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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, 2010, the agency used as data base the Medicaid/MediKan paid claims for services the eighteen month period ending the previous December. Certain claims were excluded from the data base while some others were modified before including in the data base as listed below.

2.4110 Claims Excluded from the Data Base

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

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2.4450 Modification of Relative Weights for Selected DRG Pairs and Triplets

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

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

2.4500 Group Payment Rates

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

2.4510 Determination of Group Payment Rates

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

OS Notification

State/Title/Plan Number: Kansas 10-014

Type of Action: SPA Approval

Required Date for State Notification: 12/14/2010

Fiscal Impact: FFY 11 $-0- FFY 12 $-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, 2010, 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, 2009 and updating the budget neutrality factor to ensure that overall inpatient hospital payments do not increase over SFY 2010. This is an annual SPA filed by the State in which the State moves the base period for claims and cost data forward by twelve months and updates the budget neutrality factor to ensure current SFY payments do not increase over the prior SFY. Funding for these services comes from State general revenue and an approved hospital provider tax. Public process / public notice requirements were met. Tribal consultations were not required for this SPA. There are no tribal providers of inpatient hospital services in Kansas. The changes proposed in this SPA will not affect the provision of services to tribal members

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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