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

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

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

2.4100 Data Base

For developing the DRG relative weights, group payment rates, and other system components for use effective October 1, 2009, the agency used as data base the Medicaid/MediKan paid claims for services the eighteen month period ending the previous December. Certain claims were excluded from the data base while some others were modified before including in the data base as listed below.

2.4110 Claims Excluded from the Data Base

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

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2.4250 continued

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

Analysis

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

2.4260 Inflation of the Cost and Charge Data

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

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(Reserved for future use)

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2.4450 Modification of Relative Weights for Selected DRG Pairs and Triplets

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

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

2.4500 Group Payment Rates

The agency determined group payment rates for the general hospital groups discussed in section 2.3000. The group payment rates are used in conjunction with DRG relative weights and other components developed for the Kansas DRG reimbursement system to determine payment. An adjustment factor of -.47% was applied to the group payment rates effective October 1, 2009 as a budget neutrality factor.

2.4510 Determination of Group Payment Rates

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

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2.4600 DRG Daily Rates

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

2.4700 Hospital Specific Medicaid Cost to Charge Ratios

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

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

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

2.5000 Determination of Payment Under the DRG Reimbursement System

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

Pursuant to Senate Substitute for House Bill 2912, as passed by the 2004 Kansas Legislature, the state of Kansas plans to spend approximately $100 million from the Health Care Access Improvement Fund in state fiscal year 2005 to improve health care delivery and related health activities.

The specific payment changes approved by the Health Care Access Improvement Panel, created pursuant to the legislation, are as follows:

1) Inpatient Hospital payment rates that were in effect on June 30, 2004 would be increased by 34.4% for all Kansas licensed hospitals except state owned or operated hospitals. Effective March 1, 2006, inpatient hospital payment rates effective February 28, 2006 will be decreased by 6.4%;
2) Inpatient Access Improvement Adjustment payments will be made on a fixed per diem increase and a percentage increase, as described in #1 above, to assure that all Kansas hospitals are treated equitably. The per diem increase is intended to ensure Medicaid payments rise with the hospital volume of Medicaid patient care and that hospitals with low case mix indexes are fairly compensated for their fixed costs, which continue to rise rapidly.
    - Eligibility Criteria
        - All hospitals that receive DRG payments except state owned and operated facilities
    - Payment
        - A fixed per diem payment of $66.50 per calendar year 2004 Medicaid inpatient day paid as of 6/27/2005, excluding Medicare crossover claims and excluding HMO encounter data.

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2.6000 Settlements and Recoupments

There shall be no year end settlements under the DRG reimbursement system with the exception of critical access hospitals, which are settled to cost as noted under 3.1000. However, some settlements and recoupments may occur because of Surveillance/Utilization Review or other reviews which determine that payments were in error.

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

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

3.1000 Critical Access Hospital Reimbursement

Effective for the reimbursement of inpatient fee-for-service claims for dates of service on or after October 5, 2007 critical access hospitals (CAHs) will be cost settled based on 100% of the reasonable cost of providing the services. Reasonable costs will be determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of cost or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. Subject to the 96-hour average for inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished to hospital inpatients.

1) Allowable Medicaid costs are defined as the costs Medicare defines as allowable on the Medicare finalized cost report. The Medicare fiscal intermediary's review of the Medicare cost report is relied on for the determination of reasonable costs and the finalized Medicare cost report will be used for determining final Medicaid allowable costs. CAHs will report Medicaid fee-for-service claim Inpatient charges. For the cost report settlement, the cost report cost-to-charge ratios are applied to the appropriate billed Medicaid charges by cost center to determine Medicaid reimbursable ancillary costs. Medicaid patient days are multiplied by the routine cost per-diem per the Medicare cost report for determining Medicaid routine cost. The sum of these components will be the Medicaid reimbursable cost for all Medicaid inpatient fee-for-service claims.

2) Inpatient CAH interim payments will be made using the established DRG rate times the applicable DRG weight factor. Payment will be the resulting interim cost amount less any applicable deductions necessary to arrive at the Medicaid net reimbursement amount. Upon receipt of the finalized Medicare cost report, interim payments made using the DRG rate are settled to cost based reimbursement using Title XIX data filed on the Medicare cost report.

3) CAHs will be permitted to request interim Medicaid cost settlements by filing an interim Medicare cost report. KHPA will consider issuing an additional interim payment during the period. The interim cost report will be used for calculating and issuing an interim

OS Notification

State/Title/Plan Number: Kansas 09-004

Type of Action: SPA Approval

Required Date for State Notification: 12/16/2009

Fiscal Impact: FFY 10 $-0- FFY 11 $-0-

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification: No

Provider Payment Increase: No **or Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:
Effective October 1, 2008, this amendment modifies the payment methodology for inpatient hospital services. Specific changes implemented with this amendment include: updating the Medicaid peer group rates and DRG weights using base data for the 18 month period ending December 31, 2008, updating the budget neutrality factor to ensure that overall inpatient hospital payments do not increase over SFY 2009, modifying the methodology for inflating base period routine costs, specifying that the cost to charge ratio used for out-of-state hospitals will be the statewide average ratio, and clarifying that critical access hospital payments will be settled to cost.

Other Considerations:
This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

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