

Review Financial Impact of Six Regulations

Number	Description	Ref #	Date Published	Notes	Description	Kansas Impact Notes	Estimated Financial Impact
1	Cost Limits for Public Providers	CMS 2258-FC	5/25/2007	Cannot take effect before 5-25-08	Change to the "unit" of government definition which limits the types of entities authorized to provide non-federal share funding. Also, this determines which healthcare providers would be subject to the new cost limit. A state teaching hospital with direct appropriations from the state are defined as operated by a unit of government.	Kansas University (KU) Hospital is the only hospital of this type in Kansas. CMS has previously approved the hospital as a public entity capable of providing non-federal share funding. UPL is currently calculated using a cost-based method.	No Impact
					Entities with direct access to tax revenues are a "unit of government".		
					Medicaid payments to "governmentally operated providers" may not exceed cost as defined using the Medicare cost report. This limit does not apply to DSH payments and certain other payments with statutorily mandated payment rates.	KU Hospital's reimbursement method is current cost-based, determined using the Medicare cost report. Other state operated psychiatric care facilities are cost-based as well. These hospitals receive DSH; however, DSH is not included in the cost limit.	No Impact
					The cost limit does apply to governmentally operated entities that are paid by the state as healthcare providers for professional services. The cost limit may apply to physicians employed by a governmental entity and to faculty practice plans wholly owned by the governmental entity.	Fee-based Kansas professional payments are less than cost.	No Impact
					Payments from MCOs to governmental providers are subject to the cost limit.	MCOs are required to pay governmental providers consistent with Medicaid FFS.	No Impact
					CMS will not trace the source of IGT funding from governmental providers. Such providers collect funds from a variety of sources besides tax revenues.		No Impact
					States may decide how to allocate FFP associated with provider CPEs as they see fit. CMS will not require states to pass federal matching funds to providers that have certified the costs to draw down those funds.		No Impact

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Number	Description	Ref #	Date Published	Notes	Description	Kansas Impact Notes	Estimated Financial Impact
2	Payments for GME	CMS 2279-P	5/23/2007	delayed until 5-25-08	Costs and payments associated with DIRECT Graduate Medical Education programs are not eligible for FFP under state Medicaid programs. CMS states the costs are not explicitly authorized as eligible for FFP under the Medicaid Statute. CMS contends the states' current methodology does not provide for clear accountability, the payments are difficult to track, and there is little assurance that the payments are supporting GME programs that provide benefit to Medicaid beneficiaries. CMS will continue to pay for IME (indirect medical education) because IME pays for the extra patient costs incurred by teaching hospitals (as opposed to education costs).	Kansas pays both GME and IME. Eliminating GME will result in a reduction in federal Medicaid funds.	\$5,889,609 for 5 years/ \$1,177,921.92 for 1 year See attached workpaper.
3	Payment for Hospital OP Services	CMS 2213-P	9/28/2007		Rule provides clarification on the outpatient clinic and hospital facility services definition and upper payment limit. The rule narrows the regulatory definition of OP hospital services and adopts restrictive and mandatory approaches to calculating the upper payment limits for OP hospital and clinic services provided by private providers. The rule requires the use of Medicare fee schedules instead of costs for determining the upper payment limit for private clinic services.	Kansas pays OP hospital services using a fee-based method that is generally well below the cost incurred for providing the services. The fee payments will fall significantly below a cost report based UPL calculation. We have recently submitted a State Plan Amendment for supplemental payments for certain licensed professional services that proposes a method that exceeds costs. Please find a copy included.	No Impact

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Number	Description	Ref #	Date Published	Notes	Description	Kansas Impact Notes	Estimated Financial Impact
					CMS defined the definition of "outpatient hospital services". Non-traditional OP services must be excluded from the definition. If the services are not treated as OP under Medicare, they must be excluded for Medicaid. For example, professional services are excluded from the definition of hospital OP services regardless of whether or not the hospital bills for the services. Areas that are not OP provider-based areas of the hospital are excluded. Hospital-based rural health clinic services are excluded.	Kansas does not include professional services within the definition of hospital services.	No Impact
4	Provider Taxes	CMS 2275-P	3/23/2007-proposed	eff 1-1-08	Clarifies issues in the original regulation. Adds more stringent language for applying the hold-harmless test. CMS gains flexibility in identifying relationship between provider taxes and payments.	Kansas Medicaid Provider Tax is a relatively new program that began in SFY2005 with CMS approval of the methodology. CMS conducted an audit of the KS Provider Tax fund and payouts during CY2007. Due to the recent approval and review, the Kansas program is in compliance with the current regulations. In regards to the proposed CMS rule, we do not know how the clarifications may impact this program. However it is clear that loss of this program has the potential to severely restrict KS Medicaid beneficiaries access to hospital & physician providers. KS would anticipate a reduction of 25% in KS Medicaid claims payments rates due to the loss of federal matching funds as well as an elimination of direct access payments to hospital providers. Documents describing the tax and payments that could be affected are attached.	Uncertain of Impact
					Implements broad based MCO tax as required by DRA. MCO tax cannot be exclusively for Medicaid MCOs. This becomes effective October 1, 2009.	No such tax currently.	No impact

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Number	Description	Ref #	Date Published	Notes	Description	Kansas Impact Notes	Estimated Financial Impact
5	Coverage of Rehabilitative Services	CMS 2261-P	8/16/2007- proposed rule	delayed until 6-30-2008	The Medicaid rehab option authorizes reimbursement for other diagnostic, screening, preventive and rehabilitative services including any medication or remedial services (provided in a facility, home or other setting) recommended by a physician or other licensed practitioner of the healing arts. States use the rehab option to reduce institutionalization and to finance community-based services for many, including mental illness. CMS is prohibiting payment for services through the rehab option if such services could be funded through other federal, state or local programs. Further, rehab services can no longer be provided in any setting. Also, Medicaid payment is now prohibited for services a state also provided to non-Medicaid-eligible individuals free of charge	This category funds most community mental health services provided through the public mental health system to children and adults with serious mental disorders, as well as services for those with physical or developmental disabilities. See specific comments below concerning coverage restrictions.	See Below
					Exclude FFP for expenditures for "habilitation services"	KS Medicaid does not currently pay for habilitative services if provided by an Early Childhood, Head Start or local education providers.	No Impact
					Only permit recreational and social activities specified in the rehab treatment plan.	KS Medicaid does not currently pay for these services unless billed as psycho-social activities.	No Impact
					Prohibit payment under rehab option for r/t in an institutional, community or home setting. Non-coverage of IP psych services.	This would result in a significant change and reduction as all of these services are currently covered as a SPA service, HCBS service or through the mental health system.	undetermined
					Clarify MCD payment rules to allow coverage of non-MCD eligible parents and others involved in a MCD bene's treatment	In Kansas, if the bene is not present in the session and the therapist does not relate the connection or need for the service to be provided without the bene present, KS Medicaid does not pay.	No Impact
					Require that covered rehab services are identified under a written rehab plan. A treatment plan must be in place. The treatment plan must have goals and objectives.	Kansas Medicaid documentation requirements are currently similar to those in the proposal.	No Impact

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Number	Description	Ref #	Date Published	Notes	Description	Kansas Impact Notes	Estimated Financial Impact
6	Payments for Costs of School Administrative and Transportation Services	CMS 2287-P	12/28/2007	delayed until 6-30-2008	The final rule would eliminate reimbursement under the Medicaid program for the costs of certain activities that are not necessary for the proper and efficient administration of the State plan, or if they do not meet the definition of an optional transportation benefit. Federal Medicaid payments would no longer be available for administrative activities performed by school employees or contractors, or anyone under the control of a public or private educational institution, and transportation from home to school and back for school-aged children.	KS Medicaid does not pay for transportation from home to school for school-aged children. KS Medicaid does have an administrative program. The administrative program coordinates care and provides management for Medicaid school-aged children. School employees perform administrative activities such as determining Medicaid eligibility and the management of community-based activities.	Federal dollars for administration for 5 years=\$16,495,569/\$3,299,113.8 for 1 year.

KANSAS MEDICAID STATE PLAN

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Methods and Standards for Establishing Payment Rates

Qualified Licensed Professional Services

Supplemental payments for certain licensed professional services

- (1) Notwithstanding other provisions of this section, effective February 8, 2008, supplemental payments are available under this paragraph to certain Qualified Licensed Professionals who provide services at a Large Public Kansas Teaching Hospital. In order to be a Qualified Licensed Professional, a professional must be:
 - (i) A Kansas licensed professional; and
 - (ii) Enrolled as a Kansas Medicaid provider; and
 - (iii) Employed by or affiliated with a Large Public Kansas Teaching Hospital, as defined in Attachment 4.19-A, or employed by the University of Kansas School of Medicine-Wichita Medical Practice Association.
- (2) For services rendered by Qualified Licensed Professionals, a supplemental payment will be made that is equal to the difference between the Medicaid payments otherwise made and payments at the Medicare Equivalent of the Average Commercial Rate Payment. Payment will be made quarterly and will not be made prior to the delivery of services.
- (3) The Medicare Equivalent of the Average Commercial rate to be paid to Qualified Licensed Professionals will be determined as follows:
 - I. Compute Average Commercial Fee Schedule: For the base period, compute the average commercial allowed amount per CPT Code, including patient share amounts, for the top five payers for procedure codes with payment rates. The top five commercial third party payers will be determined by total billed charges.
 - II. Calculate the Base Period Average Commercial Payment Ceiling: Multiply the Average Commercial Fee Schedule as determined in (3) I. above by the number of times each procedure code was rendered in the base period and paid to Qualified Licensed Professionals on behalf of Medicaid beneficiaries as reported from the MMIS. The sum of the product for all procedure codes shall determine the Base Period Average Commercial Payment Ceiling.
 - III. Determine the Base Period Medicare Payment Ceiling: For each of the procedure codes used to determine the Average Commercial Payment Ceiling in (3) II., multiply the base period non-facility, Medicare allowed rate from the April release Resource Based Relative Value Scale (RBRVS) by the number of times each procedure code was rendered in

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Methods and Standards for Establishing Payment Rates

Qualified Licensed Professional Services (continued)

the base period and paid to Qualified Licensed Professionals on behalf of Medicaid beneficiaries as reported from the MMIS. The sum of the product for all procedure codes shall represent the Base Period Medicare-Equivalent Payment Ceiling.

- IV. Determine the Medicare-Equivalent of the Average Commercial Rate: Divide the Base Period Average Commercial Payment Ceiling computed in (3) II. by the Base Period Medicare Payment Ceiling determined in (3) III.
- V. Periodic Updates to the Medicare Equivalent of the Average Commercial Rate: The State may periodically update this ratio.

(4) Determination of Supplemental Payment

- (i) The supplemental payment ceiling will be determined as follows: The Medicare-Equivalent of the Average Commercial Rate is multiplied by Medicare payment at the non-facility rate per CPT Code then multiplied by Medicaid volume by CPT Code for the same period as reported through the MMIS.

(Medicare Equivalent of the Average Commercial Rate) X
(Medicare Payment per CPT Code) X (Medicaid Volume per
CPT Code) = Payment Ceiling.

Medicare payment at the non-facility rate and Medicaid volume for those services are derived from the same period.

- (ii) The Medicaid Supplemental Payment to Qualified Licensed Professionals shall equal the current period supplemental payment ceiling at the Medicare Equivalent of the Average Commercial Rate less all Medicaid payments, including enhanced payments, for procedure codes rendered in the current period and paid to Qualified Licensed Professionals on behalf of Medicaid beneficiaries as reported from the MMIS. Medicaid volume and payments shall include all available payments and adjustments.

Name	Quarter				5 Year projected
	2008 DME + IME Payment	2008 IME only Payment	Difference	Loss of Fed \$ Times 60% of Difference	Fed \$ Loss Amount
Hospital #1	\$1,307.69	\$681.99	\$625.70	\$375.42	\$7,508.40
Hospital #2	\$5.88	\$5.88	\$0.00	\$0.00	\$0.00
Hospital #3	\$128.16	\$105.21	\$22.95	\$13.77	\$275.40
Hospital #4	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Hospital #5	\$32,656.25	\$26,146.70	\$6,509.55	\$3,905.73	\$78,114.60
Hospital #6	\$7,621.19	\$6,945.68	\$675.51	\$405.31	\$8,106.20
Hospital #7	\$7,721.53	\$6,438.21	\$1,283.32	\$769.99	\$15,399.80
Hospital #8	\$7,413.67	\$6,529.08	\$884.59	\$530.75	\$10,615.00
Hospital #9	\$9,077.63	\$7,663.53	\$1,414.10	\$848.46	\$16,969.20
Hospital #10	\$1,043,122.88	\$789,863.52	\$253,259.36	\$151,955.62	\$3,039,112.40
Hospital #11	\$879,062.25	\$652,936.54	\$226,125.71	\$135,675.43	\$2,713,508.60
TOTAL	\$1,988,117.13	\$1,497,316.34	\$490,800.79	\$294,480.48	\$5,889,609.60

**Provider Assessment
Fund Reconciliation
(State Funds Only)
\$USD**

	SFY 2005 Actual \$	SFY 2006 Actual	SFY 2007 Actual
ASSESSMENT REVENUE			
Provider Tax Invoiced (Informational)	33,742,838	32,610,459	32,500,256
Adjustments	-	193,115	158,173
Gross Revenue (Tax Collected)	33,742,838	32,417,344	32,342,083
Credits/Refund *	-		
Net Tax Revenue (NR)	33,742,838	32,417,344	32,342,083
Federal Match			
Net Fund Revenue (NR)	33,742,838	32,417,344	32,342,083
FUND DISBURSEMENTS			
Direct Access Inpatient	5,775,914	5,835,094	5,875,040
Direct Access Outpatient	4,363,470	4,408,177	3,959,143
Less: Re-Coopments	1	1	1
Total Direct Access Payments (T1)	10,139,385	10,243,272	9,834,183
Hospital Rate Increase:			
In-Patient	13,328,850	10,304,576	15,452,735
Out-Patient	2,675,863	5,502,150	3,497,832
Physician Rate Increase (Applicable Procedure Codes)	-	143,513	8,500,000
MCO Rate Increase		1,346,060	11,583,648
Total Rate Increase Disbursements (T2)	16,004,713	17,296,299	39,034,215
Graduate Medical Education Disbursements	0	0	400,000
Total Disbursements (TD)	26,144,097	27,539,571	49,268,398
SFY Fund Activity Balance Excess (Deficit)	7,598,741	4,877,773	(16,926,315)
Total Fund Balance Excess (Deficit)	7,598,741	12,476,513	(4,449,802)

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65-6207

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6207. Definitions. As used in K.S.A. 2006 Supp. 65-6207 to 65-6220, inclusive, and amendments thereto, the following have the meaning respectively ascribed thereto, unless the context requires otherwise:

- (a) "Department" means the department of social and rehabilitation services.
- (b) "Fund" means the health care access improvement fund.
- (c) "Health maintenance organization" has the meaning provided in K.S.A. 40-3202, and amendments thereto.
- (d) "Hospital" has the meaning provided in K.S.A. 65-425, and amendments thereto.
- (e) "Hospital provider" means a person licensed by the department of health and environment to operate, conduct or maintain a hospital, regardless of whether the person is a federal medicaid provider.
- (f) "Pharmacy provider" means an area, premises or other site where drugs are offered for sale, where there are pharmacists, as defined in K.S.A. 65-1626, and amendments thereto, and where prescriptions, as defined in K.S.A. 65-1626, and amendments thereto, are compounded and dispensed.
- (g) "Assessment revenues" means the revenues generated directly by the assessments imposed by K.S.A. 2006 Supp. 65-6208 and 65-6213, and amendments thereto, any penalty assessments and all interest credited to the fund under this act, and any federal matching funds obtained through the use of such assessments, penalties and interest amounts.

History: L. 2004, ch. 89, § 1; Apr. 22.

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65-6208

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6208. Assessment imposed on hospital providers; rate. (a) Subject to the provisions of K.S.A. 2006 Supp. 65-6209, and amendments thereto, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to 1.83% of each hospital's net inpatient operating revenue for the hospital's fiscal year 2001. In the event that a hospital does not have a complete twelve-month 2001 fiscal year, the assessment under this section shall be \$200,000 until such date that such hospital has completed the hospital's first twelve-month fiscal year. Upon completing such first twelve-month fiscal year, such hospital's assessment under this section shall be the amount equal to 1.83% of such hospital's net operating revenue for such first completed twelve-month fiscal year.

(b) Nothing in this act shall be construed to authorize any home rule unit or other unit of local government to license for revenue or impose a tax or assessment upon hospital providers or a tax or assessment measured by the income or earnings of a hospital provider.

History: L. 2004, ch. 89, § 2; Apr. 22.

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65-6209

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6209. Same; exemption for certain hospital providers. (a) A hospital provider that is a state agency, the authority, as defined in K.S.A. 2006 Supp. 76-3304, and amendments thereto, a state educational institution, as defined in K.S.A. 76-711, and amendments thereto, or a critical access hospital, as defined in K.S.A. 65-468, and amendments thereto, is exempt from the assessment imposed by K.S.A. 2006 Supp. 65-6208, and amendments thereto.

(b) A hospital operated by the department in the course of performing its mental health or developmental disabilities functions is exempt from the assessment imposed by K.S.A. 2006 Supp. 65-6208, and amendments thereto.

History: L. 2004, ch. 89, § 3; Apr. 22.

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65-6210

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6210. Same; payment date for hospitals; delayed payment schedules; penalties. (a) The assessment imposed by K.S.A. 2006 Supp. 65-6208, and amendments thereto, for any state fiscal year to which this statute applies shall be due and payable in equal installments on or before June 30 and December 31, commencing with whichever date first occurs after the hospital has received payments for 150 days after the effective date of the payment methodology approved by the centers for medicare and medicaid services. No installment payment of an assessment under this act shall be due and payable, however, until after:

(1) The hospital provider receives written notice from the department that the payment methodologies to hospitals required under this act have been approved by the centers for medicare and medicaid services of the United States department of health and human services under 42 C.F.R. 433.68 for the assessment imposed by K.S.A. 2006 Supp. 65-6208, and amendments thereto, has been granted by the centers for medicare and medicaid services of the United States department of health and human services; and

(2) in the case of a hospital provider, the hospital has received payments for 150 days after the effective date of the payment methodology approved by the centers for medicare and medicaid services.

(b) The department is authorized to establish delayed payment schedules for hospital providers that are unable to make installment payments when due under this section due to financial difficulties, as determined by the department.

(c) If a hospital provider fails to pay the full amount of an installment when due, including any extensions granted under this section, there shall be added to the assessment imposed by K.S.A. 2006 Supp. 65-6208, and amendments thereto, unless waived by the department for reasonable cause, a penalty assessment equal to the lesser of:

(1) An amount equal to 5% of the installment amount not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter; or

(2) an amount equal to 100% of the installment amount not paid on or before the due date.

For purposes of subsection (c), payments will be credited first to unpaid installment amounts, rather than to penalty or interest amounts, beginning with the most delinquent installment.

(d) The effective date for the payment methodology applicable to hospital providers approved by the centers for medicare and medicaid services shall be the date of July 1 or January 1, whichever date is designated in the state plan submitted by the department of

social and rehabilitation services for approval by the centers for medicare and medicaid services.

History: L. 2004, ch. 89, § 4; L. 2004, ch. 141, § 1; July 1.

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65-6211

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6211. Same; notice of assessment; method of payment; assessment adjustment when a hospital ceases operations. (a) After December 31 of each year, except as otherwise provided in this subsection, and on or before March 31 of the succeeding year, the department shall send a notice of assessment to every hospital provider subject to assessment under this act.

(b) The hospital provider notice of assessment shall notify the hospital provider of its assessment for the state fiscal year commencing on the next July 1.

(c) If a hospital provider operates, conducts or maintains more than one licensed hospital in the state, the hospital provider shall pay the assessment for each hospital separately.

(d) Notwithstanding any other provision in this act, in the case of a person who ceases to operate, conduct or maintain a hospital in respect of which the person is subject to assessment in K.S.A. 2006 Supp. 65-6208, and amendments thereto, as a hospital provider, the assessment for the state fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under K.S.A. 2006 Supp. 65-6208, and amendments thereto, by a fraction, the numerator of which is the number of the days during the year during which the provider operates, conducts or maintains a hospital and the denominator of which is 365. Immediately upon ceasing to operate, conduct or maintain a hospital, the person shall pay the adjusted assessment for that state fiscal year, to the extent not previously paid.

(e) Notwithstanding any other provision in this act, a person who commences operating, conducting or maintaining a hospital shall pay the assessment computed under subsection (a) of K.S.A. 2006 Supp. 65-6208, and amendments thereto, in installments on the due dates stated in the notice and on the regular installment due dates for the state fiscal year occurring after the due dates of the initial notice.

History: L. 2004, ch. 89, § 5; Apr. 22.

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65-6212

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6212. Hospital provider assessments not imposed or discontinued, when; disbursement or refund of proceeds. (a) The assessment imposed by K.S.A. 2006 Supp. 65-6208, and amendments thereto, shall not take effect or shall cease to be imposed and any moneys remaining in the fund attributable to assessments imposed under K.S.A. 2006 Supp. 65-6208, and amendments thereto, shall be refunded to hospital providers in proportion to the amounts paid by them if the payments to hospitals required under subsection (a) of K.S.A. 2006 Supp. 65-6218, and amendments thereto, are changed or are not eligible for federal matching funds under title XIX or XXI of the federal social security act.

(b) The assessment imposed by K.S.A. 2006 Supp. 65-6208, and amendments thereto, shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax under title XIX of the federal social security act. Moneys in the health care access improvement fund derived from assessments imposed prior thereto shall be disbursed in accordance with subsection (a) of K.S.A. 2006 Supp. 65-6218, and amendments thereto, to the extent that federal matching is not reduced due to the impermissibility of the assessments and any remaining moneys shall be refunded to hospital providers in proportion to the amounts paid by them.

History: L. 2004, ch. 89, § 12; Apr. 22.

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65-6213

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6213. Assessment imposed on health maintenance organizations, rate. The department shall assess each health maintenance organization that has a medicaid managed care contract awarded by the state and administered by the department an assessment fee that equals 5.9% of nonmedicare premiums collected by that health maintenance organization. The assessment shall be calculated by reference to information contained in the health maintenance organization's statement filings for the previous state fiscal year.

History: L. 2004, ch. 89, § 7; Apr. 22.

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65-6214

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6214. Same; payment date for health maintenance organizations; delayed payment schedules; penalties. (a) The assessment imposed by K.S.A. 2006 Supp. 65-6213, and amendments thereto, for any state fiscal year to which this statute applies shall be due and payable in equal installments on or before June 30 and December 31, commencing with whichever date first occurs after the health maintenance organization has received payments for 150 days after the effective date of the payment methodology approved by the centers for medicare and medicaid services. No installment payment of an assessment under this act shall be due and payable, however, until after:

(1) The health maintenance organization receives written notice from the department that the payment methodologies to health maintenance organizations required under this act have been approved by the centers for medicare and medicaid services of the United States department of health and human services and the state plan amendment for the assessment imposed by K.S.A. 2006 Supp. 65-6213, and amendments thereto, has been granted by the centers for medicare and medicaid services of the United States department of health and human services; and

(2) the health maintenance organization has received payments for 150 days after the effective date of the payment methodology approved by the centers for medicare and medicaid services.

(b) The department is authorized to establish delayed payment schedules for health maintenance organizations that are unable to make installment payments when due under this section due to financial difficulties, as determined by the department.

(c) If a health maintenance organization fails to pay the full amount of an installment when due, including any extensions of time for delayed payment granted under this section, there shall be added to the assessment imposed by K.S.A. 2006 Supp. 65-6213, and amendments thereto, unless waived by the department for reasonable cause, a penalty assessment equal to the lesser of:

(1) An amount equal to 5% of the installment amount not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter; or

(2) an amount equal to 100% of the installment amount not paid on or before the due date.

For purposes of this subsection (c), payments shall be credited first to unpaid installment amounts, rather than to penalty or interest amounts, beginning with the most delinquent installment.

(d) The effective date for the payment methodology applicable to health maintenance organizations approved by the centers for medicare and medicaid services shall be the

date of July 1 or January 1, whichever date is designated in the state plan submitted by the department of social and rehabilitation services for approval by the centers for medicare and medicaid services.

History: L. 2004, ch. 89, § 8; L. 2004, ch. 141, § 2; July 1.

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65-6215

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6215. Same; notice of assessment; method of payment; assessment adjustment when a health maintenance organization ceases operations. (a) After December 31 of each year, except as otherwise provided in this subsection, and on or before March 31 of the succeeding year, the department shall send a notice of assessment to every health maintenance organization subject to assessment under this act.

(b) The health maintenance organization notice of assessment shall notify the health maintenance organization of its assessment for the state fiscal year commencing on the next July 1.

(c) If a health maintenance organization operates, conducts or maintains more than one health maintenance organization in the state, the health maintenance organization shall pay the assessment for each health maintenance organization separately.

(d) Notwithstanding any other provision in this act, in the case of a person who ceases to operate, conduct or maintain a health maintenance organization in respect of which the person is subject to assessment in K.S.A. 2006 Supp. 65-6213, and amendments thereto, as a health maintenance organization, the assessment for the state fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under K.S.A. 2006 Supp. 65-6213, and amendments thereto, by a fraction, the numerator of which is the number of days during the year during which the health maintenance organization operates, conducts or maintains a health maintenance organization and the denominator of which is 365. Immediately upon ceasing to operate, conduct or maintain a health maintenance organization, the person shall pay the adjusted assessment for the state fiscal year, to the extent not previously paid.

(e) Notwithstanding any other provision in this act, a person who commences operating, conducting or maintaining a health maintenance organization shall pay the assessment computed under K.S.A. 2006 Supp. 65-6213, and amendments thereto, in installments on the due dates stated in the notice and on the regular installment due dates for the state fiscal year occurring after the due dates of the initial notice.

History: L. 2004, ch. 89, § 9; Apr. 22.

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65-6216

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6216. Health maintenance organization assessments not imposed or discontinued, when; disbursement or refund of proceeds. (a) The assessment imposed by K.S.A. 2006 Supp. 65-6213, and amendments thereto, shall not take effect or shall cease to be imposed and any moneys remaining in the fund attributable to the assessment imposed by K.S.A. 2006 Supp. 65-6213, and amendments thereto, shall be refunded to health maintenance organizations in proportion to the amounts paid by such health maintenance organizations if the payments to health maintenance organizations required under subsection (b) of K.S.A. 2006 Supp. 65-6218, and amendments thereto, are changed or are not eligible for federal matching funds under title XIX or XXI of the federal social security act.

(b) The assessment imposed by K.S.A. 2006 Supp. 65-6213, and amendments thereto, shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax under title XIX of the federal social security act. Moneys in the health care access improvement fund derived from assessments imposed prior thereto shall be disbursed in accordance with subsection (b) of K.S.A. 2006 Supp. 65-6218, and amendments thereto, to the extent that federal matching is not reduced due to the impermissibility of the assessments and any remaining moneys shall be refunded to health maintenance organizations in proportion to the amounts paid by such health maintenance organizations.

History: L. 2004, ch. 89, § 10; Apr. 22.

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65-6217

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6217. Health care access improvement fund; amounts credited; authorized expenditures; interest earnings; accrual accounting procedure. (a) There is hereby created in the state treasury the health care access improvement fund, which shall be administered by the secretary of social and rehabilitation services. All moneys received for the assessments imposed by K.S.A. 2006 Supp. 65-6708 and 65-6213, and amendments thereto, including any penalty assessments imposed thereon, shall be remitted to the state treasurer in accordance with K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the health care access improvement fund. All expenditures from the health care access improvement fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the secretary of social and rehabilitation services or the secretary's designee.

(b) The fund shall not be used to replace any moneys appropriated by the legislature for the department's medicaid program.

(c) The fund is created for the purpose of receiving moneys in accordance with this act and disbursing moneys only for the purpose of improving health care delivery and related health activities, notwithstanding any other provision of law.

(d) On or before the 10th day of each month, the director of accounts and reports shall transfer from the state general fund to the health care access improvement fund interest earnings based on:

(1) The average daily balance of moneys in the health care access improvement fund for the preceding month; and

(2) the net earnings rate of the pooled money investment portfolio for the preceding month.

(e) The fund shall consist of the following:

(1) All moneys collected or received by the department from the hospital provider assessment and the health maintenance organization assessment imposed by this act;

(2) any interest or penalty levied in conjunction with the administration of this act; and

(3) all other moneys received for the fund from any other source.

(f) (1) On July 1 of each fiscal year, the director of accounts and reports shall record a debit to the state treasurer's receivables for the health care access improvement fund and shall record a corresponding credit to the health care access improvement fund in an amount certified by the director of the budget which shall be equal to the sum of 80% of the moneys estimated by the director of the budget to be received from the assessment imposed on hospital providers pursuant to K.S.A. 2006 Supp. 65-6208, and amendments thereto, and credited to the health care access improvement fund during such fiscal year,

plus 53% of the moneys estimated by the director of the budget to be received from the assessment imposed on health maintenance organizations pursuant to K.S.A. 2006 Supp. 65-6213, and amendments thereto, and credited to the health care access improvement fund during such fiscal year, except that such amount shall be proportionally adjusted during such fiscal year with respect to any change in the moneys estimated by the director of the budget to be received for such assessments, deposited in the state treasury and credited to the health care access improvement fund during such fiscal year. Among other appropriate factors, the director of the budget shall take into consideration the estimated and actual receipts from such assessments for the current fiscal year and the preceding fiscal year in determining the amount to be certified under this subsection (f). All moneys received for the assessments imposed pursuant to K.S.A. 2006 Supp. 65-6208 and 65-6213, and amendments thereto, deposited in the state treasury and credited to the health care access improvement fund during a fiscal year shall reduce the amount debited and credited to the health care access improvement fund under this subsection (f) for such fiscal year.

(2) On June 30 of each fiscal year, the director of accounts and reports shall adjust the amounts debited and credited to the state treasurer's receivables and to the health care access improvement fund pursuant to this subsection (f), to reflect all moneys actually received for the assessments imposed pursuant to K.S.A. 2006 Supp. 65-6208 and 65-6213, and amendments thereto, deposited in the state treasury and credited to the health care access improvement fund during the current fiscal year.

(3) The director of accounts and reports shall notify the state treasurer of all amounts debited and credited to the health care access improvement fund pursuant to this subsection (f) and all reductions and adjustments thereto made pursuant to this subsection (f). The state treasurer shall enter all such amounts debited and credited and shall make reductions and adjustments thereto on the books and records kept and maintained for the health care access improvement fund by the state treasurer in accordance with the notice thereof.

History: L. 2004, ch. 89, § 11; L. 2004, ch. 141, § 3; July 1.

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65-6218

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6218. Assessment revenues; guidelines for disbursement; health care access improvement panel; composition, organization and annual report. (a) Assessment revenues generated from the hospital provider assessments shall be disbursed as follows:

(1) Not less than 80% of assessment revenues shall be disbursed to hospital providers through a combination of medicaid access improvement payments and increased medicaid rates on designated diagnostic related groupings, procedures or codes;

(2) not more than 20% of assessment revenues shall be disbursed to providers who are persons licensed to practice medicine and surgery or dentistry through increased medicaid rates on designated procedures and codes; and

(3) not more than 3.2% of hospital provider assessment revenues shall be used to fund health care access improvement programs in undergraduate, graduate or continuing medical education, including the medical student loan act.

(b) Assessment revenues generated from the health maintenance organization assessment shall be disbursed as follows:

(1) Not less than 53% of health maintenance organization assessment revenues shall be disbursed to health maintenance organizations that have a contract with the department through increased medicaid capitation payments;

(2) not more than 30% of health maintenance organization assessment revenues shall be disbursed to fund activities to increase access to dental care, primary care safety net clinics, increased medicaid rates on designated procedures and codes for providers who are persons licensed to practice dentistry, and home and community-based services;

(3) not more than 17% of health maintenance organization assessment revenues shall be disbursed to pharmacy providers through increased medicaid rates.

(c) For the purposes of administering and selecting the disbursements described in subsections (a) and (b) of this section, the health care access improvement panel is hereby established. The panel shall consist of the following: Three members appointed by the Kansas hospital association, two members who are persons licensed to practice medicine and surgery appointed by the Kansas medical society, one member appointed by each health maintenance organization that has a medicaid managed care contract with the department of social and rehabilitation services, one member appointed by the Kansas association for the medically underserved, and one representative of the department of social and rehabilitation services appointed by the governor. The panel shall meet as soon as possible subsequent to the effective date of this act and shall elect a chairperson from among the members appointed by the Kansas hospital association. A representative of the

panel shall be required to make an annual report to the legislature regarding the collection and distribution of all funds received and distributed under this act.

History: L. 2004, ch. 89, § 13; L. 2004, ch. 141, § 4; July 1.

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65-6219

Chapter 65.--PUBLIC HEALTH

Article 62.--MISCELLANEOUS PROVISIONS

65-6219. Administration and enforcement of act. To the extent practicable, the department shall administer and enforce this act and collect the assessments, interest and penalty assessments imposed under this act using procedures generally employed in the administration of the department's other powers, duties and functions.

History: L. 2004, ch. 89, § 6; Apr. 22.

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Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

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.

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.

SEP - 5 2007

TN # 06-21 Approval Date _____ Effective Date 12/29/06 Supersedes TN # 06-02

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Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

- 3) Enhancements for Level 4 Nursery will be made for hospital obstetrical care in rural areas that are challenged with maintaining access to intensive neonatal and post delivery care.
- Eligibility Criteria
 - Rural hospitals with 100 or more Medicaid days in Level 4 nurseries with services during calendar year 2004 paid as of 6/27/2005
 - Rural hospitals are defined as those hospitals in Groups 2 or 3 as described in section 2.3000 of Attachment 4.19-A
 - Level 4 days are defined for both eligibility and payment as services reported on the claim form under Revenue Code 0174
 - Not State owned or operated hospital
 - Payment
 - \$700 per Medicaid Level 4 nursery day with services during calendar year 2004 paid as of 6/27/2005, including Medicare crossover days, but excluding HMO encounter claims.
- 4) Psychiatric care enhancement for behavioral health services provided to Medicaid Clients in urban areas. The need has grown as some inpatient providers have closed psychiatric units. The psychiatric payment enhancement supplements providers who do not receive the benefit of disproportionate share payments.
- Eligibility Criteria
 - Must meet all of the following:
 - General acute care hospital
 - Hospitals in urban areas are defined as those hospitals in Group 1 as in section 2.3000 of Attachment 4.19-A.
 - Non-DSH provider in State FY 2005
 - Not State owned or operated
 - Psychiatric days are defined for both eligibility and payment as services reported on the claim form under revenue codes 114, 124, 134, 144, and 154.
 - Payment
 - \$625 per Medicaid psychiatric day with services during calendar year 2004 paid as of 6/27/2005, including Medicare crossover days, but excluding HMO encounter claims.
- 5) Rehabilitation services payment for general hospitals with large volumes of Medicaid rehabilitation patients. Due to the variety of rehabilitation patients admitted, these hospitals have larger Medicaid fixed costs and more extensive operations.
- Eligibility Criteria
 - General acute care hospital
 - Provides more than 125 Medicaid days of rehabilitation care with services during calendar year 2004 paid as of 6/27/2005.
 - Not State owned or operated
 - Rehabilitation services are defined for both eligibility and payment as services reported on the claim form under revenue codes 118, 128, 138, 148 and 158.
 - Payment
 - \$600 per Medicaid rehabilitation day with services during calendar year 2004 paid as of 6/27/2005, including Medicare crossover days, but excluding HMO encounter claims.

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TN # 04-06 Approval Date _____ Effective Date 07/01/04 Supersedes TN # New

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- 6) Coronary care unit (CCU) adjustment payments to encourage hospitals with large volumes of Medicaid admissions. It is well documented that coronary care patients do better in facilities with larger service volume. This adjustment payment is designed to encourage high Medicaid hospitals also to be centers for coronary care for our Medicaid population.

Eligibility Criteria

- A Disproportionate Share Hospital (DSH) during State FY 2005.
 - Has a Medicaid inpatient utilization rate greater than 23% using the same data as used for the State FY 2005 DSH determination, and
 - Provides more than 100 Medicaid CCU admissions with services during calendar year 2004 paid as of 6/27/2005, including Medicare crossover days, but excluding HMO encounter claims.
 - Not State owned or operated
 - CCU admissions are defined for both eligibility and payment as services reported on the claim form under revenue codes 210, 211, 212, 213, 214, or 219.
- Payment
 - \$6350 per Medicaid CCU admission as reported with services during calendar year 2004 paid as of 6/27/2005, including Medicare crossover days, but excluding HMO encounter claims.

- 7) Trauma hospital payments are designed to offset some of the high Medicaid fixed costs of maintaining a trauma center. This increase in payment for those Medicaid cases that required a trauma center for treatment to offset the additional costs of providing ongoing access to this level of emergency care.

• Eligibility Criteria

- Non-state owned level 1 and level 2 trauma hospitals as defined by the American College of Surgeons.
 - ICU admissions are defined for payment as services reported under the claim form in revenue codes 200, 201, 202, 203, 204, 206, 207, 208, or 209.
- Payment
 - \$400 per Medicaid Intensive care unit (ICU) admission with services during calendar year 2004, including Medicare crossover claims, but excluding HMO encounter claims, paid as of June 27, 2005.

OCT 19 2005

TN # 04-06 Approval Date _____ Effective Date 07/01/04 Supersedes TN # New