Evaluation of Uncompensated Care Pool and Delivery System Reform Incentive Payment Program Funding for Kansas Medicaid 1115 Waiver

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1 Executive Summary

In 2013, the Centers for Medicare and Medicaid Services (CMS) approved a Section 1115 Demonstration Waiver ("KanCare," also known as "KanCare 1.0") for the Kansas Department of Health and Environment (KDHE). In the Waiver, CMS approved KDHE to contract with Managed Care Organizations (MCOs) to deliver high quality health care services to beneficiaries and to provide additional funding to hospitals through two Safety Net Care Pool (SNCP) programs – an Uncompensated Care (UC) Pool and a Delivery System Reform Incentive Payment (DSRIP) program. The UC Pool was created to provide funding to hospitals for uncompensated care to Medicaid beneficiaries and to the uninsured population.[1] DSRIP provides funding to hospitals to implement projects that transform the delivery system by improving access and quality while reducing costs. In State Fiscal Year (SFY) 2016, KDHE distributed $74.5 million to hospitals through the UC Pool and DSRIP.

The purpose of this report is to be responsive to Item 70 of the Special Terms and Conditions (STCs) mandated by CMS for the demonstration's subsequent renewal. STC 70 stated that "… the state shall submit a transition plan to CMS based on the experience with the DSRIP pool, actual uncompensated care trends in the state, and investment in value based purchasing or other payment reform options."[2] A subsequent communication from CMS[3] containing additional guidance regarding the components of this report stated that the report author needs to be "a non-governmental entity that is independent of provider interests on Medicaid provider payments made under the uncompensated care pool (UC Pool) and delivery system reform incentive payment (DSRIP) program." KDHE engaged Navigant to complete this report.

In accordance with STC 70 and additional communications received from CMS, this report focuses on the purpose, adequacy, payments and effect of the existing UC Pool, DSRIP program, and other value-based purchasing programs initiated by KDHE. Information in this report is intended to summarize results of the current waiver, KanCare 1.0, to help inform discussions on the design of the next waiver renewal, KanCare 2.0. Details regarding size and design of the UC Pool, DSRIP program, other SNCP program(s) and other value-based purchasing efforts to be included in KanCare 2.0 are outside the scope of this report.

In particular, this report analyzes general Medicaid funding needs including UC Pool and DSRIP funding, Medicaid shortfall, uncompensated care, and the need for additional funding moving forward. Data analyzed is from hospital services provided to Medicaid and uninsured beneficiaries during SFY 2016, which extended from July 1, 2015 through June 30, 2016.

Generally, all hospitals, and in particular safety net hospitals provide care to patients that do not have the resources to pay for their own healthcare. As such, hospitals incur costs for which little or no reimbursement is provided by those receiving the services. Our analysis shows that UC Pool funding is a vital component for sustaining access to quality care in Kansas for Medicaid and uninsured beneficiaries. Our study found that, in the aggregate, hospitals received Medicaid payments that covered approximately 53 percent of the costs incurred in providing services to those eligible for Medicaid services and the uninsured.[4] Ten percent of total

[1] KanCare 1115 Demonstration Waiver. Page 40, STC 66.
[2] KanCare 1115 Demonstration Waiver. Page 54, STC 70.
[3] Attachment to an email sent from CMS to KDHE on May 11, 2017.
[4] This figure excludes DSRIP payments as they are not directly tied to patient care.

Medicaid hospital reimbursements came from the UC Pool, which were distributed to 51 hospitals in SFY 2016. Those 51 hospitals incurred 69 percent of the hospital-related cost of care for all uninsured residents in Kansas. If UC Pool payments are not considered, the pay-to-cost ratio for Medicaid and uninsured services would drop to 48 percent.[5] Further, when including UC Pool payments and reducing Medicaid reimbursements by the amount of local contributions to Medicaid funding, the aggregate pay-to-cost ratio for care of Kansas Medicaid and uninsured residents is 49 percent.

In addition, the pay-to-cost percentages are expected to reduce further as a result of anticipated reductions in state Disproportionate Share Hospital (DSH) defined under the Patient Protection and Affordable Care Act (PPACA), which are scheduled to begin in Federal Fiscal Year (FFY) 2018. The FFY 2018 reduction is estimated to be approximately $9 million, and additional reductions are planned for each year through FY 2025.

DSRIP program funding helped to offset underfunded services by providing outcomes based incentive payments for the implementation of transformative projects in two hospitals. As part of this study, we reviewed progress reported by the DSRIP hospitals relative to the commitments they had made to be eligible for the DSRIP funding, and generally found that the hospitals had made progress relative to their goals. However, while results of the DSRIP program projects appear positive, DSRIP funds are intended as an investment to improve health care delivery and overall population health. DSRIP funds are not intended to offset costs of patient care. As a result, they do not factor into the payment-to-cost comparisons documented in this report.

Our study validates the need for ongoing support of Kansas hospitals through some form of SNCP funding.

[5] This figure excludes DSRIP payments as they are not directly tied to patient care.

2 Introduction

KDHE's current 1115 Demonstration Waiver includes two Safety Net Care Pools (SNCPs): a UC Pool program, and a DSRIP program. Both of these programs provide supplemental payments to a subset of the hospitals in Kansas. In addition, the UC Pool program is related to the long-standing DSH program as both the UC Pool and the DSH programs provide some funding to hospitals for uncompensated care provided to Medicaid beneficiaries and patients with no insurance. In contrast, the DSRIP program offers incentive payments to hospitals for infrastructure improvements and development of new processes and procedures intended to improve the quality of care and improve efficiency of care provided to residents of Kansas. DSRIP payments are tied to these investments in healthcare delivery improvements and are not tied to care provided to specific individuals on specific dates of service.

This document provides information that will inform decisions regarding these two programs for the upcoming KanCare 2.0 waiver renewal, anticipated to go into effect on January 1, 2019. For example, CMS and KDHE may use analysis in this report to determine the size of a UC Pool in KanCare 2.0. KDHE will document detailed design of the KanCare 2.0 Safety Net Care Pools in future communications with CMS.

In particular, this report documents the amount of uncompensated care for the Medicaid and uninsured populations in Kansas using SFY 2016 data. For the Medicaid population, this includes Medicaid shortfall, which is the difference between hospital cost of care provided to Medicaid beneficiaries and Medicaid reimbursement through traditional fee-for-service and Medicaid managed care (MC). For the uninsured population, this includes hospital cost of care net of the small amounts of self-pay received by the hospitals. Our analysis focuses on residents of Kansas, but does include a small number of out-of-state hospitals that treated reasonably significant numbers of Kansas Medicaid recipients in SFY 2016.

2.1 Medicaid Funding and Payment

In fiscal year 2015, the Medicaid and the State Children's Health Insurance Program (CHIP) were sources of health coverage for an estimated 90 million people, about 28 percent of the population of the United States.[6] Nationally, the Medicaid and CHIP programs accounted for 16.8 percent, approximately $509 billion, of total U.S. health care spending.[7] Those served by these programs include children, many low-wage workers and their families, persons who have physical and mental disabilities, and seniors with Medicare.

Financing for Medicaid and CHIP programs is a shared responsibility of the Federal government and the states. States that operate their Medicaid programs in compliance with Federal guidelines are entitled to Federal reimbursement for a share of their total program expenditures. States incur qualifying expenditure by making payments to health care providers and managed care plans, and by incurring costs associated with performing administrative tasks such as making eligibility determinations, enrolling and monitoring providers, and processing claims. The states complete and submit quarterly expenditure reports in order to receive the Federal matching dollars.

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[6] MACPAC: https://www.macpac.gov/wp-content/uploads/2016/12/MACStats_DataBook_Dec2016.pdf
[7] Ibid.

In Kansas, annual Medicaid expenditures in SFY 2016 were projected to be $3.49 billion. The Federal Medical Assistance Percentage (FMAP) for Kansas Medicaid was 0.5596 for reimbursement of medical care and 0.5 for state Medicaid administrative costs for that same period. Thus, for every dollar Kansas Medicaid spent on medical care, the Federal Government funded 55.96 cents of the expenditure.

As such, of the SFY 2016 Medicaid expenditures of $3.49 billion, $1.60 billion was funded through non-federal (state and local) dollars, and $1.90 billion was funded from federal matching dollars.[8] The state portion of funding for Medicaid and CHIP comprised 22.5 percent of the overall state budget.[9] Of the $3.49 billion projected spend for the Kansas Medicaid program in SFY 2016, our calculations identified that $639 million was distributed to hospitals through traditional fee-for-service claim payments, managed care claim payments, supplemental payments defined in the State Plan, and supplemental payments defined through the 1115 Demonstration Waiver, including the UC Pool and DSRIP programs.

2.2 Medicaid Governance – State Plans and Demonstration Waivers

As a condition of receiving Federal Medicaid funds, Section 1902 of the Social Security Act (the Act) requires states to have an approved state plan on file with CMS, the Federal agency responsible for coordinating Medicaid, which details the manner in which the states implement all Federal Medicaid requirements. In conjunction with its mandate to manage costs and assure access to quality care, CMS monitors each state Medicaid program, oversees the approval of State Plan Amendments (SPAs), waivers, and demonstrations and provides guidance to states through State Medicaid Director (SMD) and State Health Official (SHO) letters. To the extent that material program modifications are subsequently needed, states are required to submit a SPA to CMS for review and approval in advance of implementing any changes.

The Act further provides states flexibility in certain areas to operate their programs outside of some of the standard Federal requirements that would otherwise apply, known as waiver authorities. In particular, Section 1115 of the Act gives broad authority to the Secretary to authorize “any experimental, pilot or demonstration project likely to assist in promoting the objectives of the programs” specified in that section of the Act. Under Section 1115 research and demonstration authority, states may waive certain provisions of the Medicaid and CHIP statutes related to state program design such as Medicaid eligibility criteria, covered services, and service delivery and payment methods used by the state to administer the program. Section 1115 demonstrations also include a research or evaluation component and are initially approved for five years, with potential for future renewals. The ability to waive certain aspects of the Medicaid statute gives states flexibility to experiment with different approaches to program operation, service delivery, and financing in terms of both program expansion and contraction, with the condition that the programs remain budget neutral. Approval of states’ waiver applications and subsequent renewals are at the discretion of the Secretary of the Federal Department of Health and Human Services (HHS).[10]

All states operate one or more Medicaid waivers, and one of the goals of a number of the states’ waivers is to provide funding for care for the uninsured. Kansas implemented the KanCare 1115 Demonstration Waiver in January of 2013. Among other initiatives, this waiver established two SNCPs. The first is a UC Pool created for the purpose of supporting hospitals with the

[8] National Association of State Budget Offices: Examining 2014 – 2016 State Spending, 2016.
[9] Ibid.
[10] Ibid.

costs associated with providing care to the uninsured. Although between Calendar Years (CYs) 2013 through 2015 the number of uninsured individuals in Kansas declined, there are still individuals who remain uninsured in the state. The U.S. Census Bureau reported that in 2016 approximately 10.6 percent of individuals aged 65 and under in Kansas had no health insurance.[11]

The second SNCP is a DSRIP program which provides incentive payments to hospitals for the development and implementation of approved programs that support the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities). Under DSRIP, participating hospitals must implement new, or significantly enhance existing, health care initiatives. For each project, the hospital should describe the specific measurable goals for improving the health outcomes of patients and the populations the hospital services, the data analytics that support the selection of these goals, and how it will carry out the project that is designed to achieve these specific goals. The DSRIP program funding is available in Demonstration Years (DYs) 3 through 5. DSRIP incentive payments are not direct reimbursement for service delivery.

Maximum total computable payments combined for the UC Pool and DSRIP programs are $80,856,550 annually. In the first two years of the demonstration, all of these funds are distributed through the UC Pool. In years 3 through 5, a gradually increasing amount of these funds is distributed through DSRIP and a decreasing amount is distributed through the UC Pool.

CMS also included in the STCs for the 2013 KanCare 1115 Demonstration Waiver, a requirement for the State to submit a report reviewing the SNCP programs in the 2013 waiver to inform decisions on similar programs in future waiver renewals. The requirement calls for an independent entity to complete the report and as such, KDHE engaged Navigant to complete this work.

2.3 Report Requirements

The requirement for the independent report was specified in STC 70 of the KanCare 1115 Demonstration Waiver and was further described in an additional communication sent from CMS to KDHE. The primary intent of this report is to "size" uncompensated care in Kansas and document the value obtained through the DSRIP program in order to inform both the state and CMS when making future decisions about these programs and decisions on how to sustainably support the safety net population.

Specifically, the following elements are addressed in this report consistent with CMS criteria described in the additional communication regarding the report:

A. A detailed description and analysis of the Medicaid payments to providers under the UC Pool and DSRIP program (all types) for the reporting period. The report must also include how the state funds the various payments and how payments to providers correspond to amounts reported on the CMS-64. The report must note any gaps in payment as well as overages in the current funding structure.

[11] US Census Bureau, Quick Facts, 2016. https://www.census.gov/quickfacts/table/PST045215/20

B. A detailed analysis of UC Pool payments for each provider type that are attributable to each of the following:
   - Uninsured individuals
   - Medicaid beneficiaries

C. For the amount of UC Pool and DSRIP program payments attributable to Medicaid beneficiaries, for each provider type, comparison of the funds that are attributable, in aggregate and by age-band to the following: [12]
   - Managed Care shortfall
   - Fee-for-service shortfall

D. The total amount of UC Pool and DSRIP program that is provided by each provider type to each of the following: unqualified aliens, qualified aliens subject to a 5-year ban. This analysis must include use of age-banding as determined appropriate. [13]

E. An analysis of factors that contribute to the necessity of payments for uninsured individuals and Medicaid beneficiaries, including the following:
   - The number of uninsured individuals in the state
   - The number of Medicaid beneficiaries
   - Factors that impact access to coverage. At a minimum, these must include geographic location, state of residency or homelessness rates.

F. An analysis of the findings and conclusions drawn from the factors that contribute to the Medicaid shortfall, uncompensated care, and the necessity of uncompensated care payments overall as well, including the casual and solution role of fee-for-service (FFS) payment rates and managed care contracting requirements.

G. Amount of DSRIP made to participating providers by project.

H. Analysis of measurable UC Pool and DSRIP program project outcomes achieved by participating provider per project.

I. Any state specific circumstances for CMS to take into account as it reviews the UC Pool program.

J. Any state specific circumstances for CMS to take into account as it reviews the state's DSRIP program.

2.4 Report Organization

The analyses in this report include data for a total of 166 hospitals. Due to the large number of providers in the analyses, most data tables summarize information by hospital category. We selected the following categories:

- Acute Care Hospitals

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[12] Please note, this report does not provide a summary of UC Pool and DSRIP payments by age-band as this information was not available.

[13] Please note, this report does not summarize UC Pool and DSRIP amounts for unqualified aliens and qualified aliens subject to the 5-year ban as this information was not available.

- Children's Hospitals
- Critical Access Hospitals (CAHs)
- Specialty Hospitals (Include psychiatric and rehabilitation hospitals)
- State Hospitals

The remainder of this report is organized into the following sections:

- Chapter 3: Background, where we provide general information about the KanCare 1115 Demonstration Waiver, the Safety Net Care Pool (SNCP) which includes the Uncompensated Care (UC) Pool and the Delivery System Reform Incentive Payment (DSRIP) program;

- Chapter 4: Value Based Purchasing and Payment Reform, where we discuss value based payment reform initiatives implemented by Kansas within the Waiver which include financial incentives for the MCOs;

- Chapter 5: DSRIP Program, where we discuss the DSRIP program in detail, the progress and measurement of projects implemented, as well as payments made through the program;

- Chapter 6: Description of Funding and Payment Methods, where we describe all Kansas Medicaid payments to hospitals and how these payments are funded;

- Chapter 7: Comparison of Payments to Costs, where we calculate pay-to-cost ratios using a variety of combinations of payments and costs to measure the adequacy of Medicaid reimbursements to hospitals;

- Chapter 8: Future of Uncompensated Care Services and Related Funding in Kansas, where we review projected reductions in DSH allotments in future years;

- Chapter 9: Conclusion, where we provide a brief conclusion for Kansas' SNCP programs

3 Background

This chapter provides an overview of the Kansas 1115 Demonstration Waiver. Specifically, we discuss the goals of the waiver as well as the SNCP programs in detail. In addition, in this chapter we review the Medicaid population in Kansas and provide detailed information on the uninsured population in the state.

3.1 1115 Waiver Programs Overview

The State of Kansas implemented the KanCare 1115 Demonstration Waiver in January of 2013. This Demonstration Waiver was implemented to achieve several important goals which are to provide integration and coordination of care, improve the quality of care provided to Medicaid recipients, control Medicaid costs and to establish long-lasting reforms that sustain improvements in the quality of health and wellness of Medicaid recipients.[14] The State of Kansas determined that contracting with Managed Care Organizations (MCOs) would result in the efficient and effective provision of healthcare services and would allow for the integration of healthcare services to Medicaid recipients, which aligns with the state's goals. [15] As a result, the KanCare waiver established a managed care Medicaid program, thereby expanding the state's previous managed care program.

This Demonstration Waiver also established two SNCP programs to support hospitals with costs associated with the uninsured population. The two SNCP programs are the UC Pool and the DSRIP programs. These SNCP programs, as well as their goals, are discussed in more detail later in this chapter.

3.1.1 Managed Care Service Delivery

The KanCare 1115 Demonstration Waiver expanded the managed care Medicaid program in the State. This waiver, along with the state's other 1915(c) Home and Community Based (HCBS) waivers, expanded the managed care delivery system for State Plan and HCBS waiver services and allowed the State to transition almost all Medicaid recipients to managed care programs. These efforts expanded Kansas' prior Medicaid managed care program, which consisted of the HealthWave and HealthConnect Kansas programs.

The KanCare waiver mandated that the following State Plan eligibility groups enroll with MCOs in order to receive waiver services:

- Pregnant woman at 150 percent of the Federal Poverty Level (FPL)
- Poverty level children – FPL varies by age category
- Low income families with children
- Work transition (transitional medical assistance)
- Extended medical
- Foster care medical
- Adoption support medical
- Supplemental Security Income (SSI) recipients
- Pickle amendment
- Adult disabled child
- Early or disabled widows and widowers

[14] KanCare 1115 Demonstration Waiver. Page 3.
[15] KanCare Program – Medicaid State Quality Strategy: http://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/KS%20KanCare%20Quality%20Strategy%202014.pdf

- Child in an institution

This reform of the Kansas Medicaid system expanded the managed care program and resulted in a shift of enrollees from FFS to managed care. Based on data provided by the State for SFY 2016, approximately 91.3 percent of Medicaid recipients were enrolled in managed care. This represents a significant increase from SFY 2013 levels when approximately 58.9 percent of Medicaid recipients were enrolled in managed care. Medicaid enrollment information as well as the calculation of the proportion of managed care enrollees to total enrollees is displayed in Figure 1 below.

Figure 1 - FFS and Managed Care Enrollment in Kansas Medicaid

SFY	Total Medicaid FFS Enrollees	Total Medicaid MC Enrollees	Total Enrollees	Percentage of MC to Total Enrollees
2013	167,426	239,964	407,390	58.9%
2014	25,640	392,642	418,282	93.9%
2015	27,779	406,744	434,523	93.6%
2016	39,115	408,472	447,587	91.3%

In addition to increasing the size of the Medicaid managed care program, the implementation of KanCare 1.0 included a reprocurement of managed care plans, which required new contracts between KDHE and managed care plans. Included in the Medicaid Managed Care contracts were new Pay-For-Performance (P4P) incentives. The P4P incentives involved definition of a variety of performance measures and associated targets. Also, to implement these payment incentives, a percentage of capitation payments is withheld until a contract year is completed and MCO performance can be measured. Once performance is measured, some or all of the withheld capitation payments is disbursed by KDHE to the MCOs.

3.1.2 Uncompensated Care Pool Program Overview

As discussed earlier, the KanCare 1115 Demonstration Waiver established a SNCP program that is comprised of two components. The first component is a UC pool and the second is a DSRIP program. The UC pool provides support to hospitals with costs associated with providing care to the uninsured population and for uncompensated cost of care to Medicaid beneficiaries. Uninsured individuals are defined as individuals with no source of third party coverage for services.[16] In Kansas, the UC Pool is comprised of two sub-pools. The first sub-pool is the Health Care Access Improvement Program (HCAIP) Pool and the second is the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool.

In SFY 2016, 49 hospitals received payments through the HCAIP Pool, totaling just under $41 million in payments. The level of payment a hospital receives through this pool varies based on the hospital's calculated uncompensated care cost as well as the type of services the hospital provides. To determine the payment for each hospital, the State first calculates aggregate uncompensated care costs[17] across all HCAIP hospitals and then determines the percentage each hospital can receive of its uncompensated care costs. This percentage will be increased if the hospital provides psychiatric services, all three levels of Neonatal Intensive Care Unit

[16] KanCare 1115 Demonstration Waiver. Page 40, STC 66.
[17] For this calculation, "uncompensated care costs" equal the Kansas portion of uncompensated care for the uninsured plus Kansas Medicaid shortfall.

(NICU) services (Levels I, II, and III), or trauma services. The increase depends on which services, and the level of the services, the hospital provides. Aggregate uncompensated care payments through the HCAIP Pool are subject to a limit of $41 million for each of the five years of this Demonstration Waiver.

Uncompensated care payments made to hospitals through the second sub-pool, the LPTH/BCCH Pool, are determined based on payment data submitted by providers to the state and on cost data reported on the hospitals' Medicare 2552-10 cost reports. Further, in each demonstration year, 75 percent of the total funding is available for designated LPTH providers while 25 percent is available to the designated BCCHs. The KanCare 1115 Demonstration Waiver identifies one designated LPTH provider, University of Kansas Hospital, and one designated BCCH provider, Children's Mercy Hospital in Kansas City, Missouri. Similar to the HCAIP Pool, payments provided through the LPTH/BCCH Pool are subject to annual limits. These limits, however, vary based on the demonstration year. The annual limits for the HCAIP and LPTH/BCCH sub-pools can be found in Figure 2 below.

Figure 2 - Annual UC Pool Limits

Demonstration Year	HCAIP Pool	LPTH/BCCH Pool	Total UC Pool
DY 1	$41,000,000	$39,856,550	$80,856,550
DY 2	$41,000,000	$39,856,550	$80,856,550
DY 3	$41,000,000	$29,856,550	$70,856,550
DY 4	$41,000,000	$19,856,550	$60,856,550
DY 5	$41,000,000	$9,856,550	$50,856,550

It should be noted that the total payments received by hospitals (i.e. payments under the state plan, Medicaid managed care, DSH, and UC payments) cannot exceed eligible uncompensated care costs. These payments must remain within DSH limits and DSH audit rules. It should also be noted that the total funding available through the LPTH/BCCH uncompensated care sub-pool decreases in each demonstration year beginning with demonstration year three. The reason for the decline in the level of the UC Pool is the implementation of the DSRIP program. Beginning with demonstration year three, the Waiver shifts SNCP funding from the UC Pool to the DSRIP program.

3.1.3 Delivery System Reform Incentive Payment (DSRIP) Program Overview

The goals of the DSRIP program are to enhance access to health, the quality of care and the health of the population. As such, funding is made available through the waiver to designated LPTH and BCCH hospitals to support initiatives implemented to achieve these goals.[18] To participate in this program, providers must submit detailed plans to the state which outline the initiatives that will be undertaken to achieve these goals and must identify project milestones as well as measures through which the impact of the initiatives can be determined. Initiatives undertaken through the DSRIP plans must also be consistent with CMS' triple aims of improving care, improving health of the population and lowering costs of care. A detailed description of the types of initiatives implemented by hospitals as well as the measures of outcomes is available in Chapter 4 of this report.

[18] Under the 2013 Waiver, the only LPTH provider is University of Kansas Hospital and the only BCCH provider is Children's Mercy Hospital in Kansas City, Missouri.

Hospitals participating in this program may receive payments through this pool only if they can demonstrate meeting the milestones and measures identified in their DSRIP plan. The total allowable funding available for the DSRIP program is $10 million in demonstration year three and increases by $10 million in each subsequent demonstration year. As discussed above, the KanCare 1115 Waiver shifts funding from the UC Pool to the DSRIP Program. As the funding for the UC Pool declines, the funding available to hospitals through the DSRIP program increases. The aggregate SNCP funding available in each demonstration year therefore remains at $80,856,550.

A summary of the total DSRIP funding by demonstration year can be found in the Figure 3 below.

Figure 3 - Annual DSRIP Limits

Demonstration Year	DSRIP Pool
DY 1	N/A
DY 2	N/A
DY 3	$10,000,000
DY 4	$20,000,000
DY 5	$30,000,000

3.2 Characteristics of the Kansas Medicaid Population

The total number of Medicaid enrollees in Kansas has steadily increased between SFY 2013 and SFY 2016. During this time period, the total number of Medicaid enrollees increased by 9.9 percent to 447,587 enrollees in SFY 2016. As discussed in the section above, the reform of the Kansas Medicaid system resulted in a significant shift from FFS enrollment to managed care enrollment. Due to these reforms, the proportion of total enrollees in managed care increased and the proportion the traditional FFS program decreased between SFY 2013 and SFY 2016. The proportion of enrollees in FFS declined significantly from 41.1 percent to 8.7 percent during this timeframe.

We further evaluated the changes in enrollment for FFS and managed care services by age group to determine if any particular age groups were driving the increases observed in enrollment between SFYs 2014 and 2016. For this comparison, we reviewed trends in enrollment for individuals aged 20 and under, 21 to 64 and 65 and above. Almost 59 percent of the increase in FFS enrollment during this time period is driven by the 20 and under age group.

The increase in managed care enrollment during this period is primarily driven by the 21 to 64 age group. Between SFY 2014 and SFY 2016, approximately 58 percent of the managed care enrollment increase is attributed to the 21 to 64 age group. Figure 4 below provides a summary of total FFS and managed care enrollment by age group.

Figure 4 - FFS and Managed Care Enrollment by Age Group

SFY	Total FFS Enrollment			Total Managed Care Enrollment		
	20 and Under	21 to 64	65 and Above	20 and Under	21 to 64	65 and Above
2013	64,453	70,421	32,552	216,435	23,525	4
2014	601	14,850	10,189	286,309	83,506	22,827
2015	1,375	15,689	10,715	293,800	90,360	22,584
2016	8,503	18,938	11,674	293,962	92,658	21,852

3.3 Characteristics of the Uninsured Population

In analyzing the need for continuation of an UC Pool, it is important to recognize the populations that are provided medical services through these funds. A variety of factors, such as citizenship status, age, poverty level, employment status, physical location, and living condition, may contribute to individuals being uninsured. In addition, the physical location factor often affects the percentage of uninsured patients treated at individual hospitals. Because of proximity to low-income residents, some hospitals treat a higher percentage of uninsured patients than others, thus having a greater need for financial support through the DSH and UC Pool programs.

Like the national rate of uninsureds, which dropped from 14.5 percent to 9.4 percent from calendar years 2013 to 2015, the rate in Kansas was also down from 12.3 percent to 9.1 percent over this same period[19]. HealthInsurance.org reports this is an all-time low for the state[20]. The US Census reported the number of uninsured Kansans under age 65 to be 261,000 in 2015 and 308,000 in 2016. The 2016 number represents 10.6 percent of the 2.9 million residents[21]. Another study produced by the Kaiser Family Foundation (KFF) in 2016 reported a similar estimate of the uninsured population in Kansas.[22] The KFF report stated that the uninsured population in Kansas totaled 279,300 in 2015. Persons over age 65 are typically covered by Medicare and are not included in the uninsured figures provided.

3.3.1 Citizenship Status

In 2014, KFF reported that 10 percent of non-elderly (under age 65) uninsured Kansans were ineligible for coverage due to immigration status[23]. Section 1312 of the Affordable Care Act states, "If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be

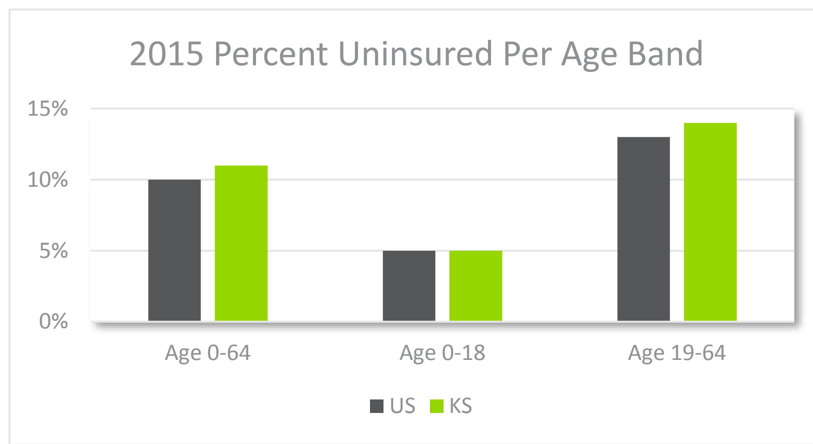
[19] US Census Bureau, "Population Without Health Insurance Coverage by State: 2013-2015", https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf
[20] Louise Norris, "Kansas and the ACA's Medicaid Expansion," April 4, 2017, https://www.healthinsurance.org/kansas-medicaid/
[21] US Census Bureau, "Quick Facts," 2016, https://www.census.gov/quickfacts/table/PST045215/20
[22] Kansas Health Institute, August 2016, "Annual Insurance Update", http://www.khi.org/assets/uploads/news/14532/aiu2016_final_web.pdf
[23] Kaiser Family Foundation, "How Will the Uninured in Kansas Fare Under the Affordable Care Act?," January 6, 2014, http://www.kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-kansas/

covered under a qualified health plan in the individual market that is offered through an Exchange."[24]

3.3.2 Age

Of the 279,300 uninsured Kansans in 2015 estimated in the 2016 KFF report, 13 percent (37,600) were identified to be children, ages 0-18, and the remaining 87 percent (241,700) were identified to be adults, ages 19-64.[25] KFF also published data showing that Kansas had 55,000 non-elderly people under age 65 in the "coverage gap" which is a category of people who have income above the value that would grant Medicaid eligibility but below that allowing them access to Marketplace premium tax credits. Of those 33 percent are non-White and 74 percent are adults without dependent children. Over half (54 percent) of Kansas' uninsureds under age 65 reside in a family where at least one person works at least part-time.[26]

Figure 5 - US and Kansas Uninsured Per Age Band



The percentage of young adults in Kansas age 19–25 without health insurance has declined from 24.6 percent in 2009 to 19.2 percent in 2014, which may be the result of the Affordable Care Act (ACA) rule, effective September 23, 2010, allowing young adults to stay on their parents' insurance until age 26.

3.3.3 Poverty

One factor contributing to the size of the safety net population is the number of Kansans living in poverty. According to the 2015 US Census[27], 13 percent of Kansans are living at or below the FPL based on the official poverty measure from Census figures released in September 2016. Figure 6 below shows the percentage of Kansans living in poverty by county. While some

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[24] Michael K. Gusmano, March 15, 2012, "Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care", http://undocumentedpatients.org/issuebrief/health-policy-and-access-to-care/

[25] Kansas Health Institute, August 2016, "Annual Insurance Update", http://www.khi.org/assets/uploads/news/14532/aiu2016_final_web.pdf

[26] Rachel Garfield - Kaiser Family Foundation, October 19, 2016,:"The Coverage Gap: Uninsured Poor Adults in States that Do No Expand Medicaid," http://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

[27] US Census Bureau, "Quick Facts," 2016, https://www.census.gov/quickfacts/fact/map/KS/IPE120215#viewtop

counties are certainly more populous than others, it is interesting to note that the highest rates of persons living below the FPL are in the more populous lower southeast corner of the state, while we find that the highest rate of uninsured actually live in the more rural lower southwest corner of the state.

Figure 6 - 2016 US Census: Kansas Poverty by County

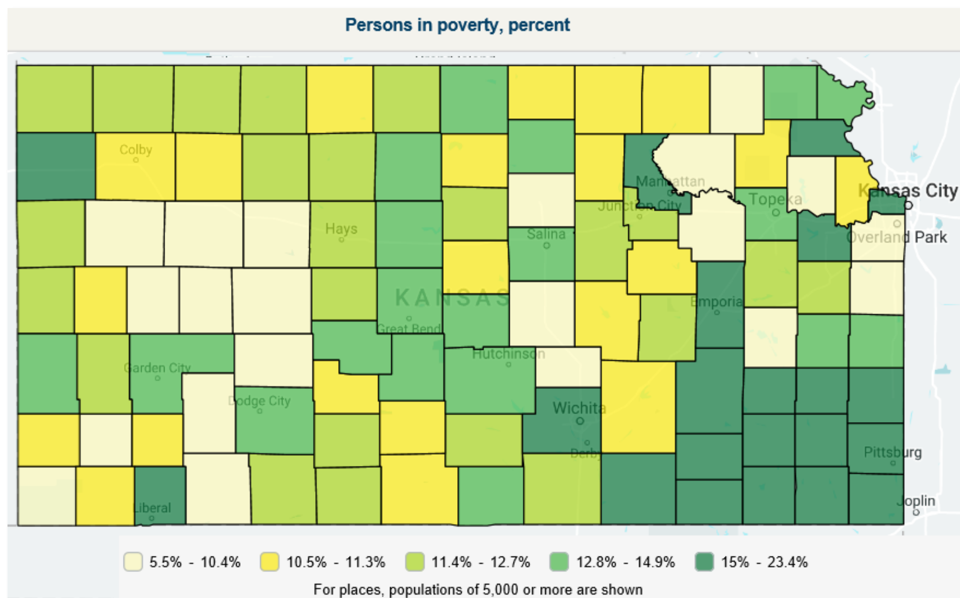
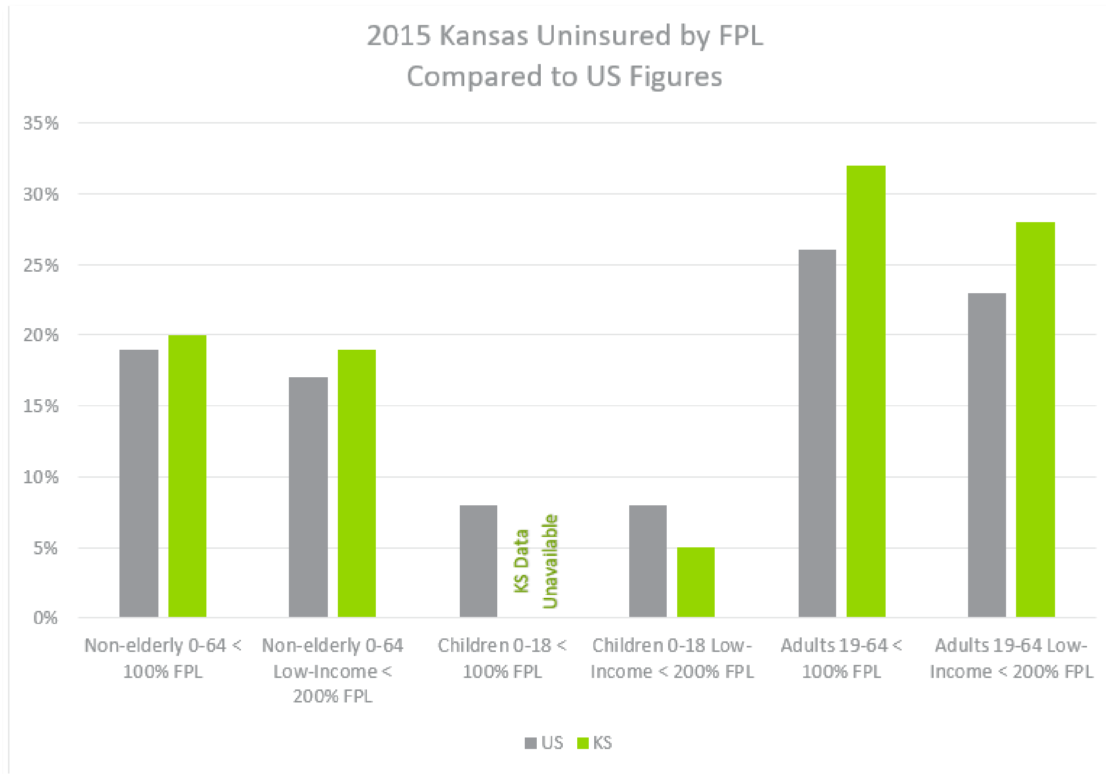


Figure 7 below compares income levels of uninsured residents in Kansas to United States national averages. As a whole, the percentage of uninsured residents with relatively low incomes in Kansas is quite similar to the percentage for the U.S. as a whole, where “low income” is defined as less than 200 percent of the FPL. For persons under age 65, Kansas is just a couple of percentage points above the national average. Similarly, when reviewing adults between the ages of 19 and 64, Kansas is just a few percentage points higher. When reviewing data for children under the age of 19, the state is actually a few points lower than the national data.

Figure 7 - US and Kansas Uninsured by FPL



Source: http://www.kff.org/state-category/health-coverage-uninsured/health-insurance-status/

3.3.4 Unemployment

Another contributing factor to Kansas' rate of uninsured is the rate of unemployment. In May 2016, Kansas Department of Labor[28] reported 4.2 percent as the seasonally adjusted unemployment rate. In looking at the unadjusted rate, it was as low as 3.6 percent the previous December and as high as 4.8 percent in July 2016 then cycled back down to 3.8 percent in December 2016.

Although the Kansas unemployment rate continues to improve, the number of unemployed persons in the labor force remains fairly constant, and was at 62,921 as of July 2016.[29]

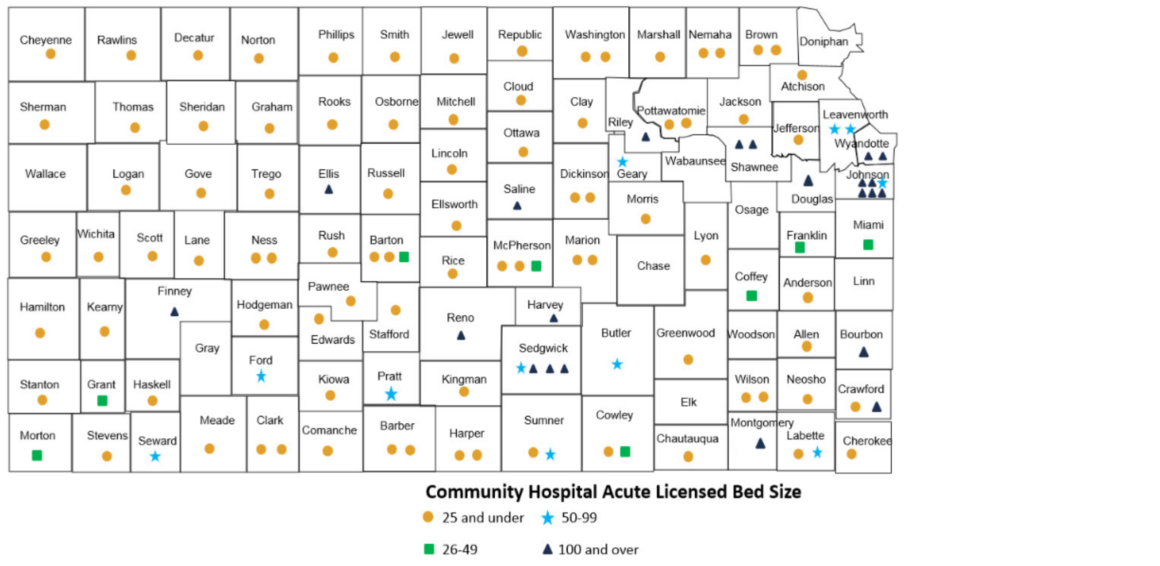
3.3.5 Geographic Location of Hospitals & Uninsureds

The Kansas Hospital Association published a 2015 map[30], shown in Figure 8 below, showing the size and quantity of hospitals per county. As one would expect, the counties having the

[28] Kansas Department of Labor, https://klic.dol.ks.gov/admin/gsipub/htmlarea/uploads/LR%20July2017%20SA%20Rate%20Chart%20file.pdf
[29] Bureau of Labor Statistics, https://www.bls.gov/news.release/laus.htm
[30] Kansas Hospital Association, 2015, "Distribution of Kansas Community Hospitals", http://www.kha-net.org/DataProductsandServices/STAT/FinancesandCoverage/

largest and the most hospitals are located in the more urban areas of the state. Note that there are nine Kansas counties that do not have a hospital at all, but the surrounding counties each have at least one. Three of the counties without a hospital are on the state border. Osage and Wabaunsee are the only counties without a hospital that are also adjacent to another county without a hospital.

Figure 8 - Distribution of Kansas Community Hospitals



The lower southwest corner of the state contains the eleven counties where more than 15 percent of the residents under age 65 are uninsured. Per the 2015 US Census, this area is "largely Hispanic and presumably many are not Medicaid or SCHIP eligible"[31]. According to the CDC, "nearly half (49.8 percent) of all uninsured Kansas children under age 19 live in four largest population centers: Sedgwick County (Wichita), Johnson and Wyandotte counties (Kansas City metropolitan area), Shawnee County (Topeka), and Douglas County (Lawrence). However, the southwest corner of the state has many counties with high concentrations of uninsured children under age 19"[32].

The upper northeast corner of the state contains the 20 counties where fewer than 10 percent of the population under age 65 are uninsured. The uninsured rate for each county in Kansas is shown in Figure 9 below for 2015 for residents under the age of 65.

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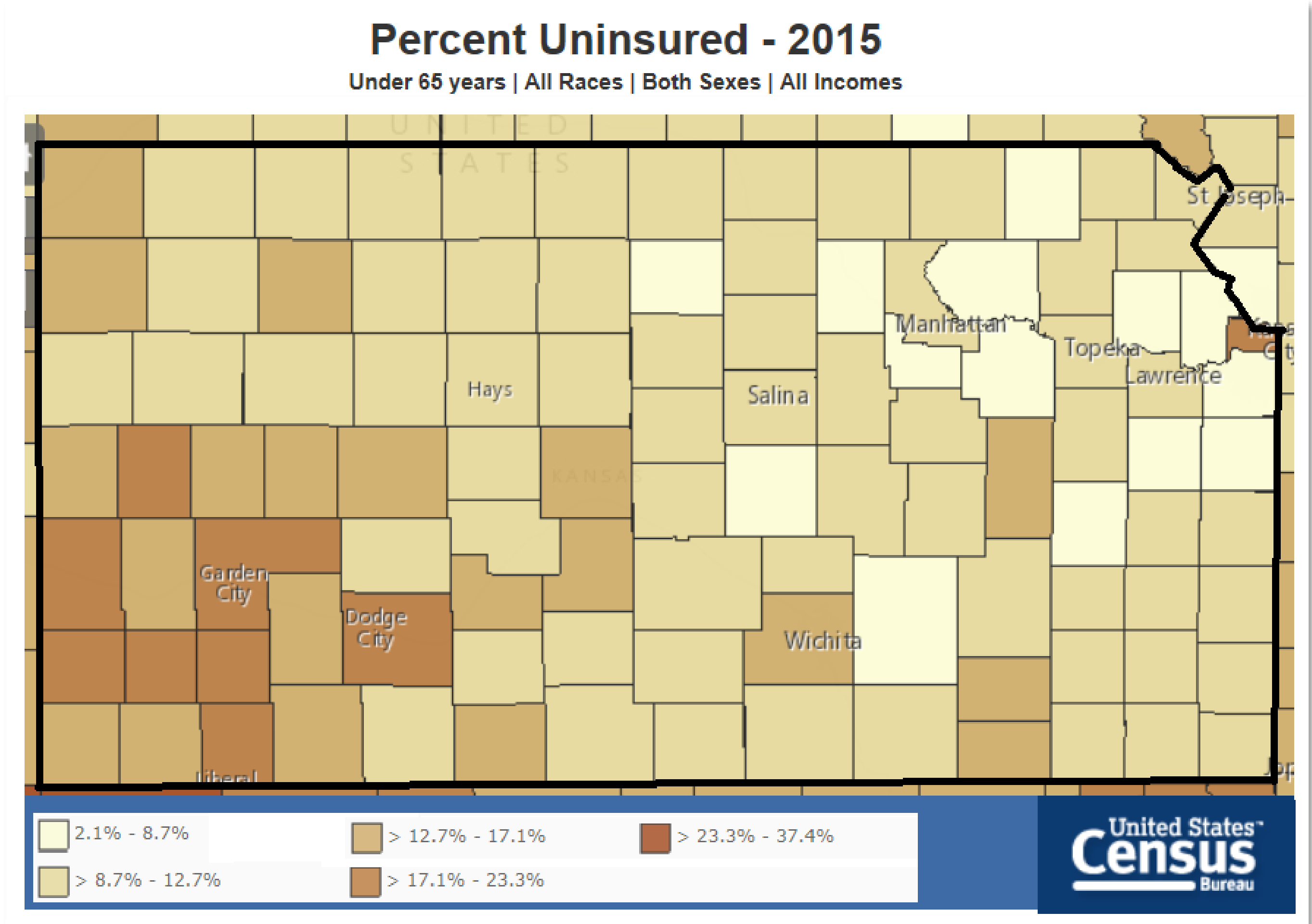
[31] Kansas Department of Health and Environment, September 22, 2014, "Maternal and Child Health Services Title V Block Grant State Narrative for Kansas", http://www.kdheks.gov/c-f/downloads/MCH_BG_2015App_2013AR.pdf
[32] Centers for Disease Control, www.cdc.gov/vaccines/imz-managers/coverage/nis/child/index.html

Figure 9 - Uninsured Rate by County in Kansas - 2015



Source:
https://www.census.gov/did/www/sahie/data/interactive/sahie.html?s_appName=sahie&s_measures=ui_snc&s_statefips=20&s_searchtype=sc

3.3.6 Homelessness

Lack of adequate housing is another critical factor affecting the level of uninsured and the need for an effective health safety net. According to a report issued by the Corporation for Supportive Housing, "access to safe, quality, affordable housing – and the supports necessary to maintain that housing – constitute one of the most basic and powerful social determinants of health."[33] As a group, the homeless tend to have high health needs across multiple systems of care. For example, homelessness, particularly when combined with behavioral health issues, is associated with increased risk for obesity, cardiovascular disease, diabetes, HIV/AIDS, hypertension and other chronic medical conditions due to factors such as sedentary lifestyles,

[33] Corporation for Supportive Housing (CSH), July 2014, "Housing is the Best Medicine Supportive Housing and the Social Determinants of Health", http://www.csh.org/wp-content/uploads/2014/07/SocialDeterminantsofHealth_2014.pdf

risky behaviors, poor diet, lack of exercise, and metabolic alterations attributable to psychiatric medications.[34] That being the case, the health related costs for this group are often much higher than their absolute numbers might suggest.

Kansas has among the lowest rates of homelessness in the U.S. at 7.7 people per 10,000 population which is far below 1 percent of the total state population and also less than the national rate of 17.7 people per 10,000.[35] As reported by the website EndHomelessness.org, the Kansas rate of homeless dropped 7 percent from 2014 to 2015.[36]

While it is difficult to get detailed information on the exact location of Kansas' homeless population, the two counties with the most shelters and services are in the more urban areas of Sedgwick (Wichita area) and Wyandotte County (Kansas City area).[37] Synergy Services, which operates shelters and continuum of care services, reports that there are 2,000 homeless teens every night in metropolitan Kansas City.[38] While this number is from a different source, it would represent a large portion of the total homeless population of 2,255 from the Housing and Urban Development (HUD) count as shown below.

Figure 10 - HUD 2016 Continuum of Care

	Emergency Shelter	Traditional Housing (Safe Haven Transition)	Unsheltered	Total
Persons in Households Without Children	**675**	**263**	**271**	**1,209**
Persons Age 18 to 24	30	35	25	90
Persons Over Age 24	645	228	246	1,119
Persons in households with at least one adult and one child	**403**	**614**	**10**	**1,027**
Children Under Age 18	251	363	6	620
Persons Age 18 to 24	12	12	1	25
Persons Over Age 24	140	239	3	382
Persons in Households with only Children	**2**	**16**	**1**	**19**
Total Homeless Persons	**1.080**	**893**	**282**	**2,255**

[34] Ibid.
[35] United States Interagency Council on Homelessness, "Total People Experiencing Homelessness on a Given Night in 2016", https://www.usich.gov/tools-for-action/map/#fn[]=1400&fn[]=3100&fn[]=6300&fn[]=10400&fn[]=13200&all_types=true&year=2016&state=KS
[36] http://endhomelessness.org/wp-content/uploads/2016/10/2016-soh.pdf
[37] National Alliance to End Homelessness, October, 2016, "The State of Homelessness in America", http://sheltersforhomeless.com/kansas-assistance.html
[38] Synergy Services, "One Homeless Night", http://www.synergyservices.org/?page=Main_News_and_Events_One_Homeless_Night

4 Value Based Purchasing and Payment Reform

STC number 70 for the KanCare 1.0 Demonstration Waiver, which provided the initial requirements for this report, requested a review of "investment in value based purchasing or other payment reform options." In response to this request, results of the value based payment (VBP) reform initiatives implemented within KanCare 1.0 are reviewed in this chapter. The results reviewed are from calendar year 2015 as these are the most recent data available.

4.1 KanCare MCO Contract Requirements

The KanCare MCO contract defines operational, clinical, educational, payment, quality, technical and other requirements for the MCOs to uphold in order to deliver KanCare to Medicaid beneficiaries. KDHE refers to these as Pay for Performance (P4P) incentives and considers them to be key to their VBP efforts.

4.1.1 Pay for Performance Incentives (P4P)

The P4P program allows the State to withhold a portion of the capitation payment each year to incentivize quality performance in various areas. MCOs can earn back the withheld funds by meeting targets on a set number of operational performance measures.

As an example of the types of P4P measures required of the MCOs, Figure 11 lists the performance measures and associated targets for Year 5, which is calendar year 2017.

Figure 11 - Calendar Year 2017 KanCare Pay for Performance Measures

No.	Ref. ID	Measure	Description	Data Source	Measure Weight	2017 Performance Target
Physical Health						
1.	M01.4	Comprehensive Diabetes Care (CDC): *HbA1c Control (< 8.0%)*	Percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%).	Healthcare Effectiveness Data and Information Set [HEDIS] (Hybrid)	7.14%	Unless otherwise noted, KDHE will set Performance Targets as follows: • *>= 50th percentile benchmark:* 100% of incentive payment for measure • *>=5 percentage point improvement:* 100% • *>=3 percentage point improvement:* 50%

No.	Ref. ID	Measure	Description	Data Source	Measure Weight	2017 Performance Target
2.	M18.1	Childhood Immunization Status: *Combination 10*	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday [HEDIS measure Combination 10]	HEDIS (Hybrid)	7.14%	
3.	M18.11	Immunizations for Adolescents: *Combination 2*	Percentage of adolescents 13 years of age who had recommended immunizations by their 13th birthday (Meningococcal; tetanus, diphtheria toxoids and acellular pertussis [Tdap]; human papillomavirus [HPV])	HEDIS (Hybrid)	7.14%	

No.	Ref. ID	Measure	Description	Data Source	Measure Weight	2017 Performance Target
4.	M19.1	Timeliness of Prenatal Care	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.	HEDIS (Hybrid)	7.14%	
5.	N/A	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Percentage of members 3–6 years of age who had one or more well-child visits with a primary care provider (PCP) during the measurement year.	HEDIS (Hybrid)	7.14%	
6.	N/A	Cervical Cancer Screening	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	HEDIS (Hybrid)	7.14%	
Dental						
7.	M10.3	Annual Dental Visit: *Total*	Percentage of members 2–20 years of age who had at least one dental visit during the measurement year.	HEDIS (Admin)	7.14%	
Nursing Facility (NF)						

No.	Ref. ID	Measure	Description	Data Source	Measure Weight	2017 Performance Target
8.	N/A	Residents of a NF or nursing facility for mental health (NFMH), receiving antipsychotic medication ***Lower rate indicates better performance.**	Percentage of long-term stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome.	Minimum Data Set (MDS)	7.14%	This is not a HEDIS measure, so no benchmark comparison. • *>=2.5 percentage point improvement:* 100%
9.	N/A	Nursing Home residents discharged to the community who are admitted to a hospital within 30 days of discharge ***Lower rate indicates better performance.**	Percentage of NF discharges who are admitted to a hospital within 30 days of discharge from the NF.	MDS/ Encounter Data	7.14%	This is not a HEDIS measure, so no benchmark comparison. • *Rate <= 11%:* 100% OR • *>=5 percentage point improvement:* 100%
Behavioral Health						
10.	N/A	Use of Multiple Concurrent Antipsychotics in Children and Adolescents ***Lower rate indicates better performance.**	Percentage of children and adolescents 1 to 17 years of age who were on two or more concurrent antipsychotic medications: - Total Age (i.e., 1-17).	HEDIS (Admin)	7.14%	• *Rate <= 4.75%:* 100%
Home- and Community-Based Services (HCBS)						
11.	N/A	Authorizations of plans of care loaded into Authenticare within 5 calendar days of plan of care start date	Percentage of HCBS members receiving Authenticare required services who had authorizations of plans of care loaded into Authenticare within 5 calendar days of plan of care start date.	Authenticare	7.14%	This is not a HEDIS measure, so no benchmark comparison. • *>= 75% of plans loaded into Authenticare within 5 days of plan of care start date:* 100% OR • *>= 15 percentage point improvement:* 50%

No.	Ref. ID	Measure	Description	Data Source	Measure Weight	2017 Performance Target
12.	N/A	Residents of a NF or NFMH discharged to a community setting	Percentage of NF and NFMH residents indicating a desire to return to the community who are discharged to a community setting during the year.	MDS	7.14%	This is not a HEDIS measure, so no benchmark comparison. • *>= 50 percent:* 100%
Encounter Data						
13.	M17.1	Covered service accurately submitted via Encounter data	Percent of covered service accurately submitted via encounter data within 30 days of claim paid date.	Encounter Data	7.14%	>=98% each quarter • Measure value will be 1.785% per quarter (7.14% / 4 quarters)
14.	M17.2	Service payments matched to / validated by encounter record	Percent of reported financials reflecting service payments that are matched to/validated by an encounter record submitted by the MCO.	Encounter Data	7.14%	>=98% each quarter • Measure value will be 1.785% per quarter (7.14% / 4 quarters)

4.1.2 MCO Provider Quality Incentive Programs

The MCOs have also implemented provider-level incentive programs to improve the quality of care received by beneficiaries. For example, Figure 12 lists provider incentive programs implemented by Amerigroup[39].

Figure 12 - Amerigroup Provider Incentive Programs

Provider Incentive Program (PQIP)	Shared Savings Arrangements	Behavioral Health Quality Improvement Program (BHQIP)	Obstetrical Quality Improvement Program (OBQIP)	Provider Access and Quality Care Program (PAQCP)
• Encourages effecient, preventive and cost-effective care • Implemented January 2017 • Uses quality measures and HEDIS-like assessment process for pay-for performance	• Aims to improve quality and decrease costs • Implemented in 2013 • Utilizes performance targets unique to each contract	• Incentive program for Community Mental Health Centers • Implemented in January 2016 • Eligible providers must meet quality and utilization goals	• Incentivizes OB GYN providers for pre and post-natal care • Implemented January 2017 on a pilot basis	• Developed to incent PCP groups with panels less than 250 beneficiaries • Slated to go-live in 2018

4.2 Key Outcomes

The contracts between KDHE and the MCOs included a variety of VBP reform initiatives against which the MCOs are measured. As shown in the tables below, the MCOs have had strong performance through calendar year 2015. In general, the program has experienced increased access to care and decreased inpatient days and hospital utilization. Select outcomes for all three MCOs are listed in Figure 13 below.

Figure 13 - Calendar Year 2015 KanCare Utilization Key Outcomes by MCO

MCO	Utilization Outcomes
Amerigroup[40]	• 80 percent of providers met the Shared Savings quality threshold • 7.7 percent increase in seven-day follow-up after inpatient behavioral health discharge • 15.7 percent increase in follow-up care for children prescribed ADHD medications
UnitedHealthcare (UHC)[41]	• 65 percent of UHC membership are assigned to PCP with a value-based payment arrangement
Sunflower Health Plan[42]	• 67 percent of membership are assigned to PCP participating in a pay-for-performance arrangement

[39] Source: Amerigroup Kansas, Inc. Quality Incentive Programs and Shared Savings Arrangements.PDF
[40] Amerigroup Kansas, Inc. Quality Incentive Programs and Shared Savings Arrangements
[41] UnitedHealthcare Kansas Community and State value based Collaboration Overview August, 2017
[42] Sunflower Health Plan Pay for Performance Programs Whitepaper, August 1, 2017

Select results related to changes in utilization attributable to the work performed through the DSRIP program are shown in Figure 14 below. The utilization counts in this figure are scaled per 1,000 enrollees.

Figure 14 - Calendar Year 2015 KanCare Utilization Key Outcome Summary

Type of Service	Units Reported	KanCare CY 2015[1]	Pre-KanCare CY 2012[1]	Change in Utilization[1]	Percent Difference
Dental	Claims	1,161	880	281	32%
Inpatient	Days	851	1,189	-338	-28%
Outpatient Emergency Room	Claims	746	762	-16	-2%
Transportation	Claims	793	617	176	29%
Primary Care Physician	Claims	4,517	3,728	789	21%
Note(s): 1) Utilization counts in this table[43] are per 1,000 enrollees					

[43] Annual Report to CMS Regarding Operation of 1115 Demonstration Waiver Program – Year Ending 12.31.16 (December 31, 2016) 19-20.

5 DSRIP Program

The Kansas DSRIP program was approved by CMS in 2014 under the KanCare Demonstration. DSRIP delivers funds to hospitals to develop programs that *enhance access to health care, the quality of care, and the health of the patients and families they serve.* Funds are available for the final three years of the demonstration and each DSRIP program varies by hospital to meet the needs of the population served. Hospitals were required to create Hospital DSRIP Plans which were approved by the State and CMS. Each Hospital DSRIP Plan included descriptions of projects and associated milestones and outcomes.[44]

As mentioned previously, payments under the DSRIP program did not begin until DY 3 of the current KanCare waiver. DY 3 was calendar year 2015. Payments and outcomes described in this chapter are for DSRIP activity completed in DY's 3 and 4, which is a timeframe of January 2015 through December of 2016.

5.1 Description of the DSRIP Program

The following key elements provide an overview of the DSRIP program and were described as part of the January 2014 Demonstration approval documentation and Special Terms and Conditions:

- **Eligibility.** The Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool hospitals are the only hospitals eligible for DSRIP because of their unique ability to affect Kansas' delivery system.[45] Only one hospital qualified as an LPTH, The University of Kansas Hospital (TUKH), and only one hospital qualified as a BCCH, Children's Mercy Hospital (CMH) in Kansas City, Missouri. [46]

- **Hospital DSRIP Plans.** Each eligible DSRIP hospital was required to create a Hospital DSRIP Plan. These plans required CMS and State approval. Each Hospital DSRIP Plan included descriptions of projects and associated milestones and outcomes.[47]

- **DSRIP Goals and Focus Areas.** DSRIP aims to improve access to services, healthy living and healthy communities. These aims are reinforced by the following DSRIP focus areas. Hospitals are required to develop projects that address these focus areas:

    I. Access to integrated delivery systems
        a. Increase access to services, including primary care and preventive services
        b. Increase the effective and efficient use of population health management through health information technology (HIT)
        c. Increase integration of the health care delivery system, including medical, behavioral health, and social services.

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[44] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. STC #67.
[45] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. Attachments F and G.
[46] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. Attachment D.
[47] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. STC #67.

II. Prevention and management of chronic and complex diseases
   a. Improve health literacy, including nutrition education and tobacco use prevention and control
   b. Expand health and wellness programs and develop incentives for participation in these programs
   c. Expand chronic and complex care management models[48]

- **DSRIP Projects.** DSRIP focus areas were further emphasized in the DSRIP projects. Each hospital was required to implement at least two projects from the list of five projects below, and had the option to implement more. (Hospitals were not required to implement one project from each category.)

  - Access to integrated delivery systems
    - Project 1.a: Expansion of Patient Centered Medical Homes and Neighborhood

  - Prevention and management of chronic and complex diseases
    - Project 2.a: Self-Management and Care (SMAC)/Resiliency
    - Project 2.b: HeartSafe Community
    - Project 2.c: Improving Coordinated Care for Medically Complex Patients
    - Project 2.d: Statewide Expansion of Sepsis Early-Warning and Escalation Process[49]

- **Metrics and DSRIP Categories.** Each Hospital DSRIP Plan project was required to meet metrics within the following milestone categories:

  - *Category 1: Infrastructure Milestones*. These are infrastructure-related milestones a hospital must achieve to move forward with its selected and approved project. These milestones lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. These milestones must support the achievement of quality and outcomes milestones for each project.

  - *Category 2: Process Milestones*. These milestones focus on process changes and improvements. These milestones must support the achievement of quality and outcomes milestones for each project.

  - *Category 3: Quality and Outcomes Milestones*. These milestones address the impact of the project on quality metrics and beneficiary outcomes. This stage involves the broad dissemination of interventions from a list of activities identified by the state, in which major improvements in care can be achieved within 4 years. These are hospital-specific initiatives and will be jointly developed by hospitals, the state, and CMS and are unlikely to be uniform across all of the hospitals.

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[48] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. Attachments F and G.
[49] Ibid.

  - *Category 4: Population Focused Improvements*. This category evaluates the broader impact of the selected projects through the reporting of Performance Indicators across several domains selected by the state in conjunction with CMS, and may include:
    - Patient experience;
    - Care outcomes; and,
    - Population health.[50]

- **Metric Targets:** Each metric within the categories identified above was required to include targets to measure progress towards achieving DSRIP goals. Each metric is also designated as pay for reporting, pay for performance or both. This means hospitals would receive partial or full payment if the measure was reported upon and additional payment if the metric also met its target. (Specifics vary based on metric requirements.) [51]

- **Limits:** DSRIP payments are not considered patient care revenue and are not limited by DSH or other Medicaid expenditure limits. [52]

5.2 Measurement of Progress

The University of Kansas Hospital (TUKH) and Children's Mercy Hospitals and Clinics (CMH) each implemented two DSRIP projects. TUKH implemented two projects within the "prevention and management of chronic and complex diseases" focus area, while CMH implemented one project from each focus area. Both hospitals successfully received the majority of DSRIP funds available (greater than 75 percent of total funds awarded) and are on track to continue this trend. (In addition, both hospitals have petitioned for additional funds due to CMS' change in policy regarding partially achieved milestones per letters re: DSRIP Request for Reconsideration to CMS dated April 14, 2017 and May 26, 2017 [from TUKH] and May 25, 2017 [from CMH].) Figures 15 and 16 below lists the DSRIP projects for each hospital and the payment received through DY 4.

[50] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. Special Terms and Condition #67.
[51] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. Attachments F and G.
[52] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. STC #67.

Figure 15 - DSRIP Projects and Payments for The University of Kansas Hospital

The University of Kansas Hospital (TUKH)[53]		
Project	***STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis***	***Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)***
Objective	*Expand internal quality programs to reduce the prevalence of SEPSIS in rural nursing facilities and hospitals in Kansas.*	*Increase heart failure patients' ability to self-manage his or her condition.*
Funded Value	• Total (DY3-5): **$22,500,000** • DY3: $3,750,000 • DY4: $7,500,000 • DY5: $11,250,00	• Total (DY3-5): **$22,500,000** • DY3: $3,750,000 • DY4: $7,500,000 • DY5: $11,250,00
Payments Received to Date[1]	*79 percent of DY3 and DY4 award* • Total (DY3-4): **$8,862,188** • DY3: $3,190,313 • DY4: $5,671,875	*69 percent of DY3 and DY4 award* • Total (DY3-4): **$7,734,375** • DY3: $3,468,750 • DY4: $4,265,625
Key Project Outcomes	• 19 trainings conducted to 554 individuals representing 103 partner facilities (20 NFs, 24 EMS providers, 44 hospitals) • 29 percent of partner facilities have a sepsis protocol • 22 percent of partner facilities now enter sepsis-related data into the Kansas Sepsis Program Database	• Numerous trainings conducted to 160 individuals representing 85 partners • 46 SPARCC facilitators have been trained • 24 SPARCC groups have been conducted with 86 patients and 10 caregivers • 10 SPARCC facilitator training videos have been created
Note(s): 1) Numbers presented in this table are based on Demonstration Waiver years, not state fiscal years.		

[53] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017) 3-68.

Figure 16 - DSRIP Projects and Payments for Children's Mercy Hospitals and Clinics

Children's Mercy Hospitals and Clinics (CMH)[54]		
Project	***Expansion of Patient-Centered Medical Homes (PCMH) and Neighborhoods***	***Improving Coordinated Care for Medically Complex Patients (Beacon Program)***
Objective	*Promote PCMH to improve pediatric primary care in Kansas including increasing access to primary care services and the use of health information technology (HIT).*	*Improve care coordination and provide PCP consultations for rural children.*
Funded Value	• Total (DY3-5): **$7,500,00** • DY3: $1,250,000 • DY4: $2,500,000 • DY5: $3,750,000	• Total (DY3-5): **$7,500,00** • DY3: $1,250,000 • DY4: $2,500,000 • DY5: $3,750,000
Payments Received to Date[1]	*88 percent of DY3 and DY4 award* • Total (DY3-4): **$3,312,656** • DY3: $1,234,531 • DY4: $2,078,125	*78 percent of DY3 and DY4 award* • Total (DY3-4): **$2,939,531** • DY3: $1,236,406 • DY4: $1,703,125

Key Project Outcomes	• One practice achieved National Committee for Quality Assurance (NCQA) PCMH recognition
	• Numerous technical assistance and learning collaboratives have been held
	• Two HIT improvements have been implemented
	• Implemented online message board to increase practice communication
	• Developed integrated database platform
		• 92 patients (65 children and youth with medical complexity (CYMC) and 27 siblings) have been seen by Beacon staff in 2016
		  • 60 patient increase from 2015
		• 82 providers were contacted for outreach to increase PCP consults
		  • PCP consults increased from one in 2015 to 20 in 2016
		• Obtained Level III PCMH certification

Note(s): 1) Numbers presented in this table are based on Demonstration Waiver years, not state fiscal years.		

5.2.1 Key DSRIP Outcomes

DSRIP project outcomes fall within four categories and range from process type measures (Milestone Categories 1 and 2) to outcome measures (Milestone Categories 3 and 4). (See page 36 for a description of each category.) Note that some outcome measures are based on the Healthcare Effectiveness Data and Information Set (HEDIS) measures and are not yet available. Figure 17 summarizes outcomes by project; a checkmark indicates complete achievement of the outcome. Most category 1 and 2 milestones were achieved in DY3 therefore these sections will focus on category 3 and 4 milestones. It is important to note that some metrics have been modified through discussion with the State and CMS to better reflect performance and operational capabilities.

[54] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017) 3-68.

Figure 17 - DSRIP Project Outcomes Summary as of the end of Demonstration Year 4

Milestone Category[55]	STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis (TUKH)	Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC) (TUKH)	Improving Coordinated Care for Medically Complex Patients (Beacon Program) (CMH)	Expansion of Patient-Centered Medical Homes (PCMH) and Neighborhoods (CMH)
1. Infrastructure Milestones	✔	✔	✔	✔
2. Process Milestones	✔	✔	✔	*Partial Achievement*
3. Quality and Outcomes Milestones	✔	*Partial Achievement*	*Partial Achievement*	✔
4. Population Focused Improvements	*Data Not Yet Available*	*Data Not Yet Available*	✔	✔

Each project and milestone category has numerous measurable outcomes. Each year KanCare submits an annual report to CMS –these reports can be reviewed for detailed progress on each milestone category. (*2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report* is the most recently available report at the time this paper was written.)

5.2.2 TUKH Project Outcomes Achieved

TUKH met all of the reporting requirements for Milestone 3 and 4 for both projects with the exception of the *blood glucose* metric. Nearly all of the Milestone 4 metrics are based on HEDIS metrics and will be available at a future date. Therefore, it is not possible to identify the performance achievement values for population focused improvements at this time for either TUKH projects.

Figure 18 shows the outcome achievements for the Stop Sepsis project. Key measurable targets achieved include (baseline values were unavailable):

- Ten percent reduction in emergency department (ED) identification of septic patients at any stage in the continuum (80.64 percent of patients identified in 2016)
- Ten percent reduction in the number of septic patients transferred to a higher-level facility
- Ten percent reduction in the proportion of septic patients progressing to septic shock after 12 months of facility preparation[56]

[55] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017).
[56] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017) 14-29.

Figure 18 - Stop Sepsis: Standard Techniques, Operations, and Procedures for Sepsis Project Outcome Achievement as of Demonstration Year 4

Category[57]	Metric	Reporting Achievement	Performance Achievement
Milestone 3	Improved in-hospital implementation of sepsis management bundles as defined by the Surviving Sepsis Campaign	✔	✔
	Increased identification of septic patients at any stage of the continuum	✔	✔
	Increased ED identification of septic patients in early stages of sepsis (Propose deletion of metric)	✔	✔
	Percent severe sepsis patients that survived hospitalization (Proposed change)	✔	✔
	Percent severe sepsis patients that had the severe sepsis tracker completed (Proposed change)	✔	✔
	Improved ED implementation of sepsis management bundles as defined by the Surviving Sepsis Campaign	✔	✔
	Decrease in transfer of septic patients to a higher-level facility	✔	✔
	Increased identification of septic patients transferred to the hospital from a long-term care facility	✔	✔
	Decrease in proportion of septic patients progressing to septic shock after 12 months of facility participation	✔	✔
Milestone 4	Reduce overall emergency department (ED) utilization (1)	✔	*
	Reduce overall emergency department (ED) utilization (2) / frequent use	✔	*
	Decrease 30-day readmission rate following hospitalization	✔	*
	Controlling high blood pressure (HBP)	✔	✔
	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	✔	*

Note(s):
* This achievement calculation is based on HEDIS measures that are not yet available for 2016.

Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC) did not meet reporting requirements for blood glucose because participants were not required to report on this metric since the project does not target diabetic patients. Figure 19 shows the outcome achievements for SPARCC. Key measurable outcomes include (baseline values were unavailable):

[57] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017) 14-29.

- Greater than ten percent improvement in patient reported quality of life and functional health status
- Ten percent increase in the percent of patients who receive a depression assessment and screening
- Greater than ten percent reduction in patient reported heart failure admission rate[58]

Figure 19 - Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC) Project Outcome Achievement as of Demonstration Year 4

Category[59]	Metric	Reporting Achievement	Performance Achievement
Milestone 3	Quality of life and functional health status	✔	✔
	Depression assessment/screening	✔	✔
	Daily weight monitoring	✔	✔
	Heart failure (HF) admission rate	✔	✔
Milestone 4	Reduce overall emergency department (ED) utilization (1)	✔	*
	Reduce overall emergency department (ED) utilization (2) / frequent use	✔	*
	Decrease 30-day readmission rate following hospitalization	✔	*
	Controlling high blood pressure (HBP)	✔	*
	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	✔	*

Note(s):
* This achievement calculation is based on HEDIS measures that are not yet available for 2016.

[58] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017) 50-59.
[59] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017) 50-59.

5.2.3 CMH Project Outcomes Achieved

Figure 20 shows the outcome achievements for the Expansion of Patient-Centered Medical Homes (PCMH) and Neighborhoods project. CMH missed one Milestone 2 metric because one clinic was unable to submit its application for NCQA recognition on time for a 2016 approval. However, CMH was able to achieve all targets for Milestones 3 and 4. Key measurable outcomes include:

- Increasing the percentage of children 3-17 who receive height/weight/body mass index (BMI) screening and appropriate counseling from 34.7 to 75.22 percent (this represents a large improvement from the goal of 39.4 percent)
- Improved the percentage of adolescent patients who receive well-care visits from 42.3 – 52.41 percent
- Reduced ED visits for patients with asthma from 456/1000 to 292/1000[60]

Figure 20 - Expansion of Patient-Centered Medical Homes (PCMH) and Neighborhoods Project Outcome Achievement as of Demonstration Year 4

Category[61]	Metric	Reporting Achievement	Performance Achievement
Milestone 3	Height\Weight\BMI screening and Counseling for Nutrition and Physical Activity for children 3-17 years of age	✔	✔
	Percent of patients who have completed recommended HEDIS combination 2 immunizations – children age 2 years of age	✔	✔
	Percentage of children who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday	✔	✔
	Percentage of children two years of age who had hemoglobin and/or hematocrit testing for anemia screening by their second birthday	✔	✔
	Percentage of patients 12-21 years of age with who had at least one comprehensive well-care visit	✔	✔

[60] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017) 83 – 129.
[61] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017) 119-127.

Category[61]	Metric	Reporting Achievement	Performance Achievement
	Percentages of patients 2-17 years of age with diagnosis of asthma that have had an ED visit for asthma in the last 6 months. (Exclude pregnancy, childbirth, transfer from other institution, additional diagnosis of cystic fibrosis or anomalies of the respiratory system)	✔	✔
Milestone 4	X CMH ED visits with primary diagnosis of asthma/1000 CMH patients with Kansas Medicaid and diagnosis of asthma	✔	✔
	30-day all-cause readmission rate following hospitalization for patients with Kansas Medicaid	✔	✔
	Percentage of patients 3-17 years of age with Kansas Medicaid who had an outpatient visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic with: - height, weight, and body mass index (BMI) percentile documentation - counseling for nutrition - counseling for physical activity	✔	✔
	The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode	✔	✔
	Percentage of children with Kansas Medicaid who had an outpatient well child visit with a CMH Primary Care Physician (PCP)in a Children's Mercy Primary Care clinic who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday	✔	✔

Figure 21 shows the outcome achievements for the Improving Coordinated Care for Medically Complex Patients (Beacon Program) project. Many metrics were challenged by a small sample size and not all metrics had measurable outcomes. However, CMH was able to make improvements on major quality challenges such as immunizations and ED visits. In addition, CMH has a better understanding of challenges and opportunities for metrics that did not achieve the performance achievement which will further improve quality of care moving forward.

Key measurable outcomes include:

- Increased the immunization rates for patients diagnosed with asthma from 68 percent (baseline) to 92.68 percent
- Improved the number of patients who have a care plan developed from zero to 86.15 percent
- Reduced the number of ED visits for patients with asthma from 305/1000 to 139.74/1000[62]

Figure 21 - Improving Coordinated Care for Medically Complex Patients (Beacon Program) Project Outcome Achievement as of Demonstration Year 4

Category[63]	Metric	Reporting Achievement	Performance Achievement
Milestone 3	Increase Immunization Rates for Children 2 years of age and Children 6 years of age	✔	✔
	Increase the percent of patients assigned to Beacon primary care provider who have completed recommended immunizations - adolescents	✔	
	Increase the percent of patients assigned to Beacon primary care provider with a diagnosis of asthma who receive an annual influenza vaccination	✔	✔
	Increase the percentage of children two years of age who had hemoglobin and/or hematocrit testing for anemia screening by their second birthday	✔	✔
	Improve the patient/family experience Coordination of Care; "If your provider ordered labs/x-rays, or other studies, did someone call to follow up	✔	✔

[62] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017) 68 – 83.

[63] 2016 Delivery System Reform Incentive Payment Pool (DSRIP) Hospitals Annual Report Prepared for KanCare (February 28, 2017) 72-83.

Category[63]	Metric	Reporting Achievement	Performance Achievement
	the results in a timely manner?" (Yes 90% of time)		
	Increase the percent of Beacon patients who have an Emergency Information Form for use by EMS and receiving health organizations		
	Improve the number of Beacon patients who receive effective care coordination of healthcare services when needed	✔	✔
Milestone 4	X CMH ED visits with primary diagnosis of asthma/1000 CMH patients with Kansas Medicaid and diagnosis of asthma	✔	✔
	30-day all-cause readmission rate following hospitalization for patients with Kansas Medicaid	✔	✔
	Percentage of patients 3-17 years of age with Kansas Medicaid who had an outpatient visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic with: - height, weight, and body mass index (BMI) percentile documentation - counseling for nutrition - counseling for physical activity	✔	✔
	The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode	✔	✔
	Percentage of children with Kansas Medicaid who had an outpatient well child visit with a CMH Primary Care Physician (PCP)in a Children's Mercy Primary Care clinic who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday	✔	✔

5.3 Payments Made

The KanCare DSRIP Pool has released $22,848,750 to eligible providers to improve access to care and the quality of care received by Medicaid beneficiaries. This value represents 76 percent of the total amount awarded to eligible providers in the current demonstration years (DY). Providers will be eligible to receive an additional $30,000,000 in the final demonstration year.[64] The values in the figures below show totals by DY or date of service as opposed to date of payment. For example, annual payments for DY3 represent the achievements during DY3 but will be paid during DY4.

Figure 22 - Total DSRIP Payments by Demonstration Year (DY)

DY	Total
1	*N/A (no DSRIP payments in DY 1 & 2)*
2	*N/A (no DSRIP payments in DY 1 & 2)*
3	**$ 9,130,000**
4	**$ 13,718,750**
5	*N/A (current demonstration year)*
Total	**$ 22,848,750**

Figure 23 - The University of Kansas Hospital (TUKH) DSRIP Payments by Project

DY	Total TUKH	Sepsis	SPARCC
1	*N/A (no DSRIP payments in DY 1 & 2)*		
2	*N/A (no DSRIP payments in DY 1 & 2)*		
3	$ 6,659,063	$ 3,190,313	$ 3,468,750
4	$ 9,937,500	$ 5,671,875	$ 4,265,625
5	*N/A (current demonstration year)*		
Total	**$ 16,596,563**	**$ 8,862,188**	**$ 7,734,375**

Figure 24 - Children's Mercy Hospital (CMH) DSRIP Payments by Project

DY	Total CMH	Beacon Program	PCMH
1	*N/A (no DSRIP payments in DY 1 & 2)*		
2	*N/A (no DSRIP payments in DY 1 & 2)*		
3	$ 2,470,938	$ 1,236,406	$ 1,234,531
4	$ 3,781,250	$ 1,703,125	$ 2,078,125
5	*N/A (current demonstration year)*		
Total	**$ 6,252,188**	**$ 2,939,531**	**$ 3,312,656**

[64] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. Attachments F and G.

6 Description of Hospital Payment Streams and Related Funding Sources

In 2016 the Kansas Medicaid program administered funding and reimbursement for more than 400,000 eligible residents. In particular during this year, $502 million was spent on hospital inpatient and outpatient services. For services reimbursed through the traditional Medicaid fee-for-service program, the reimbursements were paid directly from Kansas Medicaid to the hospitals. For services reimbursed through the Medicaid managed care program, funds were included in the capitation rates paid by Kansas Medicaid to MCOs, and the MCOs, in turn, reimbursed the hospitals. Another $137 million was distributed by Kansas Medicaid in SFY 2016 using supplemental payments through the GME, DSH, UC Pool and DSRIP programs.

Like most Medicaid programs in the United States, Kansas Medicaid is funded and disburses payments for hospital-related medical services in a variety of ways. This section describes the funding and payment mechanisms that were in effect during SFY 2016 and were applicable for 166 hospitals included in our analysis. The 166 hospitals include all in-state acute care hospitals and six out-of-state acute care hospitals with 1,000 or more paid claims for inpatient and outpatient services provided to Kansas Medicaid recipients in SFY 2016. Included in this small set of out-of-state hospitals are two hospitals that receive payments through the Kansas Medicaid DSH program – Children's Mercy Hospital and Mercy Hospital Joplin. Children's Mercy Hospital also receives payments through the Kansas Medicaid UC Pool and DSRIP programs.

Generally, the funding for payments of hospital-related medical services provided to Medicaid recipients and the uninsured comes from five sources: 1) state general funds; 2) local expenditures funded by non-State government sources that are reported as Certified Public Expenditures (CPEs); 3) intergovernmental transfer (IGT) funding from local government sources; 4) tax revenue generated by health care-related provider taxes or assessments; and 5) Federal matching funds provided through CMS. Specifically in Kansas in SFY 2016, four of these funding sources were used to fund hospital reimbursements – only CPEs were not used.

In SFY 2016, Kansas Medicaid hospital reimbursements were distributed through six programs: 1) traditional Fee-for-Service (FFS); 2) Medicaid Managed Care, in which capitation payments are made by Kansas Medicaid to Managed Care Organizations (MCOs), and the MCOs, in turn, pay the hospitals for inpatient and outpatient services; 3) DSH; 4) Graduate Medical Education (GME); 5) DSRIP; and 6) the Uncompensated Care Pool.

6.1 Description of Data Included in Payment and Cost Analyses

The hospitals included in the analyses in this report are all the acute-care hospitals with service locations in the State of Kansas plus six hospitals in Missouri that had more than 1,000 paid claims for inpatient and outpatient services provided to Kansas Medicaid recipients in SFY 2016. Included in this small set of out-of-state hospitals are two hospitals that receive payments through the Kansas Medicaid DSH program – Children's Mercy Hospital (Kansas City, Missouri) and Mercy Hospital Joplin (Joplin, Missouri). Children's Mercy Hospital also receives payments through the Kansas Medicaid UC Pool and DSRIP programs. Combining the in-state and select out-of-state facilities, a total of 166 hospitals are included in this report.

Medical claim data included in our analyses are for hospital inpatient and outpatient services with first date of service in SFY 2016, which extends from July 1, 2015 to June 30, 2016, and

date of payment prior to July 13, 2017. Both fee-for-service and managed care encounter claims are included, and the source for both types of claims is the Kansas Medicaid Management Information System (MMIS).

Supplemental payments documented in this report were identified based on date of service, not date of payment and were provided to Navigant by KDHE. These include payments for the UC Pool, DSRIP program, DSH program, and the FFS portion of the Graduate Medical Education (GME) program.

Both the cost of care for uninsured recipients and self-pay revenue hospitals received from the uninsured were retrieved for most hospitals from the Schedule S-10 from the Medicare cost report Form 2552-10. A total of 153 hospitals had Schedule S-10 information. For these 153 facilities, cost of care for uninsured recipients was retrieved from row 21 and column 1 of the Schedule S-10. Self-pay revenue was retrieved from row 22 and column 1 of the Schedule S-10. Another 10 hospitals had no Schedule S-10 information but did have information from KDHE's DSH survey used for setting SFY 2016 DSH allotments. The Medicare cost reports used to complete these DSH surveys were from hospital fiscal years ending in 2013 and 2014. The cost reports from which schedule S-10 data was retrieved were from hospital fiscal years ending in 2015 and 2016. A remaining 10 hospitals had neither a DSH survey nor a Medicare cost Schedule S-10. For these hospitals, we assumed both the cost of care to the uninsured and self-pay revenue to be $0. Most of these are specialty rehabilitation or psychiatric facilities.

For each hospital, the cost of care for the uninsured and the self-pay revenue from the uninsured was multiplied by a percentage to obtain the portion applicable to the State of Kansas. The Kansas percentage was calculated from data in the Kansas DSH surveys and represents the percentage of Kansas Medicaid days to total Medicaid days for each provider. This percentage was available for most hospitals included in the study since the majority of hospitals were included in the DSH survey. For hospitals not included in the DSH survey, Navigant calculated the Kansas portion to apply to the uninsured and the self-pay revenue. For hospitals located in Kansas, the percentage is calculated based on the average Kansas Medicaid percentage reported in the DSH surveys for in-state hospitals. For hospitals located in Missouri, the Kansas portion is calculated based on the average reported percentage for Missouri hospitals who submitted DSH surveys. In general, 100 percent of the uninsured recipients treated by the hospital are estimated to be Kansas residents for hospitals in the interior of the State of Kansas. However, for in-state hospitals near a state border and for hospitals included in our study and located in Missouri, the Kansas Medicaid portion was estimated to be less than 100 percent.

The amount of local funding of the Medicaid program through the provider assessment and IGTs was documented by KDHE and provided to Navigant for each applicable hospital.

The cost of care provided to Medicaid recipients is also a factor included in our data analyses. This value was calculated for each hospital by multiplying the hospital's submitted charges on claims data times the hospital's all payer cost-to-charge ratio (CCR). Hospital all payer cost-to-charge ratios were calculated using Medicare cost report data retrieved from the Healthcare Cost Report Information System (HCRIS) dataset downloaded in May of 2017. A single, aggregate CCR was determined for each cost report (i.e. each hospital fiscal year) by dividing total costs by total charges. Total Costs were calculated as the sum of cost of care retrieved from Line 202, Column 5 from Schedule C Part I plus the sum of direct medical education costs retrieved from Line 118, Columns 21 and 22 from Schedule B Part I. Total charges retrieved

from Line 202, Column 8 from Schedule C Part I. The only difference between Navigant's calculation of CCRs versus the calculation used for row 1 on Schedule S-10 is that Navigant includes Direct Medical Education costs retrieved from Schedule B. The inclusion of Direct Medical Education costs is reasonably because we are included Kansas Medicaid Graduate Medical Education payments in our payment-to-cost comparisons.

Once CCRs were determined for each hospital cost report submitted in the 2552-10 format, the CCRs were applied to individual claims by identifying the hospital cost report whose timeframe (hospital fiscal year) covered the first date of service on the claim. If no hospital cost report was available in HCRIS for the date of service of the claim, the CCR calculated from the hospital's most currently available cost report in HCRIS was applied to the claim. In addition, if no cost reports were found in HCRIS for a hospital, then the statewide average CCR calculated from cost reports with a fiscal year end in 2015 was used.[65] Finally, the CCR assigned to each claim was multiplied by the submitted charges on the claim to estimate the hospital's cost for providing the services identified on that claim.

6.2 Funding of Medicaid Payments

The Kansas Medicaid program received Federal matching funds for medical services provided to Medicaid recipients using a Federal Medical Assistance Percentage (FMAP) of 55.96 percent in SFY 2016. This means that for every $100 spent by the Medicaid Agency, $44.04 came from non-Federal resources (state and local dollars) and the other $55.96 came from Federal resources.[66]

In SFY 2016, 81 percent of the non-Federal share of Medicaid funding came from state general revenues. The other 19 percent of the non-Federal share of Kansas Medicaid hospital reimbursements came from local sources through IGTs and the provider assessment. In general, IGTs may originate from public hospitals directly and from local governmental agencies to fund the non-Federal share of Medicaid reimbursements. Specifically in Kansas in SFY 2016, only one entity, University of Kansas Hospital contributed IGTs. In addition, the provider assessment was based on 1.83 percent of net inpatient revenues from hospital fiscal year 2010. State and local government funding of the Kansas Medicaid hospital reimbursements in SFY 2016 are summarized in Figure 25 below:

[65] Fiscal year end 2015 was used because we felt it was the most current year for which all or nearly all hospitals in Kansas would have a cost report included in the HCRIS dataset.

[66] Note, Kansas did not expand Medicaid under the PPACA, so the higher FMAP for the expansion population does not apply to Kansas Medicaid.

Figure 25 - Comparison of State General Funds to Local Funds Supporting Non-Federal Share of Kansas Medicaid Hospital Payments

Funding Source	Dollars[1]	Percent of Total Non-Federal Share
State General Fund	$229,261,282	81%
IGT[2]	$11,111,140	4%
Provider Assessment	$43,342,333	15%
Total Local	$54,453,473	19%
Total Non-Federal Share	$283,714,755	100%

Note(s):
1) Funds distributed through the DSRIP program are included in this table.
2) IGTs were contributed by one hospital, The University of Kansas Hospital, and helped fund their participation in the UC Pool and DSRIP programs.

Figure 26 below summarizes the distribution of State and local government funds by five categories of hospitals. As shown in this figure, the provider assessment is not applied to critical access, children's and state-owned hospitals.

Figure 26 - Distribution of State and Local Funding of Kansas Medicaid Payments Across the Five Categories of Hospitals

		Local Funding				
Hospital Category	State Share and Local Funding of Total Medicaid Payments	IGT Funding	Provider Assessment Funding	State General Funds	Percentage of Non-Federal Share from State General Funds	Percentage of Non-Federal Share from Local Funds
Acute Care Hospital	$216,080,450	$11,111,140	$41,954,265	$163,015,046	75%	25%
Children's Hospital	$40,121,577	$0	$0	$40,121,577	100%	0%
Critical Access Hospital	$20,620,777	$0	$0	$20,620,777	100%	0%
Specialty Hosp - Psych and Rehab	$3,540,008	$0	$1,388,068	$2,151,940	61%	39%
State Owned Hospital	$3,351,943	$0	$0	$3,351,943	100%	0%
Total	**$283,714,755**	**$11,111,140**	**$43,342,333**	**$229,261,282**	**81%**	**19%**

6.3 Medicaid Claim and Supplemental Payments to Hospitals

As noted in the section above, the hospitals evaluated in this report are categorized as Acute Care, Critical Access, Children's, Specialty (Psychiatric and Rehabilitation), and State-owned hospitals that provide services to Kansas Medicaid recipients. These hospitals receive payments through several different payment streams for the services they provide to Medicaid recipients. The following sections describe in detail the payment streams for each provider category as well as the source of the funding for each payment stream.

6.3.1 Claim-based Payments for Medicaid-Eligible Services

For this report, claim payments are the payments made based on submission of a claim from a hospital for services provided to a Medicaid eligible recipient. Kansas maintains a MMIS that adjudicates and determines reimbursement for inpatient and outpatient claims for recipients in the FFS program. For Medicaid beneficiaries enrolled in managed care plans under KanCare, the MCOs are responsible for the processing and payment of inpatient and outpatient claims.

Nearly $25 million of the total $43 million collected through the provider assessment in SFY 2016 was used to fund claim-based payments – both FFS and managed care capitation rates. The rest of the non-Federal share of funding of FFS and managed care claim payments, approximately $196 million, came from state general funds.

6.3.2 DSH Payments

In general, DSH payments are Federally required Medicaid inpatient hospital payment adjustments for hospitals that serve a disproportionate share of low income patients. As such, DSH funds help to offset the Medicaid shortfall and the costs incurred for care of the uninsured. The cost of care for uninsured is defined as hospital costs to care for recipients who have no health insurance or other source of third party coverage or whose health insurance does not cover any of the services related to an entire episode of care (such as a hospital admission). For DSH calculation purposes, costs of care for the uninsured are offset by patient payments. Total Federal Medicaid DSH payments to a hospital may not exceed the hospital's cost for care of Medicaid recipients and the uninsured, net of FFS, managed care, patient payments, and the UC Pool.

There are both federal and state qualifications to receive DSH payments. The two federal requirements to qualify for DSH payments are: 1) Medicaid Inpatient Utilization Rate (MIUR) must be greater than one percent; and 2) Hospital must have two obstetricians who agree to serve Medicaid patients (or a rural hospital may have any physician who agrees to perform non-emergency obstetric services). There is an exception to the latter if the hospital serves patients who are predominantly under the age of 18. For Kansas and other states not opting to implement alternative qualifying criteria, the state requirements include 1) MUIR greater than one standard deviation above the mean MUIR for all Kansas hospitals receiving Medicaid payments; and 2) a Kansas Low Income Utilization Rate (LIUR) greater than 25 percent. Hospitals that qualify for the DSH program at the beginning of a year but not when the final audit is complete, must consider this an overpayment and make a reimbursement.[67]

In SFY 2016, 72 in-state hospitals and two out-of-state hospitals qualified for and received DSH payments through the Federal DSH program. The 74 hospitals received a total $61 million in DSH funding, the non-Federal share of which came from state general funds. Federal DSH payments are made directly from the Medicaid Agency to hospitals, independently of the capitation payments made to MCOs.[68]

6.3.3 Other Supplemental Payments for Medicaid Services

Kansas Medicaid has a variety of other Medicaid payments intended to supplement reimbursements made through claim payments. Figure 27 below provides a listing and brief description of each of these supplemental payment streams.

[67] BKD National Healthcare Group. 05/13/2015. http://www.bkd.com/docs/webinars/2015/5-13-15-presentation.pdf
[68] In data figures throughout this report, DSH payments are primarily categorized as reimbursement for Medicaid recipients. A small portion of DSH payments are applied to the uninsured.

Figure 27 - Description of Supplemental Payment Streams

Supplemental Payment Program	Description
GME	Graduate Medical Education • Funds paid to a hospital as a share of the direct cost of staffing medical residents (salary, teaching, maintenance, personnel, etc.) • Calculated based on established rate per annum and region • Non-Federal share is funded through state general funds
UC Pool	Uncompensated Care Pool • Funds available for state cost of providing service to low income uninsured patients • Nearly $18 million of the Non-Federal share is funded through the provider assessment • Kansas University Hospital uses IGTs to fund its portion of the non-Federal share of UC Pool payments • Little or no state general funds are used to fund the UC Pool
DSRIP	Delivery System Reform Incentive Program • Funds paid to providers for meeting specified performance metrics • Not tied to services provided on specific dates to specific recipients • Kansas University Hospital uses IGTs to fund its portion of the non-Federal share of UC Pool payments • State general revenue is used to fund the non-Federal share of DSRIP payments to Children's Mercy Hospital

6.3.4 Summary of Kansas Medicaid Hospital Reimbursements

Figure 28 below shows the Kansas Medicaid reimbursement amounts by the five hospital categories for SFY 2016 for care of Medicaid and uninsured recipients.

Figure 28 - Total Kansas Medicaid Hospital Payments for Patient Care

Category	Medicaid FFS Claim Payments	Medicaid Managed Care Claim Payments	DSH Payments	UC Pool Payments	Total Kansas Medicaid Payments to Hospitals
Acute Care Hospital	$29,404,513	$354,343,685	$36,136,286	$54,700,680	$474,585,164
Critical Access Hospital	$1,156,819	$36,531,937	$8,890,531	$5,970,659	$52,549,946
Children's Hospital	$542,964	$71,175,491	$9,407,125	$0	$81,125,580
Specialty Hosp - Psych and Rehab	$422,403	$7,429,707	$21,549	$147,517	$8,021,176
State Hospital	$62,651	$525,070	$6,421,232	$0	$7,008,953
Total	**$31,589,349**	**$470,005,890**	**$60,876,723**	**$60,818,855**	**$623,290,817**

Figure 29 below displays "other" hospital revenues which either do not come from Kansas Medicaid ("Payments from the Uninsured") or are not related to patient care (GME and DSRIP).

Figure 29 - Total "Other" Hospital Revenues

Category	Payments from the Uninsured	GME Payments	DSRIP Payments
Acute Care Hospital	$4,483,662	$ 1,639,565	$ 9,937,500
Critical Access Hospital	$243,550	$ -	$ -
Children's Hospital	$225,093	$ -	$ 3,781,250
Specialty-Psychiatric and Rehabilitation	$16,990	$ -	$ -
State Hospital	$602,180	$ -	$ -
Total	**$5,571,475**	**$ 1,639,565**	**$ 13,718,750**

State versus local funding of the various Medicaid payment streams is shown in Figure 30 below.

Figure 30 - State Versus Local Funding for Each Hospital Payment Stream

Category	Medicaid Claim Payments (FFS and MC)	GME Payments	DSH Payments	UC Pool Payments	DSRIP Payments	Total
State Funds	$195,947,886	$322,064	$26,810,109	$2,132,741	$1,594,805	$226,807,605
Local Funds[1]	$24,954,657	$400,000	$0	$24,651,883	$4,446,933	$54,453,473
Total	**$220,902,543**	**$722,064**	**$26,810,109**	**$26,784,624**	**$6,041,738**	**$281,261,078**

Note(s):
1) Local funds are IGTs and the provider assessment.

6.3.5 Comparison to CMS-64 Report

Medicaid agencies are required to file the CMS-64 report on a quarterly basis. This report represents the actual expenditures "for which states are entitled to federal reimbursement under Title XIX and which reconciles the monetary advance made on the basis of Form CMS-37 filed previously for the same quarter."[69] Specifically related to the KanCare 1115 Demonstration Waiver, the State has the following requirement:

> "The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIV of the STCs." [70]

[69] CMS-64 Quarterly Expense Report. https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/CMS-64-Quarterly-Expense-Report.html
[70] Centers for Medicare & Medicaid Service Waiver Authority, Number 11-W-00283/7, KanCare.

These reports are used to document and communicate state expenditures made through the Medicaid program and to define the amount of funds due to states from CMS for the federal share of Medicaid costs. Thus CMS-64 reports, while routine and produced as part of standard operating practice, are very important as they affect transfer of extremely large sums of money from the federal government to state governments. Because of the importance of these reports, the specifications for this study included a request for a review to be performed of the data included in recent CMS-64 reports versus Medicaid payments documented via other sources.

This review of Medicaid payments made during state fiscal year 2016 as this was the most recent complete state fiscal year for which data was available at the time of this study. Kansas SFY 2016 ran from July 1, 2015 through June 30, 2016. Because CMS-64 reports are produced quarterly, this included CMS-64 reports for quarters ending September 30, 2015, December 31, 2015, March 31, 2016, and June 30, 2016.

Overall payments reported through CMS-64 reports aligned relatively closely with Medicaid payments reported through other sources. This comparison is shown in Table 31 below. For hospital inpatient and outpatient fee-for-service reimbursements, we used claim extracts from the Kansas MMIS to validate against payments reported on the CMS-64 reports.

Figure 31 - Medicaid payments reported for SFY 2016

	CMS-64	Other Reporting	Monetary Difference	Percentage Difference	Source of Other Reporting
FFS Hospital Claims	$28,004,839	$31,589,349	($3,584,510)	11%	Claim data from KDHE
DSH Total	$72,045,212	$67,319,504	$4,725,708	(7%)	Spreadsheet from KDHE
Overall Total	**$100,050,051**	**$98,908,853**	**$1,141,198**	**(1%)**	

Notes:
1) Data from SFY 2016.
2) Claim payments in CMS-64 reports were retrieved from reporting categories 1A and 6A.
3) DSH payments in CMS-64 reports were retrieved from reporting categories 1B and 2B.

Differences between payment amounts reported in the CMS-64 reports versus other sources can be attributed to the fact that the timeframes for payments selected in each reporting method differ slightly. CMS-64 reports include payments based on actual date of payment. In contrast, our MMIS claim data was selected based on date of service because this avoids using data skewed because of one or more large mass adjustments that could cover many dates of service and process on a single date of payment. Because there is some lag between first date of service and the date in which an individual claim is submitted by the provider and paid by Medicaid, claims included in the CMS-64 reports will not exactly match claims selected based on first date of service. Also, our claim data included billings from in-state hospitals and six out-of-state hospitals. The CMS-64 includes payments to all in-state and out-of-state hospitals. In addition for claim data, differences between payment amounts in the CMS-64 versus claim data retrieved from the MMIS may be caused by claim adjustments performed after the end of the fiscal year. Claim adjustments are recorded in CMS-64 reports as “prior period adjustments” and are reported in the report applying to the time frame in which the adjustment was performed. In our analysis, if the adjustment occurred outside of SFY 2016, it would be included in a future CMS-64 report, not in any of the four reports used in this analysis. However, the claim extract retrieved for this analysis was generated well after the end of SFY

2016 and does reflect any claim adjustments performed up through our data extract date, which was in early July, 2017.

When considering supplemental payments, data included in this report documents payments applicable to a state fiscal year. Operationally, payments applicable to a state fiscal year may not always occur within that fiscal year. This will generate differences between numbers included in this report versus numbers in the CMS-64 reports. For example, payments made just after the end of the state fiscal year and applicable to the appropriation for that fiscal year would not be included in the CMS-64 reports, but would be included in the MMIS payment totals. These differences in payment reporting criteria could explain two or three percent difference in amounts reported.

6.3.5.1 UC Pool and DSRIP to CMS-64 Reconciliation

The UC Pool Waiver data pulled from the CMS-64 reports, totals over $50M with more than half that being reported in Q1 and Q2 for this demonstration. Total UC Pool payments applicable to SFY 2016 were just under $61 million. Again, we assume this difference is related to the fact that some UC Pool payments applicable to SFY 2016 were made after the end of SFY 2016.

Figure 32 - UC Pool payments reported via CMS-64 for SFY 2016

Quarter	Total
07/01/2015 - 09/30/2015	$17,642,332
10/01/2015 - 12/31/2015	$17,894,476
01/01/2016 - 03/31/2016	$4,964,137
04/01/2016 - 06/30/2016	$11,073,278
TOTAL	$51,574,223

Because DSRIP performance metrics and project results must be measured and compared to targets before payments can be distributed, the timing of DSRIP payments always falls behind the dates in which applicable work was performed. In addition, DSRIP project results are measured based on a calendar year to align with the Demonstration Waiver year; they are not measured based on the state fiscal year. In the table below describing DSRIP data pulled from the CMS-64 reports, note that DSRIP distribution occurred only for Q2 and totaled $3,020,859. KDHE reported the total DSRIP payments made that were applicable to SFY 2016 were $13,718,750. This suggests about $10.7 million of the DSRIP payments were made after the state fiscal year ended.

Figure 33 - DSRIP payments reported via CMS-64 for SFY 2016

Quarter	Total
07/01/2015 - 09/30/2015	
10/01/2015 - 12/31/2015	$3,020,859
01/01/2016 - 03/31/2016	
04/01/2016 - 06/30/2016	
TOTAL	$3,020,859

7 Comparison of Payments to Costs

In this chapter, we summarize payment and cost information for services provided to Medicaid recipients and the uninsured in SFY 2016. We evaluate this information at an aggregate level by the hospital categories identified earlier in this report.

As we will discuss later in this chapter, hospitals do not receive the full economic benefit of amounts claimed by KDHE for Federal matching purposes for services where the non-Federal portion of funding is satisfied through IGTs and provider assessment contributions. In other words, in cases where the non-Federal portion of Medicaid funding originates from hospitals or other related local governmental sources, the net economic benefit to hospitals for care of Medicaid and uninsured recipients equates to only the Federal portion. In Kansas in SFY 2016, this is just under 52 percent of Medicaid reimbursements.

Because some of the non-Federal share of Kansas Medicaid funding originates from public hospitals, we compare Medicaid payments to hospital costs in two different ways,

1. “Gross” – Including total Federally-matched payments made
2. “Net” – Including total Federally-matched payments made, net of hospital funding of non-Federal share of Medicaid reimbursements

These payment-to-cost analyses are discussed in sections 7.3 and 7.4.

7.1 Estimate of Hospital Cost of Care

Figure 34 below summarizes the total applicable costs for services provided by Kansas hospitals and the high utilization Missouri hospitals to Kansas Medicaid and uninsured recipients in SFY 2016. Included in Figure 34 are hospital costs associated with inpatient and outpatient services provided in SFY 2016 to Medicaid FFS and managed care recipients as well as uninsured recipients.

Figure 34 - Hospital Costs for SFY 2016

Hospital Category	Medicaid FFS Costs	Medicaid Managed Care Costs	Uninsured Costs	Total Medicaid and Uninsured Costs
Acute Care	$ 92,020,237	$627,372,037	$120,261,961	$ 839,654,234
Children’s Hospital	$ 1,781,981	$161,737,408	$ 8,135,194	$ 171,654,582
Critical Access Hospital	$ 13,375,794	$102,293,414	$ 6,371,538	$ 122,040,745
Specialty Hosp – Psych and Rehab	$ 1,987,947	$ 13,364,870	$ 307,213	$ 15,660,029
State Hospitals	$ 8,025	$ 375,645	$ 32,824,262	$ 33,207,932
Total	**$109,173,982**	**$905,143,374**	**$167,900,167**	**$1,182,217,523**

7.2 Allocation of DSH, UC Pool and DSRIP Payments to Medicaid Shortfall and Care of Uninsured

The payment-to-cost analyses calculated for this report include care for both Medicaid recipients and the uninsured. As such, both DSH and UC Pool payments are included as part of the Medicaid reimbursements. In contrast, DSRIP payments are not included as these payments

are not direct reimbursement for services provided to recipients. Instead, DSRIP payments are intended to compensate hospitals for transformational improvements that support the goals of the program.

Included in the following report section are payment-to-cost calculations performed separately for Medicaid recipients (Figure 35) and for the uninsured (Figure 36). To make these calculations, we needed to apply some or all of UC Pool payments and DSH payments to reimbursement of care to the uninsured, and then apply the rest to reimbursement of care to Medicaid recipients (i.e. Medicaid shortfall).

UC Pool payments are defined in the Waiver STCs as payments intended to compensate for costs associated with the uninsured and Medicaid shortfall. For purposes of this report, we chose to apply all reimbursement from the UC Pool to care of the uninsured. We felt this was the primary purpose of the UC Pool and, in aggregate, this application still resulted in payments for care of the uninsured far below cost of that care.

As described in Chapter 6, DSH payments are Federally required Medicaid inpatient hospital payment adjustments for hospitals that serve a disproportionate share of low income patients and help to offset the Medicaid shortfall, calculated as total hospital payments for services less total costs for services, as well as the costs incurred for care of the uninsured. As such, we applied DSH payments by category of hospital to Medicaid shortfall first. If the total DSH payment for a category of hospitals exceeded Medicaid shortfall, then we applied some or all of the DSH payments to cost of care of the uninsured. Using this methodology with the KDHE data, DSH funds were applied to uninsured costs for one hospital category – state owned facilities. For these facilities, Medicaid shortfall was determined to be $0 without application of any DSH funds.

7.3 "Gross" – Payment-to-Cost Comparison Using Actual Cost

In this section, payments and costs are determined using a method similar to the one used in cost-based annual hospital Upper Payment Limit (UPL) analyses. That is, payments include the non-Federal share as well as the Federal matching portion, even in cases in which the non-Federal share is an IGT or provider assessment contribution. Also, the payment amounts include both claim payments and all supplemental payments intended to compensate hospitals for services provided to Medicaid and uninsured recipients. DSRIP payments are not included in this section, as they are not applicable to the costs of medical services offered to individual recipients. Finally, unlike UPL analyses and more like DSH analyses, payment and cost for both the FFS and managed care programs as well as for the uninsured are included in the numbers presented below.

The first two figures in this section, Figures 35 and 36, show payment-to-cost ratios separately for Medicaid recipients and for the uninsured. The last figure in this section, Figure 37, shows an overall payment-to-cost comparison that combines payments and costs for Medicaid recipients and the uninsured.

First, Figure 35 below summarizes payments and costs incurred by hospitals providing services to Medicaid recipients enrolled in either the FFS program or a Medicaid managed care plan. As described in section 7.2 above, the DSH payments included in the calculation below only include DSH payments up to the amount of the Medicaid shortfall. In cases where Medicaid shortfall is zero (that is, total Medicaid payment is greater than hospital cost of care provided to Medicaid recipients), DSH payments are not included in the Figure. This occurred for state-

owned hospitals before application of any DSH funds. Thus, all DSH payments to the state-owned hospitals are included in Figure 36 as reimbursement of care to the uninsured.

Figure 35 - Payment-to-Cost Comparison for Services Provided to Medicaid Recipients

Hospital Category	Claim Payments	GME Supplemental Payments	DSH Payments Applied to Medicaid Shortfall	Total Payments	Hospital Cost for Medicaid Services	Pay-to-Cost Ratio
Acute Care	$383,748,198	$1,639,565	$36,136,286	$421,524,049	$719,392,274	59%
Children's Hospital	$71,718,455	$0	$9,407,125	$81,125,580	$163,519,389	50%
Critical Access Hospital	$37,688,756	$0	$8,890,531	$46,579,287	$115,669,207	40%
Specialty Hosp – Psych and Rehab	$7,852,110	$0	$21,549	$7,873,659	$15,352,817	51%
State Hospitals	$587,721	$0	$0	$587,721	$383,670	153%
Total	**$501,595,239**	**$1,639,565**	**$54,455,491**	**$557,690,295**	**$1,014,317,356**	**55%**

Figure 36 below summarizes payments and costs incurred by Kansas and high utilization Missouri hospitals in providing care to recipients who did not have insurance, or whose insurance did not cover the services provided. All payments made by Kansas Medicaid through the UCP program and a portion of the payments from the DSH program are included in this table. The DSH payments applied for services provided to the uninsured represent DSH payments that exceed the Medicaid shortfall amount.

Figure 36 - Payment-to-Cost Comparison for Services Provided to the Uninsured

Hospital Category	DSH Payments Applied to Uncompensated Care	UC Pool Payments	Self-Pay Payments	Total Payments for Care of Uninsured Recipients	Total Cost for Care of Uninsured Recipients	Pay-to-Cost Ratio
Acute Care	$0	$54,700,680	$4,483,662	$59,184,342	$120,261,961	49%
Children's Hospital	$0	$5,970,659	$225,093	$6,195,752	$8,135,194	76%
Critical Access Hospital	$0	$0	$243,550	$243,550	$6,371,538	4%
Specialty Hosp – Psych and Rehab	$0	$147,517	$16,990	$164,507	$307,213	54%
State Hospitals	$6,421,232	$0	$602,180	$7,023,412	$32,824,262	21%
Total	**$6,421,232**	**$60,818,855**	**$5,571,475**	**$72,811,562**	**$167,900,167**	**43%**

Figure 37 below combines the values from the two previous figures, thus presenting an overall payment-to-cost comparison for services provided to Medicaid recipients and the uninsured. As mentioned previously, the amounts shown in this figure include costs and all payments except for incentive payments made through the DSRIP program. Also, the amounts shown below do not include any offset for the local contributions to the non-Federal share of payments (i.e. through IGTs, and the assessment program).

Figure 37 - Overall Payment-to-Cost Comparison for Medicaid Reimbursement to Kansas Hospitals

Hospital Category	Medicaid Claim Payments Plus GME	Uninsured Self-Pay	DSH Payments	UC Payments	Total Payments for Medicaid and Uninsured	Estimated Hospital Cost for Medicaid Services	Total Cost for Uninsured Recipients	Total Hospital Cost for Medicaid and Uninsured	Medicaid and Uninsured Pay-to-Cost
Acute Care	$385,387,763	$4,483,662	$36,136,286	$54,700,680	$480,708,391	$719,392,274	$120,261,961	$839,654,234	57%
Children's Hospital	$71,718,455	$225,093	$9,407,125	$5,970,659	$87,321,331	$163,519,389	$8,135,194	$171,654,582	51%
Critical Access Hospital	$37,688,756	$243,550	$8,890,531	$0	$46,822,837	$115,669,207	$ 6,371,538	$122,040,745	38%
Specialty Hosp – Psych and Rehab	$7,852,110	$16,990	$21,549	$147,517	$8,038,166	$15,352,817	$307,213	$15,660,029	51%
State Hospitals	$587,721	$602,180	$6,421,232	$0	$ 7,611,133	$383,670	$32,824,262	$33,207,932	23%
Total	**$503,234,804**	**$5,571,475**	**$60,876,723**	**$60,818,855**	**$630,501,857**	**$1,014,317,356**	**$167,900,167**	**$1,182,217,523**	**53%**

For most categories of hospitals, pay-to-cost ratios are well below 100 percent (i.e. payment is not covering cost) in each of the three calculations presented above. The only exception is the payment-to-cost ratio for state-owned hospitals for cost of care of Medicaid recipients (Figure 35)). In this exception case, the payment-to-cost ratio is above 100 percent. However, the payment-to-cost ratios are below 100 percent for both of these hospital categories when looking at the combination of cost for Medicaid recipients and the uninsured. Thus, none of these numbers suggest any hospital is potentially being paid above their DSH limit.

7.4 "Net" – Payment-to-Cost Comparison with Consideration of Local Funding of Medicaid Non-Federal Share

The payment-to-cost comparison displayed in this section describes the net economic impact to the Kansas hospitals and high utilization Missouri hospitals for care provided to Kansas Medicaid and uninsured recipients, taking into consideration the local non-Federal contributions made through IGTs and the provider assessment program. In this section, IGTs and provider assessment contributions are subtracted from the payments listed in Figure 37. The results show the actual net payments received by hospitals from the Medicaid program after considering these local contributions.

Figure 38 - Overall Payment-to-Cost Comparison Net of Local Funding of Medicaid Reimbursements

Hospital Category	Total Payments for Medicaid and Uninsured	IGT Funding	Provider Assessment Funding	Payments Reduced by Funding	Total Hospital Cost for Medicaid and Uninsured	Pay-to-Cost Ratio
Acute Care	$480,708,391	$11,111,140	$41,954,265	$427,642,986	$839,654,234	51%
Children's Hospital	$87,321,331	$0	$0	$87,321,331	$171,654,582	51%
Critical Access Hospital	$46,822,837	$0	$0	$46,822,837	$122,040,745	38%
Specialty Hosp – Psych and Rehab	$8,038,166	$0	$1,388,068	$6,650,098	$15,660,029	42%
State Hospitals	$7,611,133	$0	$0	$7,611,133	$33,207,932	23%
Total	**$630,501,857**	**$11,111,140**	**$43,342,333**	**$576,048,384**	**$1,182,217,523**	**49%**

8 Future of Uncompensated Care Services and Related Funding in Kansas

8.1 Projected Reductions in DSH Allotment

On July 28, 2017, CMS released a proposed rule[71] delineating a methodology to implement the annual reductions to state Medicaid DSH as required by the PPACA. The PPACA set forth aggregate reductions to state Medicaid DSH allotments annually from fiscal year (FY) 2014 through FY 2020, and subsequent legislation delayed the start of these reductions until FY 2018. Under current law, these reductions will run through FY 2025.

The proposed rule delineates the DSH Health Reform Methodology (DHRM) to implement the allotment reductions set to begin FY 2018. According to CMS, the proposed change accounts for relevant data that was unavailable to CMS during prior rulemaking for DSH allotment reductions originally set to take place for FY 2014 and FY 2015. As revealed in the public notice, in order to implement DSH cuts starting in FY 2018, CMS will calculate each state's unreduced DSH allotment under the current formula to serve as the base amount to which the state-specific DSH allotment reduction amount will apply annually. CMS proposes to then apply the DHRM to the unreduced DSH allotment amount on an annual basis to calculate the final allotment reductions.

8.1.1 Summary of Data Sources and Metrics for Determining DSH Reductions

The statute establishes specific parameters regarding the data sources and metrics that will be used to calculate the DSH reductions. These include the proposal to:

- Modify the DHRM factor weights to utilize data sources and metrics that are consistent with the statute, transparent, and readily available to CMS, the states, and the public.
- Use improved data sources and metrics, including:

[71] Centers for Medicare and Medicaid Services, "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions (CMS-2394-P)", https://www.federalregister.gov/documents/2017/07/28/2017-15962/medicaid-program-state-disproportionate-share-hospital-allotment-reductions#print

Figure 39 - Proposed Data Sources and Metrics for State DSH Allocations

	Data / Metric	Change From Current Requirement?	Comments
1.	DSH Medicaid Inpatient Utilization Rate (MIUR) data	No Change	Utilize MIUR data from the year that corresponds to the DSH audit state plan rate year (SPRY) used in the calculation of each state's DSH allotment reductions.
2.	Medicaid DSH data reported as required by section 1923(j) of the Social Security Act	No Change	DSH data remains the only comprehensive reported data available that is consistent with Medicaid program requirements.
3.	United States Census Bureau data	**Yes**	Previous rule encouraged use of both American Community Survey (ACS) and Annual Social and Economic Supplement to the Current Population Survey (CPS). Going forward, only ACS will be used. This source is the largest household survey in the United States, is conducted monthly, and has a sample size over 30 times larger than the CPS.
4.	Existing state DSH allotments	No Change	
5.	Form CMS-64 Medicaid Budget	No Change	
6.	Expenditure System (MBES) data	No Change	

8.1.2 DHRM Factor Weight Modification

This proposal would generate a state-specific DSH allotment reduction amount for each fiscal year specified in statute from FY 2018 through FY 2025. The total of all DSH allotment reduction amounts in a specific year would equal the aggregate annual reduction amount identified in statute for that same year. The most recent related amendments to the statute were through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, enacted April 16, 2015). Currently, the aggregate annual reduction amounts set to begin in FY 2018 are specified in section 1923(f)(7)(A)(ii) of the Social Security Act:

Figure 40 - Proposed Total DSH Reductions Under PPACA

Reduction Amount	Federal Fiscal Year
$2,000,000,000	2018
$3,000,000,000	2019
$4,000,000,000	2020
$5,000,000,000	2021
$6,000,000,000	2022
$7,000,000,000	2023
$8,000,000,000	2024
$8,000,000,000	2025
$43,000,000,000	**Total Reduction**

To implement these annual reductions, the statute requires that the HHS Secretary reduce annual state DSH allotments, and payments to states, based on a DHRM specified in section 1923(f)(7)(B) of the Social Security Act. The proposed DHRM relies on statutorily identified factors collectively to determine a state-specific DSH allotment reduction amount to be applied to the allotment that is calculated under section 1923(f) of the Social Security Act prior to the reductions under section 1923(f)(7) of the Social Security Act. The intent of the methodology is

to generate a lesser impact on low DSH states, so it imposes a smaller percentage reduction on them.

To determine the effective annual DSH allotment for each state, the state-specific annual DSH allotment reduction amount would be applied to the unreduced DSH allotment amount for its respective state. The addition of section 1923(f)(7) of the Social Security Act requires the use of a DHRM to determine the percentage reduction in annual state DSH allotments to achieve the required aggregate annual reduction in federal DSH funding.

The DHRM methodology is designed to:

- Impose a **smaller** percentage reduction on low DSH States;
- Impose the **largest** percentage reductions on:
  - States that have the lowest percentages of uninsured individuals during the most recent year for which such data are available;
  - States that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients;
  - States that do not target their DSH payments on hospitals with high levels of uncompensated care; and
- Take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.

8.1.3 Estimated State Impact

Figure 41 below, which was generated by CMS, estimates the DSH reduction for each state in FY 2018. Per CMS, "please note that this illu**strative estimate may rely on different data than what is proposed to be used when calculating annual DSH allotment reductions for FY 2018. Specifically, we anticipate that more recent data will be available when calculating the final allotment reductions. For purposes of this illustrative example, we have utilized the most** recent available data to CMS."[72]

[72] Centers for Medicare and Medicaid Services, "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions (CMS-2394-P)", https://www.federalregister.gov/documents/2017/07/28/2017-15962/medicaid-program-state-disproportionate-share-hospital-allotment-reductions#print

Figure 41 - Illustrative Estimate of DSH Reductions by State

TABLE 1: FY 2017 DSH HEALTH REFORM METHODOLOGY

*FOR ILLUSTRATION PURPOSES ONLY - FY 2017 DSH HEALTH REFORM METHODOLOGY

		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation			
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL
		50.00%	25.00%	25.00%	100.00%
	Total Reg. DSH Reduction:	$987,536,279	$493,768,140	$493,768,140	$1,975,072,559
LOW DSH Adj. Factor	Total Low DSH Reduction:	$12,463,721	$6,231,860	$6,231,860	$24,927,441
27.83%	TOTAL:	$1,000,000,000	$500,000,000	$500,000,000	$2,000,000,000

A	B	C	D	E	F	G	H
STATE	Unreduced FY 2017 DSH Allotment (Estimate)	Reduction Based on UPF Uninsured Factor	Reduction Based on HMF High Volume Factor	Reduction Based On HUF High Level Factor	Total Reduction C + D + E	Reduction Amount As Percentage of Unreduced DSH Allotment F/B	FY 2017 Reduced Allotment B - F
Alabama	$337,648,430	$24,336,783	$22,311,475	$12,205,968	$58,854,226	17.43%	$278,794,204
Arizona	$111,176,922	$7,137,605	$3,547,314	$540,535	$11,225,454	10.10%	$99,951,468
California	$1,203,730,377	$84,684,522	$27,524,140	$41,213,794	$153,422,456	12.75%	$1,050,307,921
Colorado	$101,569,041	$8,631,358	$7,177,442	$2,752,327	$18,561,127	18.27%	$83,007,914
Connecticut	$219,608,734	$27,749,875	$8,953,379	$12,499,484	$49,202,738	22.40%	$170,405,996
District of Columbia	$67,255,174	$11,161,638	$948,482	$4,788,317	$16,898,437	25.13%	$50,356,737
Florida	$219,608,734	$11,604,440	$7,724,576	$14,761,318	$34,090,334	15.52%	$185,518,400
Georgia	$295,099,237	$16,322,138	$9,642,846	$10,330,646	$36,295,629	12.30%	$258,803,608
Illinois	$236,079,390	$21,211,561	$21,228,808	$2,226,180	$44,666,550	18.92%	$191,412,840
Indiana	$234,706,837	$17,212,117	$7,854,285	$2,660,409	$27,726,811	11.81%	$206,980,026
Kansas	$45,294,302	$3,871,800	$3,187,693	$1,866,967	$8,926,460	19.71%	$36,367,842
Kentucky	$159,216,333	$16,485,287	$7,021,414	$6,556,338	$30,063,039	18.88%	$129,153,294
Louisiana	$752,888,159	$44,629,718	$8,761,366	$28,576,335	$81,967,418	10.89%	$670,920,741
Maine	$115,294,586	$9,949,588	$1,191,719	$1,053,779	$12,195,085	10.58%	$103,099,501
Maryland	$83,725,829	$9,314,506	$3,064,435	$2,498,384	$14,877,325	17.77%	$68,848,504
Massachusetts	$334,903,321	$89,406,469	$8,587,673	$7,322,652	$105,316,795	31.45%	$229,586,526
Michigan	$290,981,574	$29,838,010	$17,552,322	$19,346,010	$66,736,341	22.93%	$224,245,233
Mississippi	$167,451,660	$10,119,288	$4,755,050	$2,557,905	$17,432,243	10.41%	$150,019,417
Missouri	$520,198,191	$39,063,452	$29,634,901	$23,891,614	$92,589,967	17.80%	$427,608,224
Nevada	$50,784,519	$2,924,122	$436,562	$544,246	$3,904,930	7.69%	$46,879,589
New Hampshire	$175,795,169	$16,765,244	$2,912,141	$2,025,265	$21,702,651	12.35%	$154,092,518
New Jersey	$706,865,615	$56,618,281	$44,292,058	$52,834,997	$153,745,336	21.75%	$553,120,279
New York	$1,763,732,651	$177,505,591	$78,224,710	$73,714,317	$329,444,617	18.68%	$1,434,288,034
North Carolina	$323,922,884	$21,676,870	$14,090,407	$20,538,422	$56,305,699	17.38%	$267,617,185
Ohio	$446,080,243	$46,702,161	$25,434,391	$29,795,707	$101,932,258	22.85%	$344,147,985
Pennsylvania	$616,277,012	$63,782,334	$32,922,465	$24,331,996	$121,036,794	19.64%	$495,240,218
Rhode Island	$71,372,839	$8,426,370	$6,425,719	$1,860,620	$16,712,709	23.42%	$54,660,130
South Carolina	$359,609,303	$23,233,999	$22,965,009	$23,842,222	$70,041,229	19.48%	$289,568,074
Tennessee*	$0	$0	$0	$0	$0	0.00%	$0
Texas	$1,050,004,264	$48,245,203	$50,044,327	$49,773,279	$148,062,808	14.10%	$901,941,456
Vermont	$24,705,984	$4,369,886	$1,875,609	$775,093	$7,020,587	28.42%	$17,685,397
Virginia	$96,196,942	$7,735,598	$122,311	$3,188,924	$11,046,833	11.48%	$85,150,109
Washington	$203,138,079	$19,249,651	$12,038,303	$10,449,879	$41,737,833	20.55%	$161,400,246
West Virginia	$74,117,949	$7,570,819	$1,314,810	$2,444,211	$11,329,840	15.29%	$62,788,109
Total Regular DSH States	**$11,459,040,284**	**$987,536,279**	**$493,768,140**	**$493,768,140**	**$1,975,072,559**	**17.24%**	**$9,483,967,725**
LOW DSH STATES							
Alaska	$22,366,812	$258,424	$851,319	$136,279	$1,246,022	5.57%	$21,120,790
Arkansas	$47,367,170	$799,743	$33,070	$1,146,287	$1,979,100	4.18%	$45,388,070
Delaware	$9,940,805	$254,209	$205,569	$94,226	$554,005	5.57%	$9,386,800
Hawaii	$10,701,306	$403,540	$326,243	$78,866	$808,649	7.56%	$9,892,657
Idaho	$18,049,095	$264,628	$49,829	$87,268	$401,724	2.23%	$17,647,371
Iowa	$43,242,210	$1,394,059	$115,140	$1,361,179	$2,870,379	6.64%	$40,371,831
Minnesota	$82,011,647	$2,774,292	$218,017	$565,875	$3,558,184	4.34%	$78,453,463
Montana	$12,463,647	$174,295	$522,983	$208,536	$905,813	7.27%	$11,557,834
Nebraska	$31,072,684	$638,999	$157,417	$641,315	$1,437,730	4.63%	$29,634,954
New Mexico	$22,366,812	$306,213	$136,653	$45,268	$488,134	2.18%	$21,878,678
North Dakota	$10,488,492	$265,499	$54,018	$11,994	$331,511	3.16%	$10,156,981
Oklahoma	$39,763,220	$514,542	$1,587,344	$446,030	$2,547,915	6.41%	$37,215,305
Oregon	$49,704,028	$1,015,201	$788,620	$931,845	$2,735,666	5.50%	$46,968,362
South Dakota	$12,127,506	$245,843	$18,050	$24,036	$287,929	2.37%	$11,839,577
Utah	$21,541,402	$341,688	$1,159,479	$446,117	$1,947,284	9.04%	$19,594,118
Wisconsin	$103,801,167	$2,808,415	$436	$1,298	$2,810,149	2.71%	$100,991,018
Wyoming	$248,521	$4,131	$7,674	$5,441	$17,245	6.94%	$231,276
Total Low DSH States	**$537,256,524**	**$12,463,721**	**$6,231,860**	**$6,231,860**	**$24,927,441**	**4.64%**	**$512,329,083**
National Total	**$11,996,296,808**	**$1,000,000,000**	**$500,000,000**	**$500,000,000**	**$2,000,000,000**	**16.67%**	**$9,996,296,808**

9 Conclusion

Included in the design of KanCare 1.0 was a goal to "create a Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured."[73] This goal was achieved through creation of an Uncompensated Care Pool. Another goal of the Waiver was to "Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well."[74] A variety of programs were included in the Waiver to attain this goal, one of which was a Delivery System Reform Incentive Payment (DSRIP) program. Total computable reimbursements made through the combination of the UC Pool and the DSRIP program were capped at just under $81 million. Consistent with requirements documented by CMS, this report reviewed the results of these programs and their impact on Medicaid shortfall and uncompensated care for hospital services provided to uninsured residents of the State of Kansas. This report may be used as input to inform decisions regarding the sizes and designs of a UC Pool, DSRIP program, and other possible SNCPs to be incorporated into KanCare 2.0.

The timeframe of medical services used in our review of hospital funding, payment, and is SFY 2016, which began on July 1, 2015 and ended on June 30, 2016. This was estimated to be the most recent twelve month time period for which complete information was available. However, some results of Demonstration Year 4, which ended on December 31, 2016, for specific DSRIP programs were not available at the time this report was created and are documented accordingly in the chapter discussing the details of the DSRIP program.

The impact of incomplete DSRIP program results to this study was minimal as this study's primary focus was a review of Medicaid shortfall and uncompensated care in Kansas. To perform this review, we compared Kansas Medicaid payment to hospital cost for patient care in a variety of ways. DSRIP program payments are not intended as reimbursements for patient care and have no impact on the payment-to-cost comparisons.

Payment-to-cost comparisons, which are commonly referred to as "cost coverage percentages," were somewhat varied across our categories of hospitals both with and without consideration of local funding as shown in the following figure:

[73] KanCare 1115 Demonstration Waiver STCs, Page 3.
[74] Ibid.

Figure 42 - Cost Coverage by Hospital Category With and Without Consideration of Local Funding

Hospital Category	Total Hospital Cost for Care of Medicaid and Uninsured Recipients	Total Payments for Medicaid and Uninsured	Pay-to-Cost Ratio Independent of Source of Non-Federal Share	Medicaid and Self-Pay Payments Reduced by Local Funding	Pay-to-Cost Ratio Net of Local Funding
Acute Care	$839,654,234	$480,708,391	57%	$427,642,986	51%
Children's Hospital	$171,654,582	$87,321,331	51%	$87,321,331	51%
Critical Access Hospital	$122,040,745	$46,822,837	38%	$46,822,837	38%
Specialty Hosp – Psych and Rehab	$15,660,029	$8,038,166	51%	$6,650,098	42%
State Hospitals	$33,207,932	$7,611,133	23%	$7,611,133	23%
Total	**$1,182,217,523**	**$630,501,857**	**53%**	**$576,048,384**	**49%**

Note(s):
1) Claim, GME, DSH, and UC Pool payments are included in this figure (DSRIP payments are not included).
2) Cost of care for both Medicaid and uninsured beneficiaries are included in the hospital cost column.

These payment-to-cost comparisons indicate that hospitals are getting paid by Medicaid on average less than 55 cents per dollar spent caring for Medicaid and uninsured recipients. Even the payment-to-cost ratio for Medicaid recipients is below 55 percent. In addition, the payment-to-cost ratio for hospitals that receive UC Pool disbursements is 57 percent and the ratio for hospitals that receive both UC Pool and DSH disbursements is 60 percent. In contrast, the payment-to-cost ratio of facilities that receive no additional money through the UC Pool or DSH have a payment-to-cost ratio of only 29 percent. These numbers suggest there is value in maintaining some form of SNCP in future waiver renewals in order to maintain access to care for Medicaid and uninsured recipients.

Of course, finding ways to increase sources of the non-Federal share Medicaid reimbursement for the purpose of maintaining or increasing Medicaid reimbursement is generally a difficult task. Rarely are state legislatures interested in increasing state taxes or in shifting money from other programs to fund Medicaid services. In addition in Kansas, state general funds are already the source of a relatively high percentage (81 percent) of the non-Federal share of hospital Medicaid reimbursements. If KDHE and the hospital community in Kansas does wish to increase Medicaid reimbursements, they might consider increases in their provider assessment, and/or increases in revenue received through IGTs. The provider assessment in Kansas is currently calculated as 1.83 percent of net inpatient revenues, which is well below regulatory limits. Also, there are a relatively large number of publicly owned hospitals in Kansas. Seventy-nine of the 159 acute care hospitals in the State are owned by a governmental entity. Each of these facilities is eligible to contribute IGTs to fund the non-Federal share of Medicaid. Potentially a new UC Pool design or new methods for calculating inpatient or outpatient rates could be defined in a way that incent these providers to contribute IGTs.

Appendix A: Regulatory Summary

A.1 Federal Medicaid Requirements

A variety of federal regulations establish the requirements and provide guidelines regarding how the Kansas Department of Health and Environment (KDHE) may collect and distribute funds in operation of the Kansas Medicaid program. As long as KDHE operates its program in a way that is compliant with these regulations, it is eligible to receive federal matching funds toward allowable Medicaid expenditures. Any funding or payment practices that are not compliant with these regulations may result in denial of federal financial participation for the portion of funding that is not compliant. Any options for changes in the Kansas Medicaid program need to be developed with these guidelines in mind.

A.1.1 Medicaid State Plans

Each state operates its Medicaid program in accordance with a state plan submitted to and approved by CMS that describes the nature and scope of the program (e.g., administrative structure and operations, eligibility, covered benefits, and payment methods). Section 1902 of the Social Security Act (SSA) requires states to have a state plan on file with CMS as a condition of receiving federal Medicaid funds. The state plan demonstrates states' understanding of all federal Medicaid requirements. When states make changes to the Medicaid program in areas documented in the state plan, states are required to submit state plan amendments (SPAs) to CMS for review and approval prior to making the program modifications. Included in state plans is a description of how Medicaid fee-for-service payments are made.

A.1.2 Medicaid Waivers

The Social Security Act also contains multiple waiver authorities that provide states flexibility in certain areas by allowing them to waive certain federal requirements that would otherwise apply. For example, states can waive certain provisions of the Medicaid and CHIP statutes related to eligibility and benefits in order to explore new approaches to the delivery of and payment for health care and long-term services and supports. Waivers are also required to implement Medicaid managed care programs. The flexibility provided through waivers has enabled states to make fundamental changes to their programs. Currently, all states operate one or more Medicaid waivers. The waivers are categorized as program waivers or research and demonstration projects, and are generally referred to by the section of the Act granting the waiver authority:

- **Section 1115** gives broad authority to the Secretary to authorize "any experimental, pilot or demonstration project likely to assist in promoting the objectives of the programs" specified in that section of the Act. Under Section 1115 research and demonstration authority, states may waive certain provisions of the Medicaid and CHIP statutes related to state program design, such as eligibility criteria, covered services, and service delivery and payment methods used by the state to administer the program. Section 1115 Demonstrations include a research or evaluation component and usually are approved for a five-year period, with a potential for additional renewals after the first five years.

- **Section 1915(b)** waivers permit states to implement service delivery models (e.g., those involving primary care case management programs or managed care plans) that restrict beneficiaries' choice of providers other than in emergency circumstances.

- **Section 1915(c)** of the Medicaid statute authorizes states to provide home and community-based services (HCBS) as an alternative to institutional care in nursing homes, intermediate care facilities for individuals with mental retardation (ICF-MRs), and hospitals, and to waive the statewide requirement of who is eligible to receive HCBS services.

States have used Section 1115 authority in a variety of ways and for an array of purposes.[75] In Kansas, an 1115 Demonstration has been in place since 2013, and has been used to increase the size of the Medicaid managed care program and to implement the UC Pool and DSRIP programs. Regardless of the type of waiver, estimated federal spending over the period for which the waiver is in effect cannot be greater than it would have been without the waiver. Approval of states' waiver applications is at the discretion of the Secretary of HHS.

A.1.3 Recent Updates to Medicaid Managed Care Rules

In May 2016, CMS published the final rule for Medicaid and Children's Health Insurance Program (CHIP) programs; Medicaid managed care, CHIP delivered in managed care, and revisions to Third Party Liability (*final rule*). The rule was updated to respond to the changes in healthcare that have occurred in the past decade – primarily the movement towards Medicaid managed care. The goals of the final rule are to:

1. "Support State efforts to advance delivery system reform and improve the quality of care,
2. Strengthen the beneficiary experience of care and key beneficiary protections,
3. Strengthen program integrity by improving accountability and transparency, and
4. Align key Medicaid and CHIP managed care requirements with other health coverage programs."[76]

The rule will be implemented between mid-2017 – 2019 and potentially beyond. The rule impacts the following arenas of managed care as described in Figure 43. In some areas, the rule finalized approaches CMS had undertaken for several years as many of these items had already been required in recent waiver and State plan approvals.

[75] MACPAC. *Report to the Congress on Medicaid and CHIP. (*March 2014).
[76] Centers for Medicare and Medicaid Services, "Medicaid and CHIP Managed Care Final Rule (CMS-2390-F): Improving the Quality of Care for Beneficiaries Webinar," (May 18, 2016). Available online: https://www.medicaid.gov/medicaid/managed-care/downloads/improving-quality-of-care.pdf.

Figure 43 - Managed Care Final Rule Summary

Area[77]	Managed Care Impact
Delivery System Reform	• Allows for state flexibility for increased value-based payment arrangements • Capitation payments for enrollees with a short-term stay in an institution for mental disease • Regulates withhold requirements and incentive requirements • Allows states to capitate network providers for particular services • Implements a transition period for pass-through payments for hospitals, physicians, and nursing facilities
Modernizing and Improving Quality of Care	• Requires states to maintain time and distance standards for primary and specialty care, behavioral health, OB/GYN, hospitals, pharmacies, Managed Long-term Services and Supports, and pediatric dentists • Standardizes website and electronic information requirements (for both consumers and providers) • Establishes a quality rating system for Medicaid and CHIP managed care plans within each state • Extends quality requirements (e.g., quality strategy, external quality review (EQR), etc.) to contracts that include financial incentives • Introduces new requirements for quality strategies and EQRs
Beneficiary Experience	• Increases transparency and support requirements for enrollee choice, enrollment and information sharing • Creates a beneficiary support system to counsel enrollees • Regulates managed long-term services and supports (MLTSS)
Payment and Accountability	• Requires increased transparency and rigor during the rate setting process • Limits use of pass-through supplemental payments • Allows states to increase or decrease the certified capitation rate by 1.5 percent without submitting a new rate certification • Defines actuarial soundness • Increases encounter data requirements • Requires states to implement operational policies and procedures to prevent fraud, waste and abuse
Alignment with Other Insurers	• Introduces an 85 percent medical loss ratio • Standardizes timeframes for grievances and appeals to align with other insurers

[77] Centers for Medicare and Medicaid Services, "Medicaid and CHIP Managed Care Final Rule (CMS-2390-F): Overview of the Final Rule Webinar," (May 18, 2016). Available online: https://www.medicaid.gov/medicaid/managed-care/downloads/final-rule-overview.pdf.

The rule's impact on supplemental payments is most relevant to this report. The report defines pass-through payments as:

> *Any amount required by the state to be added to the contracted payment rates between the MCO, PIHP, or PAHP and hospitals, physicians or nursing facilities that is not for the following purposes: A specific service or benefit covered under the contract and provided to a specific enrollee; a provider payment methodology permitted under § 438.6(c)(1)(i) through (c)(1)(iii) for services and enrollees covered under the contract; a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; GME payments; or FQHC or RHC wrap around payments. This definition is consistent with the definition for pass-through payments in CMS' 2016 Medicaid Managed Care Rate Guidance.*[78]

Due to the critical nature of pass-through payments to hospitals, the final rule allows a transition period for hospitals, physicians, and nursing facilities to shift towards payments tied to services covered under the contract, value-based payments or delivery system reform initiatives to retain access.

A.2 Funding for Medicaid Programs

A.2.1 Federal Medical Assistance Percentage/Federal Financial Participation

Medicaid programs are jointly funded by the federal government and the state government. The federal government contributes funds to each state Medicaid program using a percentage referred to as the Federal Medical Assistance Percentage (FMAP). FMAP values vary by state and are computed using a formula that takes into account the average per capita income for each state relative to the national average. Each state receives multiple FMAP values: one FMAP is assigned for the traditional Medicaid program, one for the CHIP program, and additional FMAP rates for the cost of administrating the Medicaid program and for making upgrades to the program. For states that expand Medicaid, there is also a separate FMAP for the expansion population. The average FMAP rate for Medicaid services is 57 percent, but FMAPs range from 50 percent in wealthier states up to 75 percent in states with lower per capita incomes.[79] In SFY 2016, the FMAP for Kansas was 55.96 percent for reimbursement of medical care and 50 percent for state Medicaid administrative costs. This means for every medical care dollar spent by the Medicaid Agency in SFY 2016, 44.04 cents came from state resources and 56.96 cents came from federal resources. Another way to think of this is that $1.00 in state funds in SFY 2016 yields $2.27 in total funds for the Medicaid program (1 / 0.4404 = $2.27).

A.2.2 The Non-Federal Share

Since the Medicaid program's inception in 1965, flexibility in financing the non-federal share has allowed states to use local sources of healthcare financing while making these local funds eligible for federal match. Section 1902(a)(2) of the Social Security Act includes a provision requiring at least forty (40) percent of the "state share" to come from the state while allowing up to sixty (60) percent to come from local sources.[80] The most common sources of local funding are inter-governmental transfers (IGTs), certified public expenditures (CPEs), and health care

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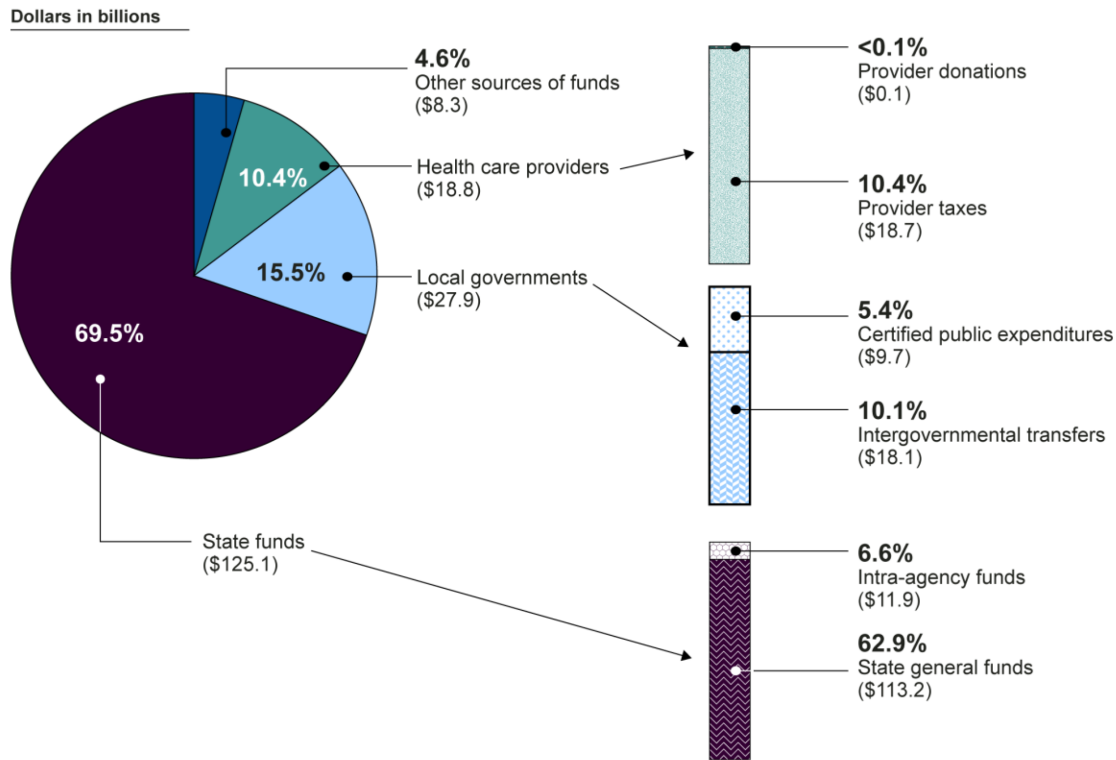
[78] 42 CFR § 438.6(a).
[79] Across all states prior to application of enhanced rates for Medicaid expansion. https://www.medicaid.gov/medicaid/program-information/index.html.
[80] The Social Security Act, Section 1902(a)(2).

related taxes, often referred to as provider assessments. IGTs and CPEs must originate from a governmental agency such as a non-Medicaid state agency or local government such as a county or municipality. Public healthcare providers, such as county hospitals or school districts, also qualify as units of local government. Provider assessments, in contrast, may be applied to both public and private providers. Provider assessments are defined by federal statute as taxes in which at least 85 percent of the tax burden falls on health care providers.[81]

A 2014 report from the Government Accountability Office (GAO) detailed the sources of non-federal share of Medicaid expenditures nationally for state fiscal year 2012.[82] As shown in Figure 44, about 70 percent of the state share comes from state general revenue. Other sources including local governments and healthcare providers (through provider assessments) also contribute significant funds towards the state share of Medicaid programs.

Figure 44 - Sources of funds for the state share of Medicaid across all Medicaid programs in the United States



Source: GAO. | GAO-14-627

Per the GAO Report, "For purposes of this report, state funds refers to state general funds and intra-agency funds, which are intra-agency payments, intra-agency transfers, and intra-agency certified public expenditures. Other sources of funds include tobacco settlement funds and state trust funds. Taxes on health care services, or the provision or payment for these services, are being reported separately as health care provider taxes."[83]

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[81] The Social Security Act, Section 1903(w)(3)(A).
[82] GAO "Medicaid Financing States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection" (GAO-14-627), Figure 1. (July 2014)
[83] Ibid.

A 2012 report from the Medicaid and CHIP Payment and Access Commission (MACPAC) related to this issue stated:

> "At various points, particularly beginning in the early 1990s, this multi-source approach to financing has been the subject of federal scrutiny, sometimes because of evidence of state excesses (GAO 2004b, GAO 1994), and sometimes in an effort to control federal spending by limiting states' ability to make expenditures that qualify for federal contributions."[84]

In addition to general revenue, there are three common forms of revenue used to fund the state share of a Medicaid program. These are inter-governmental transfers, certified public expenditures, and provider taxes/assessments:

- **Inter-Governmental Transfers (IGTs)** – the Medicaid statute does not define an inter-governmental transfer, but the plain meaning in the Medicaid context is a transfer of funding from a local governmental entity to the State.
- **Certified Public Expenditures (CPEs)** – costs incurred and certified by a public entity or governmental unit related to providing Medicaid covered services to Medicaid recipients.
- **Provider Taxes/Assessments** – the Medicaid statute recognizes State and/or local tax revenue as a permissible source of the non-federal share of Medicaid expenditures.

The federal and state statutes, regulations and other policies (e.g., Medicaid state plan amendments and waivers) related to each are discussed in the following sections.

A.2.2.1 IGTs

Federal Authority

IGTs are allowable for the purposes of funding the non-federal share based on Social Security Act Section 1903(w)(6) and 42 CFR §433.51 – "Public Funds" as the State share of financial participation, which states that "public Funds may be considered as the State's share in claiming FFP if….the public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP."

CMS requires IGTs to originate from public entities in order to be eligible for FFP. As stated in the CMS State Medicaid Directors letter entitled "SMD 14-004 – "Accountability #2: Financing and Donations" and released on May 9, 2014, funds that do not originate from a public entity are deemed "non-bona fide" and are not subject to federal matching.[85]

States have used IGTs for decades as a tool to fund the non-federal share of allowable Medicaid expenditures. A recent study by the GAO reports that 10.1 percent of the non-federal share of Medicaid expenditures was funded with inter-governmental transfers.[86] HHS, Office of

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[84] MACPAC. "Report to the Congress on Medicaid and CHIP." (March 2012)
[85] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-004.pdf
[86] Government Accountability Office, "States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrant Improved CMS Data Collection," (GAO-14-627), (July 2014)

Inspector General (OIG), CMS, and the GAO have scrutinized this funding tool through the years. In 2002, the GAO stated that "IGTs are a legitimate state budget tool and not problematic in themselves … [b]ut when they are used to carry out questionable financial transactions that inappropriately shift state Medicaid costs to the federal government, they become problematic."[87] The OIG has addressed the IGT funding mechanism as well. On one occasion, the OIG stated the "use of the IGT as part of the supplemental payment program is a financing mechanism designed solely to maximize federal Medicaid reimbursements without providing either additional funds to the participating county nursing facilities or additional medical services to their Medicaid residents."[88] Nevertheless, when implemented correctly IGTs are an acceptable form of financing and effectively used by many states on a widespread basis.

State Authority
Kansas does not rely on the use of IGTs for the majority of UC Pool and DSRIP funding; only one facility, the University of Kansas Hospital, contributed IGTs. In SFY 2016, these IGTs contributed to the non-federal share of payments made to the University of Kansas Hospital through the UC Pool and DSRIP programs. The state-level allowance for additional funds from local governmental entities for hospital services is described in #89(d) of the Terms and Conditions of the 1115 Waiver:

> *"The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments."*

A.2.2.2 CPEs

The major difference between IGTs and CPEs is that IGTs are considered a funding source while CPEs are actual expenditures resulting from providing care to patients eligible under the Medicaid program. The public provider of service certifies the uncompensated cost of services rendered to eligible individuals. The Medicaid agency records the certified expenditures and draws down the federal share of the expenditure from CMS. GAO reported that 5.4 percent of non-federal share of Medicaid expenditures for federal fiscal year 2012 was in the form of certified public expenditures.[89]

Federal Authority
As with IGTs, CPEs are governed by Social Security Act Section 1903(w)(6) and 42 CFR §433.51 – "Public Funds."

State Authority
Kansas was granted authority to use CPEs as a portion of the non-federal share of funding in the 1115 Demonstration Waiver. The Terms and Conditions of the 1115 Waiver state:

> *"To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed*

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[87] Government Accountability Office, "Intergovernmental Transfers Have Facilitated State Financing Schemes," (May 2004).
[88] Office of Inspector General, "Review of Commonwealth of Pennsylvania's Use of Intergovernmental Transfers to Finance Medicaid Supplemental Payments to County Nursing Facilities," (A-03-00-00203), (February 9, 2001).
[89] Government Accountability Office. "*States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrant Improved CMS Data Collection*" (GAO-14-627), (July 2014).

> *explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match."*[90]

KDHE did not use CPEs for hospitals reimbursements in SFY 2016.

A.2.2.3 Health Care-Related Taxes or Assessments

The third category of alternative funding sources for non-federal share of Medicaid expenditures is the use of health care-related taxes or assessments. GAO reported that 10.4 percent of non-federal share of Medicaid expenditures for federal fiscal year 2012 was paid for using these taxes or assessments.[91]

Federal Authority

The federal statute governing this source of funding is Section 1903(w)(3) of the Social Security Act. 42 CFR §433.55 – "Health Care-Related Taxes Defined." This regulation allows for the use of a tax or assessment levied on health care providers as a source of funding for the non-federal share of expenditures. The main conditions for which a tax imposed by government can be considered a health care-related tax are addressed 42 CFR §433.55 (a) through (c) as follows:

(a) *A health care-related tax is a licensing fee, assessment, or other mandatory payment that is related to —*
  (1) *Health care items or services;*
  (2) *The provision of, or the authority to provide, the health care items or services; or*
  (3) *The payment for the health care items or services.*

(b) *A tax will be considered to be related to health care items or services under paragraph (a)(1) of this section if at least 85 percent of the burden of the tax revenue falls on health care providers.*

(c) *A tax is considered to be health care related if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to other individuals or entities.*

A key item in the above conditions is the 85 percent burden in paragraph (b). A tax imposed on all businesses is not considered a health care-related tax and no limitations exist on use of the funds. For example, sales tax paid by a hospital is not considered a health care-related tax.

Only certain health care providers may be taxed under a health care-related tax and have the tax be permissible as a source of non-federal share of Medicaid expenditures. These classes of health care items or services are outlined in 42 CFR §433.56 – and in addition to inpatient

[90] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. STC #89.

[91] Government Accountability Office, "States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrant Improved CMS Data Collection" (GAO-14-627), (July 2014)

hospital and outpatient hospital services, include many different types of typical Medicaid services.

Further requirements related to a permissible health care-related tax are outlined in 42 CFR §433.68 – "Permissible health care-related taxes." Paragraph (b) of this regulation states the following:

> *Subject to the limitations specified in §433.70, a State may receive, without a reduction in FFP, health care-related taxes if all of the following are met:*
>
> *(1) The taxes are broad based*
> *(2) The taxes are uniformly imposed throughout a jurisdiction; and*
> (3) *The tax program does not violate the hold harmless provisions*[92]

One of the reasons for identifying a tax as health care-related is that the taxpayer cannot be held harmless for the tax—that is, the State cannot provide a direct or indirect guarantee that providers will receive their money back. The exception to the hold harmless provision is that "the indirect guarantee test does not apply if the tax rate falls within a "safe harbor" established under regulation" which is the 6 percent of net patient revenue described above.[93] 42 CFR §433.68(f) outlines how a taxpayer might be held harmless:

42 CFR §433.68(f) – Health Care Related Tax Hold Harmless Provision:

"A taxpayer will be considered to be held harmless under a tax program if any of the following conditions applies:

(1) The State (or other unit of government) imposing the tax provides for a direct or indirect non-Medicaid payment to those providers or others paying the tax and the payment amount is positively correlated to either the tax amount or to the difference between the Medicaid payment and the tax amount. A positive correlation includes any positive relationship between these variables, even if not consistent over time.

(2) All or any portion of the Medicaid payment to the taxpayer varies based only on the tax amount, including where Medicaid payment is conditional on receipt of the tax amount.

(3) The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount.

(i)(A) An indirect guarantee will be determined to exist under a two prong "guarantee" test. If the health care-related tax or taxes on each health care

[92] 42 CFR §433.68 Paragraph (c)(1) of the regulation defines broad based as meaning "the tax is imposed on at least all health care items or services in the class or providers of such items or services furnished by all non-federal, non-public providers in the State, and is imposed uniformly, as specified in paragraph (d) of this section." The uniformity provision requires that the unit of government that imposes the tax applies the tax to "all items or services or providers (or all providers in a class) in the area" that the unit of government has jurisdiction.
42 CFR §433.68(c)(3) does allow for waivers to the broad based and uniformity requirements. Further explanation of the waiver process is included in Appendix A: 9.1.4 Text of Federal and State Citations.
[93] MACPAC, "Health Care Related Taxes in Medicaid," (August 2012).

class are applied at a rate that produces revenues less than or equal to 6 percent of the revenues received by the taxpayer, the tax or taxes are permissible under this test. The phrase "revenues received by the taxpayer" refers to the net patient revenue attributable to the assessed permissible class of health care items or services. However, for the period of January 1, 2008 through September 30, 2011, the applicable percentage of net patient service revenue is 5.5 percent. Compliance in State fiscal year 2008 will be evaluated from January 1, 2008 through the last day of State fiscal year 2008. Beginning with State fiscal year 2009 the 5.5 percent tax collection will be measured on an annual State fiscal year basis.

(B) When the tax or taxes produce revenues in excess of the applicable percentage of the revenue received by the taxpayer, CMS will consider an indirect hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments. The second prong of the indirect hold harmless test is applied in the aggregate to all health care taxes applied to each class. If this standard is violated, the amount of tax revenue to be offset from medical assistance expenditures is the total amount of the taxpayers' revenues received by the State."

State Authority

Kansas statute 65-6208 states that an annual assessment is applied to hospital inpatient services in an amount equal to 1.83% of each hospital's net inpatient operating revenue for the hospital's fiscal year 2010. Kansas statute 65-6209 indicates that the following hospital types are exempt from the assessment – state educational institutions, critical access hospitals, state operated facilities specializing in care mental health disorders or developmental disabilities.

A.3 Payments Distributed by Medicaid Programs

The Social Security Act dictates that provider payments for Medicaid services must be adequate to ensure access to quality care for the Medicaid population but not high enough to encourage overutilization.

U.S.C. § 1396a (a)(30)(A) specifies that a Medicaid state plan must "*provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.*"

More detailed regulations exist separately for the Medicaid FFS program, which has to be documented in the State Plan, and for Medicaid managed care programs, which is documented in the State Plan or through an approved waiver. In addition, some payments (DSH and GME), are allowable in both FFS and managed care.

A.3.1 Payments Authorized through the State Plan

The traditional delivery methodology for payments under a Medicaid system was a FFS model. Each Medicaid FFS program is governed by the State Plan and reimbursements to healthcare providers are subject to Upper Payment Limits (UPLs). Reimbursements to hospitals under a Medicaid FFS program are typically made in the following forms and these payments, in aggregate, are capped for FFP by applicable UPLs:

1. Claim payments for services rendered
2. Periodic or lump-sum supplemental payments received that are compliant with federal UPL regulations
3. GME payments made to teaching hospitals to help offset the hospitals' costs for operating Graduate Medical Education programs

In addition, payments made through the DSH program are governed by the State Plan, but are not limited by the UPL. Instead, FFP for the Federal DSH program is limited in aggregate by caps set uniquely for each state and for each individual hospital based on criteria that considers Medicaid shortfall and cost of care for the uninsured.

A.3.1.1 Upper Payment Limit Supplemental Payments

The UPL regulations establish the maximum amounts of Medicaid payments that are eligible for federal matching funds. The maximum total payment is generally calculated as an approximation of what Medicare would pay for these same services, or as an approximation of hospital costs to provide these services following Medicare allowable cost rules. UPL regulations establish limits on the federal portion of Medicaid outlays for recipients paid under Medicaid FFS programs.

UPL supplemental payments are most often funded by IGTs and are designed to offset some or all of the difference between total base Medicaid FFS payments for services and the maximum payment level allowed under the regulatory UPL for those services. At the federal level, the upper payment limit for inpatient hospital services is governed by 42 CFR 447.272 – "Inpatient Services: Application of Upper Payment Limits," and outpatient hospital services fall under 42 CFR 447.321 – "Outpatient Hospital and Clinic Services: Application of Upper Payment Limits." These regulations allow states to maximize Medicaid FFS payments to hospitals. In addition to reimbursing providers for Medicaid services, supplemental payments can be made to hospitals to allow a maximum payment that is generally calculated as an approximation of Medicare payment for these same services, or as an approximation of hospital costs to provide these services.

The UPL limit is aggregated over each provider type (hospitals, nursing homes, clinics, etc.) and class (state-owned, non-state government owned, and private). State payments to any individual hospital may exceed that hospital's upper payment limit as long as the aggregated payments to hospitals in that provider class are within the overall Medicare UPL. Also, UPL limits are calculated separately for hospital inpatient and outpatient care. The result is six UPL limits for hospital reimbursement, made up of three provider classes for two different categories of service. UPL limits apply only to payments made within the parameters and authority established by each state's State Plan, which includes FFS payments (both claim-based and supplemental payments), but in many cases, including Kansas, does not include Medicaid managed care payments.

In addition, UPL calculations apply only to Medicaid recipients. Uncompensated care payments made through approved DSH programs are not limited by UPL regulations.[94] Based on recently updated regulatory changes from CMS, Medicaid agencies are required to submit UPL analyses for inpatient and outpatient hospital services reimbursement (as well as other provider types) at the beginning of each fiscal year using historical data, and are oftentimes required to submit prospective UPL analyses predicting whether or not Medicaid FFS payments, including claim and supplemental payments, will be within upper payment limits whenever submitting changes to rates or payment methods as part of a new SPA.

A.3.1.2 Claim Payments

State methods for setting hospital FFS rates are contained in the Medicaid State Plan – Attachment 4.19-A for inpatient rates and Attachment 4.19-B for outpatient rates. The rates are also published online and in the Kansas Medical Assistance Program Fee-For-Service Provider Manual – Hospital.

Inpatient rates are paid by DRG and is based on the following equation:

DRG Weight **X** *Group Payment Rate* **+** *Outlier Costs*[95]

Inpatient rates vary by hospital. The SPA states that "the methods and standards used to determined [inpatient] payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. (42 CFR 447.253(b)(1)(ii)(A)"

A.3.1.3 GME

Unlike UPL supplemental payments, states are allowed to make GME supplemental payments to hospitals in a Medicaid managed care model because they are tied to costs of maintaining Graduate Medical Education programs, not to the cost of care for Medicaid recipients.

A.3.1.4 DSH

DSH payments are intended to make Medicaid payment adjustments for hospitals that serve a disproportionate share of low–income patients with special needs. As such, DSH funds help to cover hospital costs for Medicaid shortfall and for care of the uninsured.

- Medicaid shortfall is the difference between non-DSH Medicaid payments and hospital cost to provide care to Medicaid recipients.
- The cost of care for uninsured is defined as hospital costs to care for recipients who have no health insurance or other source of third party coverage or whose health insurance does not cover any of the services related to an entire episode of care (such as a hospital admission).

DSH payments are allowed under both fee-for-service and Medicaid managed care programs. Federal Financial Participation (FFP) for Medicaid DSH payments is controlled by a limit that caps total FFP to each state for DSH payments at values pre-set within federal regulation.

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[94] In contrast, DSH limits are calculated individually for each hospital and include payments and costs for care of Medicaid recipients (both FFS and managed care) plus uncompensated care.

[95] Located online: https://www.kmap-state-ks.us/Documents/Content/Provider%20Manuals/Hospital_07122017_17165.pdf.

On July 28, 2017, CMS proposed a new rule to implement annual reductions to Medicaid DSH payments as required by the Affordable Care Act (ACA). The ACA set forth aggregate reductions to state Medicaid DSH allotments annually from fiscal year (FY) 2014 through FY 2020, and subsequent legislation delayed the start of these reductions until FY 2018. Under current law, these reductions will run through FY 2025.

The proposed rule delineates the DSH Health Reform Methodology (DHRM) to implement the allotment reductions set to begin FY 2018. According to CMS, it accounts for relevant data that was unavailable to CMS during prior rulemaking for DSH allotment reductions originally set to take place for FY 2014 and FY 2015. CMS intends to calculate each state's unreduced DSH allotment under the current formula to serve as the base amount to which the state-specific DSH allotment reduction amount will apply annually. CMS proposes to then apply the DHRM to the unreduced DSH allotment amount on an annual basis to calculate the final allotment reductions.[96]

Federal Authority

DSH supplemental payments may be made directly from the Medicaid agency to hospitals completely independent of capitation payments made to MCOs. Total Medicaid payments to a hospital, including FFS, managed care, and DSH payments, may not exceed the hospital's cost for care of Medicaid recipients and the uninsured. To enforce this limitation, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 defined a requirement for annual auditing and standard reporting of state DSH payments in comparison to hospital costs.

Section 1902(a)(13)(A)(iv) of the Social Security Act states that,

> *A State plan for medical assistance must provide for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs.*

Sections 1923(b) and (d) of the Social Security Act specify the requirements to qualify as a DSH hospital. Section 1923(c) – "Payment Adjustment" provides a variety of ways to calculate the allowable amount of DSH payment per hospital.

State Authority

DSH eligibility and payment distribution is governed by Section 6 of Attachment 4.19-A of the State Plan.

A.3.2 Payments Authorized through Medicaid Waiver(s)

Federal matching funds for Medicaid managed care programs are limited by a different set of regulations that require capitation rates paid by Medicaid to managed care organizations

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[96] Available online: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-15962.pdf?utm_campaign=pi%20subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email.

(MCOs) to be actuarially sound. In addition, federal regulations dictate that services covered by Medicaid managed care plans must be considered "paid in full" through the rate paid to the plan.[97]

Federal Authority
Federal matching funds for Medicaid managed care programs are limited by regulations regarding capitation rates paid by Medicaid to Medicaid MCOs. Federal regulation 42 CFR §438.6(c)(2)(i) dictates that "all payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound." In addition, regulation 42 CFR §438.60 dictates that services covered by Medicaid managed care plans must be considered "paid in full" through the rate paid to the plan. In May 2016, CMS further clarified these rules by publishing a final rule that will phase out Medicaid managed care pass through payments to hospitals over a 10-year period. Based on these regulations, non-DSH supplemental payments for services provided to Medicaid recipients are generally prohibited from being paid directly by Medicaid agencies to hospitals, unless they are explicitly approved through a waiver program. For example, UPL supplemental payments made directly from a state to providers for services provided to Medicaid recipients enrolled in Medicaid managed care plans are generally not allowed.

In recent years, states have explored alternative ways to maintain supplemental payments to hospitals when converting to capitated Medicaid managed care models. Several states are using 1115 waivers to move from Medicaid FFS to a managed care environment. In many cases, these waiver projects have included transitional payments that allow providers time to adjust to changes in Medicaid reimbursement, although there is no specific stipulation requiring transitional payments in either 42 CFR §431.400 or Section 1115 of the Act. Specifically in Kansas, the Uncompensated Care (UC) Pool and DSRIP program were implemented within the KanCare 1.0 Waiver.

State Authority
Managed Care Payment is addressed in the Special Terms and Conditions of the 1115 Demonstration, as amended in January 2014, and excerpted below:

> **Managed Care Requirements.** The state must comply with the managed care regulations published at 42 CFR 438. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.6. The certification shall identify historical utilization of state plan and HCBS services used in the rate development process. [98]

Also, the individual hospital DSH is used as a provider cap for UC Pool payments made to hospitals as described in the approved 1115 Demonstration cited below:

> ***Uncompensated Care (UC) Pool.*** *The UC Pool is available in DYs 1 through 5 to defray the actual uncompensated cost of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to Medicaid eligible or Approval Period: January 1, 2013 through December 31, 2017 Page 40 of 125 uninsured individuals (defined as individuals who have no source of third party coverage) incurred by hospitals. Expenditures must be claimed in accordance with the methodology described in STC 66(c) below.*

[97] Code of Federal Regulations, Title 42, Section 438.60 (October 2014)
[98] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. STC #30.

All UC payments are based on uncompensated care costs calculated in accordance with the General DSH Audit and Reporting Protocol, CMS-2198-F. Payments are made each calendar quarter based on a UC Payment Application that contains information reported by each hospital from its Medicare hospital cost report associated with the state's most recent DSH audit collection tool net of any DSH payments received in that fiscal year.

Cost and payment data included on the application must be based on the Medicare 2552.10 cost report. The state may trend the data to model costs incurred in the year in which payments are to be made. Subsequent DY application will be used to verify that a hospital's UC Payments, when combined with Disproportionate Share Hospital (DSH) payments under the state plan, did not exceed its actual uncompensated care costs in that year. For example, uncompensated care costs data from a DY 3 application will be used to determine the actual uncompensated care for DY 1 UC Payments for a qualifying hospital and the state will verify that UC Payments plus DSH payments attributable to DY 1 did not exceed the hospital's actual uncompensated care costs. Any overpayments identified in the verification process that occurred in a prior year must be recouped from the provider, with the FFP returned to CMS.

All applicable inpatient and outpatient hospital UC payments received by a hospital count as title XIX revenue, and must be included as offsetting revenue in the state's annual DSH audit reports. Providers receiving both DSH and UC Payments cannot receive total payments under the state plan, DSH, and the UC Pool (related to inpatient and outpatient hospital services) that exceed the hospital's total eligible uncompensated costs. UC Payments for physicians, non-physician professionals, pharmacy, and clinic costs are not considered inpatient or outpatient Medicaid payments for the purpose of annual hospital specific DSH limits and the DSH audit rule. All reimbursement must be made in accordance with CMS approved cost claiming protocols that are consistent with the Medicare 2552-10 cost report. [99]

[99] KanCare Demonstration Special Terms and Conditions: Approval Period January 1, 2013 through December 31, 2017. STC #66.

Appendix B: Acronyms Referenced in the Report

Figure 45 - Acronyms Included in the Report

Acronym	Description	Reference
AIDS	Acquired Immune Deficiency Syndrome	
BCCH	Border City Children's Hospital	
BMI	Body Mass Index	
CHIP	Children's Health Insurance Program	
CMH	Children's Mercy Hospital	
CMS	Centers for Medicare and Medicaid Services	www.cms.gov
COC	Continuum of Care	
CY	Calendar Year	Jan 1 – Dec 31
CYMC	Children and Youth with Medical Complexity	
DHRM	DSH Health Reform Methodology	
DSH	Disproportionate Share Hospital	
DSRIP	Delivery System Reform Incentive Program	
DY	Demonstration Year	
ED	Emergency Department	
FFS	Fee for Service	
FFY	Federal Fiscal Year	Oct 1 – Sep 30
FMAP	Federal Medical Assistance Program	
FPL	Federal Poverty Level	
GME	Graduate Medical Education supplemental payment	
HCAIP	Health Care Access Improvement Program	
HCBS	Home and Community Based Services	
HEDIS	Healthcare Effectiveness Data and Information Set	
HHS	Health and Human Services	
HIV	Human Immunodeficiency Virus	
HUD	Housing and Urban Development	www.hud.gov
KDHE	Kansas Department of Health and Environment	www.kdheks.gov
KFF	Kaiser Family Foundation	www.kff.org
LIUR	Low Income Utilization Rate	
LPTH	Large Public Teaching Hospital	
MACRA	Medicare Access and CHIP Reauthorization Act	
MC	Managed Care	
MCO	Managed Care Organization	
MIUR	Medicaid Inpatient Utilization Rate	
NCQA	National Committee for Quality Assurance	
NICU	Neonatal Intensive Care Unit	
PCMH	Patient-Centered Medical Homes	
PCP	Primary Care Physician (or Provider)	
SCHIP	State Children's Health Insurance Program	
SFY	State Fiscal Year	Kansas (Jul 31 - Jun 30)
SHO	State Health Official	
SMD	State Medicaid Director	
SNCP	Safety Net Care Pool	
SPA	State Plan Amendment	
SPARCC	Supporting Personal Accountability and Resiliency for Chronic Conditions	
SPRY	State Plan Rate Year	
SSI	Supplemental Security Income	
STC	Special Terms and Conditions	
TUKH	The University of Kansas Hospital	
UC	Uncompensated Care	

Appendix C: Summary by Hospital

Figure 46 - Summary by Hospital of Medicaid and Uninsured / Self Pay Payments

Provider Medicaid ID	Provider Medicare ID	Provider Name	Service Location State	Hospital Summary Category	Medicaid Claim Payments (FFS and MC)	DSH Payments	FFS GME Payments	UC Pool Payments	DSRIP Payments	Uninsured/Self-Pay Payments
100457200A	171373	ALLEN COUNTY REGIONAL HOSPITAL	KS	Critical Access Hospital	$1,238,065	$688,802	$0	$0	$0	$0
100294110A	171316	ANDERSON COUNTY HOSPITAL	KS	Critical Access Hospital	$423,859	$338,532	$0	$0	$0	$0
100098770A	171304	ASHLAND DISTRICT HOSPITAL	KS	Critical Access Hospital	$299,350	$11	$0	$0	$0	$0
100098780A	171382	ATCHISON HOSPITAL	KS	Critical Access Hospital	$2,586,387	$363,310	$0	$0	$0	$15,048
200726500A	170201	BLUE VALLEY HOSPITAL INC	KS	Acute Care Hospital	$450	$0	$0	$0	$0	$0
100099420A	170110	BOB WILSON MEMORIAL GRANT COUNTY HOSPITAL	KS	Acute Care Hospital	$272,979	$949,407	$0	$190,069	$0	$0
100409190A	171310	CHEYENNE COUNTY HOSPITAL	KS	Critical Access Hospital	$141,961	$28,016	$0	$0	$0	$0
100080290B	173300	CHILDRENS MERCY HOSPITAL	KS	Childrens Hospital	$7,497,964	$4,194,298	$0	$1,006,521	$0	$0
100098840A	171362	CITIZENS MEDICAL CENTER INC	KS	Critical Access Hospital	$785,132	$56,362	$0	$0	$0	$0
100099000A	171333	CLARA BARTON HOSPITAL ASSOCIATION INC	KS	Critical Access Hospital	$610,392	$0	$0	$0	$0	$0
100098830A	171371	CLAY COUNTY MEDICAL CENTER	KS	Critical Access Hospital	$619,789	$107,953	$0	$0	$0	$0
100098870A	171349	CLOUD COUNTY HEALTH CENTER INC	KS	Critical Access Hospital	$389,374	$95,484	$0	$0	$0	$1,253
100099230A	171326	CO OF LOGAN NEW FRONTIERS HLTH SVCS	KS	Critical Access Hospital	$99,225	$190,316	$0	$0	$0	$0
100098820A	170094	COFFEY COUNTY HOSPITAL	KS	Acute Care Hospital	$532,970	$124,462	$0	$77,797	$0	$0
100107200A	170145	COFFEYVILLE REGIONAL MEDICAL CENTER INC	KS	Acute Care Hospital	$3,454,402	$656,732	$0	$257,391	$0	$0
100098850A	171312	COMANCHE COUNTY HOSPITAL	KS	Critical Access Hospital	$122,258	$0	$0	$0	$0	$0
100002650A	171354	COMMUNITY HEALTHCARE SYSTEM, INC	KS	Critical Access Hospital	$747,270	$195,394	$0	$0	$0	$0
100005390A	171363	COMMUNITY MEMORIAL HEALTHCARE INC	KS	Critical Access Hospital	$506,002	$0	$0	$0	$0	$0
201144320A	174020	COTTONWOOD SPRINGS LLC	KS	Specialty Hosp - Psych and Rehab	$37,757	$0	$0	$0	$0	$0
100413880A	171352	DECATUR HEALTH SYSTEMS INC	KS	Critical Access Hospital	$133,877	$0	$0	$0	$0	$0
100429240A	170194	DOCTORS HOSPITAL LLC	KS	Acute Care Hospital	$332,540	$0	$0	$5,708	$0	$0
100103100A	171317	EDWARDS COUNTY HOSPITAL AND HEALTHCARE CENTER	KS	Critical Access Hospital	$88,332	$0	$0	$0	$0	$0
100410070A	171301	ELLINWOOD DISTRICT HOSPITAL	KS	Critical Access Hospital	$215,408	$39,239	$0	$0	$0	$0
100104390A	171327	ELLSWORTH COUNTY MEDICAL CENTER	KS	Critical Access Hospital	$252,649	$0	$0	$0	$0	$20,734
100102550A	171374	FREDONIA REGIONAL HOSPITAL	KS	Critical Access Hospital	$739,952	$147,593	$0	$0	$0	$487
100099600A	260137	FREEMAN OAK HILL HEALTH SYSTEM	MO	Acute Care Hospital	$3,307,695	$0	$0	$0	$0	$0
200769500G	170202	GALICHIA HEART HOSPITAL	KS	Acute Care Hospital	$0	$0	$0	$0	$0	$622
100089280A	170074	GEARY COUNTY COMMUNITY HOSPITAL	KS	Acute Care Hospital	$1,998,900	$638,080	$0	$431,577	$0	$16,364

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600020640C	175245	GGNSC EDWARDSVILLE III LLC	KS	Specialty Hosp - Psych and Rehab	$0	$0	$0	$0	$0	$0
100004200A	171376	GIRARD MEDICAL CENTER ORTHOPEDICS	KS	Critical Access Hospital	$908,091	$0	$0	$0	$0	$0
100088450A	171370	GOODLAND REGIONAL MEDICAL CENTER	KS	Critical Access Hospital	$530,508	$371,618	$0	$0	$0	$0
100099330A	171367	GOVE COUNTY MEDICAL CENTER	KS	Critical Access Hospital	$161,943	$0	$0	$0	$0	$14,961
100089360A	171325	GRAHAM COUNTY HOSPITAL	KS	Critical Access Hospital	$256,232	$0	$0	$0	$0	$0
100396140A	170191	GREAT BEND REGIONAL HOSPITAL LLC	KS	Acute Care Hospital	$2,238,074	$71,736	$0	$368,515	$0	$25,888
100409390A	171332	GREAT PLAINS OF KIOWA COUNTY INC	KS	Critical Access Hospital	$318,063	$248,319	$0	$0	$0	$0
200383210E	171359	GREELEY COUNTY HEALTH SERVICES INC	KS	Critical Access Hospital	$149,957	$0	$0	$0	$0	$0
100098920A	171339	GREENWOOD COUNTY HOSPITAL	KS	Critical Access Hospital	$438,015	$41,389	$0	$0	$0	$88
100091560A	171300	GRISELL MEMORIAL HOSPITAL	KS	Critical Access Hospital	$30,372	$0	$0	$0	$0	$0
100099390A	171322	HAMILTON COUNTY HOSPITAL	KS	Critical Access Hospital	$147,743	$0	$0	$0	$0	$0
100098950A	171365	HANOVER HOSPITAL	KS	Critical Access Hospital	$527,007	$0	$0	$0	$0	$0
100098960A	171366	HARPER COUNTY HOSPITAL DIST 5 OF HARPER COUNTY KS	KS	Critical Access Hospital	$141,846	$106,834	$0	$0	$0	$0
100098970A	170013	HAYS MEDICAL CENTER INC	KS	Acute Care Hospital	$4,832,348	$0	$0	$976,706	$0	$0
100099580A	260006	HEARTLAND REGIONAL MEDICAL CENTER	MO	Acute Care Hospital	$631,684	$0	$0	$0	$0	$7,613
100098980A	171340	HERINGTON MUNICIPAL HOSPITAL	KS	Critical Access Hospital	$289,117	$0	$0	$0	$0	$10,287
100098990A	171341	HIAWATHA COMMUNITY HOSPITAL	KS	Critical Access Hospital	$766,542	$65,049	$0	$0	$0	$3,555
200594550A	171357	HILLSBORO COMMUNITY MEDICAL CENTER	KS	Critical Access Hospital	$158,080	$0	$0	$0	$0	$0
100099040A	171369	HODGEMAN COUNTY HEALTH CENTER	KS	Critical Access Hospital	$166,476	$0	$0	$0	$0	$1,311
100244350A	171319	HOLTON COMMUNITY HOSPITAL	KS	Critical Access Hospital	$476,223	$0	$0	$0	$0	$0
200575150C	171320	HORTON COMMUNITY HOSPITAL	KS	Critical Access Hospital	$240,335	$136,130	$0	$0	$0	$0
100102470A	171346	HOSPITAL DISTRICT NO 6 OF HARPER COUNTY KANSAS	KS	Critical Access Hospital	$153,674	$274,233	$0	$0	$0	$0
100099160A	171330	HOSPITAL DISTRICT NUMBER 1 OF RICE COUNTY	KS	Critical Access Hospital	$586,807	$564,875	$0	$0	$0	$304
100088340A	170020	HUTCHINSON REGIONAL MEDICAL CENTER INC	KS	Acute Care Hospital	$5,929,246	$0	$0	$425,912	$0	$168,731
100080370A	171314	JEFFERSON COUNTY MEMORIAL HOSPITAL INC	KS	Critical Access Hospital	$17,590	$0	$0	$0	$0	$0
100099530A	171309	JEWELL COUNTY HOSPITAL	KS	Critical Access Hospital	$505,824	$133,721	$0	$0	$0	$0
200054230B	170188	KANSAS CITY ORTHOPAEDIC INSTITUTE LLC	KS	Acute Care Hospital	$2,076	$0	$0	$0	$0	$0
100340110A	170186	KANSAS HEART HOSPITAL LLC	KS	Acute Care Hospital	$940,360	$0	$0	$111,887	$0	$0
200408390C	170197	KANSAS MEDICAL CENTER LLC	KS	Acute Care Hospital	$1,192,668	$0	$0	$86,367	$0	$0
100106820A	173025	KANSAS REHABILITATION HOSPITAL	KS	Specialty Hosp - Psych and Rehab	$342,569	$0	$0	$5,262	$0	$0
200257840A	170196	KANSAS SPINE & SPECIALTY HOSPITAL	KS	Acute Care Hospital	$1,854,919	$0	$0	$0	$0	$0

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100289220A	170183	KANSAS SURGERY AND RECOVERY CENTER LLC	KS	Acute Care Hospital	$493,317	$0	$0	$0	$0	$0
100099110A	171313	KEARNY COUNTY HOSPITAL	KS	Critical Access Hospital	$1,186,111	$538,116	$0	$0	$0	$18,124
100099090A	171331	KIOWA DISTRICT HOSPITAL	KS	Critical Access Hospital	$102,244	$0	$0	$0	$0	$1,612
400140510A		KVC - WHEATLAND PSYCHIATRIC HOSPITAL	KS	Specialty Hosp - Psych and Rehab	$2,988	$21,549	$0	$0	$0	$0
200641910E		KVC HOSPITALS INC	KS	Specialty Hosp - Psych and Rehab	$5,188,593	$0	$0	$0	$0	$0
100088190A	170120	LABETTE COUNTY MEDICAL CENTER	KS	Acute Care Hospital	$3,079,565	$305,728	$0	$281,117	$0	$0
100098890A	171303	LANE COUNTY HOSPITAL	KS	Critical Access Hospital	$305,305	$0	$0	$0	$0	$0
200406540C	174006	LARNED STATE HOPSITAL	KS	State Hospital	$298,517	$6,421,232	$0	$0	$0	$324,441
100099120A	170137	LAWRENCE MEMORIAL HOSPITAL	KS	Acute Care Hospital	$8,873,267	$676,440	$0	$957,658	$0	$66,876
100099140A	171360	LINCOLN COUNTY HOSPITAL	KS	Critical Access Hospital	$92,791	$0	$0	$0	$0	$0
100099150A	171358	LINDSBORG COMMUNITY HOSPITAL ASSOCIATION	KS	Critical Access Hospital	$116,267	$0	$0	$0	$0	$243
200743710A	172003	LTAC HOSPITAL OF WICHITA LLC	KS	Acute Care Hospital	$271,919	$0	$0	$0	$0	$0
100389670A	170190	MANHATTAN SURGICAL HOSPITAL LLC	KS	Acute Care Hospital	$327,248	$0	$0	$0	$0	$0
600072800C		MARKLEYSBURG HEALTHCARE INVESTORS	KS	Specialty Hosp - Psych and Rehab	$2,463	$0	$0	$0	$0	$0
100002710A	170105	MCPHERSON HOSPITAL, INC.	KS	Acute Care Hospital	$782,210	$209,649	$0	$132,419	$0	$0
100103430A	171321	MEADE DISTRICT HOSPITAL	KS	Critical Access Hospital	$215,725	$0	$0	$0	$0	$0
200421350F	170180	MEADOWBROOK REHABILITATION HOSPITAL	KS	Acute Care Hospital	$368,104	$0	$0	$128,492	$0	$0
100092110A	171334	MEDICINE LODGE MEMORIAL HOSPITAL	KS	Critical Access Hospital	$148,491	$0	$0	$0	$0	$1,518
100098760A	171381	MEMORIAL HOSPITAL	KS	Critical Access Hospital	$624,875	$61,783	$0	$0	$0	$0
100642360A	170182	MENORAH MEDICAL CENTER	KS	Acute Care Hospital	$1,595,780	$0	$0	$739,972	$0	$459
100089300B	170058	MERCY HOSPITAL FORT SCOTT	KS	Acute Care Hospital	$2,144,656	$349,554	$0	$311,827	$0	$53,587
100099200A	170075	MERCY HOSPITAL INC	KS	Acute Care Hospital	$43,245	$119,626	$0	$25,915	$0	$261
100089300A	170010	MERCY HOSPITAL INDEPENDENCE	KS	Acute Care Hospital	$156,835	$0	$0	$0	$0	$13,731
200654200A	260001	MERCY HOSPITAL JOPLIN	MO	Acute Care Hospital	$1,371,671	$7,330	$0	$0	$0	$76,659
200655850A	171308	MERCY MAUDE NORTON HOSPITAL	KS	Critical Access Hospital	$326,915	$249,563	$0	$0	$0	$665
100099280A	170109	MIAMI COUNTY MEDICAL CENTER INC	KS	Acute Care Hospital	$608,542	$0	$0	$199,250	$0	$2,323
100106800A	173026	MID AMERICA REHABILITATION HOSPITAL	KS	Specialty Hosp - Psych and Rehab	$299,674	$0	$0	$8,732	$0	$0
201088090A	170199	MINIMALLY INVASIVE SURGERY HOSPITAL	KS	Acute Care Hospital	$3,317	$0	$0	$0	$0	$0
100099190A	171368	MINNEOLA DISTRICT HOSPITAL	KS	Critical Access Hospital	$130,019	$77,762	$0	$0	$0	$0
100107000B	171375	MITCHELL COUNTY HOSPITAL HEALTH SYSTEMS	KS	Critical Access Hospital	$920,509	$0	$0	$0	$0	$0
100098880A	171379	MORRIS COUNTY HOSPITAL	KS	Critical Access Hospital	$319,761	$0	$0	$0	$0	$0

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100087540A	170166	MORTON COUNTY HOSPITAL	KS	Acute Care Hospital	$210,574	$481	$0	$28,739	$0	$0
100099300A	170006	MOUNT CARMEL MEDICAL CENTER	KS	Acute Care Hospital	$6,497,084	$894,028	$0	$768,115	$0	$0
100099360A	171315	NEMAHA VALLEY COMMUNITY HOSPITAL	KS	Critical Access Hospital	$159,543	$9	$0	$0	$0	$0
100004340A	171380	NEOSHO MEMORIAL REGIONAL MEDICAL CENTER	KS	Critical Access Hospital	$3,482,181	$928,224	$0	$0	$0	$50
100091900A	171336	NESS COUNTY HOSPITAL	KS	Critical Access Hospital	$116,398	$0	$0	$0	$0	$0
100080400A	171384	NEWMAN MEMORIAL COUNTY HOSPITAL DBA NEWMAN REGIONA	KS	Critical Access Hospital	$3,137,520	$713,595	$0	$0	$0	$0
100102820A	170103	NEWTON MEDICAL CENTER CORPORATION	KS	Acute Care Hospital	$2,831,559	$0	$0	$412,700	$0	$1,427
100004950A	171378	NINESCAH VALLEY HEALTH SYSTEMS INC	KS	Critical Access Hospital	$289,666	$0	$0	$0	$0	$817
100099220A	171348	NORTON COUNTY HOSPITAL	KS	Critical Access Hospital	$355,450	$172,804	$0	$0	$0	$0
100099250A	170049	OLATHE MEDICAL CENTER INC	KS	Acute Care Hospital	$7,944,357	$0	$0	$619,283	$0	$43,682
100101120B	174004	OSAWATOMIE STATE HOSPITAL	KS	State Hospital	$289,204	$0	$0	$0	$0	$277,739
100099260A	171364	OSBORNE COUNTY MEMORIAL HOSPITAL	KS	Critical Access Hospital	$138,085	$69,169	$0	$0	$0	$14,769
200570210A	171302	OSWEGO COMMUNITY HOSPITAL	KS	Critical Access Hospital	$103,008	$13,992	$0	$0	$0	$0
100409220A	171328	OTTAWA COUNTY HEALTH CENTER	KS	Critical Access Hospital	$35,739	$25,010	$0	$0	$0	$219
100453760A	170176	OVERLAND PARK REGIONAL MEDICAL CENTER	KS	Acute Care Hospital	$11,520,148	$0	$0	$2,461,494	$0	$11,383
100112110A	171345	PAWNEE VALLEY COMMUNITY HOSPITAL INC	KS	Critical Access Hospital	$594,673	$0	$0	$0	$0	$0
100409050A	171353	PHILLIPS COUNTY HOSPITAL	KS	Critical Access Hospital	$173,762	$0	$0	$0	$0	$95
100005670A	174016	PRAIRIE VIEW HOSPITAL	KS	Acute Care Hospital	$12,008	$328,866	$0	$0	$0	$367,855
100099320A	170027	PRATT REGIONAL MEDICAL CENTER CORPORTATION	KS	Acute Care Hospital	$1,226,159	$0	$0	$119,101	$0	$8,174
201076530A	170203	PREMIER SURGICAL INSTITUTE	KS	Acute Care Hospital	$69,253	$0	$0	$0	$0	$0
201112570A	172004	PROMISE HOSPITAL OF OVERLAND PARK INC	KS	Acute Care Hospital	$1,190,510	$0	$0	$0	$0	$0
600105400C		PROVIDENCE LIVING CENTER INC	KS	Specialty Hosp - Psych and Rehab	$0	$0	$0	$0	$0	$0
201074830A	170146	PROVIDENCE MEDICAL CENTER	KS	Acute Care Hospital	$10,108,546	$4,396,645	$0	$1,767,168	$0	$0
100099270A	170014	RANSOM MEMORIAL HOSPITAL	KS	Acute Care Hospital	$2,249,789	$573,126	$0	$260,072	$0	$21,185
100099550A	171307	RAWLINS COUNTY HEALTH CENTER	KS	Critical Access Hospital	$158,376	$0	$0	$0	$0	$0
201119660A	173032	REHABILITATION HOSPITAL OF OVERLAND PARK	KS	Specialty Hosp - Psych and Rehab	$225,658	$0	$0	$0	$0	$0
100409140A	171361	REPUBLIC COUNTY HOSPITAL	KS	Critical Access Hospital	$550,090	$0	$0	$0	$0	$0
200265030A	260027	RESEARCH MEDICAL CENTER	MO	Acute Care Hospital	$1,898,770	$0	$0	$0	$0	$1,299
100099310A	171311	ROOKS COUNTY HEALTH CENTER	KS	Critical Access Hospital	$464,365	$350,559	$0	$0	$0	$0
100099100A	171342	RUSH COUNTY MEMORIAL HOSPITAL	KS	Critical Access Hospital	$64,513	$0	$0	$0	$0	$0
100306710A	171350	RUSSELL REGIONAL HOSPITAL	KS	Critical Access Hospital	$363,488	$270,753	$0	$0	$0	$0

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100409160A	171338	SABETHA COMMUNITY HOSPITAL	KS	Critical Access Hospital	$279,573	$0	$0	$0	$0	$106,461
201074770A	170009	SAINT JOHN HOSPITAL, INC	KS	Acute Care Hospital	$821,336	$534,822	$0	$293,289	$0	$0
100088000A	170133	SAINT LUKES CUSHING MEMORIAL HOSPITAL	KS	Acute Care Hospital	$1,287,812	$905,960	$0	$447,184	$0	$0
100332210A	170185	SAINT LUKES SOUTH HOSPITAL INC	KS	Acute Care Hospital	$940,753	$0	$0	$279,158	$0	$218,276
100105940A	170012	SALINA REGIONAL HEALTH CENTER INC	KS	Acute Care Hospital	$10,472,022	$0	$64,539	$757,002	$0	$366,716
100358410A	170187	SALINA SURGICAL CENTER LLC	KS	Acute Care Hospital	$309,544	$0	$0	$15,126	$0	$0
100080490A	171324	SATANTA DISTRICT HOSPITAL	KS	Critical Access Hospital	$126,021	$0	$0	$0	$0	$0
100091670B	171372	SCOTT COUNTY HOSPITAL INC	KS	Critical Access Hospital	$448,084	$102,655	$0	$0	$0	$0
100104910A	171318	SEDAN CITY HOSPITAL	KS	Critical Access Hospital	$198,369	$0	$0	$0	$0	$0
100414290A	172007	SELECT SPECIALTY HOSPITAL - WICHITA	KS	Acute Care Hospital	$744,519	$0	$0	$0	$0	$0
100259020A	172005	SELECT SPECIALTY HOSPITAL KANSAS CITY INC	KS	Acute Care Hospital	$793,381	$0	$0	$0	$0	$0
100093850A	170104	SHAWNEE MISSION MEDICAL CENTER INC	KS	Acute Care Hospital	$18,083,100	$0	$2,524	$3,133,658	$0	$2,144,419
100080380A	171347	SHERIDAN COUNTY HOSPITAL	KS	Critical Access Hospital	$107,882	$0	$0	$0	$0	$0
100409890A	171377	SMITH COUNTY MEMORIAL HOSPITAL	KS	Critical Access Hospital	$220,321	$15,790	$0	$0	$0	$403
100080590A	170150	SOUTH CENTRAL KANSAS REGIONAL MEDICAL CENTER	KS	Acute Care Hospital	$1,379,372	$776,003	$0	$192,538	$0	$101,462
100098790A	170175	SOUTHWEST KANSAS EMERGENCY PHYSICIANS LLP	KS	Acute Care Hospital	$3,392,806	$1,914	$0	$496,448	$0	$0
100099490A	170068	SOUTHWEST MEDICAL CENTER	KS	Acute Care Hospital	$2,660,235	$388,686	$0	$393,023	$0	$0
100088310A	170023	ST CATHERINE HOSPITAL	KS	Acute Care Hospital	$4,878,290	$1,786,504	$0	$875,476	$0	$79,431
200298750C	171356	ST LUKE HOSPITAL AND LIVING CENTER	KS	Critical Access Hospital	$127,737	$0	$0	$0	$0	$1,658
100099590A	260138	ST LUKES HOSPITAL OF KANSAS CITY	MO	Acute Care Hospital	$1,576,987	$0	$0	$0	$0	$0
100080610A	170016	ST. FRANCIS HEALTH CENTER INC	KS	Acute Care Hospital	$11,567,806	$375,163	$4,042	$1,697,802	$0	$886
100099380A	171323	STAFFORD COUNTY HOSPITAL	KS	Critical Access Hospital	$111,851	$0	$0	$0	$0	$0
100099050A	171343	STANTON COUNTY HOSPITAL	KS	Critical Access Hospital	$53,412	$115,496	$0	$0	$0	$0
100099020A	171335	STEVENS COUNTY HOSPITAL	KS	Critical Access Hospital	$157,801	$0	$0	$0	$0	$28,888
100099400A	170086	STORMONT VAIL REGIONAL MEDICAL CENTER	KS	Acute Care Hospital	$33,486,380	$1,229,618	$6,867	$4,221,756	$0	$122,954
200370550C	170198	SUMMIT SURGICAL LLC	KS	Acute Care Hospital	$52,548	$0	$0	$0	$0	$0
100099500A	171329	SUMNER COUNTY HOSPITAL DISTRICT NO 1	KS	Critical Access Hospital	$126,785	$19,474	$0	$0	$0	$0
100088990A	170039	SUMNER REGIONAL MEDICAL CENTER	KS	Acute Care Hospital	$567,029	$163,913	$0	$135,631	$0	$0
100088620A	170017	SUSAN B. ALLEN MEMORIAL HOSPITAL	KS	Acute Care Hospital	$2,553,441	$1,415,764	$0	$455,163	$0	$0
100080290A	263302	THE CHILDREN'S MERCY HOSPITAL	MO	Childrens Hospital	$64,220,491	$5,212,827	$0	$4,964,138	$3,781,250	$225,093
100099540A	171355	TREGO COUNTY LEMKE MEMORIAL HOSPITAL	KS	Critical Access Hospital	$222,300	$22,110	$0	$0	$0	$0
100103330A	170040	UNIVERSITY OF KANSAS HOSPITAL AUTHORITY	KS	Acute Care Hospital	$67,601,114	$117,242	$0	$14,892,413	$9,937,500	$449,173

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100265560A	170142	VIA CHRISTI HOSPITAL MANHATTAN INC	KS	Acute Care Hospital	$3,817,212	$0	$0	$781,587	$0	$0
200677860A	170200	VIA CHRISTI HOSPITAL WICHITA ST TERESA INC	KS	Acute Care Hospital	$264,649	$0	$0	$269,974	$0	$109,290
600032920A		VIA CHRISTI HOSPITALS	KS	Acute Care Hospital	$3,363	$0	$0	$0	$0	$0
100080640B	170122	VIA CHRISTI HOSPITALS WICHITA INC	KS	Acute Care Hospital	$59,563,419	$16,341,119	$1,019,450	$7,718,787	$0	$0
100105420A	173028	VIA CHRISTI REHABILITATION HOSPITAL INC	KS	Specialty Hosp - Psych and Rehab	$1,257,679	$0	$0	$123,689	$0	$16,990
100420870A	171337	WAMEGO CITY HOSPITAL	KS	Critical Access Hospital	$311,123	$0	$0	$0	$0	$0
100099440A	171351	WASHINGTON COUNTY HOSPITAL	KS	Critical Access Hospital	$118,860	$69,066	$0	$0	$0	$0
100327110A	170123	WESLEY MEDICAL CENTER INC	KS	Acute Care Hospital	$63,531,338	$1,797,690	$542,143	$5,499,414	$0	$2,933
100106780A	173027	WESLEY REHABILITATION HOSPITAL	KS	Specialty Hosp - Psych and Rehab	$494,730	$0	$0	$9,834	$0	$0
100099560A	171306	WICHITA COUNTY HEALTH CENTER	KS	Critical Access Hospital	$177,795	$0	$0	$0	$0	$0
100005090A	171383	WILLIAM NEWTON MEMORIAL HOSPITAL	KS	Critical Access Hospital	$2,505,053	$881,421	$0	$0	$0	$0
100099210A	171344	WILSON COUNTY HOSPITAL	KS	Critical Access Hospital	$750,191	$0	$0	$0	$0	$0
Total					**$501,595,239**	**$60,876,723**	**$1,639,565**	**$60,818,855**	**$13,718,750**	**$5,571,475**

Figure 47 - Summary by Hospital of Medicaid and Uninsured Cost of Care and Funding of Medicaid Program

Provider Medicaid ID	Provider Medicare ID	Provider Name	Service Location State	Hospital Summary Category	CCR	Uninsured/ Self-Pay Payments	Cost of Care to Medicaid Recipients	Charity Care Cost	IGT Contributions	Provider Assessment Contributions
100457200A	171373	ALLEN COUNTY REGIONAL HOSPITAL	KS	Critical Access Hospital	0.467544	$0	$3,286,981	$97,536	$0	$0
100294110A	171316	ANDERSON COUNTY HOSPITAL	KS	Critical Access Hospital	0.751328	$0	$2,706,202	$346,756	$0	$0
100098770A	171304	ASHLAND DISTRICT HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$409,789	$804	$0	$0
100098780A	171382	ATCHISON HOSPITAL	KS	Critical Access Hospital	0.360002	$15,048	$6,098,613	$490,502	$0	$0
200726500A	170201	BLUE VALLEY HOSPITAL INC	KS	Acute Care Hospital	0.152627	$0	$0	$0	$0	$0
100099420A	170110	BOB WILSON MEMORIAL GRANT COUNTY HOSPITAL	KS	Acute Care Hospital	0.734376	$0	$0	$0	$0	$0
100409190A	171310	CHEYENNE COUNTY HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$580,085	$97,070	$0	$0
100080290B	173300	CHILDRENS MERCY HOSPITAL	KS	Childrens Hospital	0.300424	$0	$19,557,495	$0	$0	$0
100098840A	171362	CITIZENS MEDICAL CENTER INC	KS	Critical Access Hospital	0.528118	$0	$2,360,136	$95,779	$0	$0
100099000A	171333	CLARA BARTON HOSPITAL ASSOCIATION INC	KS	Critical Access Hospital	0.618757	$0	$1,691,414	$259,652	$0	$0
100098830A	171371	CLAY COUNTY MEDICAL CENTER	KS	Critical Access Hospital	0.482080	$0	$1,440,938	$29,863	$0	$0
100098870A	171349	CLOUD COUNTY HEALTH CENTER INC	KS	Critical Access Hospital	0.572464	$1,253	$1,947,372	$44,555	$0	$0
100099230A	171326	CO OF LOGAN NEW FRONTIERS HLTH SVCS	KS	Critical Access Hospital	0.820770	$0	$521,341	$0	$0	$0
100098820A	170094	COFFEY COUNTY HOSPITAL	KS	Acute Care Hospital	0.598233	$0	$2,164,341	$0	$0	$0
100107200A	170145	COFFEYVILLE REGIONAL MEDICAL CENTER INC	KS	Acute Care Hospital	0.344344	$0	$8,279,891	$419,141	$0	$0
100098850A	171312	COMANCHE COUNTY HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$211,185	$6,970	$0	$0
100002650A	171354	COMMUNITY HEALTHCARE SYSTEM, INC	KS	Critical Access Hospital	0.613521	$0	$2,908,953	$154,207	$0	$0
100005390A	171363	COMMUNITY MEMORIAL HEALTHCARE INC	KS	Critical Access Hospital	0.530414	$0	$1,416,189	$94,153	$0	$0
201144320A	174020	COTTONWOOD SPRINGS LLC	KS	Specialty Hosp - Psych and Rehab	0.406852	$0	$235,974	$0	$0	$0
100413880A	171352	DECATUR HEALTH SYSTEMS INC	KS	Critical Access Hospital	1.000000	$0	$550,348	$273	$0	$0
100429240A	170194	DOCTORS HOSPITAL LLC	KS	Acute Care Hospital	0.190776	$0	$834,870	$0	$0	$0
100103100A	171317	EDWARDS COUNTY HOSPITAL AND HEALTHCARE CENTER	KS	Critical Access Hospital	0.725375	$0	$418,546	$0	$0	$0
100410070A	171301	ELLINWOOD DISTRICT HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$569,849	$4,861	$0	$0
100104390A	171327	ELLSWORTH COUNTY MEDICAL CENTER	KS	Critical Access Hospital	0.756196	$20,734	$915,701	$97,145	$0	$0
100102550A	171374	FREDONIA REGIONAL HOSPITAL	KS	Critical Access Hospital	0.660140	$487	$2,828,099	$17,575	$0	$0
100099600A	260137	FREEMAN OAK HILL HEALTH SYSTEM	MO	Acute Care Hospital	0.208686	$0	$7,838,689	$1,920,562	$0	$0
200769500G	170202	GALICHIA HEART HOSPITAL	KS	Acute Care Hospital	0.581734	$622	$0	$60,756	$0	$0
100089280A	170074	GEARY COUNTY COMMUNITY HOSPITAL	KS	Acute Care Hospital	0.355080	$16,364	$6,423,597	$425,250	$0	$0

Provider Medicaid ID	Provider Medicare ID	Provider Name	Service Location State	Hospital Summary Category	CCR	Uninsured/ Self-Pay Payments	Cost of Care to Medicaid Recipients	Charity Care Cost	IGT Contributions	Provider Assessment Contributions
600020640C	175245	GGNSC EDWARDSVILLE III LLC	KS	Specialty Hosp - Psych and Rehab	0.581734	$0	$7,315	$0	$0	$0
100004200A	171376	GIRARD MEDICAL CENTER ORTHOPEDICS	KS	Critical Access Hospital	0.511217	$0	$3,007,388	$48,475	$0	$0
100088450A	171370	GOODLAND REGIONAL MEDICAL CENTER	KS	Critical Access Hospital	0.591524	$0	$1,973,268	$39,332	$0	$0
100099330A	171367	GOVE COUNTY MEDICAL CENTER	KS	Critical Access Hospital	0.892532	$14,961	$468,766	$41,297	$0	$0
100089360A	171325	GRAHAM COUNTY HOSPITAL	KS	Critical Access Hospital	0.891856	$0	$782,859	$0	$0	$0
100396140A	170191	GREAT BEND REGIONAL HOSPITAL LLC	KS	Acute Care Hospital	0.431493	$25,888	$5,477,025	$192,400	$0	$0
100409390A	171332	GREAT PLAINS OF KIOWA COUNTY INC	KS	Critical Access Hospital	1.000000	$0	$474,791	$46,472	$0	$0
200383210E	171359	GREELEY COUNTY HEALTH SERVICES INC	KS	Critical Access Hospital	0.688212	$0	$665,093	$0	$0	$0
100098920A	171339	GREENWOOD COUNTY HOSPITAL	KS	Critical Access Hospital	0.625822	$88	$1,423,808	$13,026	$0	$0
100091560A	171300	GRISELL MEMORIAL HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$70,952	$47,041	$0	$0
100099390A	171322	HAMILTON COUNTY HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$560,709	$280,065	$0	$0
100098950A	171365	HANOVER HOSPITAL	KS	Critical Access Hospital	0.836704	$0	$662,044	$0	$0	$0
100098960A	171366	HARPER COUNTY HOSPITAL DIST 5 OF HARPER COUNTY KS	KS	Critical Access Hospital	0.909951	$0	$485,828	$32,713	$0	$0
100098970A	170013	HAYS MEDICAL CENTER INC	KS	Acute Care Hospital	0.275559	$0	$14,455,943	$731,863	$0	$0
100099580A	260006	HEARTLAND REGIONAL MEDICAL CENTER	MO	Acute Care Hospital	0.375456	$7,613	$2,795,109	$1,697,490	$0	$0
100098980A	171340	HERINGTON MUNICIPAL HOSPITAL	KS	Critical Access Hospital	0.719168	$10,287	$811,149	$10,413	$0	$0
100098990A	171341	HIAWATHA COMMUNITY HOSPITAL	KS	Critical Access Hospital	0.711203	$3,555	$2,642,732	$13,158	$0	$0
200594550A	171357	HILLSBORO COMMUNITY MEDICAL CENTER	KS	Critical Access Hospital	0.531020	$0	$428,254	$12,043	$0	$0
100099040A	171369	HODGEMAN COUNTY HEALTH CENTER	KS	Critical Access Hospital	0.752866	$1,311	$457,598	$14,546	$0	$0
100244350A	171319	HOLTON COMMUNITY HOSPITAL	KS	Critical Access Hospital	0.614036	$0	$1,480,265	$6,353	$0	$0
200575150C	171320	HORTON COMMUNITY HOSPITAL	KS	Critical Access Hospital	0.501727	$0	$1,003,588	$32,349	$0	$0
100102470A	171346	HOSPITAL DISTRICT NO 6 OF HARPER COUNTY KANSAS	KS	Critical Access Hospital	1.000000	$0	$630,745	$6,596	$0	$0
100099160A	171330	HOSPITAL DISTRICT NUMBER 1 OF RICE COUNTY	KS	Critical Access Hospital	0.992021	$304	$1,332,674	$16,460	$0	$0
100088340A	170020	HUTCHINSON REGIONAL MEDICAL CENTER INC	KS	Acute Care Hospital	0.267576	$168,731	$15,383,397	$275,894	$0	$0
100080370A	171314	JEFFERSON COUNTY MEMORIAL HOSPITAL INC	KS	Critical Access Hospital	1.000000	$0	$221,868	$0	$0	$0
100099530A	171309	JEWELL COUNTY HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$682,207	$2,729	$0	$0
200054230B	170188	KANSAS CITY ORTHOPAEDIC INSTITUTE LLC	KS	Acute Care Hospital	0.235962	$0	$11,246	$91,823	$0	$0
100340110A	170186	KANSAS HEART HOSPITAL LLC	KS	Acute Care Hospital	0.290169	$0	$2,508,771	$40,153	$0	$443,370
200408390C	170197	KANSAS MEDICAL CENTER LLC	KS	Acute Care Hospital	0.300719	$0	$3,682,282	$13,752	$0	$536,293

Provider Medicaid ID	Provider Medicare ID	Provider Name	Service Location State	Hospital Summary Category	CCR	Uninsured/ Self-Pay Payments	Cost of Care to Medicaid Recipients	Charity Care Cost	IGT Contributions	Provider Assessment Contributions
100106820A	173025	KANSAS REHABILITATION HOSPITAL	KS	Specialty Hosp - Psych and Rehab	0.532363	$0	$725,709	$0	$0	$225,771
200257840A	170196	KANSAS SPINE & SPECIALTY HOSPITAL	KS	Acute Care Hospital	0.203762	$0	$3,143,734	$29,618	$0	$416,318
100289220A	170183	KANSAS SURGERY AND RECOVERY CENTER LLC	KS	Acute Care Hospital	0.273228	$0	$1,117,974	$45,222	$0	$311,394
100099110A	171313	KEARNY COUNTY HOSPITAL	KS	Critical Access Hospital	0.675344	$18,124	$2,664,221	$79,717	$0	$0
100099090A	171331	KIOWA DISTRICT HOSPITAL	KS	Critical Access Hospital	1.000000	$1,612	$497,865	$20,920	$0	$0
400140510A		KVC - WHEATLAND PSYCHIATRIC HOSPITAL	KS	Specialty Hosp - Psych and Rehab	0.581734	$0	$8,333	$0	$0	$0
200641910E		KVC HOSPITALS INC	KS	Specialty Hosp - Psych and Rehab	0.581734	$0	$5,233,035	$0	$0	$14,643
100088190A	170120	LABETTE COUNTY MEDICAL CENTER	KS	Acute Care Hospital	0.307908	$0	$8,471,909	$349,062	$0	$334,507
100098890A	171303	LANE COUNTY HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$502,872	$11,868	$0	$0
200406540C	174006	LARNED STATE HOPSITAL	KS	State Hospital	0.795145	$324,441	$383,670	$13,026,931	$0	$0
100099120A	170137	LAWRENCE MEMORIAL HOSPITAL	KS	Acute Care Hospital	0.228752	$66,876	$17,880,101	$2,171,226	$0	$797,500
100099140A	171360	LINCOLN COUNTY HOSPITAL	KS	Critical Access Hospital	0.986474	$0	$493,722	$22,842	$0	$0
100099150A	171358	LINDSBORG COMMUNITY HOSPITAL ASSOCIATION	KS	Critical Access Hospital	0.670238	$243	$733,379	$35,450	$0	$0
200743710A	172003	LTAC HOSPITAL OF WICHITA LLC	KS	Acute Care Hospital	0.382394	$0	$1,097,668	$0	$0	$103,086
100389670A	170190	MANHATTAN SURGICAL HOSPITAL LLC	KS	Acute Care Hospital	0.192602	$0	$1,268,378	$15,654	$0	$27,981
600072800C		MARKLEYSBURG HEALTHCARE INVESTORS	KS	Specialty Hosp - Psych and Rehab	0.581734	$0	$1,658	$0	$0	$0
100002710A	170105	MCPHERSON HOSPITAL, INC.	KS	Acute Care Hospital	0.401427	$0	$2,348,267	$413,822	$0	$116,507
100103430A	171321	MEADE DISTRICT HOSPITAL	KS	Critical Access Hospital	0.929079	$0	$1,287,302	$179,620	$0	$0
200421350F	170180	MEADOWBROOK REHABILITATION HOSPITAL	KS	Acute Care Hospital	0.401052	$0	$206,907	$0	$0	$80,297
100092110A	171334	MEDICINE LODGE MEMORIAL HOSPITAL	KS	Critical Access Hospital	1.000000	$1,518	$438,771	$12,988	$0	$0
100098760A	171381	MEMORIAL HOSPITAL	KS	Critical Access Hospital	0.580514	$0	$2,651,903	$89,206	$0	$0
100642360A	170182	MENORAH MEDICAL CENTER	KS	Acute Care Hospital	0.168714	$459	$3,681,880	$405,808	$0	$1,357,532
100089300B	170058	MERCY HOSPITAL FORT SCOTT	KS	Acute Care Hospital	0.287782	$53,587	$5,837,544	$1,322,127	$0	$241,871
100099200A	170075	MERCY HOSPITAL INC	KS	Acute Care Hospital	0.891182	$261	$442,742	$10,130	$0	$16,352
100089300A	170010	MERCY HOSPITAL INDEPENDENCE	KS	Acute Care Hospital	0.453426	$13,731	$0	$1,156,982	$0	$133,436
200654200A	260001	MERCY HOSPITAL JOPLIN	MO	Acute Care Hospital	0.271070	$76,659	$4,127,356	$4,545,352	$0	$0
200655850A	171308	MERCY MAUDE NORTON HOSPITAL	KS	Critical Access Hospital	1.000000	$665	$958,563	$55,859	$0	$0
100099280A	170109	MIAMI COUNTY MEDICAL CENTER INC	KS	Acute Care Hospital	0.300186	$2,323	$2,481,116	$188,787	$0	$71,942
100106800A	173026	MID AMERICA REHABILITATION HOSPITAL	KS	Specialty Hosp - Psych and Rehab	0.561172	$0	$682,778	$0	$0	$506,150

Provider Medicaid ID	Provider Medicare ID	Provider Name	Service Location State	Hospital Summary Category	CCR	Uninsured/ Self-Pay Payments	Cost of Care to Medicaid Recipients	Charity Care Cost	IGT Contributions	Provider Assessment Contributions
201088090A	170199	MINIMALLY INVASIVE SURGERY HOSPITAL	KS	Acute Care Hospital	0.452167	$0	$230,553	$0	$0	$32,311
100099190A	171368	MINNEOLA DISTRICT HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$615,437	$34,473	$0	$0
100107000B	171375	MITCHELL COUNTY HOSPITAL HEALTH SYSTEMS	KS	Critical Access Hospital	0.550898	$0	$2,476,454	$186,618	$0	$0
100098880A	171379	MORRIS COUNTY HOSPITAL	KS	Critical Access Hospital	0.478434	$0	$802,903	$16,175	$0	$0
100087540A	170166	MORTON COUNTY HOSPITAL	KS	Acute Care Hospital	0.856875	$0	$1,043,656	$2,941	$0	$95,187
100099300A	170006	MOUNT CARMEL MEDICAL CENTER	KS	Acute Care Hospital	0.278409	$0	$15,120,840	$3,370,905	$0	$565,454
100099360A	171315	NEMAHA VALLEY COMMUNITY HOSPITAL	KS	Critical Access Hospital	0.592891	$0	$495,770	$35,804	$0	$0
100004340A	171380	NEOSHO MEMORIAL REGIONAL MEDICAL CENTER	KS	Critical Access Hospital	0.354207	$50	$9,540,931	$728,338	$0	$0
100091900A	171336	NESS COUNTY HOSPITAL	KS	Critical Access Hospital	0.920273	$0	$518,737	$0	$0	$0
100080400A	171384	NEWMAN MEMORIAL COUNTY HOSPITAL DBA NEWMAN REGIONA	KS	Critical Access Hospital	0.404507	$0	$7,811,566	$377,144	$0	$0
100102820A	170103	NEWTON MEDICAL CENTER CORPORATION	KS	Acute Care Hospital	0.318533	$1,427	$7,906,699	$346,258	$0	$496,289
100004950A	171378	NINESCAH VALLEY HEALTH SYSTEMS INC	KS	Critical Access Hospital	0.543624	$817	$1,017,914	$13,986	$0	$0
100099220A	171348	NORTON COUNTY HOSPITAL	KS	Critical Access Hospital	0.745331	$0	$952,554	$44,989	$0	$0
100099250A	170049	OLATHE MEDICAL CENTER INC	KS	Acute Care Hospital	0.259558	$43,682	$19,716,593	$1,026,011	$0	$1,754,310
100101120B	174004	OSAWATOMIE STATE HOSPITAL	KS	State Hospital	1.000000	$277,739	$0	$19,797,331	$0	$0
100099260A	171364	OSBORNE COUNTY MEMORIAL HOSPITAL	KS	Critical Access Hospital	0.987873	$14,769	$477,918	$104,299	$0	$0
200570210A	171302	OSWEGO COMMUNITY HOSPITAL	KS	Critical Access Hospital	0.633833	$0	$716,981	$10,382	$0	$0
100409220A	171328	OTTAWA COUNTY HEALTH CENTER	KS	Critical Access Hospital	1.000000	$219	$247,654	$39,002	$0	$0
100453760A	170176	OVERLAND PARK REGIONAL MEDICAL CENTER	KS	Acute Care Hospital	0.128451	$11,383	$21,876,110	$1,601,302	$0	$2,867,880
100112110A	171345	PAWNEE VALLEY COMMUNITY HOSPITAL INC	KS	Critical Access Hospital	0.512976	$0	$2,303,604	$102,933	$0	$0
100409050A	171353	PHILLIPS COUNTY HOSPITAL	KS	Critical Access Hospital	1.000000	$95	$1,047,759	$57,114	$0	$0
100005670A	174016	PRAIRIE VIEW HOSPITAL	KS	Acute Care Hospital	0.978996	$367,855	$26,629	$833,015	$0	$61,116
100099320A	170027	PRATT REGIONAL MEDICAL CENTER CORPORTATION	KS	Acute Care Hospital	0.487571	$8,174	$4,030,693	$130,315	$0	$103,593
201076530A	170203	PREMIER SURGICAL INSTITUTE	KS	Acute Care Hospital	0.263187	$0	$446,679	$0	$0	$285,029
201112570A	172004	PROMISE HOSPITAL OF OVERLAND PARK INC	KS	Acute Care Hospital	0.640973	$0	$2,022,028	$0	$0	$101,498
600105400C		PROVIDENCE LIVING CENTER INC	KS	Specialty Hosp - Psych and Rehab	0.581734	$0	$592	$0	$0	$0
201074830A	170146	PROVIDENCE MEDICAL CENTER	KS	Acute Care Hospital	0.168407	$0	$18,595,788	$2,943,113	$0	$1,670,726
100099270A	170014	RANSOM MEMORIAL HOSPITAL	KS	Acute Care Hospital	0.337591	$21,185	$5,795,312	$101,621	$0	$136,557
100099550A	171307	RAWLINS COUNTY HEALTH CENTER	KS	Critical Access Hospital	0.984489	$0	$591,264	$6,136	$0	$0

Provider Medicaid ID	Provider Medicare ID	Provider Name	Service Location State	Hospital Summary Category	CCR	Uninsured/ Self-Pay Payments	Cost of Care to Medicaid Recipients	Charity Care Cost	IGT Contributions	Provider Assessment Contributions
201119660A	173032	REHABILITATION HOSPITAL OF OVERLAND PARK	KS	Specialty Hosp - Psych and Rehab	0.372633	$0	$785,870	$0	$0	$172,054
100409140A	171361	REPUBLIC COUNTY HOSPITAL	KS	Critical Access Hospital	0.904563	$0	$1,876,156	$79,669	$0	$0
200265030A	260027	RESEARCH MEDICAL CENTER	MO	Acute Care Hospital	0.135413	$1,299	$3,014,541	$1,802,084	$0	$0
100099310A	171311	ROOKS COUNTY HEALTH CENTER	KS	Critical Access Hospital	0.607200	$0	$1,534,330	$16,798	$0	$0
100099100A	171342	RUSH COUNTY MEMORIAL HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$471,034	$0	$0	$0
100306710A	171350	RUSSELL REGIONAL HOSPITAL	KS	Critical Access Hospital	0.702886	$0	$1,369,520	$82,287	$0	$0
100409160A	171338	SABETHA COMMUNITY HOSPITAL	KS	Critical Access Hospital	0.784705	$106,461	$725,521	$146,131	$0	$0
201074770A	170009	SAINT JOHN HOSPITAL, INC	KS	Acute Care Hospital	0.227773	$0	$3,093,937	$632,769	$0	$331,975
100088000A	170133	SAINT LUKES CUSHING MEMORIAL HOSPITAL	KS	Acute Care Hospital	0.213152	$0	$3,455,363	$809,036	$0	$0
100332210A	170185	SAINT LUKES SOUTH HOSPITAL INC	KS	Acute Care Hospital	0.191677	$218,276	$2,529,026	$915,330	$0	$907,739
100105940A	170012	SALINA REGIONAL HEALTH CENTER INC	KS	Acute Care Hospital	0.244929	$366,716	$20,711,509	$1,861,149	$0	$1,668,224
100358410A	170187	SALINA SURGICAL CENTER LLC	KS	Acute Care Hospital	0.249284	$0	$1,214,149	$23,153	$0	$119,164
100080490A	171324	SATANTA DISTRICT HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$768,048	$20,449	$0	$0
100091670B	171372	SCOTT COUNTY HOSPITAL INC	KS	Critical Access Hospital	0.843367	$0	$1,471,312	$50,923	$0	$0
100104910A	171318	SEDAN CITY HOSPITAL	KS	Critical Access Hospital	0.945970	$0	$819,029	$77,982	$0	$0
100414290A	172007	SELECT SPECIALTY HOSPITAL - WICHITA	KS	Acute Care Hospital	0.245324	$0	$1,541,667	$0	$0	$264,868
100259020A	172005	SELECT SPECIALTY HOSPITAL KANSAS CITY INC	KS	Acute Care Hospital	0.330594	$0	$1,686,767	$0	$0	$276,266
100093850A	170104	SHAWNEE MISSION MEDICAL CENTER INC	KS	Acute Care Hospital	0.161997	$2,144,419	$29,594,277	$16,024,834	$0	$3,671,450
100080380A	171347	SHERIDAN COUNTY HOSPITAL	KS	Critical Access Hospital	0.846269	$0	$432,290	$18,731	$0	$0
100409890A	171377	SMITH COUNTY MEMORIAL HOSPITAL	KS	Critical Access Hospital	0.799781	$403	$948,538	$69,032	$0	$0
100080590A	170150	SOUTH CENTRAL KANSAS REGIONAL MEDICAL CENTER	KS	Acute Care Hospital	0.599402	$101,462	$4,047,494	$938,423	$0	$96,302
100098790A	170175	SOUTHWEST KANSAS EMERGENCY PHYSICIANS LLP	KS	Acute Care Hospital	0.265483	$0	$7,536,218	$31,937	$0	$421,735
100099490A	170068	SOUTHWEST MEDICAL CENTER	KS	Acute Care Hospital	0.311830	$0	$5,989,288	$340,392	$0	$223,748
100088310A	170023	ST CATHERINE HOSPITAL	KS	Acute Care Hospital	0.360751	$79,431	$11,269,642	$3,047,430	$0	$588,633
200298750C	171356	ST LUKE HOSPITAL AND LIVING CENTER	KS	Critical Access Hospital	0.691306	$1,658	$828,147	$14,287	$0	$0
100099590A	260138	ST LUKES HOSPITAL OF KANSAS CITY	MO	Acute Care Hospital	0.211881	$0	$5,061,249	$0	$0	$0
100080610A	170016	ST. FRANCIS HEALTH CENTER INC	KS	Acute Care Hospital	0.242543	$886	$28,212,469	$3,511,313	$0	$1,782,323
100099380A	171323	STAFFORD COUNTY HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$218,309	$0	$0	$0
100099050A	171343	STANTON COUNTY HOSPITAL	KS	Critical Access Hospital	1.000000	$0	$302,497	$22,536	$0	$0
100099020A	171335	STEVENS COUNTY HOSPITAL	KS	Critical Access Hospital	0.914563	$28,888	$1,074,516	$107,759	$0	$0

Provider Medicaid ID	Provider Medicare ID	Provider Name	Service Location State	Hospital Summary Category	CCR	Uninsured/ Self-Pay Payments	Cost of Care to Medicaid Recipients	Charity Care Cost	IGT Contributions	Provider Assessment Contributions
100099400A	170086	STORMONT VAIL REGIONAL MEDICAL CENTER	KS	Acute Care Hospital	0.210543	$122,954	$58,321,433	$4,366,042	$0	$4,240,968
200370550C	170198	SUMMIT SURGICAL LLC	KS	Acute Care Hospital	0.357606	$0	$187,078	$0	$0	$77,601
100099500A	171329	SUMNER COUNTY HOSPITAL DISTRICT NO 1	KS	Critical Access Hospital	0.987947	$0	$242,227	$0	$0	$0
100088990A	170039	SUMNER REGIONAL MEDICAL CENTER	KS	Acute Care Hospital	0.388836	$0	$2,203,038	$0	$0	$39,995
100088620A	170017	SUSAN B. ALLEN MEMORIAL HOSPITAL	KS	Acute Care Hospital	0.274823	$0	$7,227,551	$343,161	$0	$226,577
100080290A	263302	THE CHILDREN'S MERCY HOSPITAL	MO	Childrens Hospital	0.413383	$225,093	$143,961,893	$8,135,194	$0	$0
100099540A	171355	TREGO COUNTY LEMKE MEMORIAL HOSPITAL	KS	Critical Access Hospital	0.715034	$0	$1,017,539	$18,176	$0	$0
100103330A	170040	UNIVERSITY OF KANSAS HOSPITAL AUTHORITY	KS	Acute Care Hospital	0.189599	$449,173	$96,398,841	$24,391,349	$11,111,140	$0
100265560A	170142	VIA CHRISTI HOSPITAL MANHATTAN INC	KS	Acute Care Hospital	0.264402	$0	$9,341,936	$988,236	$0	$786,768
200677860A	170200	VIA CHRISTI HOSPITAL WICHITA ST TERESA INC	KS	Acute Care Hospital	0.282242	$109,290	$1,004,771	$1,267,456	$0	$222,990
600032920A		VIA CHRISTI HOSPITALS	KS	Acute Care Hospital	0.581734	$0	$23,197	$0	$0	$0
100080640B	170122	VIA CHRISTI HOSPITALS WICHITA INC	KS	Acute Care Hospital	0.222257	$0	$110,135,755	$30,042,837	$0	$7,052,134
100105420A	173028	VIA CHRISTI REHABILITATION HOSPITAL INC	KS	Specialty Hosp - Psych and Rehab	0.501234	$16,990	$6,811,929	$307,213	$0	$222,370
100420870A	171337	WAMEGO CITY HOSPITAL	KS	Critical Access Hospital	0.537761	$0	$1,044,786	$520,885	$0	$0
100099440A	171351	WASHINGTON COUNTY HOSPITAL	KS	Critical Access Hospital	0.698370	$0	$413,156	$0	$0	$0
100327110A	170123	WESLEY MEDICAL CENTER INC	KS	Acute Care Hospital	0.119043	$2,933	$86,818,761	$2,046,673	$0	$5,796,469
100106780A	173027	WESLEY REHABILITATION HOSPITAL	KS	Specialty Hosp - Psych and Rehab	0.529859	$0	$859,622	$0	$0	$247,080
100099560A	171306	WICHITA COUNTY HEALTH CENTER	KS	Critical Access Hospital	1.000000	$0	$370,435	$16,012	$0	$0
100005090A	171383	WILLIAM NEWTON MEMORIAL HOSPITAL	KS	Critical Access Hospital	0.448530	$0	$5,447,177	$328,905	$0	$0
100099210A	171344	WILSON COUNTY HOSPITAL	KS	Critical Access Hospital	0.495393	$0	$3,320,273	$14,342	$0	$0
Total					**N/A**	**$5,571,475**	**$1,014,317,356**	**$167,900,167**	**$11,111,140**	**$43,342,333**