order of the steps performed for the computations involved. For example, the establishment of the data base (Subsection 2.4100) was necessary before cost determination (Subsection 2.4200), outlier claims had to be identified (Subsection 2.4300) prior to separating them out from the data base (Subsection 2.4410).

2.4100 Data Base

For developing the DRG relative weights, group payment rates, and other system components for use effective October 1, 2010, the agency used as data base the Medicaid/MediKan paid claims for services the eighteen month period ending the previous December. Certain claims were excluded from the data base while some others were modified before including in the data base as listed below.

2.4110 Claims Excluded from the Data Base

- crossover claims (Medicare paid by Medicaid).
- swing bed claims.
- claims paid from out-of-state hospitals.
- claims from transferring hospitals (in case of transfers, only the claims from the final discharging hospitals were included in the data base), except for DRG 789..
- adjusted claims (in cases where a hospital resubmitted a claim with corrections, the original claim was excluded from the data base. Only the final paid claim was included).
- interim claims which could not be matched together.

- claims with unusually low cost data for the given DRG, or other abnormal data.

2.4120 Claims Modified Before Including in the Data Base

Interim claims were identified and matched together to result in either a complete stay or a lengthy stay where no discharge had occurred.

2.4200 Determination of the Costs of Claims

The cost of each claim in the data base was determined using the cost data from the respective hospital's cost report, as discussed below.

2.4210 Cost Reports

The Department used the most recently available unaudited hospital cost reports to obtain the cost data for determining costs of claims.

2.4220 Cost Data

The cost data considered for computing costs of claims included education and capital costs. Indirect and direct medical education costs were later removed, however, as specified in Section 2.4240.

2.4230 Cost Determination

The reimbursable Medicaid/MediKan cost of each claim was computed by applying the per day rates (Worksheet D-1) and cost-to-charge ratios (Worksheet C) obtained from the corresponding hospital's cost report, to the covered Medicaid/MediKan days and ancillary charges on the claim.

2.4240 Hospital Specific Adjustments

Medical Education: Indirect and direct medical education costs identified in the cost reports were removed.

2.4250 Example to Illustrate Cost Determination

Data

- Medicaid days and charges from a claim (the first and third columns in the routine service table and the second column in the ancillary service table).

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2.4250 continued

- Rates and cost-to-charge ratios from the hospital cost report (the second column in the routine service table and the first column in the ancillary service table).

Computations

Routine Cost = No. of Days x Rate
Ancillary Cost = Charges x Ratio

Routine Services	Medicaid/Medikan Days	Rate	Charges	Cost
Routine	6	$247.70	$1,500	$1,486.20
Nursery	0	300.42	0	.00
ICU	1	399.36	400	399.36
CCU	0	399.36	0	.00
Sub 1	0	247.70	0	.00
Sub 2	0	247.70	0	.00
Subtotal - Routine	7		$1,900	$1,885.56

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2.4250 continued

Ancillary Services	Ratio	Charges	Cost
Operating Room	0.673302	$ 150.00	$ 101.00
Recovery Room	0.673302	30.00	20.20
Delivery Room	1.167897	.00	.00
Anesthesia	0.768581	75.00	57.64
Radiology - Diagnostic	0.725719	225.00	163.29
Radiology - Therapeutic	0.725719	.00	.00
Nuclear Medicine	0.587560	.00	.00
Laboratory	0.709475	175.00	124.16
Blood	0.709475	25.00	17.74
Respiratory Therapy	0.338426	.00	.00
Physical Therapy	0.689033	.00	.00
Occupational Therapy	2.700472	.00	.00
Speech Therapy	0.912793	.00	.00
EKG	0.206447	50.00	10.32
EEG	0.206447	.00	.00
Medical Supplies	0.473224	325.00	153.80
Pharmacy	0.437813	400.00	175.13
Renal Dialysis	0.000000	.00	.00
Ultrasound	0.477787	.00	.00
Emergency	1.508338	.00	.00
Subtotal (Used for Other Charges Ratio)		$1,455.00	$ 823.28
Other Charges	0.56650	.00	.00
Subtotal - Ancillary		$1,455.00	$ 823.28
Total Medicaid Charges and Cost		$3,355.00	$2,708.84

Analysis

In this example, the final cost of the claim is $2,708.84.

2.4260 Inflation of the Cost and Charge Data

Due to the variety of cost report time periods and discharge dates present in the data base, all routine and ancillary cost from each claim was inflated to the midpoint of the state fiscal year for which the DRG weights will apply. Inflation is calculated using the CMS Hospital Prospective Payment Reimbursement Market Basket from the most recent quarter available at the time of the update. For ancillary lines, where cost is calculated using charges present on the claim, cost is inflated from the discharge date to the midpoint of the SFY. For routine lines, where cost is calculated using the average cost per day of the hospital's cost report period, cost is inflated from midpoint of the cost report period to the midpoint of the SFY.

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(Reserved for future use)

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2.4300 Identification of Outlier Claims in the Data Base

2.4310 Mean Costs and Mean Lengths of Stay

After determining costs of all claims in the data base (as discussed in subsection 2.4200), the claims were accumulated by DRG number. The next step was to compute the following for each DRG:

- Mean cost per stay
- Standard deviation of the cost per stay
- Mean length of stay (LOS)
- Standard deviation of the length of stay
- Geometric mean length of stay

2.4320 Establishment of Outlier Limits

Cost and day outlier limits were then computed for each DRG by adding 1.94 standard deviations to the mean as shown in the following formulae:

Cost Outlier Limit =	Mean Cost Per Stay	+ 1.94 x	Standard Deviation of Cost
Day Outlier Limit =	Geometric Mean Length of Stay	+ 1.94 x	Standard Deviation of LOS

Note: The day outlier limits were rounded down to the nearest whole number because portions of a day were not considered as a full inpatient day.

A claim is an outlier if its cost or length of stay exceeds the cost or day outlier limit respectively. Therefore, the costs and lengths of stay of all claims in each DRG were compared with the cost and day outlier limits established as discussed above for the corresponding DRG, to determine which claims were cost or day outliers.

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2.4330 Example of Identifying Outliers

	Days	Cost
Claim # 1 -	1	$1,039
Claim # 2 -	1	972
Claim # 3 -	1	916
Claim # 4 -	1	446
Claim # 5 -	2	1,054
Claim # 6 -	2	495
Claim # 7 -	2	1,976
Claim # 8 -	2	743
Claim # 9 -	3	1,131
Claim #10 -	3	923
Claim #11 -	3	2,479
Claim #12 -	3	1,573
Claim #13 -	4	1,234
Claim #14 -	4	1,196
Claim #15 -	4	1,641
Claim #16 -	4	2,749
Claim #17 -	5	1,586
Claim #18 -	5	1,583
Claim #19 -	5	2,341
Claim #20 -	10	3,314

Computations

Total Cost..... $29,391
Mean Cost Per Stay (Total Cost/Total Claims)..... 1,470
Standard Deviation of the Cost Per Day..... 746

Total Number of Days..... 65 days
Mean Length of Stay (Total Days/Total Claims)..... 3.25
Standard Deviation of the LOS..... 2.05
Geometric Mean Length of Stay. 2.70

Cost Outlier Limit = Mean Cost Per Stay + 1.94 x Std. Dev.
= $1,470 + (1.94 x $746)
= $2,917

Day Outlier Limit = Geometric Mean LOS + 1.94 x Std. Dev.
= 2.70 + (1.94 x 2.05)
= 6.68 days
or 6 days

Analysis

Cost Outliers: All claims with costs up to and including $2,917 (the cost outlier limit) are non-cost outlier claims. Claims with costs over $2,917 are outlier claims. Among the above listed claims, only claim #20 is a cost outlier with a cost of $3,314.

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2.4330 continued

Day Outliers: Claims with lengths of stay of 6 days or less are non-day outlier claims, whereas claims with lengths of stay 7 days and higher are day outliers. Out of the claims listed in this example, only claim #20 with a LOS of 10 days is a day outlier.

2.4400 DRG Relative Weights

The agency developed DRG relative weights specific to the Kansas Medicaid/MediKan utilization of general hospital inpatient services. The weights for low-volume DRGs were determined using DRG weights from external data, with preference given to DRG weights derived from populations expected to be similar to the Kansas Medicaid population.

DRG relative weights are used in conjunction with other components of the DRG reimbursement system for computing payment. Determination of payment is discussed in section 2.5000.

2.4410 Data Base Adjustments for DRG Weight Computations

In computing DRG relative weights the cost of each outlier claim (identified in subsection 2.4300) was capped at the outlier threshold for the DRG.

2.4420 Determination of Kansas Medicaid-Specific DRG Relative Weights

For each DRG the following averages were computed from the adjusted data base:

- average cost per stay;
- average length of stay; and
- average cost per day.

The above "average" costs and LOS differ from the "mean" costs and LOS determined earlier in subsection 2.4300. The data base used for the mean costs and mean lengths of stay in subsection 2.4300 included outlier claims, whereas, the above average costs and LOS were computed from the adjusted data base consisting of non-outlier claims and outlier claims capped at the outlier threshold of that DRG (subsection 2.4410).

An "overall average cost" for each DRG was determined from the adjusted data base. Assigning this overall average cost a weight of 1.00, a relative weight was computed for each DRG based on its average cost per stay determined above, as compared to the overall average cost:

$$\text{DRG Relative Weight} = \frac{\text{Average Cost of the DRG}}{\text{Overall Average Cost}}$$

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2.4430 Example to Illustrate the Computation of Kansas Medicaid-Specific DRG Weights

Data

This example uses the same data as in subsection 2.4330, "Example of Identifying Outliers". Since claim #20 was determined to be both a cost and a day outlier, listed below are the claims, including the capped outlier claims used in computing the relative weight of this DRG:

	Days	Cost
Claim # 1 -	1	$1,039
Claim # 2 -	1	972
Claim # 3 -	1	916
Claim # 4 -	1	446
Claim # 5 -	2	1,054
Claim # 6 -	2	495
Claim # 7 -	2	1,976
Claim # 8 -	2	743
Claim # 9 -	3	1,131
Claim #10 -	3	923
Claim #11 -	3	2,479
Claim #12 -	3	1,573
Claim #13 -	4	1,234
Claim #14 -	4	1,196
Claim #15 -	4	1,641
Claim #16 -	4	2,749
Claim #17 -	5	1,586
Claim #18 -	5	1,583
Claim #19 -	5	2,341
Claim #20 -	6	2,917

Overall Average Cost: $2,106.68
(All claims in data base)

Computations

Total Cost.....$28,994.00
Average Cost Per Stay (Total Cost/Total Claims).. 1,449.70

$$\text{Relative Weight of the DRG} = \frac{\text{Average Cost of the DRG}}{\text{Overall Average Cost of all DRGs}}$$

$$= \frac{1,449.70}{2,106.68}$$

$$= .6881$$

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(2.4430 continued)

Analysis

The relative weight of .6881 in this example means that this DRG is less expensive to treat than the average DRG (with a weight of 1.0000). In other words, it indicates this DRG costs 31.19% less in relation to average DRGs.

2.4440 Modification of Relative Weights for Low-Volume DRGs

If very few paid claims are available for a DRG, any one claim can have a significant effect on that DRG's relative weight, day outlier limit, cost outlier limit, and daily rate. A statistical methodology was used to determine the minimum sample size required to set a stable weight for each DRG, given the observed sample standard deviation. For DRG's lacking sufficient volume in the Kansas Medicaid claims data base, the DRG weight was derived using an external data base derived from the Healthcare Cost and Utilization Project's (HCUP) nationwide inpatient data set, with preference given to populations expected to be similar to the Kansas Medicaid population (e.g. Colorado, Iowa, Illinois, Indiana, Kansas, and Missouri were used in the FY 2007 update). The selection of populations used is subject to availability within the HCUP data set. When this alternative was not sufficient, normalized Medicare weights were utilized.

Outlier thresholds and average length of stay statistics for DRG's with externally derived weights were set using the appropriate statistics from the same external source. For DRG's whose weights were derived from Federal Medicare weights, in which case published cost outlier thresholds are based on a substantially different formula than is used by Kansas Medicaid, a least-squares regression equation was used to estimate the outlier threshold, based on the DRG weight.

2.4445 Hospital Acquired Conditions

Effective October 1, 2008, with Kansas Medicaid's transition to MS DRG's, Medicaid will follow Medicare's policy with regard to a reduced DRG payment for a hospital acquired condition (HAC). Approved inpatient hospital rates are not applicable for HAC's that are identified as non-payable by Medicare. The agency will apply the Medicaid rate reduction for a hospital-acquired condition through Medicaid's use of the MS DRG grouper for DRG assignment.

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19(A)

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 (A) .

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____ Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physicians services) of the plan:

Effective January 6, 2012 reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

Provider-Preventable Conditions are defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any Health-Care Acquired Conditions (HCAC). For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number of days associated with diagnoses not present on admission for any HCAC. The number of reduced days shall be based on the average length of stay (ALOS) on the diagnosis tables published by the ICD vendor used by the Kansas Medicaid program.

No payment shall be made for inpatient services for Other Provider Preventable Conditions (OPPCs). OPPCs include the three Medicare National Coverage Determinations: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

i. The identified provider-preventable conditions would otherwise result in an increase in payment.
ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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2.4450 Modification of Relative Weights for Selected DRG Pairs and Triplets

For DRG "pairs" and "triplets", a base DRG may contain up to three severity classes. A base DRG may have no complications or co-morbidity, complications and co-morbidity (CC), or major complications and co-morbidity (MCC). Severity classes reflect, within a base DRG, that additional diagnosis for a case may significantly increase resource consumption. Each DRG class has a separate DRG number.

During the calculation of the DRG weights, if a lower DRG weight results for a higher severity DRG class, the agency assigns the higher severity DRG a weight that exceeds the lower severity DRG class. For this situation, the agency increases the higher severity DRG by the average percentage increase of the Medicare DRG weights for the type of DRG "pair" or "triplet." The agency performs the adjustment in a manner that ensures total reimbursement for the base DRG is unchanged. This overriding assignment ensures that the higher severity DRG has a higher DRG weight than the lower DRG class.

2.4500 Group Payment Rates

The agency determined group payment rates for the general hospital groups discussed in section 2.3000. The group payment rates are used in conjunction with DRG relative weights and other components developed for the Kansas DRG reimbursement system to determine payment. An adjustment factor of 6.87% was applied to the group payment rates effective October 1, 2010 as a budget neutrality factor.

2.4510 Determination of Group Payment Rates

The same adjusted data base as used for DRG weights (subsection 2.4420) was used for developing group rates. Claims were identified by hospital and then sorted by the three groups based on the hospital assignments to groups. All claims were thus divided into three groups.

(Reserved for future use)

Substitute per letter dated 3/19/01

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2.4520 Example of Group Rate Computation

The following is a highly simplified example which, while illustrating the methodology used, does not represent actual numbers.

Data

Group 1		Group 2		Group 3	
DRG Cost	DRG Weight	DRG Cost	DRG Weight	DRG Cost	DRG Weight
$1,500	.5000	$1,200	.5000	$1,000	.5000
2,000	.8000	2,000	1.0000	2,000	1.0000
2,500	1.0000	800	.4000	600	.6000
3,000	1.2000	2,500	1.3000		
4,000	1.5000	3,000	1.4000		
1,000	.4000	5,000	1.8000		
6,000	2.2000	1,600	.7400		
4,500	1.4000				
2,500	1.0000				
2,000	.9000				

Computations	Group 1	Group 2	Group 3
Total Cost of Claims	$ 29,000	$16,100	$ 3,600
Total DRG Weight	10.9000	7.1400	2.1000
Total Number of Claims	10	7	3
Average Cost	$ 2,900	$ 2,300	$ 1,200
Average DRG Weight	1.0900	1.0200	.7000
Group Payment Rate	$ 2,660.55	$ 2,254.90	$ 1,714.29

The group payment rate was computed by dividing the average cost by the average DRG weight.

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2.4600 DRG Daily Rates

The agency computed DRG daily rates for all DRG classifications. These rates will be used for computing reimbursement in cases involving day outliers, transfers, and eligibility changes (see subsections 2.5300, 2.5400, and 2.5600).

2.4700 Hospital Specific Medicaid Cost to Charge Ratios

The agency established a cost to charge ratio of Medicaid utilization of inpatient services for each hospital. This ratio shows a comparison of Medicaid reimbursable costs of general hospital inpatient services with the corresponding covered charges.

Cost to charge ratios (CCR's) were calculated using the cost reports submitted by hospitals and charge data from the claims database used to compute the DRG weights and hospital group rates.

These ratios will be used in the DRG reimbursement system to estimate costs of claims for determining whether the claims meet the cost outlier criteria (subsection 2.5110), and also to compute payment for cost outliers (subsection 2.5310). Please note these ratios should not be confused with the cost to charge ratios of various ancillary service departments computed in hospital cost reports. The cost to charge ratio for out-of-state hospitals is a statewide average ratio.

2.5000 Determination of Payment Under the DRG Reimbursement System

This section provides policies and methodologies for the determination of payment in various situations under the DRG reimbursement system.

(Reserved for future use)

(Reserved for future use)

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

2.5100 Identification of Outlier Claims.

Each claim that is eligible for an outlier payment, will be tested to determine whether it meets the cost and/or day outlier criteria. If the claim does not qualify as either a cost or a day outlier, the standard DRG payment will be made to the hospital, unless the claim falls under one of the categories discussed in subsections 2.5400 through 2.5720 and another method is used for computing payment.

2.5110 Test for Cost Outlier

The covered charges on the claim will be multiplied by the pre-established Medicaid cost to charge ratio for the hospital (subsection 2.4700) to estimate the cost of the claim. If the estimated cost is higher than the cost outlier limit established for the DRG which has been assigned to the claim, a cost outlier payment will be made to the hospital in addition to the standard DRG amount.

2.5120 Testing for Day Outlier

If the covered length of stay on the claim is higher than the day outlier limit established for the DRG that has been assigned to the claim, a day outlier payment will be made to the hospital in addition to the standard DRG amount.

2.5130 Example of Testing for Outlier

Data

Hospital Data:	Group Payment Rate	$ 2,836
	Cost to Charge Ratio	.78
Claim Data:	Covered Charges	$39,760
	Covered Length of Stay	50 days
DRG Data:	DRG Weight	4.2294
	Cost Outlier Limit	$32,899
	Day Outlier Limit	67 days
	Daily Rate	$ 503
	Adjustment Percentage	.78

Computation/Comparison

Testing for Cost Outlier

Estimated Cost of Claim	=	Covered Charges x Ratio	
	=	$39,760	x .78
	=	$31,013	

Compare With Cost Outlier Limited $32,899

Section 2.5130 continued

Testing for Day Outlier:

Covered Length of Stay	50 days
Compare with Day Outlier Limit	67 days

Analysis

Cost Outlier: The estimated cost of the claim ($31,013) is less than the cost outlier limit ($32,899). Therefore, the claim is not a cost outlier.

Day Outlier: The covered length of stay on the claim (50 days) is less than the day outlier limit (67 days). Therefore, the claim is not a day outlier.

2.5200 Standard DRG Payment

Standard DRG amount will constitute the base payment for an inpatient discharge except in those situations where a partial payment may be made. Any outlier payment for the qualifying claims will be in addition to the standard DRG payment.

Standard DRG amount for a claim can be obtained by multiplying the relative weight of the DRG assigned to the claim, by the group payment rate assigned to the hospital.

Example of Standard DRG Payment Calculation:

Referring to the data in subsection 2.5130:
Standard DRG Payment = DRG Weight x Hospital Group Payment Rate

=	4.2294	x	$2,836
=	$11,995		

2.5300 Payment for Outlier Claims

If a covered general hospital inpatient stay is determined to be a cost or day outlier, the total reimbursement will consist of the standard DRG payment plus an additional amount for the outlier portion of the claim.

2.5310 Cost Outlier Payment

The payment for the cost outlier portion of a claim will be obtained by multiplying the difference between the estimated cost of the claim and the applicable cost outlier limit, by the DRG adjustment percentage. Cost outlier payment will be made for up to 360 inpatient days of stay, beyond which only day outlier payment will be made.

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2.5310 continued

Example of Computing Cost Outlier Payment:

Data

Hospital Data	:	Same as subsection 2.5130
Claim Data	:	Covered Charges…$45,980
DRG Data	:	Same as subsection 2.5130
Standard DRG Payment:		$11,995 (from subsection 2.5200)
Assumption	:	Not a day outlier

Computations

Estimated Cost	=	Covered Charges	x	Hospital Ration		
	=	$45,980	x	.78		
	=	$35,864				
Payment for Cost		Estimated		Cost Outlier	DRG Adj.	
Outlier Portion	=	(Cost	-	Limit)	x	Percentage
	=	($35,864	-	$32,899)	x	.78
	=	$2,313				
Total Payment	=	Std. DRG Pymt	+	Outlier Pymt.		
	=	$11,995	+	$2,313		
	=	$14,308				

2.5320 Day Outlier Payment

The payment for the day outlier portion will be obtained by multiplying the difference between the covered length of stay and the applicable day outlier limit, by the DRG daily rate and the DRG adjustment percentage.

Example of Day Outlier Payment Computation:

Data

Hospital Data	:	Same as subsection 2.5130
Claim Data	:	Covered Length of Stay……73 days
DRG Data	:	Same as subsection 2.5130
Standard DRG Payment:		$11,995 (from subsection 2.5200)
Assumption	:	Not a cost outlier

Computations

Payment for		Covered		Day		DRG		DRG
Day Outlier	=	[Length	-	Outlier]	x	Daily	x	Adjustment
Portion		[of Stay		Limit]		Rate		Percentage
	=	(73	-	67)	x	$503	x	.78
	=	$2,354						

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Section 2.5320 continued

Total Claim Payment	=	Standard DRG Payment	+ Outlier Payment
	=	$11,995	+ $2,354
	=	$14,349	

2.5330 Simultaneous Cost and Day Outlier Payment

If a covered general hospital inpatient stay is determined to be both a cost outlier and a day outlier, the reimbursement will be the greater of the amounts computed for cost outlier and day outlier.

Example of Payment for Simultaneous Cost and Day Outlier:

Data

Total Claim Payment for Cost Outlier…$14,308 (subsection 2.5310)
Total Claim Payment for Day Outlier…. $14,349 (subsection 2.5320)

Analysis

The higher of the two amounts, $14,349, will be the reimbursement amount for the claim which meets both cost outlier and day outlier criteria.

2.5340 Pay No More Than Charges

After the determination of the payment, including any applicable outliers, hospitals shall be paid the lesser of the Medicaid allowed amount and their allowed charges. Allowed charges are determined based upon which revenue codes are allowed as covered services.

2.5400 Payment for Transfers

When a recipient is transferred during a covered general hospital inpatient stay from one hospital to another hospital, or to a psychiatric or rehabilitation unit of the same hospital, the reimbursement to all hospitals involved in the transfer(s) will be computed as follows.

2.5410 Transferring Hospital(s)

The reimbursement to each transferring general hospital shall be the DRG daily rate for each covered day of stay. Total payment to each transferring hospital shall be no greater than the standard DRG amount, except where the transferring hospital is eligible for outlier payments.

2.5420 Discharging Hospital

The discharging general hospital shall be reimbursed the standard DRG amount. If the claim qualifies as an outlier, the discharging hospital shall be eligible for an outlier payment based solely on the length of stay at the discharging hospital.

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2.5430 Transfer To or From a non DRG Hospital

If the transferring hospital or the discharging hospital is not a hospital reimbursed under the DRG system as identified in 2.1000, reimbursement to the non DRG hospital will be computed according to the methodology for non DRG hospitals.

2.5440 Example of Payment Determination in Transfers

The following situation will provide an illustration of the various payment methods used when a patient is transferred from one hospital to another. Although the situation may not be realistic with regard to the medical treatment provided, it shows all basic payment methods for patient transfers through a single example.

A patient is admitted to a state operated hospital (Hospital A), and after a stay of two days with $1,400 in billed charges, the patient is transferred to a general hospital (Hospital B). Hospital B has the patient for three days and the case is assigned DRG #186. Hospital B is in Group 2. The patient is then transferred to another general hospital (Hospital C) due to complications. The patient is discharged after six days from Hospital C, and is assigned DRG #186. Hospital C is in Group 1.

Payment to Hospital A: Since Hospital A is a state operated hospital, the payment will be determined using the methodology specified in the section on state operated hospitals.

Payment to Hospital B: Hospital B is a transferring general hospital, and will therefore be paid a DRG daily rate for each day of stay, with total payment limited by the standard DRG amount.

Data Used for this example:

DRG Daily Rate	$ 597
DRG Weight	.6515
Group 2 Rate	$2307

The transfer payment will be computed by multiplying the number of days times the DRG daily rate; i.e., 3 times $597, or $1,791. This amount will be compared against the standard DRG amount, and the lesser of the two shall be paid. The standard DRG amount is .6515 times $2,307, or $1,503. Therefore, Hospital B would be paid $1,503.

Payment to Hospital C: Hospital C is a discharging general hospital, and would therefore be paid the standard DRG amount plus any outlier payment, if applicable.

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Section 2.5440 continued

Data Used for this example:

DRG Weight	.6515
Group 1 Rate	$2836

The standard DRG amount is $1,847.65. If this claim had been a day and/or a cost outlier, an additional payment would be made.

2.5500 Payment for Re-admission

2.5510 Readmission to the Same Hospital

If a recipient is readmitted to the same hospital within 15 days of discharge, and if the readmission is determined to have resulted from an inappropriate discharge; the reimbursement will be made only for the first admission.

2.5520 Readmission to a Different Hospital

If a recipient is readmitted to a different hospital within 15 days of discharge, and if the readmission is determined to have resulted from an inappropriate discharge; payment will be made only to the second hospital to which the patient was readmitted. Payment made to the first hospital for the original (first) admission will be recouped.

2.5530 Determination of Payment for Re-admission

Whether the reimbursement should be made for the first or the second admission (i.e., the original admission or the subsequent readmission), will be ruled by the discussion in the preceding subsections 2.5510 and 2.5520. The amount of reimbursement in each situation will be determined as provided in subsections 2.5100 through 2.5400.

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2.5600 Recipient Eligibility Changes

If a recipient is determined ineligible for the Medicaid/MediKan Program for a portion of the inpatient stay, reimbursement shall be made to the general hospital only for those days of stay which were also days of eligibility. No reimbursement shall be made for services provided on days when a recipient was ineligible for the Medicaid/MediKan Program.

The payment amount will consist of the DRG daily rate for each eligible day during the impatient stay in the hospital. No more than the standard DRG payment plus any outlier payment (if applicable), will be allowed as the total payment. Only the Medicaid covered inpatient days and charges will be used for outlier payment computation.

2.5700 Payment for Interim Billings

Hospitals will be allowed to submit interim bills for inpatient stays longer than 30 days. Each interim bill must cover 30 or more continuous days of service except the discharge billing and the federal fiscal year end cut-off billing, each of which may include less than 30 days as the situation may be.

2.5710 Payment for First Interim Billing

The first interim bill will be treated like any other claim, in the sense that it will be tested to determine if it meets the cost and/or day outlier criteria. If the stay covered in the first interim bill does not qualify as an outlier, only the standard DRG amount would be paid. If the claim exceeds the cost and/or day outlier limit(s), an appropriate outlier payment will be made in addition to the base amount.

2.5720 Payment for Second and Subsequent Interim Billings

At the time of each interim bill after the first, an outlier payment amount will be determined using the cumulative cost and days since the date of admission through the last service date included in the current interim billing. One of the following two situations may occur:

Up to 360 Days: Up until 360 days of continuous stay, the Department will authorize the fiscal agent to pay the higher of cost and day outlier amounts for each interim bill.

Longer than 360 Days: When the stay becomes longer than 360 days, only day outlier payments will be made.

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2.6000 Settlements and Recoupments

There shall be no year-end settlements under the DRG reimbursement system. However, some settlements and recoupments may occur because of Surveillance/Utilization Review or other reviews which determine that payments were in error.

3.0000 General Hospital Reimbursement for Inpatient Services Excluded from The DRG Reimbursement System

Effective January 18, 2013, reimbursement for heart, liver, and bone marrow transplant services shall be excluded from the DRG payment system. Reimbursement for these transplants shall be based upon the lesser of reasonable costs or customary charges, contingent upon transplant surgery. Due to the unusual nature of these services, negotiated rates which pay no more than the DRG daily rate may be paid. For services provided prior to the transplant surgery, or if transplant surgery is not performed, reimbursement shall be made according to the DRG payment system.

3.1000 Critical Access Hospital Reimbursement

The Critical Access Hospital (CAH) cost settlement process will end for inpatient discharges and outpatient dates of services on or after 1/1/2013. Settlement related to inpatient discharges and outpatient dates of service prior to 1/1/2013 will continue per previous State Plan Amendment methodology until finalized.

Effective 1/1/2013, a CAH Adjustment Factor (CAF) will be applied to CAH reimbursement for the Inpatient Discharges and Outpatient dates of service on or after 1/1/2013. The hospital-specific CAF is a prospective factor calculated using experience in previous cost reporting years. The factor for Year 1 (calendar 2013) is based upon the 2011 cost reporting period. Year 2 will be calculated using year-end 2012 cost reports, and so forth. The funds associated with the CAF are capped prospectively with hospital specific factors. (By contract, managed care organizations adopt the CAF methodology as the basis for their CAH reimbursement.)

For calendar year 2013, the CAF is calculated as the difference between each hospital's Fee For Service incurred costs and Fee For Service payments received as a ratio to total payments received. The period for this calculation is based on each CAH's cost reporting period ending in 2011, and factors are developed separately for both inpatient and outpatient. The CAF is adjusted to make it consistent prospectively with statewide aggregate CAH cost settlements during the 2011 cost reporting period. Effective 1/1/2025 the Kansas State Legislature added eight million dollars to the statewide aggregate CAH cost settlements during the 2011 cost report period. These funds will be split between inpatient CAF settlements and outpatient CAF settlements using the same percentage split as the inpatient and outpatient CAF settlements in 2013.

After 2013, an adjustment to the CAF will be included for prior year overpayment or underpayment that may have occurred in the aggregate relative to the estimated cap. CAHs will always receive at least the fee-for-service rate. Beginning with cost reporting year 2013, all allowable Medicaid charges will be used to calculate the CAF.

Allowable Medicaid costs are defined as the costs Medicare defines as allowable on the Medicare finalized cost report. The Medicare fiscal intermediary's review of the Medicare cost report is relied on for the determination of reasonable costs and the finalized Medicare cost report will be used for determining final Medicaid allowable costs.

3.0000 General Hospital Reimbursement for Inpatient Services Excluded from The DRG Reimbursement System (Continued)

Effective January 18, 2013, reimbursement for heart, heart-lung and lung transplant procedures were established based upon 85% of the current Medicare fee schedule rates when billed separately for professional services. Payment for transplants received out of state will be contractually negotiated with the transplant facility for up to 70% of billed charges. Medicaid will reimburse providers using the current FMAP. All hospitals providing transplant services must be a Medicare approved transplant facility.

Effective January 18, 2013, reimbursement for bariatric procedures were established based upon 85% of the current Medicare fee schedule rates when billed separately for professional services. Kansas Medicaid will reimburse Centers of Excellence providers for bariatric surgery for services rendered to Medicaid beneficiaries when selection criteria are met.

Effective January 1, 2023, long-acting reversible contraceptive (LARC) devices are excluded from the DRG Reimbursement System. The devices will be reimbursed as outlined on Attachment 4.19-B #12.a., Prescribed Drugs, Methods and Standards for Establishing Payment Rates, Physician Administered Drugs (PADS).

Effective June 20, 2025, select pharmaceuticals that are considered “carve out drugs” are excluded from the DRG Reimbursement System. “Carve out drugs” are defined as select pharmaceuticals that are greater than or equal to one hundred thousand dollars in drug costs within 365 days and can be found on the state’s website at: https://www.kdhe.ks.gov/2359/Carve-Out-Drugs. These pharmaceuticals will be reimbursed as outlined in Attachment 4.19-B #12.a., Prescribed Drugs, Methods and Standards for Establishing Payment Rates, Physician Administered Drugs (PADS).

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4.0000 Reimbursement for Inpatient Services in State Operated Psychiatric Hospitals, State Institutional Alternatives (SIA) and Large Public Kansas Teaching Hospitals

Reimbursement for inpatient services in state operated psychiatric hospitals shall be based upon the lesser of reasonable costs or customary charges for covered services rendered to eligible individuals. These costs shall include Medicare allowable costs, including but not limited to malpractice, capital, physician services, and education as allowed under federal law. Reimbursement for inpatient services in State Institutional Alternatives (SIA) shall be based upon the lesser of reasonable costs or customary charges for covered services rendered to eligible individuals. These costs shall include Medicare allowable costs, including but not limited to malpractice, capital, physician services, and education as allowed under federal law. Reimbursement for inpatient services in large public Kansas teaching hospitals is determined upon the Standard DRG payment plus an additional amount for outlier claims. Outlier payment for large public Kansas teaching hospitals are calculated consistent with the method described at 2.5100 and 2.5300. Effective May 17, 2019, and updated annually on a calendar year basis beginning January 1, 2020, the group payment rate for large public Kansas teaching hospitals calculated pursuant to sections 2.4500-2.4520 will be calculated in the following manner:

1. FFS DRG Pricing:
    a. The most recent two historical years of FFS utilization will be priced at the current effective DRG schedule to align with the year that the Academic Base Rate will be effective.
    b. This uses the KU Peer Group Rate prior to the adjustment for the Academic Base Rate and includes both the projected base DRG payment and outlier payments.
2. Encounter DRG Pricing:
    a. The most recent two historical years of encounter utilization at the current effective DRG schedule to align with the year that the Academic base rate will be effective.
    b. This uses the KU Peer Group Rate prior to the adjustment for the Academic Base Rate and includes both the projected base DRG payment and outlier payments.
3. Encounter percent of billed pricing:
    a. The most recent historical years of Encounter utilization is priced at the effective percent of billed schedule for the following year that the Academic Base Rate will be effective.
    b. The billed charges are trended from the historical period to the current calendar year effective period based on KU's historic charge master increases.
4. Upper Payment Limit (UPL):
    a. KU provided historic UPL information for the prior two historical years.
    b. Fiscal year was used as a benchmark due to KU UPL reporting period.
5. Academic Base Rate Adjustment:
    a. The KU Peer Group rate will be increased through an iterative process in such a manner the following conditions are met:
        i. The encounter DRG pricing with the updated KU Peer Group will be less than the Encounter percent of billed pricing; and
        ii. The FFS DRG Pricing with the updated KU Peer Group will be less than the historic UPL levels.
    b. Once the conditions are met, the updated KU Peer Group is finalized as the KU Academic Base Rate.

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4.0100 Inpatient Hospital Upper Payment Limit Narrative

I. The Basis of the UPL Formula

Kansas uses a payment-based demonstration of the upper payment limit (UPL) based on a comparison of the Medicaid payments to equivalent Medicare payments.

IP Template – Medicare Payment-to-Charge ratio X Medicaid Charges.

II. Source of the UPL Medicare Equivalent Data

Kansas uses the most recently filed or settled CMS 2552 hospital cost report as the source of Medicare data. The filed cost report and the settled cost reports are used. The base year is two years prior to the rate year. The State uses MMIS data from the base year, two years prior to the rate year, to calculate a reasonable Medicare estimate.

III. Cost Report References

Kansas uses the source data from the Medicare cost report to calculate payment-to-charge ratios from the cost centers on the CMS 2552 that are used to report inpatient facility cost, payment and charge data. From Worksheet E, Part A (Payments) / Worksheet D-4 (Charges), the following worksheets, columns, and lines are used:

D-3, D-4, E Part A, and E-3 Parts II, III, IV, and V.

The Medicare payment data represent the gross reported payment data.
Kansas uses the Medicare payments reported in Schedule E and includes the deductibles and coinsurance.

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IV. Medicaid Charge Data

Medicaid adjudicated inpatient hospital facility charge data from each of the hospitals in the demonstration are applied to each hospital's specific payment-to-charge data. This determines a reasonable Medicare equivalent payment amount for Medicaid equivalent services.

The Medicaid covered charges/days/discharges are from paid claims reported from the MMIS.

The claim dates of service are from the last full state fiscal year. A state fiscal year runs from July 1 of a previous calendar year through June 30 of a current calendar year. The cost reports used are the most currently available reports in HCRIS as of the March quarterly release of the following year. About half of the cost reports have a fiscal year end of the prior year and the other half will have a fiscal year end of the following year.
The State includes only those Medicaid charges that come from in-state Medicaid residents. All crossover claims are excluded. All physicians and other professional service charges are also excluded.

V. Medicaid Payment Data

The Medicare estimate for equivalent Medicaid services is compared to the Medicaid payment data from the demonstration rate year. If the Medicaid payment data are at or below the Medicare estimate, the state's inpatient hospital reimbursement methodology complies with the UPL regulations.

The Medicaid base payment data are reported from the MMIS. Medicaid payment data include all base and supplemental payments to inpatient hospital providers. Graduate Medical Education (GME) is reported separate from base payments in the UPL summary.

Medicaid payment data excludes crossover claims. The Medicaid payment is reported as gross of primary care payments, deductibles and copays. The state applies the Market Basket Inflation factor to account for how Medicaid payment rate changes between the base period and the UPL period. The dollar amount of payments for the UPL base period does not equal the "claimed" amounts on the CMS-64, Medicaid Expenditures report for the UPL time period. A small volume of out-of-state claims and regular claim adjustments creates a difference in the data.

VI. Trends and Adjustments to the UPL Data

Because UPL calculations rely on data from prior periods, the data is trended to the current rate year using The Market Basket Inflation factor. The state does not trend volume/utilization. A claims completion factor is not applied to the charge/day/discharge data. A claims completion factor is not applied to the payment data.

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VII. State UPL Data Demonstration Structure

Kansas conducts three UPL demonstrations for the following facilities: 1. State government owned or operated hospitals; 2, Non-state government owned or operated hospitals; and 3. Privately owned or operated hospitals.

All Medicaid base and supplemental payments are included in the demonstration and are separately identified. The data demonstration does not include only in-state hospitals. Out of state hospitals with at least ten Kansas Medicaid claims are included in the UPL calculation. The data on the payments are obtained from the cost report of the out of state hospitals. The out of state hospitals are included in the "private" provider category. Critical Access Hospitals (CAHs) are included in the UPL calculation. CAHs are treated the same as any other hospital.

4.1000 Reimbursement for Inpatient Services in Border City Children's Hospitals

Reimbursement for inpatient services in border city children's hospitals is determined upon the Standard DRG payment plus an additional amount for outlier claims. Outlier payment for border city children's hospitals are calculated consistent with the method described at 2.5100 and 2.5300.

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5.0000 Reimbursement for NF Services (Swing Beds) in General Hospitals

Reimbursement for NF services (swing beds) provided in general hospitals (swing bed hospitals) shall be pursuant to 42 CFR 447.280.

6.0000 Disproportionate Share Payment Adjustment

The Kansas Medical Assistance Program shall make a reimbursement adjustment for disproportionate share hospitals which are either located in the State of Kansas or located outside of the State of Kansas but operate a hospital that is located within the State of Kansas. The reimbursement adjustment for disproportionate share hospitals shall be made for hospitals eligible under criteria contained in 6.1000 below. The calculated reimbursement adjustment will be made in quarterly installments to DSH eligible hospitals.

For hospitals to be eligible under 6.1000, they must have at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the State Plan, except where the hospital serves predominantly individuals under 18 years of age, or where non-emergency obstetric services to the general population were not offered as of July 1, 1988. In rural areas the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. Please see section 6.5000 for additional instructions.

All references in the Disproportionate Share sections to Medicaid payments and days refer to both fee for service and managed care.

6.1000 Eligibility for DSH Payment

Eligibility for Disproportionate Share Hospital (DSH) payments shall be determined if:

(A) The hospital's Medicaid inpatient utilization rate exceeds the lesser of one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or 25 percent; or

(B) The hospital's low-income utilization rate exceeds 25 percent.

(C) For purposes of paragraph (A), the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period (regardless of whether such patients receive medical assistance on a fee-for-services basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

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6.1000 Eligibility for DSH Payment (continued)

(D) For purposes of paragraph (B), the term "low-income utilization rate" means, for a hospital, the sum of –

(1) the fraction (expressed as a percentage) –
   a. the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan approved under this title (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and
   b. the denominator of which is the total amount of net inpatient revenues of the hospital for patient services in the period; and

(2) a fraction (expressed as a percentage) –
   a. the numerator of which is the total amount of the hospital's charges for inpatient and outpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in (1) a. in the period reasonably attributable to inpatient hospital services, and
   b. the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the period.

(E) Hospitals will be deemed disproportionate share hospitals in accordance with 42 U.S.C. §1396r-4(b).

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6.2000 Limitation on DSH Payments

A. Limitation on Total DSH Funds Allocated
The allocation of DSH funds is structured so as not to exceed the allotment determined by Centers for Medicare & Medicaid Services (CMS) in accordance with section 1923(f)(3) of the Social Security Act. As the DSH payment methodology described in subsequent sections allocates only available DSH funding, in no case shall allocated DSH funds exceed the Kansas federal allotment.

B. All Hospitals are limited to no more than their Uncompensated Care Costs (UCC). UCC is the uncompensated cost of care to the Kansas portion of uninsured and the uncompensated cost of care to Medicaid participants. The data to be used in the calculating of each hospital's UCC will be obtained from several sources including a hospital DSH survey, Medicaid paid claims data, and the hospital's Medicare cost report. The period of the data to be utilized will coincide with the period of the Medicare cost report, filed with Medicare, for each hospital that is available no later than four months prior to the start of the state fiscal year (SFY) for which payments are being made. This limitation is computed by Medicaid below.

B1. UCC Uninsured Inpatients - For purposes of the DSH calculation the uninsured are defined as those individuals who lack third party coverage for eligible services received. Hospitals are required to submit on their annual DSH survey the amount of uninsured days, charges, and payments attributable to inpatient hospital services. These uninsured days and charges will be grouped by cost center and multiplied by the hospital's inpatient per diems and cost-to-charge ratios, as calculated from their Medicare cost report, to arrive at total inpatient uninsured costs. The total inpatient payments received from the uninsured will be subtracted from the costs to arrive at the uncompensated uninsured inpatient costs. The reported uninsured charges and payments should exclude non-hospital services such as: Skilled Nursing Facilities (SNF), Nursing Facility (NF), Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), as well as physician charges.

B2. UCC Uninsured Outpatients – For purposes of the DSH calculation the uninsured are defined as those individuals who lack third party coverage for eligible services received. Hospitals are required to submit on their annual DSH survey the amount of uninsured charges and payments attributable to outpatient hospital services. These uninsured charges will be grouped by cost center and multiplied by the hospital's outpatient (ancillary) cost to charge ratios, as calculated from their Medicare cost report, to arrive at total outpatient uninsured costs. The total outpatient payments received from the uninsured will be subtracted from the costs to arrive at the uncompensated uninsured outpatient costs. The reported uninsured charges and payments should exclude non-hospital services such as: Skilled Nursing Facilities (SNF), Nursing Facility (NF), Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), as well as physician charges.

B3. Kansas Medicaid Inpatient Days in last available fiscal year of hospital. The Kansas Medicaid Inpatient Days will be obtained from paid claims data for the period of the hospital's cost report used in the DSH calculation as identified in Section 6.2000 B.

B4. All Medicaid Inpatient Days in last available fiscal year of hospital. All Medicaid inpatient days are the total of Kansas inpatient Medicaid days obtained from the paid claims summary, and the hospitals out-of-state Medicaid inpatient days obtained from the hospital DSH survey. The service period for accumulating these days will coincide with the cost reporting period identified in 6.2000 B.

B5. Kansas portion of Medicaid inpatient days (B3 / B4).

B6. Kansas portion of Uninsured Inpatient Uncompensated Cost (B1 x B5).

B7. Kansas portion of Uninsured Outpatient Uncompensated Cost (B2 x B5).

B8. UCC Kansas Medicaid Inpatients – The UCC related to Kansas Medicaid inpatients is calculated by multiplying the Kansas Medicaid inpatient days and charges, as obtained from the paid claims summary, times the inpatient per diems and cost-to-charge ratios by cost center, as determined from the hospital's cost report, to arrive at calculated Medicaid inpatient costs. Total Kansas inpatient Medicaid payments, including any supplemental or enhanced payments, are then subtracted from the calculated Medicaid inpatient costs to arrive at the UCC for Kansas inpatient Medicaid services. If the result of this calculation is a negative, or gain, this amount is used to reduce the hospital's overall UCC.

B9. UCC Kansas Medicaid Outpatients – The UCC related to Kansas Medicaid outpatients is calculated by multiplying the Kansas Medicaid outpatient charges, as obtained from the paid claims summary, times the outpatient (ancillary) cost-to-charge ratios by cost center, as determined from the hospital's cost report, to arrive at calculated Medicaid outpatient costs. Total Kansas Outpatient Medicaid payments, including any supplemental or enhanced payments, are then subtracted from the calculated Medicaid outpatient costs to arrive at the UCC for Kansas outpatient Medicaid services. If the result of this calculation is a negative, or gain, this amount is used to reduce the hospital's overall UCC.

B10. Total Hospital-Specific DSH Limitation ("DSH limit") = (B6 + B7 + B8 + B9). The calculated DSH limit will be annualized if a cost report period less than 12 months is used in the calculations.

(Reserved for future use)

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

6.3000 Allocation of DSH Funds

Effective for DSH calculations beginning with federal fiscal year (FFY) 2020, total available DSH funds shall be distributed among DSH-eligible hospitals as defined in Section 6.1000 above based upon each hospital's burden of UCC (DSH limit) relative to their peers within the pools established below. The calculations of the total available DSH funds and the DSH funding pools is contained in Sections 6.3000 A and B. The State will expend its annual DSH allotment. If CMS changes the DSH allotment for a prior year, the State will adjust the expenditures based on Sections 6.3000 A, B, C, and D. In addition, pools of DSH funding will be established for like groups of hospitals to establish limitations on the available funding for each pool.

A. Available DSH funds to the following types of hospitals will be established as follows:
   1. The Institutes for Mental Disease (IMD) Pool - Will be equal to the Federal IMD DSH allotment for the State of Kansas.

   2. Out-of-State Hospital Maximum Pool – DSH-eligible out-of-state hospitals will share up to a maximum pool of DSH funds. The pool of DSH funds available for DSH-eligible out-of-state hospitals will be calculated each year and limited to the lesser of 10 percent of the non-IMD Federal DSH allotment for the State of Kansas or the amount calculated in Sections 6.3000 C and D.

   3. State-Owned or Operated Teaching Hospital Maximum Pool – DSH-eligible hospitals that are state-owned or operated and provide graduate medical education programs will share up to a maximum pool of DSH funds. The pool of DSH funds available for DSH-eligible state-owned or operated teaching hospitals will be calculated each year, and limited to .25 percent of the non-IMD Federal DSH allotment for the State of Kansas.

   4. Large Hospital Pool – Large hospitals will share a pool of DSH funds. Large hospitals are defined as all DSH-eligible, non-IMD, non-state hospitals, in the state of Kansas, with 500 or more available hospital beds, as reported on the Medicare cost report, defined in Section 6.2000 B.
      a. Initial large hospital pool determination is as follows:
         i. For the initial year (FFY 2020), the available DSH funds for the large hospital pool will initially be equal to $18,677,107.
            1. For purposes of the initial year (FFY 2020) only, references to the prior year DSH payments or allotments in this section are referencing FFY 2018.
         ii. For FFY 2021 and after, the large hospital pool will initially be equal to the prior year large hospital pool excluding any IMD allotment reclassified in the prior year to the large hospital pool, in accordance with Section 6.3000 B.1.a.
      b. Adjust for the change in the hospitals qualifying under the large hospital pool.
         i. A reduction to the large hospital pool will be made equal to the hospital's prior year DSH payment, if the hospital is no longer eligible for the large hospital pool but was included in the prior year. The prior year DSH payment will exclude pool reclassifications from the IMD pool defined under 6.3000 A.1.
         ii. An increase to the large hospital pool will be made equal to the hospital's prior year DSH payment, if the hospital is newly eligible for the large hospital pool but was not included in the prior year. The prior year DSH payment will exclude pool reclassifications from the IMD pool defined under 6.3000 A.1.

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c. Take the lesser of:
   i. The sum of Sections 6.3000 A.4.a and b, above, multiplied by the percentage change in the current year Kansas non-IMD federal DSH allotment, compared to the Kansas non-IMD federal DSH allotment used in the prior year's DSH calculations.
   ii. The sum of all large hospital DSH limits calculated under Section 6.2000 B in the current year DSH payment calculation.

d. Prior year federal DSH allotment changes will only be recognized in the large pool when the allotment for the specific DSH payment year is determined to be final by CMS and the State. If the change in allotment is for a prior year but impacts the specific DSH year indirectly, no change will be made to the indirectly impacted DSH year until that DSH year allotment is also deemed final by CMS and the State.

5. Other In-State DSH-Eligible Hospital Pool – Hospitals eligible for DSH payments that are not classified as IMDs and were not included in any of the pools under Section 6.3000 A, above, will be distributed the remaining DSH funds from the non-IMD federal DSH allotment. The remaining DSH funds for distribution to this pool will consist of the non-IMD federal DSH allotment for the State of Kansas less the DSH payments calculated for DSH-eligible hospitals included in all other pools under Section 6.3000 A, above.

B. Funds available will be established in the following order:
   1. IMD Hospital Pool
      a. Any IMD allotment not able to be used by the IMD hospital pool, due to DSH limits, under Section 6.2000 B, may be reclassified, to all non-IMD hospital pools under Section 6.3000 A, based on each pool's initial calculated proportion of the total non-IMD pool.

   2. Non-IMD Pools
      a. Out-of-State Hospital Maximum Pool
      b. State-Owned/Operated Teaching Hospital Maximum Pool
      c. Large Hospital Pool
      d. Other in-State DSH-Eligible Hospital Pool

   i. Unused DSH funds from any non-IMD pool will be reclassified to the "Other in-State DSH-Eligible Hospital Pool".

The following table illustrates the methodology used to calculate the total DSH funds available and the amounts allocated to each pool. The amounts are for example purposes only and will not be used in the actual DSH payment calculations.

EXAMPLE Large Hospital Pool Calculations

Prior Year Final Adjusted Large Hospital Pool		$ 21,485,362
Less Prior Year IMD Pool Reclassifications to the Large Hospital Pool		$ (3,740,476)
Reductions for Large Hospitals No Longer Eligible for the Pool (Prior Year DSH Payment excluding IMD Pool Reclassifications)		$ -
Increase for Newly Eligible Large Hospitals (Prior Year DSH Payment excluding IMD Pool Reclassifications)		$ -
Sub-total Large Hospital Pool		$ 17,744,886
Prior Year Kansas Non-IMD Federal Allotment	$53,916,268	
Current Year Kansas Non-IMD Federal Allotment	$56,748,739	
Percentage Change in Non-IMD Federal Allotment		5.25%
Sub-total Large Hospital Pool		$18,677,107
Sum of All Large Hospital DSH Limits For Current DSH Payment Year		$65,506,030
Total Large Hospital Pool (Lesser of)		$18,677,107

EXAMPLE Adjusted DSH Pool Calculations:

Description	Initial Pool	Proportional % of Non-IMD Pool	Pool Reclassifications for Unused Pool Funds	Adjusted Pool
Total Federal DSH Allotment	$ 46,364,567			
FMAP	54.74%			
Total DSH Funds Available	$ 84,699,611			
IMD Pool of DSH Funds (Published by CMS)	$ 27,950,872		$ (14,905,997)	$ 13,044,875
Non-IMD Pool of DSH Funds	$ 56,748,739	100.00%	$ 14,905,997	$ 71,654,736
Out-of-State Hospitals (10% of Non-IMD Pool)	$ 5,674,874	10.00%	$ 1,490,600	$ 7,165,474
State-Owned/Operated Teaching Hospitals (.25% of Non-IMD Pool)	$ 141,872	0.25%	$ 37,265	$ 179,137
Large Hospital Pool (Calculated above)	$ 18,677,107	32.91%	$ 4,905,564	$ 23,582,671
Non-IMD Pool Sub-Total	$ 24,493,853	43.16%	$ 6,433,429	$ 30,927,282
Remaining Non-IMD Allotment for Other In-State DSH-Eligible Hospital Pool	**$ 32,254,886**	**56.84%**	**$ 8,472,569**	**$ 40,727,455**

C. The allocation of DSH funds among eligible hospitals that are not IMDs will distribute DSH funds proportionally to hospitals in each pool based upon each hospital's relative burden of Kansas UCC (DSH limit) to their total hospital cost, as follows:

1. **Three-Year Rolling Average Hospital Burden** - The hospital burden of each DSH-eligible hospital is calculated to determine the percentage of the hospital's business that is related to providing Kansas uncompensated care. This burden is calculated by dividing the hospital's DSH limit, as defined in Section 6.2000 B., by the hospital's total cost. For purposes of the hospital burden calculation, the total hospital cost will be determined from the hospital's cost report as identified in Section 6.2000 B. The total hospital cost will be the total cost from Worksheet B Part I of the cost report less any costs associated with non-hospital services such as: Skilled Nursing Facilities (SNF), Nursing Facilities (NF), Rural Health Clinics (RHC), Home Health Agencies (HHA), and Federally Qualified Health Centers (FQHC). Total hospital cost will be annualized if the cost report period is less than 12 months. A three-year rolling average of the hospital burden will be used for the allocation of the DSH funds. The three-year rolling average of the hospital burden will be calculated as follows:
   a. U = hospital-specific DSH limit calculated under Section 6.2000 B.
   b. C = hospital-specific total costs as determined in this section, excluding non-hospital services.
   c. Hospital-specific burden: B = U/C
   d. F^A = three-year rolling average hospital burden. The average of the current year and two previous DSH years' hospital-specific burden, if available. If no burden was calculated in either of the previous two years, the applicable years will not be used in the average. If a burden was calculated in the previous two years for DSH payment eligibility, even if it was zero, it will be used in the three-year rolling average hospital burden.

2. **Hospital Scaling Factor** - All rural hospitals will have a scaling factor of 150 percent applied to the hospital-specific DSH limit calculated under Section 6.2000 B. The term "rural hospitals", as used in this section, refers to all critical access hospitals, rural hospitals, frontier hospitals, and densely settled rural hospitals, as determined by the State, no later than four months prior to the start of the federal fiscal year for which payments are being made. All other hospitals will have a scaling factor of 100 percent applied to the hospital-specific DSH limit.
   a. F^S = hospital scaling factor

3. **Burden-Adjusted DSH Limit** - Represents the hospital's DSH limit adjusted for the hospital's three-year rolling average burden and the hospital scaling factors.
   a. $B^A = F^A \times U \times F^S$

4. **Proportion of Burden-Adjusted DSH Limit** - Represents the hospital's proportion of the burden-adjusted DSH limit compared to all other DSH-eligible non-IMD hospitals.
   a. D^L = proportion of burden-adjusted DSH Limit for large hospital pool hospitals.
   b. D^O = proportion of burden-adjusted DSH Limit for all other non-IMD hospitals.
   c. Large Hospital Pool: $D^L = B^A$ / Total Burden-Adjusted DSH Limit (B^A) for all DSH-eligible non-IMD hospitals included in the large hospital pool.
   d. Non-IMD Pool Excluding Large Hospital Pool: $D^O = B^A$ / Total Burden-Adjusted DSH Limit (B^A) for all DSH-eligible non-IMD hospitals excluded from the large hospital pool.

5. **Formula for DSH Payment** -
   a. P^L = large hospital pool as determined under Section 6.3000 A.4, including any non-IMD pool reclassification to the large hospital pool, under Section 6.3000 B.1.
   b. P^N = total Kansas non-IMD allotment, including any non-IMD pool reclassification, under Section 6.3000 B.1 less P^L.
   c. $D^L * P^L$ for large hospital pool.
   d. $D^O * P^N$ for all other non-IMD hospital pool.

6. **Reclassifications** - Any amounts allocated to a non-IMD hospital in excess of their available DSH limit or in excess of maximum allowed payments under any pool will be reclassified to other hospitals in accordance with Section 6.3000 B. The proportion allocated to each applicable hospital will be based on their proportion of the total calculated DSH payments under Section 6.3000 C.5, above, not to exceed their hospital-specific DSH limit.

7. **Critical Access Hospital (CAH) minimum percent of DSH limit paid** - CAHs eligible for a DSH payment will receive the greater of the current year calculated hospital-specific DSH payment or 37 percent of their hospital-specific DSH limit.
   a. Increases in CAH DSH payments due to the 37 percent minimum will be offset by proportional adjustments to all hospitals in the other in-state DSH-eligible hospital pool based on their individual calculated DSH payment allocations. It will not impact the out-of-state, state-owned/operated teaching, or large hospital pools.

D. Eligible hospitals that are defined as Institutes for Mental Disease (IMDs) will receive an allocation of DSH funds from the allotted IMD pool as defined in Sections 6.3000 A and B, above. The allocation to DSH-eligible IMD hospitals will be calculated by dividing each eligible IMD hospital's DSH limit by the total DSH limit for all DSH-eligible IMD hospitals. The percentage calculated will then be multiplied by the total allotment for IMD hospitals, as defined in Sections 6.3000 A and B, above. Each IMD hospital will receive the lesser of the calculated amount or their DSH limit as defined in Section 6.2000 B.

E. DSH payments found in the DSH audit process that exceed the hospital-specific DSH limits may be recouped from the hospitals to reduce their DSH payments to their hospital-specific DSH limit. Any payments that are recouped from hospitals as a result of the DSH audit will be redistributed to hospitals that are shown to have been paid less than their hospital-specific DSH limits. Total redistribution payments may not exceed total DSH recoupment to date. To redistribute the funds, the State will do the following:

   a. Hospitals closed or bankrupt as of the date of the redistribution calculation may be excluded from the funds available for redistribution and will be excluded from any available redistribution.

   b. Redistribute the state IMD DSH recoupment to all other eligible state IMD hospitals that are shown to have been paid less than their hospital-specific DSH limits in the DSH audit. The redistribution will occur proportionally based on each hospital's total available DSH limit in the DSH audit (shortfall) to the total shortfall for all state IMD hospitals, not to exceed each hospital-specific DSH limit. Any overpayment which cannot be redistributed within the state-IMD hospitals will be redistributed to non-IMD state hospitals using the same methodology.

   c. Redistribute the remaining DSH recoupment to all in-state eligible hospitals that are shown to have been paid less than their hospital-specific DSH limits in the DSH audit. The redistribution will occur proportionally based on each hospital's remaining DSH limit in the DSH audit (shortfall) to the total shortfall for all in-state eligible hospitals, not to exceed each hospital-specific DSH limit.

F. Hospital Payment Adjustment - If a hospital Medicaid non-DSH payment (claims, supplemental, etc.) is adjusted in a subsequent period, and the amount previously was included in the calculation of the hospital's DSH limit, the claims payment adjustment impact on the DSH limit will be reflected in the period of adjustment (repayment). As such, the transaction will be treated prospectively and prior year DSH payments will not be adjusted.

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

6.3500 Payment Methodology of DSH Allocation

The Medicaid State Agency will make federal quarterly payments to each hospital through the MMIS as allocated in Section 6.3000.

6.4000 Transition Provisions

The following transition provisions are provided to lessen the immediate impact of the new DSH methodology. The transition provisions will be applied to the computed DSH payments at the end of the calculation using the following method:

A. The IMD pool and the state-owned/operated teaching hospital maximum pool are both excluded from the transition provisions.

B. Transition will be accomplished over a three year period (FFY 2020 through 2023).

C. A percentage of the current year calculated DSH payment and two previous years DSH payments, if applicable, will result in an adjusted DSH payment.
   1. 50 percent of current year DSH payment.
   2. 25 percent of one year prior DSH payment.
   3. 25 percent of two years prior DSH payment.

   The adjusted DSH payments will then be proportionally adjusted separately between the large hospital pool and all others subject to the transition provision. The large hospital pool will retain the total DSH payments allocated prior to the transition provision. The large hospital pool adjustment will be made based on each hospital's adjusted DSH payment as a percentage of the total adjusted DSH payments multiplied by the available pool funds. All others subject to the transition provision will receive an adjustment based on each hospital's adjusted DSH payment as a percentage of the total adjusted DSH payments multiplied by the remaining available funds.

6.5000 Request for Review

If a hospital is not determined eligible for a disproportionate share payment adjustment according to Section 6.1000, they may request, in writing, a review of the determination within 15 days from the notification of the final payment adjustment amount. Any data supporting the redetermination of eligibility must be provided with the written request.

A. Appeals rights are limited to errors in the DSH formula and errors that may result in material overstatement of DSH based on data submitted in the hospital's DSH form.

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

7.0000 Change of Ownership

7.1000 Department Notification and Provider Agreements

a. Each hospital shall notify the Department in writing at least 60 days prior to the effective date of the change of ownership. Failure to do so shall result in the forfeiture of rights to payment for covered services provided to recipients by the previous owner or owners in the 60 day period prior to the effective date of the change of ownership. Failure to notify the Department in writing at least 60 days prior to the effective date of the change of ownership shall result in the new owner or owners assuming responsibility for any overpayment made to the previous owner or owners before the effective date of the change of ownership. This shall not release the previous owner of responsibility for such overpayment. This notification requirement may be waived at the discretion of the Department based upon the showing of good cause by a hospital changing ownership. The new owner or owners shall submit an application to be a provider of services in the program and shall not receive reimbursement for covered services provided to recipients from the effective date of the change of ownership until the date upon which all requirements for participation pursuant to state regulations have been met or until the date upon which an application to be a provider of services in the program is received by the Department, whichever comes later.

b. At least 60 days before the dissolution of the business entity, the change of ownership of the business entity, or the sale, exchange or gift of 5% or more of the depreciable assets of the business entity, the Department shall be notified in writing. If the business entity fails to provide 60 days written notice, no reimbursement shall be made. This notification requirement may be waived at the discretion of the Department based upon the showing of good cause by a hospital changing ownership.

c. If a sole proprietor not incorporated under applicable state law transfers title and property to another party, a change of ownership shall have occurred. An application to be a provider of service shall be submitted to the Department by the new owner and affiliated providers.

d. Transfer of participating provider corporate stock shall not in itself constitute a change of ownership. Similarly, a merger of one or more corporations with the participating provider corporation surviving shall not constitute a change of ownership. A consolidation of two or more corporations which creates a new corporate entity shall constitute a change of ownership, and an application to be a provider of services shall be submitted to the Department by the new owner and affiliated providers.

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

7.1000 continued

e. Each partnership that is dissolved shall not require a new provider agreement if at least one member of the original partnership remains as the owner of the facility. Each addition or subdivision to a partnership or any change of ownership resulting in a completely new partnership shall require that an application to be a provider of services be submitted to the Department by the new owner and affiliated providers.

f. The change of or creation of a new lessee, acting as a provider of services, shall constitute a change of ownership. An application to be a provider of services shall be submitted to the Department by the new lessee and affiliated providers. If the lessee of the facility purchases the facility, the purchase shall not constitute a change in ownership.

7.2000 Certification Surveys

Each new owner or owners shall be subject to certification by Medicare.

7.3000 Cost Limitations

a. For each asset in existence on July 18, 1984, which is subsequently sold, the valuation of the asset for reimbursement purposes shall be the lesser of the allowable acquisition cost of the asset to the owner of record on July 18, 1984, or the acquisition cost of the asset to the new owner.

b. For each asset not in existence on July 18, 1984, the valuation of the asset for reimbursement purposes shall be the lesser of the acquisition cost of the asset to the first owner of record or the acquisition cost of the asset to the new owner.

c. Costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, shall not be allowable.

8.0000 Audits

The Department shall perform any reviews or audits deemed appropriate to insure the reasonableness of the cost of reimbursed services. The Department shall continue to receive information from the fiscal intermediaries of Medicare under the common audit agreement which shall identify costs incurred and which will allow for comparisons to be made to the payment which would have been made under the existing Medicare cost reporting system.

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

9.0000 Public process for proposed changes in methods and standards for establishing payment rates – inpatient hospital care. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

10.0000 Direct and Indirect Graduate Medical Education Payments

Effective with discharges on and after January 1, 2005, payments will be made for graduate medical education (GME) services for Kansas hospital inpatient claims. This payment is in addition to the standard DRG payment. This section only applies to hospitals being reimbursed using the DRG methodology. This section does not apply to hospitals being reimbursed under Section 4.0000.

The hospital-specific medical education rate has two components, the direct graduate medical education (DGME) rate and the indirect medical education (IME) rate. The sum of the two rates, or fractions, is the overall graduate medical education (GME) factor, or rate, for the hospital and for application to the DRG payment. These are computed as follows:

- Direct Medical Education (DGME): For discharges on and after January 1, 2005, the DGME factor: is the lesser of total direct medical education cost or aggregate approved costs divided by the total costs of the hospital. This data is from the most recent available Medicare cost report as of the start of each State fiscal year.

- For discharges on and after July 1, 2009, the DGME ratio will be similar to Medicare's DGME formula. The DGME factor will be determined by dividing the hospital's Medicaid patient days by the hospital's total patient days, per worksheet E-3, Part IV, line 5 of the Medicare cost report. This fraction is multiplied by the hospital's total DGME allowable amount as identified on worksheet E-3, Part IV, line 3.25 of the Medicare cost report form. The resulting amount is divided by the Medicaid DRG base amount, for each hospital from the State's most recent fiscal year end. The data is from the Medicare cost report, for each hospital, used for the biennial update of the inpatient MSDRG peer group rates and weights.

- Indirect Medical Education (IME) Factor = 2.1 x ((1 + ratio of full time equivalent interns and residents to hospital beds excluding nursery) $^{\wedge 0.405}$ – 1). This data is from the Medicare cost report, for each hospital, used for the biennial update of the inpatient MSDRG peer group rates and weights.

    - Effective for discharges on and after January 1, 2023, the IME factor is 2.86.

- Hospital-Specific Medical Education Rate = Medicaid hospital DRG Group rate (peer group rate) X (DGME factor + IME factor).

- The hospital's GME claim payment is determined by multiplying the hospital-specific medical education rate times the claim DRG base amount (hospital peer group amount multiplied by the DRG weight for the claim).

- Payments shall be made at least quarterly based upon the claims processed and paid during the previous quarter. This applies to claims that are applicable to this section of the State Plan that have not previously been reimbursed for medical education.

Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

Narrative Explanation of Reimbursement Formula

Under the Medicaid program, the State of Kansas pays psychiatric residential treatment facilities (PRTFs) for care and treatment provided to residents who are eligible for Medicaid benefits. The Kansas Department of Aging and Disability Services (the Department) administers the PRTF program pursuant to an interagency agreement with the Kansas Department of Health and Environment, Division of Health Care Finance, the single state Medicaid agency.

There are two classes of PRTFs:

I. Class I is a PRTF that meets all:
   A. Requirements for Medicaid participation as specified in 42 CFR 441.151, and
   B. State standards and licensing requirements for a Class I PRTF including:
      1) Accreditation by the Joint Commission,
      2) Being licensed, but not Medicaid certified, as a psychiatric hospital, and
      3) Not refusing to admit any otherwise qualified Medicaid beneficiary who has a documented need for residential inpatient psychiatric treatment.

II. Class II is a PRTF that meets all:
   A. Requirements for Medicaid participation as specified in 42 CFR 441.151, and
   B. State standards and licensing requirements of a Class II PRTF.

The narrative explanation of the reimbursement formula for each class of PRTF is divided into three major sections: Historical Costs, Rate Calculations, and Payment Limits.

Narrative Explanation of Reimbursement Formula for Class I PRTF

1) Historical Cost

Cost Reports

Providers are required to submit information on all costs incurred during the fiscal period from July 1st through June 30th on a uniform cost report, the PRTF Financial and Statistical Report. It organizes the commonly incurred business expenses of PRTFs into five reimbursable cost centers (Administration; Facility Operating; Property; Room, Board, and Support; and Treatment) and one non-reimbursable/non-resident related cost center. Reporting of non-reimbursable/non-resident related costs allows total operating expenses to be reconciled to the PRTFs' accounting records. Cost reports are to be submitted by September 30th

The cost report and cost report instructions are provided in Attachment 1.

Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

Narrative Explanation of Reimbursement Formula

Mid-Period Reports

To accommodate a mid-period treatment cost adjustment, a report of costs incurred during the six-month period starting immediately after the end of the cost report period described above. The mid-period report will be for costs incurred July 1st through December 31st. Mid-period cost reports are to be submitted by March 31st, using the same form and format as the annual cost report.

Allowable Costs

Allowable costs are determined in accordance with the Principles of Reimbursement as outlined in the Provider Reimbursement Manual CMS Publication 15-1 and OMB Super Circular 2 CFR §200 Uniform Guidance for Administrative Requirements, Cost Principles, and Audit Requirements.

All cost reports, including mid-period reports, are desk reviewed by the Department or its designee auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

Change of Owner/Provider

When a non-arms length change of provider takes place or when an owner of real estate assumes the operations from the leasee, the PRTF will be treated as an on-going operation. In this situation, the related provider or owner shall be required to file the appropriate year end cost report or mid-period report in conformance with the schedule described above. The new operator or owner is responsible for obtaining historical cost information from the prior operator for the months needed to submit accurate and complete reports that includes costs incurred when the new operator was not involved in running the PRTF. The cost report information from the old and new operators shall be combined to prepare a 12-month cost report or a 6-month mid-period report in conformance to the schedule described above.

When an arms-length change in provider takes place, the new owner assumes the reimbursement rate of the old owner until the new owner can submit a full year or mid-period cost report in conformance with the schedule described above.

New Provider

The per diem rate for a new Class I PRTF will be based on a projected cost report reviewed by the Department for reasonableness. The Department will determine reasonableness by comparing projected costs with other similar PRTFs. In making these comparisons, the

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Department will make appropriate adjustments and allowances to account for staffing ratios and unique physical plant requirements needed to serve children and adolescents who have a higher acuity of mental illness compared with those served by other PRTFs. The approved initial rates will be paid until new rates can be established from a complete full year cost report period using the rate calculation methods described below. Once a new rate is established from a full year cost report period, a retrospective cost settlement will be made from the first day of operation of the new Class I PRTF to the date that the new prospective rate is set.

2) Rate Calculations

Reimbursement rates will be calculated for the payment rate period of January 1st through December 31st, with a mid period adjustment to the Treatment cost center effective for the payment rate period from July 1st through December 31st.

Inflation

Inflation will be applied to all allowable reported costs except:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

Inflation will be applied from the midpoint of each cost report period to the midpoint of the rate payment period. The inflation will be based on the IHS Global Insight, National Skilled Nursing Facility Market Basket without Capital Index (IHS Index).

The IHS Indices listed in the latest available quarterly publication will be used to develop the inflation tables used for all payment schedules processed during the payment rate period. This may require the use of forecasted data. The inflation tables will not be revised until the next payment rate period.

Per Diem Costs

Per diem costs are determined by dividing each PRTF's inflated allowable costs, for each cost center, by the total number of reported resident bed days. Total PRTF reimbursement will include the actual allowed inflated per diem costs for each of the Administration; Facility Operating; Property; Room, Board, and Support; and Treatment cost centers.

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Mid-Period Rate Adjustment

The Treatment cost center will be adjusted for the difference between the inflated allowable per diem costs calculated for the full year rate payment period and the inflated allowable per diem costs calculated for the mid-period adjustment. This difference will be added to the rate currently in effect on July 1 and will be paid through the end of the rate payment period, December 31.

3) Payment Limits

Owner/Related Party/Director/Co-Director Limits

All Class I PRTFs cost related to owner/related party compensation will be limited. Since salaries and other compensation of owners and related parties are not subject to the usual market constraints, specific limits are applied to the reported amounts. First, amounts paid to non-working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have their compensation limited by the percent of their total work time to a standard work week. The owners and related parties must be licensed or certified by the state to perform services requiring such credentials.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled, "Statement of Owners and Related Parties." This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and the description of the work performed for each owner and/or related party.

Comparable Private Pay Rates

Class I PRTFs are to be reimbursed the lower of the calculated Medicaid rate or their private pay rate. The Department maintains a registry of private pay rates. It is the responsibility of the facilities to send the Department their private pay rate updates so that the registry is current. When new Medicaid rates are determined, if the private pay rate reflected in the registry is lower, then the facility is held to that private pay rate until the facility sends notification that it has a higher private pay rate.

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Narrative Explanation of Reimbursement Formula for Class II

1) Historical Cost

Cost Reports

Providers are required to submit information on all costs incurred during the fiscal period from July 1st through June 30th on a uniform cost report, the PRTF Financial and Statistical Report. It organizes the commonly incurred business expenses of PRTFs into five reimbursable cost centers (Administration; Facility Operating; Property; Room, Board, and Support; and Treatment) and one non-reimbursable/non-resident related cost center. Reporting of non-reimbursable/non-resident related costs allows total operating expenses to be reconciled to the PRTFs' accounting records. Cost reports are to be submitted by September 30th.

The cost report and cost report instructions are provided in Attachment 1.

Mid-Period Reports

To accommodate a mid-period treatment cost adjustment, a report of costs incurred during the six-month period starting immediately after the end of the cost report period described above will be required. The mid-period report will be for costs incurred July 1st through December 31st. Mid-period cost reports are to be submitted by March 31st, using the same form and format as the annual cost report.

Allowable Costs

Allowable costs are determined in accordance with the Principles of Reimbursement as outlined in the Provider Reimbursement Manual CMS Publication 15-1 and OMB Super Circular 2 CFR §200 Uniform Guidance for Administrative Requirements, Cost Principles, and Audit Requirements.

All cost reports, including mid-period reports, are desk reviewed by the Department or its designee auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

Change of Owner/Provider

When a non-arms length change of provider takes place or when an owner of real estate assumes the operations from the leasee, the PRTF will be treated as an on-going operation. In this situation, the related provider or owner shall be required to file the appropriate year end cost

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report or mid-period report in conformance with the schedule described above. The new operator or owner is responsible for obtaining historical cost information from the prior operator for the months needed to submit accurate and complete reports that includes costs incurred when the new operator was not involved in running the PRTF. The cost report information from the old and new operators shall be combined to prepare a 12-month cost report or a 6-month mid-period report in conformance to the schedule described above.

When an arms length change in provider takes place, the new owner assumes the reimbursement rate of the old owner until the new owner can submit a full year or mid-period cost report in conformance with the schedule described above.

New Provider

The per diem rate for a new PRTF will be the total of the state-wide median of each cost centers calculated at the last full year cost report until the new PRTF can report a full year cost report in conformance with the schedule described above.

2) Rate Calculations

Reimbursement rates will be calculated for the payment rate period of January 1st through December 31st, with a mid period adjustment to the Treatment cost center effective for the payment rate period from July 1st through December 31st.

Inflation

Inflation will be applied to all allowable reported costs except:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

Inflation will be applied from the midpoint of each cost report period to the midpoint of the rate payment period. The inflation will be based on the IHS Global Insight, National Skilled Nursing Facility Market Basket without Capital Index (IHS Index).

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The IHS Indices listed in the latest available quarterly publication will be used to develop the inflation tables used for all payment schedules processed during the payment rate period. This may require the use of forecasted data. The inflation tables will not be revised until the next payment rate period.

Per Diem Costs

Per diem costs are determined by dividing each PRTF's inflated allowable costs, for each cost center, by the total number of reported resident bed days. Total PRTF reimbursement will include the actual allowed inflated per diem costs for each of the cost centers for Administration; Facility Operating; Property; and Room, Board, and Support or the upper payment limit for each of these cost centers, whichever is less, plus the actual allowable inflated per diem for the Treatment cost center.

Mid-Period Rate Adjustment

The Treatment cost center will be adjusted for the difference between the inflated allowable per diem costs calculated for the full year rate payment period and the inflated allowable per diem costs calculated for the mid-period adjustment. This difference will be added to the rate currently in effect on July 1 and will be paid through the end of the rate payment period, December 31.

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3) Payment Limits

Cost Center Limits

Cost center limits are established for the Administration; Facility Operating; Property; Room, Board, and Support cost centers by determining the median per diem cost of all PRTFs plus a percent of the median. Cost center limits will be calculated as follows:

Administration	125% of median
Facility Operating	135% of median
Property	110% of median
Room, Board, and Support	120% of median

Treatment costs will not be subject to a cost center limit.

Owner/Related Party/Director/Co-Director Limits

All PRTFs' costs related to owner/related party compensation will be limited. Since salaries and other compensation of owners and related parties are not subject to the usual market constraints, specific limits are applied to the reported amounts. First, amounts paid to non-working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have their compensation limited by the percent of their total work time to a standard work week. The owners and related parties must be licensed or certified by the state to perform services requiring such credentials.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled, "Statement of Owners and Related Parties." This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and the description of the work performed for each owner and/or related party.

Comparable Private Pay Rates

PRTFs are to be reimbursed the lower of the calculated Medicaid rate or their private pay rate. The Department maintains a registry of private pay rates. It is the responsibility of the facilities to send the Department their private pay rate updates so that the registry is current.

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When new Medicaid rates are determined, if the private pay rate reflected in the registry is lower than the Medicaid rate, the facility is held to that private pay rate until the facility sends notification that it has a higher private pay rate.

Methods and Standards for Establishing Payment Rates
Brain Injury Rehabilitation Facility (BIRF)

Reimbursement Rate

Pursuant to the Kansas legislative appropriations, and effective 7/1/2023, the Brain Injury Rehabilitation Facility (BIRF) rate will be increased from $700 per day to $1,400 per day.